in addition to drugs and talking therapies. These may include help with the relationship with the partner. The father is often a major source of stress, but can also be a major support. This may involve assisting with practical problems such as housing, or facilitating the provision of a stronger or more supportive social network.

The role of psychiatrists and all those caring for the emotional well-being of women in the perinatal period, and for the future child, is much more than helping with diagnosed psychiatric disorders.

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Supporting psychological well-being around the time of birth: what can we learn from maternity care?

The early identification and management of perinatal mental problems for women without pre-existing mental disorders is largely dependent on health professionals within maternity care and primary care[1]. Despite being willing to offer mental health care, there is evidence that many of these health professionals often do not feel confident and feel ill equipped to identify and support women with mental health problems[2].

While training and clearer care pathways will undoubtedly contribute to improve professional confidence in managing perinatal mental disorders, there are some features of the maternity care context that should be considered when moving forward to optimize perinatal mental health care: a) the overarching focus on health rather than ill health; b) the need to differentiate between manifestations related to pregnancy or childbirth and mental health problems.

A brief look at the history of maternity care in the latter half of the 20th century provides some insights into its overarching focus on health. Hospital births in the UK grew from just over 60% in 1960 to 96% by 1990. Alongside this development there was a change in how women gave birth. Spontaneous childbirth was the norm during the 1960s, with an induction rate of just 8%. Induction rates grew to 39% by 1974[3]. The increasing trend in obstetric interventions was evident internationally and became the driver for change in the 1990s. In 1990, the World Health Organization released *Care in Normal Birth: A Practical Guide*. Changing Childbirth was launched in the UK in 1993 and the Mother Friendly Childbirth Initiative in North America was launched in 1996. Recurring principles in these initiatives were the empowerment of women and autonomy in childbirth process while doing no harm. These remain the corner stone of maternity care today.

These maternity care principles are among the dimensions of psychological well-being outlined by Fava and Guidi[4] in a previous Forum in this journal: environmental mastery, personal growth, purpose in life, autonomy, self-acceptance and positive relations with others. Psychological well-being, that promotes flourishing rather than simply the absence of illness, should find a natural home in maternity care and yet, until recently, it has been relatively understudied[5].

Howard and Khalifeh[1] highlight that women with common mental disorders have adverse pregnancy outcomes such as preterm birth, although the evidence is by no means consistent. Conversely, there is growing evidence that women with high positive affect have higher gestational age and reduced risk of preterm birth than those with low positive affect, even after controlling for the effects of birthweight and psychosocial stress[6]. As with common mental disorders, the evidence is not consistent, with some studies demonstrating effect sizes that are not clinically meaningful[7] or statistically significant[5].

Much more research is needed to understand psychological well-being around the time of birth and its impact on the maternity population as a whole. Incorporating psychological well-being into care would offer an innovative approach to screening, prevention, and the interventions that we offer women. Reframing perinatal mental health to include psychological well-being may also help address stigma associated with diagnosis and treatment of perinatal disorders, that is heightened in the perinatal period due to a sense of shame and guilt related to being perceived as a "bad" mother. Focusing on psychological well-being should in no way detract from the identification and treatment of women with mental disorders. The promotion of euthymia (a state of internal calm and contentment) within general psychiatry has much to offer perinatal mental health care[4].

The second, and related, issue is the need to differentiate between the manifestations of pregnancy or childbirth and mental health problems. Running parallel to changes in maternity care were developments in perinatal mental health research and practice. In the 1960s and 70s, postpartum blues became popularized as a mild disorder that impacted on most women in the days just after childbirth. Postnatal depression also came to the fore in research and practice. By the 1980s there were queries about the legitimacy of such diagnoses. A. Oakley, a British sociologist, noted in her book *Women Confined* that women's accounts of depression in her research

sample reflected exhaustion, sleep deprivation, and feeling ill prepared for the shock of becoming a new parent, rather than being a psychological disorder[8]. Subsequent research indicates that the reality is likely to be much more complicated than either of these positions suggest.

Howard and Khalifeh note that measurement of perinatal mental health is hindered by lack of understanding of the importance of somatic symptoms[1]. Well-validated symptom checklists for depression in the general population, such as the Patient Health Questionnaire, have questions on tiredness and sleep disturbance that can be difficult to interpret, as it is unclear if these somatic symptoms are pregnancy-related or mental health-related. This does not mean that such questions are redundant. Rather, they provide a clear rationale for collaborative research and practice to disentangle the unique features of mental health in the perinatal period and in particular what constitutes ill health.

Yonkers et al[9] conducted an observational study of 838 women which aimed to determine if the rates of behavioral and somatic symptoms in pregnant women vary across trimesters and independently of a possible depressive disorder diagnosis. Women completed the Composite International Diagnostic Interview and the Edinburgh Postnatal Depression Scale before 17 weeks of gestation, at 26-30 weeks of pregnancy and 4-12 weeks postpartum. Pregnant women often experienced somatic symptoms in the first trimester of pregnancy, although depressed women still differed from those who were not depressed. Appetite increase, oversleeping and agitation were not informative symptoms in regard to identifying a major depressive disorder in pregnancy. It is important to explore this complex relationship further, as failure to do so could lead to the over-pathologizing of mental health manifestations on the one hand and on the other failure to identify obstetric complications in women with mental disorders, who are at increased risk for a range of obstetric adverse outcomes[1].

Despite perinatal mental disorders being the commonest complication of childbearing, mental health care continues to languish in the shadow of physical health care in the perinatal period. Throughout all the changes in maternity care, women with mental health problems have struggled to have their voices heard. Howard and Khalifeh have documented the considerable progress that has been made in perinatal mental health care, but many challenges remain. Much can and needs to be done to support the psychological well-being of women and their families. Reframing how we conceptualize perinatal mental health to include well-being approaches that acknowledge the complex relationship between pregnancy and mental health provides an opportunity to find effective solutions, so that more women and their families flourish.

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Perinatal mental health and the COVID-19 pandemic

Howard and Khalifeh[1] provide us with an excellent account of the epidemiology of perinatal mental health; the importance of social determinants of mental ill health, such as poverty, racism, and gender-based violence; and the state of current evidence to inform intervention and service delivery models. Their timely and comprehensive review of the current state of evidence identifies critical gaps in knowledge that will be important to address as the COVID-19 pandemic unfolds, particularly with regard to the intersection of individual level and community level interventions.

Once the worst impacts of the COVID-19 pandemic are past, the questions that should concern us are: a) how well prepared were we for an event on this scale; b) what service delivery models and intervention strategies are the most effective in supporting parent mental health when families and communities are faced with such large-scale upheaval; and c) what can be done to guard against events such as COVID-19 further entrenching mental health inequalities, both *within* high income countries, and *between* low, middle and high income countries.

With governments enforcing restrictions on travel, closing schools and workplaces, encouraging people to stay at home and limiting social gatherings, families with young children face a series of multi-faceted and unanticipated challenges. First-time parents are finding themselves caring for a newborn at home with limited or no access to support from extended family and restricted access to primary health care and mental health services. Parents of older children are faced with keeping them occupied at home for an extended (and unknown) period of time, coupled with responsibility for supervision of home schooling.

Millions of people previously employed have lost their jobs, with little chance of finding alternative employment at least in the short term. Those fortunate enough to have ongoing employment are having to navigate ways of maintaining paid work schedules and simultaneously manage the care of children at home. Not surprisingly, by early April 2020, the Australian national helpline for parents experiencing perinatal depression or anxiety (PANDA) had already recorded a 30% increase in calls to its telephone counselling service.

Globally, family violence services are