



The Edinburgh Postnatal Depression Scale for Fathers: A contribution to the validation for an Italian sample



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ARTICLE INFO

Article history:

Received 23 October 2014

Revised 5 February 2015

Accepted 6 February 2015

Keywords:

Depression

Fathers

Perinatal

Edinburgh Postnatal Depression Scale

Validation

ABSTRACT

Objective: The aims of the study are to contribute to the validation of the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987) on a sample of Italian fathers (both men in the perinatal period than those with grown-up children) and to analyze its factorial structure.

Methods: Four hundred thirty-six fathers participated; specifically, we used two samples. The first was composed of 334 fathers, 39 of which were depressed new fathers. We conducted explorative factor analysis and receiver operator characteristic analysis. The second sample was composed of 102 fathers, 22 of which were depressed new fathers. We conducted confirmative factor analysis on this second sample. We administered the Italian version of the EPDS (Carpiniello et al., 1997; Benvenuti et al., 1999), the Beck Depression Inventory-II (Ghisi et al., 2006) and the Center for Epidemiological Studies Depression Scale (Fava, 1983).

Results: The test seems to detect not depression but a state of distress including depressive symptoms, anxiety and unhappiness. Results showed a two-factor structure, different from that of mothers. The optimal cutoff for Italian fathers is 12/13.

Conclusions: The EPDS is a valid and reliable instrument, useful in the perinatal period for screening fathers at risk for perinatal distress and in need of psychological support.

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1. Introduction

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 2013)* [1] among the specifier of major depressive disorder include one with “peripartum onset,” which replaces the previous “postpartum onset,” present in the text revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (2002)* [2]. This new term is because the specifier refers to a depressive episode with onset up to 4 weeks after the birth but also to the episodes with onset during pregnancy. In fact, the *DSM-5* [1] points out that about half of postpartum depressive episodes had onset during pregnancy. It also highlights how often these perinatal depressive episodes occur together with anxiety and panic attacks. It is interesting to note that the *DSM-5* [1], despite the recent interest in the paternal perinatal depression, does not refer to the possible presence of this disorder in the fathers but continues to refer only to maternal experience.

There is little knowledge about paternal perinatal depression, but it is important to understand and accept these feelings of depression also in fathers. In fact, as showed by the review of Paulson and Bazemore (2010) [3], 10.4% of fathers analyzed in their study were characterized by such a diagnosis, thus demonstrating how the disorder is also present in fathers.

The paternal perinatal depression is associated with the poor quality of the couple relationship and the negative effects on their children, in that they experience high levels of distress [4]. In addition, when the

father suffers from depression, the symptoms of the mother may be exacerbated; and children are most at risk of developing social, psychological and cognitive deficits [5,6]. The negative influence of the paternal perinatal depression on the development of the child also happens regardless of the partner’s depression: increased risk of psychopathology in children during adolescence [7], increased risk of behavioral problems in 3 1/2 years, especially in male children [8]. Perinatal depression generally occurs later in fathers than in mothers, even after the first year of a child’s life and often shortly after the acute phase of depression of the wife [9–12].

The importance of studying the paternal perinatal depression is also showed by studies that, by the late 90s, have pointed out that the male depressive symptoms may be different from the typical symptomatic expression in women [13–15]. Studies show that bouts of anger and irritability, emotional rigidity, strong self-criticism, sleep disturbances and significant changes in body weight are common symptoms in male depressive experience. Men also would show a greater tendency to demonstrate suffering, focusing on work compulsively and alcohol and drugs abuse [16,17]. Finally, Matthey et al. (2003) [18] suggested, with regard to postnatal depression, how in new fathers the anxiety may be more frequent than depression. This is in line with the *DSM-5* [1] which, referring to the female perinatal depressive episodes, states that they occur frequently together with anxiety and panic attacks. These gender differences in the symptoms could be the basis of the greater prevalence of diagnosed depression in women; the tools used are in fact based on the conventional symptoms, which are based on the prototypical female depressive experience [19].

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Hence, there is a need for a tool that can screen for the perinatal depressive disorder in the fathers, so as to further research in this area but, most of all, to identify the fathers who need psychological support. One of the most used tools for screening in mothers is the Edinburgh Postnatal Depression Scale (EPDS) [20]. It is a 10-item self-report questionnaire, constructed to assess depressive symptoms in postpartum women; since the traditional tools for the assessment of depression put a lot of attention to somatic symptoms, some of which may be associated with normal physiological changes characteristic of pregnancy (sleep disorders, weight gain, difficulty concentrating, loss of sexual interest, feeling of tiredness and fatigue). The response format is a 4-point Likert scale (0 to 3), with an overall score between 0 and 30.

There are EPDS validation studies for mothers in at least 25 countries [21]. Validation studies in fathers, however, are extremely rare.

1.1. Validation of the EPDS in the fathers

The first validation study of the EPDS in fathers was conducted in Australia by Matthey et al. (2001) [22] and included both subjects with depressive disorders and with anxiety disorders. Regarding the validity, the correlation between EPDS and Center for Epidemiological Studies Depression (CES-D) [23] was found to be $r = .62$. Both the standardized Cronbach's alpha (.81) and split-half reliability (.78), using the Spearman–Brown coefficient, were calculated for reliability. An analysis of the items revealed that those on the crying and self-harm (9 and 10) had the lowest item-total correlations. Receiver operating characteristic (ROC) analysis revealed finally as the ideal cutoff for the screening of major and minor depression is 9/10 but, if considering the anxiety disorders, is more appropriate a lower value, 5/6. Edmondson et al. (2010) [24] conducted a second validation study on 189 English fathers. With regard to the cutoff values, they found 10/11 as the score indicative of a probable major depression, while 8/9 as the appropriate score to assess the possible presence of depression or generalized anxiety disorder.

There are two validation studies conducted in the far east. The first was conducted by Lai et al. (2010) [25] on a sample of 551 Chinese fathers. They found 10/11 as the optimal cutoff value to identify depression; the standardized Cronbach's alpha value was .87 and, split-half reliability (Spearman–Brown), .84. Tran et al. (2012) [26] conducted a validation study in North Vietnam, on a sample of 231 fathers. They found 4/5 as the optimal cutoff value to detect the possible presence of depression or anxiety; the Cronbach's alpha was .65.

Matthey (2008) [27] conducted a further study on factorial structure comparing fathers and mothers. As established by previous studies [28–31], they found a two-factor solution in mothers, with the Items 3, 4 and 5 (named EPDS-3A) which saturate the factor relating to anxiety disorders. The various solutions attempted for fathers did not produce a clear factor structure.

A final validation study, conducted recently by Massoudi et al. (2013) [32], has been done in Sweden on a sample of 882 fathers and showed a good internal consistency of the test ($\alpha = .81$). In addition, because of different factor structure for fathers and mothers reported by Matthey (2008) [27], they also carried out an explorative factor analysis (EFA). This showed an extremely low value of saturation of Item 10, relating to thoughts of self-harm, which led the authors to exclude it from further factorial analysis. The factorial structure emerged from the analysis conducted on just 9 items showing the presence of two factors. One factor, which the authors defined “distress,” includes the three items related to anxiety symptoms (EPDS-3A) and the three related to unhappiness. Items 1 and 2, on the fundamental aspects of depression, saturate on the other factor. Item 6 did not have a high saturation on neither of the two factors. As regards the cutoff (referred to the total score based on 10 items), they identified a value of 12 or more for the screening of major depression and a value of 9 or more for the screening of minor or major depression. The authors also suggest a value of 8 or more for screening anxiety; however, they did not show the data for ROC analysis

of the EPDS-3A. Based on their findings, Massoudi et al. (2013) [32] concluded that the EPDS in fathers has a factor structure different from that found in mothers; they added that the EPDS administered to fathers, rather than depression, identifies distress, including in fact the items related to worry, anxiety and unhappiness. They also suggest that the EPDS may be useful to screen the possible presence of major depression, but they do not recommend its use for the screening of minor depression and anxiety disorders.

1.2. The present study

The objective of this study is to contribute to the validation of the EPDS on a sample of Italian fathers (both men in the perinatal period than those with grown-up children) and to analyze its factorial structure, since the limited studies in the literature suggest a different factor structure in fathers and in mothers. In Italy, Carpiniello et al. (1997) [33] and Benvenuti et al. (1999) [34] validated the EPDS on Italian mothers, but they did not conduct the EFA and the confirmatory factor analysis (CFA).

2. Methods

2.1. Participants

Participants were 436 fathers residing in Central Italy: future fathers (i.e., men at their first parenting experience, assessed at about 30 weeks partners' gestation), new fathers (i.e., assessed between the first and the fourth week after childbirth) and men who are fathers of grown-up children. Specifically, we had two convenience samples. We used the first one to conduct the analysis of reliability and convergent validity and to run the EFA and the ROC analysis. On the second sample, we performed the CFA.

The participants of the first sample were 334 men aged between 18 and 54 years ($M = 33$, $S.D. = 5.7$). In addition, as regards their educational level: 3.6% have only primary school education, 24.3% have secondary school education, 50.3% attended high school or a technical institute, and 21.9% having a university degree. For the marital status, 43.4% are married, while the others cohabit or are divorced.

The second sample was composed of 102 men, they were aged between 21 and 49 years ($M = 34$, $S.D. = 6.2$).

Table 1 summarizes the characteristics of the subsamples constituting the two samples, that is: sample size, time of assessment, if they are or not a group of fathers with a diagnosis of major depression and if this diagnosis was made by means of a clinical interview, and the statistical analysis conducted on each subsamples.

The rationales for the samples' size are the following: for the EFA on the first sample, we calculated 30 subjects per item (we needed less than 300 participants); for the CFA on the second sample, we chose to have lesser participants; hence, we calculated 10 subjects per item (we needed less than 100 participants).

2.2. Materials

2.2.1. Edinburgh Postnatal Depression Scale

The Italian version was administered [33,34] of the EPDS [20].

2.2.2. Beck Depression Inventory-II

The Italian validation was administered (Ghisi et al., 2006) [35] of the Beck Depression Inventory-II (BDI-II, Beck et al., 1996) [36]. It is a self-report questionnaire consisting of 21 items. The items all refer to the previous week.

2.2.3. Center for Epidemiological Studies Depression Scale

The Italian validation was administered [37] of the CES-D Scale [23]. It is a 20-item self-report, which refers to the previous week. The response format is a 4-point Likert scale (1 = rarely or never, 4 = always or almost always). The total score ranges from 20 to 80.

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