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Research report

Comparison of four self-report measures and a generic mood question to screen for anxiety during pregnancy in English-speaking women



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ABSTRACT

Background: Increasingly researchers and clinicians have called for perinatal mental health depression screening to be broadened to also screen for significant levels of anxiety. This study therefore aimed to compare the screening performance during pregnancy of four self-report anxiety measures, as well as a generic mood question.

Method: The measures tested were two measures of general anxiety (the anxiety subscales of the Edinburgh Depression Scale and the Hospital Anxiety and Depression Scale), and two measures of pregnancy specific anxiety by Huizink and colleagues, and Rini and colleagues (both originally called the Pregnancy-Related Anxiety Questionnaire). A generic mood question (Matthey Generic Mood Question) asking about stress, anxiety, unhappiness or difficulty coping was also tested. Between 132 and 389 women completed these measures at their first antenatal clinic appointment and up to 249 women completed a diagnostic interview and various measures two weeks later.

Results: The generic mood question performed best, detecting between 58% and 87% of high scorers on the other measures, including 80% of the women with an anxiety disorder. The next best measure was the EDS anxiety subscale, detecting between 26% and 73% of high scorers on the other measures, though this only detected 54% of the women with an anxiety disorder.

Limitations: Findings are only applicable to English-speaking women. In addition whether the findings can be applied to women later in their pregnancy, or postpartum, is not known.

Conclusion: Services wishing to screen for not only possible depression but also possible anxiety should use the generic mood question. For those services which currently use the EDS we recommend they also score the three-item anxiety subscale.

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1. Introduction

The experience of anxiety during the course of pregnancy has important clinical implications for the mother and the baby (Glover, 1997; Huizink et al., 2003), and anxiety symptoms during pregnancy are associated with an increased risk of developing postnatal depression (Sutter-Dallay et al., 2004).

Many researchers and clinicians thus recognise that screening for anxiety should be conducted (Jomeen, 2004; Matthey et al., 2003; Matthey, 2004; Miller et al., 2006), both in pregnancy and postpartum, and thus there is a need to identify which screening

measures may be optimal for this purpose. Muzik et al. (2000) concluded that “Further research is clearly needed in order to identify or create screening measures for postpartum anxiety disorders” (p.73).

One issue to consider when screening women for anxiety in the perinatal period is whether to use a measure of general anxiety, or one screening for anxiety specific to the pregnancy or postpartum period. Pregnant women experience specific worries, such as concerns about pain and loss of control during the delivery, or worries about changes in their personal life due to the pregnancy, such as giving up work (Fenwick et al., 2009; Statham et al., 1997). We have thus chosen to compare the utility of both general and pregnancy-specific anxiety measures in this antenatal study.

As with depression questionnaires, there are many self-report anxiety questionnaires that may, therefore, be suitable for screening for anxiety in the perinatal period. These measures vary not only in their item or symptom content, but also in the construct

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being measured (eg., how a person is feeling vs. how bothered the person is by the symptoms), and the time frame for the symptoms (eg., the past 7 days or the past 4 weeks).

Our rationale for the measures in this study is that the two general measures of anxiety needed to assess the same construct (how the woman was feeling), and over the same time frame (the past 7 days). For the pregnancy-specific anxiety measures, both measures assessed the woman's feelings, thoughts, or expectations about her pregnancy, birth, and baby, though it was not possible to identify pregnancy-specific measures that also assessed the same time frame. The two measures we chose thus had different time frames—one for how the woman was currently feeling, and the other for how she had been feeling over the past 7 days, this latter one therefore being comparable to the general measures of anxiety.

In addition, we included, after the study commenced, a generic mood question to test its usefulness at screening for the presence of any emotional difficulty, not just anxiety.

While we also included the traditional 'gold standard' of a diagnostic interview for the presence or absence of a DSM anxiety disorder, we used the attribution probe question to rule out the presence of symptoms probably just due to the normal physical changes of pregnancy, as described by Matthey and Ross-Hamid (2011).

We chose to compare the different measures using the top 15% on each as an indicator of the woman experiencing a high level of anxiety that would warrant further investigation within a screening context. We have also used the DSM anxiety diagnoses as a quasi gold-standard, to see how well each measure detects women meeting criteria for these disorders. However we do not analyse how well this usual 'gold standard' does in detecting women who score high on the self-report measures, but will leave these analyses to a separate paper directly exploring the validity of DSM diagnoses as a 'gold standard' in the perinatal screening context.

2. Method

2.1. Procedure

The study had the appropriate Ethics approval, and all participants provided informed consent. English-speaking women attending a public hospital's antenatal clinic, in Sydney (Australia), for their first appointment were recruited. These women completed several mood questionnaires at this visit (Time 1: T1), both while waiting to see the midwife (a demographics questionnaire and an anxiety questionnaire) and also during their appointment with the midwife (the Edinburgh Depression Scale—EDS; Cox et al., 1987 and a second anxiety questionnaire). The order of the two anxiety measures at Time 1 was counterbalanced. Approximately two weeks later (Time 2: T2) the women were contacted by phone and completed the same mood questionnaires. In addition the researcher administered a diagnostic screening interview for depression and anxiety disorders at this T2 interview, as well as the full diagnostic interview for any disorder on which the participant scored positive from the screener. All women not currently seeing a health professional for emotional issues were asked at Time 2 if they would like to do so, regardless of their scores on the various measures.

Piloting of the study showed that a maximum of two additional self-report measures could be given to participating women without causing undue delays in the normal day-day operation of the antenatal clinic. Thus at different stages in the study different measures were trialled, and the number of participants completing each measure is not therefore equal.

All participants completed the EDS, however, as this was routine clinical practice in the participating health service.

All measures were scored using an acetate overlay scoring sheet template to minimise scoring errors that have been shown to frequently occur in the use of such self-report scales (Matthey et al., in press).

2.2. Anxiety measures: 'high' score classification consideration

Previously the first author has highlighted the need for clinicians and researchers to use the correct validated cut-off scores on the EDS (Matthey et al., 2006), as errors in this regard are often made when reporting on rates of probable depression. Since that publication the first author has conducted research highlighting the questionable validity of some diagnoses in the perinatal period (Matthey and Ross-Hamid, 2011), thus throwing into question the validity of these cut-off scores which have been determined against these diagnoses.

Thus, in this study, rather than apply cut-off scores that may in fact need to be re-calibrated given the questionable validity of DSM diagnoses, we have chosen to adopt the approach used by others (eg., Condon and Corkindale, 1997; Hanington et al., 2011; O'Connor et al., 2002) and identified participants scoring in the more severe end of each scale, by using the top 15% or so of participants as being those with a high level of anxiety on each measure.

2.3. Measures

2.3.1. Edinburgh Depression Scale-anxiety subscale (EDS-3A—derived from the EPDS; Cox et al., 1987)

The EPDS/EDS (Cox et al., 1987, 1996), which asks respondents how they have been feeling over the past 7 days, consists of 10 items, and is usually used to screen for depression. However, three of the items have consistently been found to load on an anxiety factor (eg., Bowen et al., 2008; Ross et al., 2003). These are item 3 ("I have blamed myself unnecessarily when things went wrong"), item 4 ("I have been anxious or worried for no good reason"), and item 5 ("I have felt scared or panicky for no very good reason"). Each item has four response options. Total scores on this anxiety subscale range from 0 to 9, with higher scores indicating increasing anxiety. The first author termed this subscale the EDS-3A (Matthey, 2008). In the current study the top 15% or participants at T1 were identified using a cut-off score of 5 or more. Cronbach's alpha in this study (T1 data) was 0.75 ($N=389$).

2.3.2. Hospital Anxiety and Depression Scale-anxiety subscale (HADS-A; Zigmond and Snaith, 1983)

The HADS comprises two subscales, depression (HADS-D) and anxiety (HADS-A), each being 7 items long. These items are about general anxiety, and do not refer specifically to the pregnancy. Items include 'I feel tense' or 'wound up' and 'I get sudden feelings of panic'. As with the EDS, the time frame for each question is how the respondent has been feeling over the past 7 days, with four response options for each item. The total score ranges from 0 to 21, with higher scores indicating increasing anxiety. The authors reported good psychometric properties for the measure. Inspection of T1 data ($N=255$) shows that the top 15% of women in this study are identified with a score of 9 or more. In this study Cronbach's alpha was 0.86 ($N=255$).

2.3.3. Pregnancy-Related Thoughts (PRT; Rini et al., 1999)

In the original publication this measure is called the Pregnancy Related Anxiety Questionnaire (Rini et al., 1999). With permission

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