Procrastination, Dependence and Social Loafing: Comparison in High/Low Task Visibility between Active/Passive Procrastinators

Tung-Yen Chen\textsuperscript{1}, Tzu-Lang Chang\textsuperscript{1} and Chao-Yu Chen\textsuperscript{2}

\textsuperscript{1}Doctoral Student, Major in Education, School of Management, Da-Yeh University, Taiwan.

\textsuperscript{2}Doctoral Student, Major in Education, School of Management, Da-Yeh University, Taiwan.

\textbf{Correspondence:}
Shao-I Chiu: Associate Professor of Graduate Institute of Professional Development in Education, DA-YEH University, Taiwan. Address: No.168, University Rd., Dacun, Changhua 51591, Taiwan (R.O.C).
Received: 19 March 2020; Accepted: 11 April 2020

\textbf{ABSTRACT}

\textbf{Background:} Postpartum psychiatric disorders have devastating consequences not only on the women, but also for the child and family. Not much is known about the magnitude and pattern of these disorders since the entrenchment of relative peace in this geo political zone of the country, hence this study.

\textbf{Aims and Objectives:} The study aimed to determine the clinical, psychosocial and socio demographic characteristics of women diagnosed with postpartum psychiatric conditions in a tertiary health institution in Damaturu, North East Nigeria.

\textbf{Methods:} We conducted a retrospective review between May 2017 and April 2019 of cases with post partum psychiatric conditions and extracted relevant data using an instrument designed by the authors.

\textbf{Results:} Majority of the participants had vaginal delivery 62/82 (75.6%), were married 68/82 (82.9%), had full term babies 63/82 (76.8%) and developed post partum psychiatric symptoms less than four weeks after delivery 80/82 (97.5%). Depression was the commonest type of post partum psychiatric illness 47/82 (57.3%), followed by mania 14/82 (17.1%), bipolar disorders 8/82 (9.8%) and schizophrenia 6/82 (7.3%). The husbands were the primary caregivers in 63.4% of the participants while more than half of them were not booked 45/82 (54.9%).

\textbf{Conclusion:} The study offered some insight into the occurrence of mental health disorders during the perinatal period among women in Damaturu, North East Nigeria. Therefore, there is need for early detection and effective management of post partum psychiatric disorders in a timely and proactive fashion as this is essential for optimal mental well being of the mother and child.

\textbf{Keywords} Post partum psychiatric disorders, Tertiary health institution, Damaturu, North East Nigeria.

\textbf{Introduction} The World Health Organization (WHO) describes the post-partum period as the most critical and yet the most neglected phase in the
lives of mothers and babies, most maternal morbidity and mortality occur during the post-partum period [1]. Post-partum psychiatric disorders are mental disturbances which occur in women of child bearing age within four weeks of childbirth [2]. The disorders are thought to occur three times more commonly in the developing than in developed countries [3].

The perinatal mental health of women living in low- and middle-income countries has only recently become the subject of research [4], in part because greater priority has been assigned to preventing pregnancy related deaths. In addition, some have argued that in resource-constrained countries, women are prevented from experiencing post-partum psychiatric disorders through the influence of social and traditional cultural practices during pregnancy and in the post-partum period [5,6].

Post-partum psychiatric disorders can be mainly divided into three groups: post-partum blues, post-partum depression and the post-partum psychosis and are reported to affect between 1/1000 and 2/1000 women after childbirth [7]. These disorders are serious and common with important implications for the welfare of the family and development of the child [8]. The effects are not only borne by the patients but their children and relatives [9]. They are largely under diagnosed and under treated reiterating the fact that routine screening during post-partum clinic visits should form an integral part of the assessment.

The etiology of post-partum psychiatric disorders is a complex interaction of psychological, social, biological factors in addition to genetic and environmental factors. Puerperal hormone shifts, obstetrical complications, sleep deprivation and increased environmental stresses are possible contributing factors to the onset of the illness [10,11]. Additional risk factors include primiparous patient, family history of psychiatric illness, personal psychiatric history particularly mania [12].

Nigeria records one of the worst rates of maternal and infant morbidity/mortality in the world13. However, there is paucity of reports on the magnitude of the full spectrum of mental health morbidity associated with pregnancy and delivery in the country. This study aimed to describe the obstetric and socio demographic profile of women treated for post-partum psychiatric disorders over a two year period in a tertiary hospital in the North Eastern Nigeria. This review will help to further build on the epidemiology of women’s reproductive mental health by utilizing data from this study and contributing to the pool of knowledge needed for robust planning of service delivery to women at risk of post-partum psychiatric disorders.

**Methods**

This was a two-year retrospective case note reviews of women diagnosed with post-partum psychiatric disorders between May, 2017 and April, 2019 in Yobe State Specialist Hospital, Damaturu, Nigeria. Each case was critically evaluated and reviewed by a consultant psychiatrist and the diagnosis of post-partum psychiatric disorder was made using the International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10). Case notes were retrieved manually from the health record department of the hospital. The hospital is a 300 bedded referral institution with facilities and mental health professionals (two full time consultant psychiatrists, five visiting consultant psychiatrists, five psychiatric nurses and clinical psychologists) to care for the mentally ill in Yobe State, neighboring states in the north eastern region of Nigeria and the West African sub region as well. Other clinical services such as nephrology, cardiology, urology, orthopedic surgery etc. are also rendered in the hospital.

A proforma was developed by the researchers to collect relevant information from the case notes based on literature such as age, marital status, level of education, gravidity, parity, gender of the baby etc. The questionnaire also contained questions on family size, family history of mental illness, marital satisfaction and relationship with spouse in the family.

The study was approved by the Research and Ethical Committee of Yobe State Specialist Hospital, Damaturu. All the data collected were coded and analysed using the Statistical Package for Social Sciences version 21 software.

**Results**

A total of 82 women were included in the study whose age groups showed 42.7% were between 20 and 27 years as shown in table 1. Majority of the participants were Muslims 85.4% (70/82) and married 82.9% (68/82). Half of the respondents were full housewives 50% (41/82) and had cordial relationship with their spouses 51.2% (42/82). About a quarter of them had tertiary education 24.4% (20/82).

| Demographic factors | Groups | Freq. | %   |
|---------------------|--------|-------|-----|
| **Age (years)**     |        |       |     |
| 10-19               | 20     | 24.4  |
| 20-29               | 35     | 42.7  |
| 30-39               | 21     | 25.6  |
| 40-49               | 6      | 7.3   |
| Total               | 82     | 100.0 |
| **Number of times delivered** |        |       |     |
| First               | 3      | 3.7   |
| Second              | 17     | 20.7  |
| Third               | 19     | 23.2  |
| Fourth              | 18     | 22.0  |
| Fifth and above     | 25     | 30.5  |
| Total               | 82     | 100.0 |
| **Religion**        |        |       |     |
| Islam               | 70     | 85.4  |
| Christianity        | 12     | 14.6  |
| Total               | 82     | 100.0 |
| **Marital Status**  |        |       |     |
| Single              | 2      | 2.4   |
| Married             | 68     | 82.9  |
| Separated           | 5      | 6.1   |
| Divorced            | 5      | 6.1   |
| Widowed             | 2      | 2.4   |
| Total               | 82     | 100.0 |
Table 1: Socio demographic characteristics of the patients (N=82).

| Tribe       | Frequency | Percentage |
|-------------|-----------|------------|
| Kanuri      | 38        | 46.3       |
| Hausa       | 21        | 25.6       |
| Fulani      | 14        | 17.1       |
| Yoruba      | 5         | 6.1        |
| Igbo        | 3         | 3.7        |
| Others      | 1         | 1.2        |
| Total       | 82        | 100.0      |

| Education   | Frequency | Percentage |
|-------------|-----------|------------|
| No formal education | 22        | 26.8       |
| Primary     | 26        | 31.7       |
| Secondary   | 14        | 17.1       |
| Tertiary    | 20        | 24.4       |
| Total       | 82        | 100.0      |

| Employment  | Frequency | Percentage |
|-------------|-----------|------------|
| Employed    | 28        | 34.1       |
| Unemployed  | 12        | 14.6       |
| Full housewife | 41        | 50.0       |
| Student     | 1         | 1.2        |
| Total       | 82        | 100.0      |

| Family Type | Frequency | Percentage |
|-------------|-----------|------------|
| Polygamous  | 49        | 59.8       |
| Monogamous  | 33        | 40.2       |
| Total       | 82        | 100.0      |

| Number of Children | Frequency | Percentage |
|--------------------|-----------|------------|
| 1-4                | 53        | 64.6       |
| 5-8                | 22        | 26.8       |
| 9 or more          | 7         | 8.5        |
| Total              | 82        | 100.0      |

| Quality of Spousal Relationship | Frequency | Percentage |
|---------------------------------|-----------|------------|
| Not applicable                  | 2         | 2.4        |
| Cordial                         | 42        | 51.2       |
| Not cordial                     | 38        | 46.3       |
| Total                           | 82        | 100.0      |

Table 2: Psychosocial and Clinical variables N=82.

Table 2 shows the distribution of psychosocial and clinical variables of the women. A little above half of them reported perceived social support 56.1% (46/82), poor marital satisfaction 52.4% (43/82), history of assault 51.2% (42/82) and no history of previous abortion or miscarriage 54.9% (45/82). Majority did not have co morbid medical illness 64.6% (53/82) while half of them did not plan the index delivery 50% (41/82).

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| History of stillbirth | Yes | 35 | 42.7 |
| No        | 47     | 57.3     |
| Total     | 82     | 100.0    |

| Psychiatric diagnosis | Groups | Frequency | Percentage |
|-----------------------|--------|-----------|------------|
| Acute psychotic episode | Yes   | 36        | 43.9       |
| No                    | 46     | 56.1      |
| Total                 | 82     | 100.0     |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Perceived social support | Yes | 46 | 56.1 |
| No        | 36     | 43.9     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Planned index delivery | Yes | 41 | 50.0 |
| No        | 41     | 50.0     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Desirability of pregnancy | Yes | 42 | 51.2 |
| No        | 40     | 48.8     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Marital satisfaction | Good | 39 | 47.6 |
| Poor      | 43     | 52.4     |

Table 3a shows a little above half of them were diagnosed with depression 57.3% (47/82), 17.1% of them had mania, 7.3% had schizophrenic like disorder and 9.8% were diagnosed with bipolar disorder. Majority of them had no family history of mental illness 78% (64/82) while a little above half of them had no complication during delivery 56.1% (46/82). A little above two fifths of them reported onset of symptoms one to two weeks after delivery 42.7% (35/82).

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| History of abortion/miscarriage | Yes | 36 | 43.9 |
| No        | 45     | 54.9     |
| Missing   | 1      | 1.2      |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Co morbidity | Yes | 29 | 35.4 |
| No        | 53     | 64.6     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| History of substance use | Yes | 31 | 37.8 |
| No        | 51     | 62.2     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| History of Assault | Yes | 42 | 51.2 |
| No        | 40     | 48.8     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Bipolar   | 8      | 9.8       |
| Not otherwise specified | 3 | 3.7 |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Psychiatric diagnosis | Yes | 36 | 43.9 |
| No        | 46     | 56.1     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Acute psychotic episode | Yes | 33 | 40.2 |
| No        | 44     | 50.0     |
| More than 4 weeks | 2 | 2.5 |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Onset of Symptoms after delivery | Yes | 36 | 43.9 |
| No        | 46     | 56.1     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Bipolar   | 8      | 9.8       |
| Not otherwise specified | 3 | 3.7 |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Acute psychotic episode | Yes | 33 | 40.2 |
| No        | 44     | 50.0     |
| Total     | 82     | 100.0    |

| Variables | Groups | Frequency | Percentage |
|-----------|--------|-----------|------------|
| Bipolar   | 8      | 9.8       |
| Not otherwise specified | 3 | 3.7 |
| Total     | 82     | 100.0    |
The findings from this study revealed that majority of the women post-partum psychiatric disorders. This was a retrospective study of case files of women who were diagnosed with post-partum psychiatric disorders using the International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10) diagnostic criteria and presents the North Eastern Nigeria perspective on the pattern of post-partum psychiatric disorders.

The findings in the study also showed that majority of the respondents with post-partum psychiatric disorders were unemployed and full housewives who were not gainfully employed. This agrees with the findings of Kheirabadi et al. [22] who found unemployment to be significantly associated with increased rate of post-partum psychiatric disorders. One possible explanation to this is that, unemployment may be particularly detrimental to the mental health after childbirth because of financial worries and anxiety for the future related to the baby.

Our study found that post-partum psychiatric disorders were most common among women who did not desire the pregnancy. This tends to support the findings of Mohammed et al. [23] who found that unplanned or undesired pregnancy was an associated factor in the development of post-partum psychiatric disorders among Jordanian women. The reason for this might be that, the mothers were not psychologically prepared and might have difficulty in providing effective and responsive care to their infants, thereby leading to the development of psychological distress.

Marital dissatisfaction has been reported in many related studies as risk factor for post-partum psychiatric disorders [24,25]. This was also found in this current study as more than half of the respondents with post-partum psychiatric disorders reported poor marital satisfaction. This finding may be explained by the fact that marital satisfaction is an essential component of emotional and psychological well-being and it has a positive association with general happiness and perception of overall individual health [26].

### Table 3a: Showing Distribution of Other Clinical Variables.

| Variables                        | Groups  | Frequency | Percentage |
|----------------------------------|---------|-----------|------------|
| Previous mental illness          | Yes     | 18        | 22.0       |
|                                  | No      | 64        | 78.0       |
|                                  | Total   | 82        | 100.0      |
| Previous history of puerperal related mental illness | Yes | 18 | 22.0 |
|                                  | No      | 64        | 78.0       |
|                                  | Total   | 82        | 100.0      |
| Gender of baby                   | Male    | 38        | 46.3       |
|                                  | Female  | 44        | 53.7       |
|                                  | Total   | 82        | 100.0      |
| Gestation period                 | Pre term| 9         | 11.0       |
|                                  | Full term| 63       | 76.8       |
|                                  | Post term| 10        | 12.2       |
|                                  | Total   | 82        | 100.0      |
| Delivery method                  | Vaginal | 62        | 75.6       |
|                                  | Caesarean section | 15 | 18.3 |
|                                  | Instrumental | 5 | 6.1 |
|                                  | Total   | 82        | 100.0      |
| Booking Status                   | Booked  | 37        | 45.1       |
|                                  | Unbooked| 45        | 54.9       |
|                                  | Total   | 82        | 100.0      |
| Primary caregiver                | Husband | 52        | 63.4       |
|                                  | Mother  | 15        | 18.3       |
|                                  | Other relatives | 15 | 18.3 |
|                                  | Total   | 82        | 100.0      |
| State of the child               | Alive and well | 57 | 69.5 |
|                                  | Alive and sick | 19 | 23.2 |
|                                  | Dead    | 6         | 7.3        |
|                                  | Total   | 82        | 100.0      |

Table 3b: Showing Distribution of Other Clinical Variables.

### Discussion

This was a retrospective study of case files of women who were diagnosed with post-partum psychiatric disorders using the International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10) diagnostic criteria and presents the North Eastern Nigeria perspective on the pattern of post-partum psychiatric disorders.

The findings in the study also showed that majority of the women were predominantly between the age brackets 10-29 years, this might be due to early marriage which still remains a cultural practice in the Northern Nigeria [14] and many girls married when they were twelve years old or younger [15]. The mother’s young age is a significant risk factor for post-partum psychiatric disorders, this is because the period of post-partum is very stressful as the new mother needs to cope with the care of the newborn and home, as such older mothers may have better coping strategies than the younger mothers [16]. The finding in our study differs from that of Nager et al. [17] who found that older maternal age is associated with increased risk of post-partum psychiatric disorders.

Majority of the women with post-partum psychiatric disorders in the study were married. Though, many researchers have reported that being married or in a stable partner relationship could have a protective effect [19,20], it could be argued that marriage itself can be a risk factor for post-partum psychiatric disorders where there is marital disharmony or poor spousal relationship as reported by almost half of the respondents [21].

The findings in the study also showed that majority of the respondents with post-partum psychiatric disorders were married. Though, many researchers have reported that being married or in a stable partner relationship could have a protective effect [19,20], it could be argued that marriage itself can be a risk factor for post-partum psychiatric disorders where there is marital disharmony or poor spousal relationship as reported by almost half of the respondents [21].

The study also showed that poor mental health after childbirth because of financial worries and anxiety for the future related to the baby.
In the present study, a little above half of the respondents with post-partum psychiatric disorders had history of assault. This is in keeping with the findings of Noor et al. [27] who also found that women exposed to assault or violence are at higher risk of developing mental health problems in puerperium due to the adverse ripple effects of assault on the psychological well-being of nursing mothers.

Depression is the commonest psychiatric diagnosis among women with post-partum mental health disorders in this study. This agrees with the findings of Uwakwe and Okonkwo [28] who also reported that depression is commonest in the post-partum period. Half of the respondents in this study reported that their pregnancies were not planned, this often have a greater effect on maternal health by negatively affecting mother’s psychology and bring economic burden which in turn leads to post-partum depression [28]. However, our finding in this study differs from the findings of Adewunmi and Gureje [29] who found preponderance of schizophrenia among patients in the puerperial period, this might be due to the difference in study design and the time of evaluation.

Majority of the participants developed post-partum psychiatric disorders within the first two to four weeks after delivery and most of them presented for treatment within one month of onset of illness. This however differs from the findings of Altshuler et al. [30] who reported onset of symptoms and late presentation within three months post-partum. The reason for this difference could be partly associated with the fact that at the time of the current study, there was a robust mental health awareness in all health care facilities in Yobe State of Nigeria such that many people access mental health services easily as both full time and visiting psychiatrists were on ground to attend to the mental health needs of the people.

In our study, we found female children to be more commonly born to women with post-partum psychiatric disorders, this agrees with the findings of Agrawal et al. [31] who found female gender of the babies to be positively correlated with the post-partum psychiatric disorders. Most of the women with post-partum psychiatric disorders in the study were also unbooked, this tends to support the findings of Veena et al. [32] who suggested obstetric factors such as being unbooked, problems during pregnancy as vulnerability factors in the development of post-partum psychiatric disorders.

Strengths and Limitations
The study was the first retrospective work on post-partum psychiatric disorders in a multi-speciality hospital in the North East Nigeria, though is limited to the extent to which records about the patients are kept and the design of the study also limits the inference of causality.

Conclusion
There is need for healthcare professionals to regularly screen women in puerperium as this period is a time of increased risk for the onset or exacerbation of mental health disorder. Therefore, early screening, diagnosis and timely management are very important and must be considered as mandatory part of postpartum care.

References
1. World Health Organization “WHO recommendations on post natal care of the mother and newborn”. WHO. Retrieved 22 December 2014.
2. American Psychiatric Association (APA). Diagnostic and Statistical Manual of Mental Disorders. Text revised. Washington D.C. USA, 2000.
3. Cooper PJ, Tomlinson M, Swartz L, et al. Post partum depression and the mother infant relationship in a South African peri urban settlement. British Journal of Psychiatry. 1999; 175: 554-558.
4. World Development Indicators (database). Washington. World bank. Available from Ltp://data. worldbank.org/data-catalog/ world-development indicators. 2005.
5. Stern G, Kruckman L. Multi disciplinary perspectives in post partum depression: an anthropological critique. Soc Sci. Med. 1983; 17: 1027-1041.
6. Howard R. Transcultural issues in pupeperal mental illness. Int Rev Psychiatry. 1993; 5: 253-260.
7. Kemp B, Bornartz K, Rath W. Psychiatric disturbances in the post partum period: An increasing problem? Z Geburtshilfe Neonatologie. 2003; 207: 159-165.
8. Kumar R. Post natal mental illness: A trans cultural perspective. Soc Psychiatry Psychiatr Epidemiology. 1994; 29: 250-264.
9. Adewuya AO, Ola BA, Aloba O, et al. Impact of post natal depression on infants growth in Nigeria. Journal of Affective Disorders. 2005; 108: 191-193.
10. Makanjuola RO. Psychotic disorders after childbirth in Nigerian women. Tropical and geographical Medicine. 1982; 34: 67-72.
11. Stewart DE, Vigod SN. Post partum depression; Pathophysiology, treatment and emergency therapeutics. Annual Review of Medicine. 2019; 70: 183-196.
12. Sichel DA, Driscoll JW. Women’s Moods. New York, USA. Willian Morrow and Company. 1999.
13. Unicef. Report card on maternal mortality in the world; http:// www.unicef.org/publications/files/progress for children-Lo Res 08;2008.pdf.
14. Wolf M, Abubakar A, Tsui S, et al. Child spacing Attitudes in Northern Nigeria. Washington DC.FHI. 2008.
15. National Population Commission (NPC) Nigeria and ICF International Nigeria Demographic and Health Survey 2013, Abuja Nigeria, Rock Villa, Maryland USA.NPC and ICF International.
16. Adewuya AO, Ologun YA, Ibighami OS. Post traumatic stress disorder after childbirth in Nigerian women; prevalence and risk factors, British Journal of Obstetrics and Gynaecology. 2006; 113: 284-288.
17. Nager A, Johansson L, Sundquist K. Are socio demographic factors and year of delivery associated with hospital admission for post partum psychosis? A study of 500,000 first time mothers. Acta Psychiatraca Scandinavica. 2005; 112: 47-53.
18. Nielsen Forman, Videbech P, Hedegaard M, et al. J Post partum depression identification of women at risk. British Journal of
19. Stock A, Chin L, Babl F, et al. Postnatal depression in mothers bringing infants to the emergency department. Arch Dis Childhood. 2013; 98: 36-40.
20. Oates JL, Cox S, Neema P, et al. Postnatal depression across countries and culture; a qualitative study. British Journal of Psychiatry. 2004; 186: 10-16.
21. Hammen CL. Interpersonal stress and depression in women. J Affect Discord. 2003; 74: 49-57.
22. Kheirabadi GR, Maracy MR. Perinatal depression in cohort study on Iranian women. J. Res Med Sci. 2010; 15: 41-49.
23. Mohammed K, Gamble J, Creedy D. Prevalence and factors associated with the development of antenatal and postnatal depression among Jordanian women. Midwifery; 2011; 27: e238-245.
24. Abiodun OA, Adetoro OO, Ogunbode OO. Psychiatric morbidity in a pregnant population in Nigeria. Gen Hosp Psychiatry. 1993; 15: 125-128.
25. Fatoye FO, Fauba OB. Post partum mental disorders: pattern and problems of management in Wesley Guild Hospital, Ilesha. Journal of Obstetrics and Gynaecology; 2002; 22: 508-512.
26. Renne KS. Correlates of dissatisfaction in marriage. Journal of Marriage and the family. 1970; 32: 54-67.
27. Noor A, Umi A, Taris A, et al. Postnatal depression and intimate partner violence: a nationwide clinic based cross sectional study in Malaysia; BMJ. 2018; 8: e020649.
28. Uwakwe R, Okonkwo J. Affective (depressive morbidity in puerperal Nigerian women: validation of the Edinburgh postnatal depression scale. Acta Psychiatric Scandinavia. 2003; 107: 251-259.
29. Adewunmi A, Gureje O. Puerperal psychiatric disorders in Nigerian women. East Africa Med J. 1991; 68: 775-781.
30. Altshuler L, Cohen L, Szuba M, et al. Pharmacologic management of psychiatric illness during pregnancy. Dilemmas and guidelines. American J. Psychiatry. 1996; 153: 592-606.
31. Agrawal P, Bhatia M, Malik S. Post partum psychiatric disorders: A clinical study. International J. Soc Psychiatry. 1997; 43: 217-222.
32. Veena A, Ammu L, Srinivasan K. Maternal mental health in pregnancy and child behavior. Indian J Psychiatry. 2011; 53; 351-361.