Identification of emotional problems in postpartum women by health visitors

MONICA BRISCOE

Abstract

One hundred mothers of babies aged under 15 weeks who attended well baby clinics were rated for the presence of emotional disorders by health visitors. These assessments were compared with the mothers' scores on the General Health Questionnaire (GHQ), a screening instrument for identifying psychiatric cases in the general population. The results indicate that symptoms of minor psychiatric disorder are a problem for an appreciable number of postpartum women, although the health visitors showed a misclassification rate of roughly 40%. It is suggested that routine screening using the questionnaire at the time of the baby's six week check would improve the detection rate and also enable the health visitors to give extra support to those mothers who were most in need of it.

Introduction

It is now generally recognised that there is an increased likelihood of psychiatric disorder, especially depression, after childbirth.¹ In a recent community study one in six women were depressed two months after delivery, although these conditions were only rarely recognised and treated.² One reason for this may be a general reluctance to seek help for psychological problems in a survey of women who had their first child few of those who were "truly depressed" consulted their general practitioner and none sought help.³

Health visitors are in a key position to identify signs of stress in families with young children, and are increasingly recognised as having an important part to play in detecting and managing emotional disorders.⁴ Indeed, the results of a recent survey of their work indicate that they routinely screen for a wide range of psychosocial disorders and that the proportion of clients who are identified as having a serious mental health problem is at least 20 times greater than is indicated by the official statistics.⁵ Briscoe (Psychosocial disorders: a problem for health visitors. *NCRA Conference, Oxford, September 1984*). Because they work in a preventive framework and, uniquely among health care professionals, initiate contact with clients, health visitors are excellently placed to detect potential difficulties early. This is particularly true in the postnatal period.

As several studies have suggested that mothers with emotional problems at this stage are reluctant to divulge their difficulties, it is important to establish the extent and accuracy of the identification of emotional disorder in the postnatal period by health visitors. The aims of this study were therefore: (i) to establish the extent of the identification of psychiatric disorder by health visitors in postpartum women; (ii) to compare the response of health visitors to psychiatric problems in this group; (iii) to examine how closely health visitors and mothers agree about the nature and extent of specific problems that confront the mothers.

General Practice Research Unit, Institute of Psychiatry, Denmark Hill, London SE5 8AF.
MONICA BRISCOE, PhD, lecturer

Method

Information was collected concerning 100 mothers of infants aged under 15 weeks who attended the well baby clinics of a north London health authority during one month in the summer of 1985. While the baby was being weighed each mother was asked if she would participate in the study. If she agreed she was given a questionnaire to complete before leaving the clinic. At the end of each session the health visitor was asked to complete a form for each mother who had participated in the study.

It was decided to carry out the study in baby clinics to ensure that the assessments of the health visitors related to the same time period as the mothers' self ratings. This would have been difficult to achieve if the mothers had been seen at home when the health visitors and the mothers might have completed their assessments several days apart. Apart from socio-demographic information, such as age, marital status, total number of children, and baby's age, each mother was asked if the clinic health visitor was her normal family health visitor and how well she felt this person knew her. She was then asked to complete the 30 item General Health Questionnaire (GHQ),⁶ which is a quick, acceptable, and reliable method of identifying psychiatric disorders in the general population. This instrument has the additional advantage of having recently been validated on postpartum women.⁷ Finally, the mother was asked to rate the extent to which she felt she had experienced 10 sociodemotional problems over the past week on a four point scale running from "not at all" to "very much". The 10 items were: (i) having any difficulties coping with your new baby; (ii) worried whether your baby is normal; (iii) having problems coping with older children; (iv) having problems with your husband boyfriend; (v) requiring more "support" in your life; (vi) feeling physically unwell; (vii) feeling tense or anxious; (viii) feeling unhappy or depressed; (ix) having financial difficulties; (x) having problems with housing.

Each health visitor was asked whether she and the mother's usual family health visitor, how long they had been acquainted, and how well she felt she knew the mother. She also reported whether she had seen the mother in the past three months, both at home and in the clinic; and with which other professionals she had discussed the mother. She was also asked whether she thought that the mother was suffering from emotional problems at that time. If the health visitor thought that there was either a potential or an actual problem she was asked to specify the nature of the problem and asked whether she had been aware of this problem before that day's clinic session and what action she had taken or proposed to take; or, finally, she assessed each mother with regard to the same 10 sociodemotional problems on which the mothers had rated themselves, using the same four point scale with the addition of a "don't know" category. This was a modified version of a method proposed by Hulka et al for assessing professionals' awareness of patients' attitudes and concerns regarding pregnancy and motherhood.⁸

Results

CHARACTERISTICS OF PARTICIPANTS

The mothers' ages ranged from 19 to 42 years (mean 27.5 years). 85 mothers were married or cohabiting, 14 were single, and one was divorced. Sixty two of the mothers had just had their first child, including one with twins, and the rest had between two and four children each (mean 2.3). The babies' ages ranged from 2 to 14 weeks (mean 7.2 weeks). Where there were older children in the family their ages ranged from 1 to 13 years (mean 3 years).

A total of 24 health visitors participated in the study, completing forms on between one and 11 clients each. The ages of the health visitors ranged from 26 to 58 years (mean 38.9 years). 17 were married, four were single, and three were divorced. Two thirds had children of their own, whose ages ranged from 1 year to 16 years. All but three of the health visitors worked full time, and they had been in their present posts for four months to 12 years (mean 3.2 years). The length of time that they had been professionally qualified ranged from one to 26 years (mean 7.3 years).

In 29 instances this clinic visit was the first contact between the mother and health visitor, and in a further 18 they had known each other for less than one month. Overall, three quarters of the mothers in this sample had been

in the proportion of cases in which the health visitor felt unable to make an assessment, ranging from half for marital problems to only 10% for "appearing tense or anxious". There were significant correlations between the two ratings for six of the 10 problems; in fact the correlations for the other four problems also approached significance ($p < 0.10$). Perhaps more importantly, for only two problems did the discrepancies in perception between mothers and health visitors follow a consistent trend. Health visitors overestimated the difficulties experienced in coping with the new baby compared with the mothers' ratings ($n = 54$; $r = 0.204$, $p < 0.05$, Sign test). Similarly, health visitors significantly overestimated the extent to which the mothers felt physically unwell ($n = 27$; $r = 0.6$, $p < 0.01$, Sign test). Apart from these two items, there was no clear cut trend in the differences in perception between health visitors and mothers and no evidence for any consistent bias by the health visitors when rating mothers on the more psychiatric items.

TABLE 1—Correlation coefficients between mothers' and health visitors' ratings on 10 sociodemotional problems

	N	r
(i) Coping with baby	86	0.158
(ii) Worried whether baby normal	86	0.154
(iii) Coping with older children	80	0.684**
(iv) Marital problems	80	0.159*
(v) Needing more support	79	0.144
(vi) Physically unwell	80	0.628**
(vii) Tense or anxious	80	0.170
(viii) Feeling unhappy or depressed	87	0.346*
(ix) Financial problems	86	0.521**
(x) Housing problems	87	0.577**

* To each case where the health visitor gave a "don't know" rating were excluded from analysis. In addition, for item (ii) first time mothers only were included in analysis.
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Discussion

The findings indicate that symptoms of minor psychiatric disorder are a problem for a great proportion of postpartum women. Using the 30 item GHQ as a screening test and incorporating the modifications proposed by Nott and Cutts,⁹ the prevalence rate of 31% of the present sample is remarkably similar to that found in Southampton.¹⁰ Similarly, the health visitors' identification rate of 45% of mothers having "emotional problems" in this study is remarkably similar to the figure found in the previous south London survey (M. Briscoe, Paper presented to NCRA Conference). It is clear, however, that using GHQ results as the criterion of "cases" the health visitors were not very accurate in identifying cases since they showed a misclassification rate that was consistently around 40% whichever scoring procedure was used for the GHQ.

This misclassification rate is closely similar to that found among general practitioners,¹¹ but since health visitors are in a key position to detect such problems it is particularly important that they are provided with adequate resources to carry out this task. Clearly, any criticism that is based on misclassification rates depends on the validity of the GHQ and the meaning of caseness which it defines. The results of this study, however, show that in many instances the difficulties identified by health visitors refer to the emotional correlates of social and health problems rather than to problems specifically described in psychiatric terms. Moreover, the extent of agreement between health visitors and mothers on the psychiatric problems is notable when contrasted with the tendency for health visitors to overestimate the difficulties of mothers with their babies and their own physical health. This all suggests that in assessing emotional disorder health visitors tend to use commonsense lay definitions. Moreover, the suggested professional responses to

identified emotional problems in this survey were largely restricted to extra visits and practical help—for example, contacting the housing department. Referral to or liaison with the formal psychiatric services was not once mentioned in an opinion.

The health visitors' role in screening for psychiatric difficulties is particularly important both because they initiate contact with their clients and because it is known that new mothers with emotional problems are reluctant to divulge their difficulties. Despite the criticisms which may be levelled at the GHQ as a criterion of caseness, during the collection of data several of the mothers expressed surprise and relief that they were not unique in experiencing the symptoms covered by the GHQ. Behind the smiling facade these women were severely depressed and guilt ridden; they felt unable to admit to these feelings unless specifically asked about them. This supports Nott and Cutts' view that the GHQ might be used by health visitors to screen for postpartum psychiatric disturbance.⁹

The findings also indicate that mothers are often in contact with more than one health visitor, perhaps because of staff holidays or the convenience of a particular clinic session, for example. Thus only 64% of the mothers were definitely rated by their own family health visitor, and liaison with the appropriate health visitor was the second most commonly proposed action for the mothers with emotional problems. It would therefore be useful to screen all mothers using the GHQ, possibly at the time of the baby's six week check up, thus making the result available to the family health visitor in the notes if she is not present at that clinic session. This would ensure that all mothers would be given the opportunity to ventilate their feelings and would also enable the health visitors to give extra support to those mothers who were most in need of it. Screening at six weeks post partum would ensure that virtually all mothers would be included, and by this stage any temporary "maternity blues" syndrome would have passed. Nott and Cutts have proposed not only a modified content and scoring method for the 30 item GHQ to use with postpartum women but also a short 12 item version for predicting "caseness" in this group.⁹ The shorter version is particularly appealing because it would be easier to administer. Further research on the routine use of the GHQ as a screening instrument among postpartum women is needed.

This study was conducted as part of a programme of research in the General Practice Research Unit under Professor Michael Shepherd and funded by the Department of Health and Social Security. I thank Professor Shepherd and Dr Paul Williams for helpful advice and Mrs G Webster, director of nursing services (community), for arranging access to the 24 health visitors and 100 mothers to participate in the study.

References

1. Kessler RC, Bromberg RB. A prospective study of emotional disorders in childbearing women. *Br J Psychiatry* 1984;145:17-24.
2. Cox JL, Cohen V, Redford RB. Prospective study of the psychiatric disorders of childbearing women. *Br J Psychiatry* 1980;137:11-17.
3. Kessler RC, Bromberg RB. Women's concept of depression. *Health Vis* 1985;1:11-13.
4. Ford D, Shepherd J, Kessler RC, Bromberg RB. A community study of the health visiting service. *Health Vis* 1985;1:289-301.
5. Briscoe M. Psychiatric illness with health visitors. *Health Vis* 1985;1:98-100.
6. Nott PN, Cutts L. Validation of the 30 item General Health Questionnaire in postpartum women. *Br J Psychiatry* 1985;147:19-24.
7. Nott PN, Cutts L. Validation of the 30 item General Health Questionnaire in postpartum women. *Br J Psychiatry* 1985;147:19-24.
8. Hulka BF, Kuper LL, Landwehr J, Thompson SJ. A method for measuring physicians' awareness of patients' attitudes and concerns. *Health Vis* 1985;1:101-103.
9. Nott PN, Cutts L. Validation of the 30 item General Health Questionnaire in postpartum women. *Br J Psychiatry* 1985;147:19-24.
10. Shepherd J, Kessler RC, Bromberg RB. A community study of the health visiting service. *Health Vis* 1985;1:289-301.
11. Marks J, Goldberg D, Hider P. Determinants of the detection of general psychiatric disorders: a preliminary study. *Psych Med* 1979;9:117-131.
12. Briscoe M. Screening for psychiatric disorders in general practice. *Psych Med* 1986;16:465-471.

Accepted 2 March 1986

known to the participating health visitor for less than three months. On the other hand, a tenth had had the same health visitor for over two years. The mean duration of acquaintance was 19 months (range 1-28 years).

In 64 instances both mother and health visitor agreed that the latter was the usual health visitor, and in 26 there was agreement that this was not so right of the remaining 10 mothers (mostly thought that the health visitor allocated to that particular health visitor, presumably because they had seen her before either at home or in the clinic. There was generally good agreement as to how well the health visitor knew the mother, in half the sample mother and health visitor were in complete agreement. Where they disagreed it was more often because the mother considered that her health visitor knew her better than she did, although this discrepancy in perception was not significant ($n = 50$; $r = 0.20$; $p = 0.12$, NS, Sign test).

IDENTIFICATION OF EMOTIONAL PROBLEMS

Health visitors identified emotional problems in 45 (45%) of the 100 mothers and rated 4% as having no such problems (table 1). In 10 instances they felt unable to make an assessment because they did not know the mothers well enough. Therefore, of those mothers who were rated, 40% were identified as having emotional problems. This compares with an identification rate of 45% in 166 families with infants aged under 15 months in south London who were visited at home by their own health visitors (M. Briscoe, Paper presented to NCRA Conference). There was no significant difference in the proportions of cases in the two samples identified as having emotional problems ($\chi^2 = 0.02$, 1 d.f., NS).

Furthermore, 54% of the mothers scored highly on the GHQ, and 60% of the mothers who were assessed for emotional disorder by the health visitors were correctly classified using the criterion of GHQ results (table 1).

TABLE 1—Identification of emotional problems in health visitors according to results on GHQ

Health visitor rating	GHQ results		
	No case	Case	Total No
No problem	2	22	24
Potential problem	1	11	12
Actual problem	4	16	20
Don't know	1	5	6
Total	8	54	62

The proportion of positive results on the GHQ in this sample is high compared with the 4.5% reported for postpartum women in Southampton.¹⁰ Modifying the content and the cut off point of the GHQ to the recommendations by Nott and Cutts resulted in only 31% of the present sample scoring highly compared with 30% in Southampton. This modification, however, does not give any indication of the validity of the health visitors' classification rate; 61% of mothers were correctly assessed according to this amended criterion.

Applying the predictive values derived by Nott and Cutts in their sample of postpartum women to these data (using the method of Diamond and Lilienfeld¹²) resulted in an estimate for the prevalence of 22% if the 4.5 cut off point was used and 19% if the modified GHQ was used. The predictive values of the 4.5 cut off point were applied to the data (using the method of Marks et al¹³) to calculate the identification index. The identification index is the probability that an individual who is identified as a case by a psychiatrist would be regarded by the health visitor as having an emotional problem. The value so obtained was 0.49—that is, about half of the "actual" true cases, that is, those identified by the health visitors. This corresponds well to the mean value for the identification index of 0.54 obtained by Marks et al from 91 Manchester general practitioners.¹³

Table II shows the "emotional problems" specified by the health visitors for the 41 mothers assessed as having such problems. In most these difficulties were not couched in specifically psychiatric terms but rather referred to the emotional correlates of social or health problems. Although about one third of these mothers were identified as suffering from anxiety, depression was specifically mentioned in only 7%.

Few of these cases were newly detected during the clinic session. In only nine (22%) cases had the health visitor been unaware of the problem before that clinic session, and in a further seven (17%) she had taken no action despite being aware that there was at least a potential problem. Thus in 10% of these cases the health visitor had already taken some action regarding the emotional problems that she had identified.

Table III lists the actions already taken by the health visitors, by far the most common being to increase the number of her visits. Contact with other professionals was mentioned in 28 cases, the health visitor stating that she planned to take some future action. Notably, contacting an outside agency (medical as well as social) was proposed less frequently as a future action than as one having been carried out, and again contact with formal psychiatric services was not mentioned.

TABLE II—Types of "emotional problems" mentioned by health visitors

	No. cases
Anxiety	12
Lack of confidence	6
Housing problems	6
Marital problems	6
Being feeling problems	6
Problems with baby's health	6
Behaviour problems in older child	4
Depression	4
Need for contact reassurance	4
Unhappiness	4
Problems with extended family	4

* To each case where the health visitor gave a "don't know" rating were excluded from analysis. In addition, for the 41 mothers identified as having emotional problems two problems were mentioned in 22 and one in 19 cases.

† To include coping with stress, coping with baby, behaviour problems, social contact, more often than usual, more often than usual, and last, but not least, to take to research club. All mentioned under "other".

TABLE III—Previous and future actions by health visitors regarding mothers with emotional problems

Action	No. cases	
	Previous	Future
Extra visits	13	14
Contact appropriate health visitor	1	8
Refer to general practitioner	1	1
Contact housing department	4	1
Contact social services	4	1
Longer visits	1	2
Speak to relatives	1	1
Refer to other mothers	1	1
Refer to potential support group	1	1
See regularly at clinic	1	1
Place older child in day nursery	1	1
Refer to day nursery	1	1
Refer to clinic doctor	1	1
Discuss with mother possible	1	1

* To each case where the health visitor gave a "don't know" rating were excluded from analysis. In addition, for the 41 mothers identified as having emotional problems two problems were mentioned in 22 and one in 19 cases and two in the rest. With regard to the 28 cases where the health visitor had taken action before that clinic session, the health visitor had taken action before that clinic session.

With regard to the characteristics of the mothers who were identified by the health visitors as having emotional problems, there was a significant negative correlation with age ($r = -0.192$, $p < 0.05$). Other characteristics of the mothers, such as total number of children and age of baby or of oldest child, were not associated with the identification of emotional problems. Whereas there was a significant relation with the number of home visits that the health visitor had carried out in the previous three months ($r = 0.201$, $p < 0.05$), that did not apply to the number of clinic visits over that period ($r = 0.073$, NS); this is probably attributable to the health visitors' tendency to carry out extra visits where the mothers were perceived as having emotional problems. Presumably the number of home visits is under the health visitor's control, whereas clinic visits are generally initiated by the mother. Finally, mothers who had been identified as having emotional problems were more likely to have been discussed with at least one other professional (Spearman's $r = 0.501$, $p < 0.001$). By contrast, there were no significant correlations between GHQ score and any of the maternal characteristics mentioned above.

Table IV shows the extent of agreement between health visitors and mothers with regard to specific problems. There was considerable variation

Practice Law

Court of Appeal to rule on Brightlingsea dispute over restrictive covenant

CLARE DYER

A test case which goes to the Court of Appeal on 12 May could have far-reaching implications for the right of National Health Service general practitioners to protect their practices from patient poaching by departing partners. The BMA regards the issue as so important that it has agreed to pay the costs of both sides in an attempt to establish how far longstanding partners can, in the words of a judge in an earlier case, "protect themselves against the new boy climbing on their bandwagon and then driving away with the passengers".

The case concerns a four doctor practice, the only one in the small town of Brightlingsea, Essex, which has a population of 7500. It had been a three man practice, but in 1982 two of the partners retired, and the remaining partner, Dr A F Kerr, was joined by three new partners, Dr W J Morris, Dr G D Parker, and Dr A H Morris. The partnership agreement contained a restrictive covenant of the sort usually included in general practice agreements, in this case not to practise within a radius of two miles of the partnership premises within two years of leaving the partnership and not to solicit patients.

The agreement also, unusually, compelled a partner to retire from the partnership at any time given 12 months' notice to do so by all the other partners. In late 1984 relations between Dr Morris and the other partners deteriorated. His partners became, as Dr Kerr put it, "disgruntled" with Dr Morris's performance as a partner. In January 1985 they asked him to sign a letter of resignation which would take effect six months later unless they were completely satisfied with his performance in the interim. He refused.

Year's notice to retire

In February 1985 he was given 12 months' notice to retire "for the reason that we consider that the trust necessary between partners has been breached by you." In June he told his partners that he intended to set up practice in Brightlingsea. He acquired premises at 1 Ladyship Avenue, some 100 yards from the partnership's premises at 7 Ladyship Avenue, and was granted planning permission to convert them for use as a doctor's surgery.

Two days before the expiry of the 12 months' notice the three remaining partners went to the High Court to seek injunctions restraining Dr Morris from breaching the covenant against practising within a two mile radius and from soliciting patients of the partnership to transfer to his list. The injunctions they sought were

interlocutory—temporary injunctions lasting only until a full hearing of the case. The court will grant an interlocutory injunction only if the plaintiffs have a real prospect of getting a permanent injunction—in this case, a two year injunction—at the trial.

Previous High Court decision

They failed. The judge, Mr Justice Falconer, felt bound to deny them the first injunction because of a decision in a 1980 High Court case, *Hensman v Traill*. In that case, Dr Traill, a young and inexperienced doctor joining two older, established practitioners, had agreed not to practise for five years within seven miles of the partnership premises. No such restraint applied to his partners. The partnership was dissolved upon the retirement of one of the older partners, and Dr Traill refused to agree to a similar restriction in a new partnership agreement between himself and the other partner, Dr Hensman. During negotiations, the two partners practised under a partnership at will, which either could dissolve at any time. When the partnership was dissolved, Dr Traill joined another in the same town, taking with him the records of the patients on his list.

Mr Justice Bristow dismissed Dr Hensman's action for an injunction. He ruled that the terms of the partnership at will did not include the restrictive covenant, and therefore Dr Traill was entitled to practise within a seven mile radius. But even if Dr Traill had been practising under the earlier agreement, the restriction, the judge decided, was unenforceable for two reasons. Firstly, it was against public policy.

"In my judgment, when you transpose the well known principles of common law affecting the enforcement of contracts in restraint of trade to the context of doctors conducting group practices in the National Health Service, it is not possible to regard a partnership restriction which might lead to a doctor being prevented by law from giving patients the care which he is obliged under the National Health Service to give them, as other than contrary to the basic concept of the National Health Service, and so contrary to public policy and unenforceable," said the judge.

Secondly, Dr Traill's agreement to a unilateral restraint clause was "valuable consideration" for being taken into partnership and therefore deemed to be a sale of goodwill, which is unlawful under the National Health Service Act 1977, and therefore unenforceable.

This might not be so in the *Kerr v Morris* case, where the restrictive covenant was unilateral, and the partners, Dr Morris and Dr Traill, doctors could lose the right which other professionals have to protect their practices by restrictive covenants, as long as those covenants are not unreasonably wide.

London NW1

CLARE DYER, BA, BLS, solicitor and legal journalist