

Knowledge, attitude, and practices of healthcare providers about perinatal depression in Himachal Pradesh—A cross-sectional study

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ABSTRACT

Introduction: Perinatal depression is defined as depression occurring in a woman during pregnancy or within 12 months of delivery. It has been associated with many poor outcomes, including maternal, child, and family unit challenges. This study aimed to assess the knowledge, attitude, and practices of obstetricians and primary healthcare professionals so that the knowledge gap could be assessed and they could be educated regarding the screening and treatment/referral of patients with peripartum depression. **Methods:** The study used a cross-sectional study design with convenience sampling. The data were collected through an online survey among healthcare providers using the Google Forms application. Submission of filled questionnaire implied consent for participation. Ethical approval for the study was obtained from the institutional ethics committee. The results were reported as mean and percentages. All data were analysed using Excel software 2019. **Results:** A total of 53 doctors responded to participate in the study. More than 98% of them were aware of an entity called perinatal depression. Around 89% of the participants do not screen patients for the perinatal period routinely using a screening questionnaire. About 90% of participants agreed with the need for screening for perinatal depression. Less than 50% of participants had heard about the screening questionnaire for the same. Around 89% agreed that all health professionals should have skills in recognising and managing depression. **Conclusion:** There is a need to educate healthcare workers including obstetricians about screening for perinatal depression, thus improving the quality of life of perinatal women and preventing complications due to untreated depression.

Keywords: Attitude, knowledge, perinatal depression, practice

Introduction

Perinatal depression is defined as depression occurring in a woman during pregnancy or within 12 months of delivery.^[1]

Perinatal depression manifests in different ways, varying in severity and period of onset: prenatal depression, “baby blues,” and

postpartum depression. It can occur during pregnancy, especially in the third trimester or from several weeks to several months after childbirth. Worldwide, about 10% of pregnant women and 13% of women after giving birth suffer from a mental disorder, primarily depression. In developing countries like India, this is even higher, that is, 15.6% during pregnancy and 19.8% after childbirth.^[2]

Perinatal depression has been associated with many poor outcomes, including maternal, child, and family unit challenges. Infants and young children of perinatally depressed mothers are more likely to have a difficult temperament, as well as cognitive and emotional delays.^[3]

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Received: 31-05-2022

Revised: 12-09-2022

Accepted: 10-10-2022

Published: 17-03-2023

Access this article online

Quick Response Code:



Website:
www.jfmpc.com

DOI:
10.4103/jfmpc.jfmpc_1170_22

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How to cite this article: Gupta J, Kaushal S, Priya T. Knowledge, attitude, and practices of healthcare providers about perinatal depression in Himachal Pradesh—A cross-sectional study. J Family Med Prim Care 2023;12:478-83.

Postpartum depression (PPD) is a potentially serious condition that is frequently undiagnosed and untreated because routine screening for PPD is not a standard of practice among most healthcare providers.

Much research has not been conducted to assess the knowledge, attitude, and practices of healthcare providers of obstetric care. In a qualitative study from Iran, the participants described that depression diagnosis is difficult due to insufficient knowledge among healthcare providers and the hidden signs of postpartum depression.^[4] A study by Ransing *et al.*^[5] concluded that a large knowledge gap about perinatal depression exists among perinatal women, nurses, and medical practitioners in India with 10% of doctors believing perinatal depression to be a normal part of pregnancy Ford *et al.*^[6] systematically reviewed the management of postnatal depression by general medical practitioners and reported that only 8% used standardised questionnaires for screening of postpartum depression, although most were aware of the need for screening. Branquinho *et al.*^[7] found that the knowledge of healthcare professionals is lacking in several aspects of perinatal depression like screening tools and treatment, which affects the quality of care.

Clevesy *et al.*, Long *et al.*, and Phoosuwan *et al.* have demonstrated the benefits of educational programmes in improving the screening for PPD.^[8-10] Primary healthcare professionals must be educated to identify and treat women with PPD, and guidelines and protocols must be established to guide evidence-based practice.^[11]

With this background, it was decided to assess the knowledge, attitude, and practices of obstetricians and primary healthcare professionals so that the knowledge gap could be assessed and they could be educated regarding the screening and treatment/referral of patients with perinatal depression.

Methods

Study design

A cross-sectional study design was used to study the knowledge, attitude, and practices of doctors (gynaecologists and primary healthcare doctors) attending perinatal women. The method for collecting data was through online surveys among healthcare providers. Convenience sampling was used, and doctors of Himachal Pradesh attending perinatal women (primary care physicians and gynaecologists) were invited to participate in the study. The survey instrument was distributed among these doctors using online platforms like WhatsApp and email. Submission of filled questionnaires implied consent for participation, and a statement to this effect was included in the survey instrument. Ethical approval for the study was obtained from the institutional ethics committee.

Survey instrument

A customised survey instrument was designed for this study using the Google Forms application. This questionnaire was

designed in consultation with two mental health experts. The survey instrument was pre-tested on five doctors (three primary care physicians and two gynaecologists). There were 31 questions in total. Baseline data of participants were collected; these data included age, qualification, years of experience, and place of work (Questions 1 to 7). Questions 8–19 included the assessment of knowledge regarding aetiology, risk factors, symptoms, screening, and management of perinatal depression. Questions 20–26 assessed the attitude towards perinatal depression, the need for assessment and management of depression in perinatal depression, and comfort in assessing patients' needs with depression and suicide risk. Questions from 27 to 31 assess the practice regarding perinatal depression and its screening. Question numbers 8, 12, 13, 15, 16, 27, 30, and 31 were polar questions answered as yes or no type, and question 14 was answered with yes, no, and maybe options. Questions 9–11 and 17–19 were multi-option types; each option was answered on a 5-point Likert scale from strongly disagree to strongly agree. Questions 20–26 and 28–29 also were to be answered on a 5-point Likert scale from strongly disagree to strongly agree.

Statistical analysis

The results were reported as mean and percentages. All data were analysed using Excel software 2019.

Results

Table 1 shows the demographic profile of the participants. A total of 53 doctors responded to participate in the study. The mean years of experience of the participants in obstetrics was 8.9 years.

Tables 2 and 3 show the answers to questions related to knowledge and attitude towards and practices about perinatal depression and its screening.

Discussion

Perinatal depression is a prevalent problem with far-reaching consequences not only for the patient but also for her baby and other family members.^[12] This disease has not received the attention it deserves, especially in developing countries like India. Despite the launch of India's national mental health programme in 1982, maternal mental health is still not a prominent component of the programme. Dedicated maternal mental health services are largely deficient in healthcare facilities.^[13] Whereas the responsibility of screening rests with midwives and nurses in developed countries,^[14,15] this service is mostly provided directly by doctors' attending parturients, that is, the primary care provider or gynaecologist in our country.

Knowledge

Psychiatry as a subject is taught in the MBBS curriculum. It is expected that most of our participants had some knowledge about perinatal depression and its differences from postpartum

blues. They were also able to describe the aetiology, risk factors, and symptoms of perinatal depression. A study by Hassan *et al.*^[16] in Malaysia among healthcare workers including doctors found that doctors had better knowledge about perinatal depression than other healthcare workers, though there was room for improvement.

Most of the participants recognised the need for screening for postnatal depression, but only 50% were aware of a screening tool for the same. In a qualitative study of healthcare providers (nurses and primary care physicians), it was concluded that they found it difficult to identify perinatal depression, prevent it, or intervene early because they were unaware of the screening methods.^[11]

Regarding treatment, most of the participants believed that counselling family members is the primary treatment. This belief points towards a bias in not recognising perinatal depression as

a disease requiring treatment. Only 50% recognised the need for medicines in treating perinatal depression. Eighty-nine percent of participants agreed that a psychiatrist was the best person to manage a patient with perinatal depression, but 57% believed that these patients can also be adequately managed by obstetricians. This is in contrast to findings from a study in Israel where most of the primary care physicians and paediatricians preferred referring patients to psychiatrists for treatment.^[17] This also points towards not recognising perinatal depression as a psychiatric illness requiring specialised care. Although most of the participants had some knowledge about this entity of perinatal depression, there are huge gaps in knowledge that need to be filled with training programmes for doctors engaged in managing obstetric patients and by formulating national guidelines for screening and managing such cases.

Attitude

Most of the participants recognised the need for having skills for managing patients with perinatal depression. In recent years, there has been a growing emphasis on recognising and treating mental healthcare needs. Our doctors are receptive, and any training programmes developed to enhance their skills will be well received. Nearly half of the participants were not confident in assessing suicide risk in patients recognising the need for further training in the area. A study on general practitioners' perspectives on consulting suicidal patients recognised the importance of training in assessing suicide-related risk factors.^[18]

Practices

There is a huge scope for improvement in screening women for perinatal depression. Eighty-nine percent of participants reported that they do not routinely screen patients for perinatal depression, and 72% have screened less than ten patients in their career. One-third of the participants believe that they look for symptoms of depression in their patients during the antenatal period and 40% during the postpartum period. This tells us that systematic screening for peripartum depression is practically non-existent. This area needs special focus, and steps should be taken to increase screening for perinatal depression, by increasing the focus on mental health in the curriculum, using training programmes, and by formulating guidelines.

Table 1: Profile of the participants

	n (%)
Age group	
<30 years	17 (32.1%)
31-40 years	22 (41.5%)
41-50 years	10 (18.9%)
51-60	3 (5.7%)
>60	1 (1.9%)
Gender	
Females	39 (73.6%)
Males	14 (26.4%)
Type of workplace	
Government hospital/teaching institute	47 (88.7%)
Private hospital/teaching institute	5 (9.4%)
Polyclinic or nursing home	1 (1.9%)
Qualifications	
Post-graduates	45 (84.9%)
Graduates	8 (15.1%)
Designation	
Consultants	22 (41.5%)
Senior residents	10 (18.9%)
Junior residents	13 (24.5%)
Post-MBBS medical officers (primary care physicians)	8 (15.1%)

Table 2: Knowledge, attitude, and practices about perinatal depression and its screening

Question	Yes	No
8 Are you aware about the entity called 'Perinatal (pregnancy and post-partum) depression'?	52 (98.1%)	1 (1.9%)
12 Have you heard about the term 'baby blues'?	48 (90.6%)	5 (9.4%)
13 Is postpartum depression different from baby blues?	47 (88.7%)	6 (11.3%)
14 Do you think screening for peri-natal depression is required?	Yes 48 (90.6%)	Maybe 4 (7.5%) No 1 (1.9%)
15 Have you heard about any screening questionnaire for peri-natal depression?	Yes 25 (47.2%)	No 28 (52.8%)
16 Do you think any treatment should be offered to patients of peri-natal depression?	51 (96.2%)	2 (3.8%)
27 Do you routinely screen your patients for perinatal depression with a screening questionnaire?	6 (11.3%)	47 (88.7%)
30 Do you look for symptoms suggestive of depression in ante-natal patients, if not screened with a questionnaire?	27 (50.9%)	26 (49.1%)
31 Do you look for symptoms suggestive of depression in post-partum patients, if not screened with a questionnaire?	40 (75.5%)	13 (24.5%)

Table 3: Knowledge, attitude, s and practices about perinatal depression and its screening

Question	Agree/strongly agree
9 In your opinion, what is the etiology of perinatal depression?	
Life stress	36 (67.9%)
Genetic factors	23 (43.4%)
Physical and emotional demands of child bearing and baby care	39 (73.6%)
Changes in hormones during and after pregnancy	36 (67.9%)
Weakness and faulty thinking and attitude of women	26 (49%)
10 What are the risk factors of peri-natal depression?	
Previous mental illness	39 (73.6%)
Pregnancy loss	36 (67.9%)
Ethnicity	14 (26.4%)
Neonatal illness	31 (58.5%)
Unwanted and unplanned pregnancy	32 (60.4%)
Level of education	21 (39.6%)
Poor marital relationship	35 (66%)
Maternal age	21 (39.6%)
Parity	25 (47.2%)
Lack of family support	43 (81.1%)
11 In your opinion what are the symptoms of peri-natal depression?	
Extreme sadness	44 (83%)
Delusion	5 (9.4%)
Low energy	42 (79.2%)
Hallucinations	6 (11.3%)
Crying	43 (81.1%)
Anxiety/irritability	45 (84.9%)
Illusions	0
Changes in sleeping	44 (83%)
Changes in eating pattern	34 (64.2%)
17 In your opinion what is the management of depression in peri-natal period?	
Psychotherapy	46 (86.8%)
Antidepressants	27 (50.9%)
Hormonal therapy	4 (7.5%)
Encouragement to ventilate feelings	38 (71.7%)
Maintain close observation of the mother	37 (69.8%)
Maintain safe environment	40 (75.5%)
Allow friends and relatives for social support	38 (71.7%)
Counselling husband and family members	50 (94.3%)
No treatment	0
18 In your opinion what can be the effect of untreated depression in peri-natal period?	
Poor relationship	34 (64.2%)
Suicidal thoughts	47 (88.7%)
Harm to baby	42 (79.2%)
Poor mother infant attachment	50 (94.3%)
Behavior problem in child	23 (43.4%)
Cognitive problem in child	16 (30.2%)
19 In your opinion who is the best person to treat peri-natal depression?	
Obstetrician	30 (56.6%)
Psychiatrist	47 (88.7%)
Post MBBS medical officer	5 (8.4%)
No treatment required	0
20 Do you feel comfortable in assessing and dealing with depressed patients' needs?	36 (67.9%)
21 Do you think treating depression is unnecessary as depression is merely unhappiness?	1 (1.9%)
22 One of the main causes of depression is a lack of self-discipline and will power.	18 (34%)
23 Do you think all health professionals should have skills in recognising and managing depression?	47 (88.7%)
24 Do you feel confident in assessing suicide risk in patients presenting with depression?	24 (45.2%)
25 Depression reflects a response which is not amenable to change.	13 (24.6%)
26 Recognizing and managing depression is often an important part of managing other health problems during perinatal period	49 (92.5%)

Contd...

Table 3: Contd...

Question	Agree/strongly agree
28 At what time you prefer to screen peri-natal women for depression?	
Ante-partum	17 (32.1%)
Post-partum up to 6 weeks	21 (39.6%)
Post-partum after 6 weeks up to 6 months	5 (9.4%)
Post-partum after 6 months to 1 year	4 (7.5%)
Not applicable	6 (11.3%)
29 How many peri-natal women have you screened for depression in your career?	
<10	38 (71.7%)
10-50	10 (18.9%)
50-200	4 (7.5%)
>200	1 (9.5%)

In a project to improve postpartum depression screening practices among providers in a community women's healthcare clinic, it was concluded that universal screening for perinatal depression with a standardised tool may positively influence healthcare providers' compliance in providing recommended depression screening to all women during the postpartum period. The provider education and the addition of the Edinburgh Postnatal Depression Scale (EPDS) screening criteria to the electronic health record were associated with increased rates of screening for postpartum depression.^[8]

This study employed non-random sampling, and only doctors who wished to participate filled out the questionnaire. This limits the generalisability of results. A potential bias could be that only those doctors who considered themselves knowledgeable about the subject filled out the questionnaire. The knowledge of participants could be overestimated. The sample size is small and the population is heterogeneous, further limiting generalisability (external validity).

In spite of these limitations, this study shows glaring inadequacies in knowledge as well as practices related to depression in antenatal and postpartum females.

Conclusion

To conclude, there is a need to educate healthcare workers including obstetricians about the screening for perinatal depression. We need to focus on perinatal mental health as a separate topic in undergraduate and postgraduate obstetrics curricula. Dedicated perinatal mental health services need to be stressed upon while preparing guidelines and incorporated in national programmes. Early recognition and requisite referral of perinatal women with depression can improve their quality of life and prevent complications that arise due to untreated depression.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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