

Awareness of Post-Partum Psychiatric Syndromes among Obstetricians And Gynaecologists

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Abstract : The aim of the present study was to examine the awareness of Post-Partum Psychiatric Syndromes (PPPS) amongst the Obstetricians and Gynaecologists (OB-GYNs). The sample included 30 practising OB-GYNs who met the inclusion criteria and gave written informed consent, working in private clinics and/or government hospital in either Mumbai or Delhi. Most of the participants were women. Data were collected through a self-designed questionnaire which assessed the OB-GYNs' awareness about definition, prevalence rates as well as signs and symptoms of PPPS. Results showed that OB-GYNs were able to understand PPPS, and could give correct estimates of prevalence rates. They enquired more about biological signs of PPPS, compared to psychological signs. In addition, the years of experience in the field (more or less than 12 years) had a statistically significant impact on the likelihood of asking about signs and symptoms of Post-Partum Depression listed in the questionnaire. However, this difference was not observed in terms of being able to correctly identify PPPS (depression and psychosis) presented in the form of case vignettes. The results of the present study are discussed along with implications for practice and future research.

Keywords –*Maternal Mental Health, Obstetricians and Gynaecologists (OB-GYNs), Post-Partum Depression, Post-Partum Psychiatric Syndromes (PPPS), Post-Partum Psychiatric Syndromes in India.*

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I. INTRODUCTION

In India, it is said that a woman's purpose and identity is conferred by motherhood. The child is a certification and redemption for the woman^[1]. Though society and culture put a premium on motherhood, many women do not find it a blissful experience. It is common for new mothers to feel anxious, tired, irritable, as they manage with alterations in their sleep-wake cycles, cope with the demands of the caring for the baby (along with other children), and continue managing their homes and careers. In fact, Gautam (1989) described pregnancy and post-partum period as a "maturational crisis", equal in importance to those of adolescence and menopause^[2].

The phenomenology of psychological experiences in the post-partum period may include transient mood lability, irritability and weepiness on one end, to marked agitation, delusions, delirium and confusion on the other^[3]. In psychiatric terminology, severe psychological changes experienced by women during the post-partum period are called post partum psychiatric syndromes (hereafter, referred to as PPPS).

An epidemiological study conducted by Prabhu, Asokan and Rajeswari (2005) in Chennai showed that nearly one-third (N=160) of the 478 women had post-partum psychiatric morbidity, and among them 6.5% had major psychiatric problems such as Post-Partum Depression (PPD) and Post-Partum Psychosis (PPP)^[4].

PPD perhaps, is the most widely researched of all the PPPS. Though it is acknowledged that it is a "bio-psycho-social phenomenon"^[5], the most common explanations and treatments largely remain medical in nature^[6]. The medical model does not consider the emotional and physical exhaustion that accompanies mothering^[7].

1.1 Definitions and Prevalence Rates

The ICD-10 recognises the presence of mental and behavioural disorders associated with the puerperium (F53). Within this code, presence of post-partum depression (Mild mental and behavioural disorders associated with the puerperium) is coded as F53.0. Presence of severe mental and behavioural disorders associated with the puerperium is coded as F53.1 (PPP)^[8]. Though PPD and PPP are the most frequently reported of all the PPPS, literature has documented other psychiatric conditions which may have onset in the pregnancy or the post-partum period^[3].

Post-Partum Depression (PPD). The definition of PPD has been expanded in DSM-5^[9] to include major depressive episodes with a perinatal onset (beginning in either pregnancy or within the first 4 weeks

postpartum). Although PPD and non-perinatal major depressive disorder (MDD) have the same DSM 5 diagnostic criteria, the symptoms of psychomotor agitation and lethargy are more prominent in PPD than MDD. Negative thoughts of the mother are mostly centred around the newborn baby and feelings of guilt and inadequacy are related specifically to her inability to take care of her new born and a preoccupation with his/her well-being^[10]. It is seen that PPD affects 10-15% of women^[3]. In the Indian context, a community based prospective study reported the rate of incidence of PPD to be approximately 11% in rural parts of India^[11]. Another set of data from rural India suggests that 26.3% of women reported PPD at 2-10 weeks postpartum^[12]. Further, Desai, Mehta and Ganjiwale (2012) conducted a study in Gujarat where the prevalence rate was found to be 12.5%^[13].

Post-Partum Psychosis (PPP). PPP refers to the presence of any signs severe mental and behavioural disturbance during the post-partum period, and typically refers to presence of either affective or non-affective psychosis. It has a rapid onset associated (2 weeks to 3 months post-delivery) with hallucinations or bizarre delusions, presence of infanticidal ideation, lack of reality testing, mood swings, disorganized behaviour, and cognitive impairment. The nature of delusions may involve the infant being divine, dead, possessed or having special powers^[3]. In many cases, it is a manifestation of bipolar disorder affective disorder, which may present as mania for the first time during the postpartum period. The rate of incidence is 1-2 per 1000 childbirths. Currently the prevalence is estimated to be 0.63% in India^[4]. It is reported that PPP arises 50-60% of the times during first pregnancy of a woman^[14].

Post-Partum PTSD (PP-PTSD). PP-PTSD is generally characterized by symptoms such as tension, nightmares, flashbacks and autonomic hyper-arousals which start in the post-partum period. These symptoms may persist for weeks or even months. The likelihood of recurrence towards the end of next pregnancy is high. PP-PTSD may also result in secondary tocophobia (the fear of pregnancy and childbirth)^[15].

Alcorn, O'Donovan, Patrick, Creedy and Devilly, (2010) explored the incidence of post-traumatic stress disorder (PTSD) as a consequence of childbirth and related events in Australia. Prevalence rates of PP-PTSD (N=776) were found to be 1.2% at 4–6 weeks, 3.1% at 12 weeks and 3.1% at 24 weeks postpartum. The results revealed that traumatic experiences of giving birth may have led to PTSD symptoms in the women; even though PTSD is not a common response to delivery^[16].

Post-Partum Anxiety Disorders (PP-AD) and Obsessive Compulsive Disorders (PP-OCD). Often under-diagnosed, PP-AD and PP-OCD are reportedly more common than PPD^[17]. They include the fear of cot death and maternity neurosis (excessive worry and preoccupation with the safety and health of the child). The obsessions Post-Partum OCD often revolve around thoughts or horrific images of harming the baby^[18].

Research indicates that incidence of anxiety disorders is higher in case of postnatal period than at any other time for women^[19]. In a study conducted by Heron, O'Connor, Evans, Golding, Glover & ALSPAC Study Team (2004), in England, the rate of prevalence for clinically significant anxiety symptoms (N=8323) was found to be 21%. Out of these women, 64% continued to suffer from these anxiety disorders at the time of postpartum^[20].

Rai et al. (2015) identified further factors associated with the development of PPPS. These include primigravida (becoming a mother for the first time); delivery by a caesarean section, any other perinatal or natal complication; having a past history of psychiatric illness, specifically past history anxiety and depression; family history of psychiatric illness, especially relevant in cases where the woman's mother or sister had PPPS; prior episode of any PPPS; stressful life events especially during pregnancy and near delivery; history of sexual abuse in the woman; vulnerable personality traits (such as), experiencing social isolation and presence of unsupportive spouse^[3].

There are a few studies that identify the risk factors for PPD specifically in the Indian context. They identified low income, birth of a daughter when a son was desired, and relationship difficulties with mother-in-law and parents, adverse, stressful life events during pregnancy and lack of physical help as probable risk factors for the onset of PPD^[11]. Similar results were found in the study by Desai et al (2012). Additionally, absence of someone other than mother and partner in whom the woman could confide were also found to be the strong predictors of the PPD^[13].

1.2 Costs Associated with PPPS

The postpartum period is characterised by increased physical and emotional demands on women. PPD is associated with a range of negative outcomes like detrimental effects on child's psychological development^[21], growth^[22] and infant nutrition^[23] along with suffering of the mother-infant relationship^[24] and maternal deaths due to suicide^[25].

1.3 Role of Obstetricians and Gynaecologists (OB-GYNS)

OB-GYNs are responsible for providing care for women across their life cycle. They often tend to be the first and most frequent points of medical contact for women regarding their own health especially during the post-

partum period. Research suggests that OB-GYNs are responsible for providing health care exclusively to almost 60% of women with low incomes^[26].

A study conducted by Leddy, Victoria, Farrow, Joseph and Schulkin (2012) to evaluate the knowledge, attitudes and behaviours (KABs) of OB-GYNs towards post-partum psychiatric disorders showed that those OB-GYNs who had taken the CME courses were more likely to be associated with increased screening and utilization of validated assessments^[27]. Validated screening measures, such as the Edinburgh Postnatal Depression Scale, can help clinicians make informed treatment decisions about PPD but they tend to be underutilized^[28]. It becomes, therefore, important that OB-GYNs become more familiar with the risk factors, diagnostic criteria, and management of mental health issues occurring in the postpartum period.

1.4 What can be done?

The World Health Organization (WHO) and United Nations Population Fund (UNFPA) have stated that there is a need to increase attention to the skills, attitudes and capacities of the healthcare professionals so as to augment the recognition of and assistance for women who experience postnatal depression and other mental health problems^[29].

One of the major steps in this direction would be consultation-liaison in psychiatry which involves interpretation and mediation between the patients and members of clinical team as well as between mental health and other health professionals^[30]. Another step in this regard could be the establishment of inpatient mother-baby units (MBU) which help in preventing attachment disorders.

Psychologists can play a key role by co-managing care for the patients in the OB-GYN practices by presenting behavioural health consultations, facilitating engagements with psychotherapy and presenting treatment for women and their families. This can be done by offering family therapy or psycho-educating the client about pregnancy, parenting skills, dealing with intimate relationship and family while caring for the infant, and preparing the family for the birth of the infant^[31].

The American College of Obstetricians and Gynaecologists recommends that clinicians should screen for depressive and anxiety symptoms using a standardized, well-validated tool at least once during the postpartum period^[32].

II. METHOD

Aim

The aim of the present study was to examine the awareness of Post-Partum Psychiatric Syndromes (PPPS) amongst the Obstetricians and Gynaecologists (OB-GYNs).

Awareness was defined as knowledge about definition, prevalence and signs and symptoms of PPPS. The syndromes include Post-Partum Depression, Post-Partum Psychosis, Post-Partum Post-Traumatic Stress Disorder and Post-Partum Anxiety Disorders and Obsessive Compulsive Disorders^[3].

Objectives

1. To explore awareness in terms of knowledge about definitions and prevalence of Post-Partum Psychiatric Syndromes (PPPS)
2. To assess likelihood of OB-GYNs asking the clients about symptoms of Post-Partum Depression (PPD)
3. To compare likelihood of participants asking the clients about symptoms of Post-Partum Depression (PPD) based on median years of work experience
4. To assess the accuracy of the OB-GYNs' responses to case vignettes about various psychological difficulties including PPPS
5. To compare the accuracy of the OB-GYNs' responses to case vignettes about various psychological difficulties including PPPS based on years of experience

A single group, cross-sectional, exploratory design with quantitative research methodology was used. The sample consisted of 30 practising obstetricians-gynaecologists (working in private clinics and/or government hospital) with a post-graduate degree/diploma and having minimum 2 years of experience in the field. Convenience and snow-ball sampling methods were used. A self designed questionnaire (Cronbach's Alpha for overall reliability=0.78 and for Standardized Items=0.803) was used which contained both close-ended (forced choice and multiple choice) and open-ended questions. It was given to three mental health professionals to establish its content validity. The pilot phase was conducted in Mumbai while the main phase was conducted in Delhi. Data analyses for quantitative data included descriptive statistics such as frequency, percentage, measures of central tendencies (mean and median), measures of variability (Standard deviation) and inferential statistics like Mann-Whitney U-test (to ascertain if the years of experience in the field creates a difference in the knowledge about definition, prevalence and signs and symptoms of PPPS). For the open-ended questions, content analysis was used.

Ethical Considerations

Written Informed Consent stating the purpose of the study and information about the procedure was obtained from the participants before administration of the questionnaire. Option of withdrawing consent at any time during the course of the study was also made available to them. Confidentiality and anonymity of the responses were maintained.

III. RESULTS AND DISCUSSION

Table 1: Socio-demographic and professional characteristics of OB-GYNs (N=30)

VARIABLES	MEAN	SD
Age (in years)	38.57	9.02
Years of experience as a practising OB-GYN (in years)	11.77	8.63
Years of experience as a practising OB-GYN (in years)	MEDIAN	RANGE
	12	2-35
	FREQUENCY	(%)
Gender		
Male	3	10
Female	27	90
Setting of clinical practice		
Private Clinic	8	27
Government Hospital	21	70
Both	1	3
Psychiatric posting during medical training		
Yes	25	83
No	5	17

Table 1 indicates that the mean age of the sample in the present study was 38.57 ± 9.02 years. The sample had a mean 11.77 ± 8.63 years of work experience in the field of obstetrics and gynaecology (OB-GYNs). The sample was overwhelmingly female (90%). Almost three-fourth of the sample (70%) worked only in a government hospital while 27% had only private clinical practice. Majority of the participants (83%) had had a psychiatric posting during their medical training.

Table 2: Knowledge about definitions and prevalence of Post-Partum Psychiatric Syndromes (PPPS) (N=30)

OB-GYNs' RESPONSE TO -	N	(%)
Duration of post-partum period		
42 days/ 6 weeks	26	87
40 days	1	3
3 months	1	3
3-6 months	1	3
Upto 6 months	1	3
Women experience psychological difficulties during post-partum period		
OB-GYNs who agreed	30	100
OB-GYNs who disagreed	0	0
Description of some psychological difficulties faced by women in the post-partum period		
Depression	20	67
Psychosis	9	30
Anxiety	7	23
Irritability	4	13
Difficulty in bonding with the child	3	10
Attention seeking	2	7
Generalized Anxiety Disorder (GAD)	2	7
Post Traumatic Stress Disorder (PTSD)	2	7
Post-Partum Blues	1	3
Suicidal ideation	1	3

Prevalence of PPPS in India		
>50%	0	0
41-50%	0	0
31-40%	2	7
21-30%	3	10
11-20%	9	30
<10%	16	53
Whether the response to “prevalence of PPPS in India” was correct		
Correct	25	83
Incorrect	5	17
Source of information about PPPS		
Course Content at UG	20	67
Course Content at PG	19	63
Clinical Experience	18	60
Research Articles	7	23
CMEs	3	10
Any other	0	0
OB-GYNS’ perception of adequacy of sources of information about PPPS		
Adequate	16	53
Inadequate	14	47

Table 2 shows the nature and accuracy of information the participating OB-GYNs had about PPPS. Majority of the participants (87%) correctly cited 42 days or 6 weeks as the duration of post-partum period in women^[29].

It was seen that all the participants acknowledged that women experience psychological difficulties in the post-partum period. When asked to elaborate on the kind of psychological difficulties faced (an open-ended question), the most frequently listed difficulties by them were depression (67%) followed by psychosis (30%), anxiety (23%) and irritability (10%). Other major difficulties included problems in bonding with the child (10%), attention seeking behaviour (7%), Generalized Anxiety Disorder (GAD) (7%) and Post Traumatic Stress Disorder (PTSD) (7%). One participant reported that suicidal ideation too was a psychological difficulty experienced by clients in the post-partum period.

Nearly half of the sample (53%) reported that the prevalence rate of PPPS was less than 10% in India, while 30% said that it was between 11-20%. Desai et al. (2012) reported that the prevalence of post-partum depression in India was 12.5%^[13]. The prevalence rate is estimated to be 0.63% for post partum psychosis^[4], 1-6% for post-partum PTSD and almost 21% for post-partum anxiety disorders^[19]. Thus 83% of the participants correctly estimated the prevalence rate of PPPS in India since they were not asked about the rate of prevalence for specific syndromes.

The course content at under-graduate level was the source of information about PPPS for 2/3rd of the sample (67%), followed by course content at post-graduate level for 63% and clinical experience for 60% of the sample. Other sources of information cited by them include research articles (23%) and CMEs (10%). Nearly half of the participants (47%) thought that the information provided to them about PPPS was not adequate. Leddy et al. (2011) reported a much higher dissatisfaction of the OB-GYNs with their residency period (nearly 80% said the residency training was barely accurate)^[27]. This could be because the mean age for the participants in this study was lesser than the participants in the previous study because of which they maybe more in touch with their training. Nevertheless the high levels of dissatisfaction in both the studies show that participants believe more information about PPPS is needed.

Table 3: Assessing likelihood of OB-GYNs asking the clients about symptoms of Post-Partum Depression (PPD) (N=30)

OB-GYNs’ response to likelihood of asking the mother about her--	Unlikely		Somewh at Likely		Very Likely		Almost Certain	
	(responses combined to indicate less likelihood)				(responses combined to indicate more likelihood)			
	N	%	N	%	N	%	N	%
Breast-feeding	2	7	3	10	7	23	18	60
Interest in	4	13	13	43	6	20	7	23

activities of daily living								
Exercise pattern	2	7	12	40	10	33	6	20
Diet	1	3	6	20	11	37	12	40
Sleeping pattern	4	13	9	30	11	37	6	20
Work/job	8	27	10	33	7	23	5	17
Sexual functioning	9	30	16	53	2	7	3	10
Feeling down, depressed or hopeless	9	30	16	53	3	10	2	7
Available social support	7	23	14	47	7	23	2	7
Quality of married life	10	33	17	57	2	7	1	3
Emotional attachment to the infant	11	37	10	33	6	20	3	10

Table 3 indicates that OB-GYNs were more likely to enquire about biological signs and less likely to enquire about the psychological signs of PPD. To elaborate, 87% of the participants were more likely to enquire about the mothers’ practice of breast-feeding the infant, than not. Along the similar lines, 77% of the participants were more likely to enquire about the diet patterns than not, 57% about the sleeping pattern and 53% about exercise patterns of their clients than not. However, 83% of the participants were less likely to enquire about the sexual functioning of their clients.

In contrast, the likelihood of enquiry being made about psychological status was never more than 50% for the participants. Additionally, 47% of the sample reported that it was likely that they would enquire about the client’s interest in activities of daily living, 40% were more likely to enquire about the client’s interest in their work or job, 30% about the availability of social support to their client and 30% about the emotional attachment to the infant. Further, only 17% of the sample reported that they would enquire about client’s emotions such as feeling down, depressed or hopeless and 10% said that they would ask about the quality of their client’s married life.

This is surprising, because, as Table 2 indicates, the entire sample agreed that women face psychological/emotional problems in the post-partum period. Yet they are less likely to enquire about these psychological/emotional signs from their clients. These findings are reflective of the bio-medical view of PPD that is prevalent in the case of most medical professionals^[33] which fails to consider the emotional and physical exhaustion that accompanies mothering^[7] as well as the social constraints of motherhood^[34].

Although they were more likely to enquire about biological signs, even among these, it was seen that certain functions such as breast-feeding, diet, sleep or exercise pattern were more likely to be asked for than others such as sexual functioning of their clients. This could be in line with the taboo of sexuality in the country, or they may think that sexual functioning may not be a priority for the woman, post-delivery.

Focusing less on enquiry for psychological functioning would also mean that they may miss out on eliciting core symptoms of PPD. This style of responding to the questionnaire item may be reflective of clinical practices followed by the participants when working with women in post-partum period which has important implications. OB-GYNs are responsible for providing care for women across their life cycle^[26]. They often tend to be the first and most frequent points of medical contact for women have regarding their own health problems especially during the post-partum period. They are responsible for providing health care exclusively to almost 60% of women with low incomes^[26]. Therefore, there is a need to spread more awareness about PPDs with the OB-GYNs.

Table 4: Assessing likelihood of participants asking the clients about symptoms of Post-Partum Depression (PPD) based on median years of work experience (N=30)

	Experience	N	Ranks		Mann-Whitney U test	p-value
			Mean Rank	Sum of Ranks		
Asking about	12 years and below	17	11.56	196.5	43.500	.004

Depression Symptoms						
	Above 12 years	12	13	20.65	268.5	
	Total		30			

Table 1 indicated that median years of work experience of the participants was 12 years. Based on this, the sample was divided into two groups- experience of 12 years and above or below 12 years. The responses of the two groups were compared to examine if the years of experience affected the likelihood of symptoms of PPD being elicited during post-partum visits of the mother. Table 4 indicates that there was a statistically significant difference between the two groups in their likelihood of asking about symptoms of PPD (Mann-Whitney U=43.500, p=0.004). The OB-GYNs with more than 12 years of experience in the field were more likely to ask about the symptoms listed in the questionnaire as compared to OB-GYNs who had work experience of 12 years or less. This may imply that years of experience increase the likelihood of asking questions about the general well-being of the participants (for example questions about their sleeping, breast-feeding patterns).

Table 5: Assessing the accuracy of the OB-GYNs’ responses to case vignettes about various psychological difficulties including PPPS (N=30)

Vignette 1: identifying grief	N	(%)
Correctly identified	9	30
Incorrectly identified (as a case of depression, PPD, PTSD, Psychosis, PP-P)	21	70
Vignette 2: identifying PPD		
Correctly identified	13	43
Incorrectly identified (as a case of depression, schizophrenia, PP-P, illusions, neurotic disorder, phobia)	17	57
Vignette 3: identifying PPP		
Correctly identified	12	40
Incorrectly identified (as a case of depression, PP Blues, PPD, Anxiety, Psychosis)	18	60
Vignette 4: identifying psychosis (non-post partum onset)		
Correctly identified	8	27
Incorrectly identified (as a case of depression, Post-Partum neurosis, anxiety, PP-P, PP Blues)	22	73
Total number of correctly identified vignettes		
0	5	17
1	12	40
2	9	30
3	4	13
4	0	0

Two pairs of vignettes were selected for the study. One of the pair focused on identifying PPPS while the other was focused on psychological states unrelated to post-partum. This was done so as to control for the effect of positive response bias, or acquiescence.

Table 5 indicates that 70% of the participants could not identify grief as the predominant psychological state in vignette 1. In vignette 2; nearly half the respondents (43%) were able to correctly identify post-partum depression. Vignette 3 was correctly identified as post-partum psychosis by 40% of the participants. Nearly a quarter (27%) of the sample was able to identify the presence of psychosis. In all, the maximum number of participants (40%) got one vignette correct followed by the getting 2 vignettes correct (30%). It was seen that 17% of the participants could not give any correct answer. None of the participants got all four vignettes correct. These findings are different than those observed with Leddy et al., (2011) in which 82% of the participants were able to identify PPD while 81% were able to identify PPP^[27]. This difference could be because the mean age as well as the years of experience of the participants in this study was lesser as compared to the participants of the aforementioned study. The sample size of the present is much smaller (30 as compared to 224) as well. This may signify that PPD as well as PPP is under-diagnosed by the OB-GYNs which have major ramifications for the mother, infant and the family.

Table 6: Assessing the accuracy of the OB-GYNs' total responses to case vignettes about certain psychological difficulties including PPPS based on years of experience (Mann-Whitney U) (N=30)

Ranks						
	Experience	N	Mean Rank	Sum of Ranks	Mann-Whitney U test	p-value
Total correct responses	12 years and below	17	15.97	271.50	102.500	.742
	Above 12 years	13	14.88	193.50		
	Total	30				

Based on median years of experience as previously mentioned, Mann-Whitney U-test was done. The responses of the two groups were compared to examine if the years of experience affected the accuracy of identifying PPPS. Table 6 indicates that there was no statistically significant difference between the two groups in their accuracy of identifying PPPS (Mann-Whitney U= 102.500, p= .742). This may indicate that years of experience in the field have no effect on the accuracy with which OB-GYNs are able to assess psychological difficulties in women including PPPS. It could be because the training (as mentioned in Table 2) for identifying and managing PPPS is considered to be less than adequate by almost half the participants.

IV. CONCLUSION

To conclude, the present study tried to understand the OB-GYNs' awareness of PPPS in terms of definition, prevalence rates, signs and symptoms. The results indicated that OB-GYNs are aware about the definition and prevalence rates of PPPS. They were more likely to enquire about the biological risk factors than psychological risk factors. In addition, the years of experience in the field (more or less than 12 years) had a statistically significant impact on the likelihood of asking about signs and symptoms of PPD listed in the questionnaire. However, this difference was not observed in terms of being able to correctly identify PPPS (depression and psychosis) presented in the form of case vignettes.

Limitations of the study

The sample size (N=30) and inclusion of participants from only metropolitan cities is a major limitation of the present study. However, in the Indian context, this is one of the few studies which explored the phenomenon of PPPS from the perspective of OB-GYNs.

Implications for future research and practise

The present study had an exploratory design which highlighted the important areas of concerns related to PPPS. These need to be explored in-depth in future researches. Additionally, it looked at the practitioners' perspectives model. It is important that the voices of the user-survivors be taken into consideration to develop a more holistic understanding of the phenomenon.

International organizations such as World Health Organization (WHO) and United Nations Population Fund (UNFPA) have increased focus on postnatal depression and other mental health problems among postpartum period (WHO, 2008) as tertiary prevention strategy for the mother and primary prevention for the family especially the infant. Psychologists can co-manage care for the pregnant women by presenting behavioural health consultations, facilitating engagements with psychotherapy and presenting treatment for women and their families. Therefore creating more awareness about the phenomenon of PPPS would help in fulfilling this objective.

Acknowledgements: 4 case vignettes describing cases of grief, postpartum psychosis, postpartum depression and psychosis used in the questionnaire were originally designed by DrLeddy, Ms Farrow, Dr Joseph and DrSchulkin (2011). Permission was sought from authors before using these items.

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