



The Crisis of Perinatal Mental Health in the Age of Covid-19

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Abstract

In the US, the COVID-19 pandemic adds a new source of stress for women in the perinatal period, a time when stress and anxiety are already heightened. The closures of physical mental health care spaces and lack of support could have devastating impacts on the health of postpartum women and their newborns. Yet, the pandemic creates an opportunity to innovate in the ways mental health care is delivered to pregnant and postpartum women. With the expanded capacity for video and telephone visits, researchers should continue to explore solutions for providing support networks to this vulnerable population.

Keywords Covid 19 · Pregnancy · Perinatal mental health · Perinatal depression

Significance

Previous research on pregnant women has found that natural disasters can have consequential effects on the health of women and their newborns due to increased stress and disruptions in access to social support and care. The COVID-19 pandemic adds a new level of stress to women in the perinatal period as symptoms of anxiety and depression are heightened by social distancing measures and fear of the virus. This commentary focuses primarily on the potential impacts that the COVID-19 pandemic could have on the mental health of pregnant and postpartum women in the United States. It also presents some of the actions that governments and health care systems are taking or could take to expand the ways in which mental health care is delivered, which could spur new ways to provide mental health support to a group that was underserved prior the pandemic.

Commentary

COVID-19 has had a devastating worldwide impact on physical health and on the economy. But we are only beginning to acknowledge the powerful impact of this pandemic on mental health. Symptoms of anxiety and depression are heightened by fear of the virus, social distancing, financial effects and other ramifications of a loss of normality and structure. Many are managing their fear by avoiding risky places, including healthcare facilities. There is one group, however, that cannot practice such avoidance: pregnant women. Labor and delivery is one of the few medical procedures that cannot be postponed. Hospitals have all had to change procedures in response to the pandemic, including limiting or even banning all visitors (including fathers, doulas, and other social supports for laboring women) (Centers for Disease Control and Prevention 2020b; Preston 2020). In India, laboring women even had to visit the police to obtain a 12 h pass before being allowed to approach a hospital (DHNS 2020). The United States Centers for Disease Control and Prevention (CDC) at first recommended temporarily separating infected women from their newborns (Centers for Disease Control and Prevention 2020a; Rodriguez 2020). As evidence emerged, however, including CDC studies showing a low rate of transmission from infected women to newborns and an overall decrease in preterm birth during the pandemic (Berghella et al. 2020; Zambrano et al. 2020), other bodies, including both the WHO and the American Academy of Pediatrics, have now recommended full rooming-in with hand hygiene and mask wearing (American Academy

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of Pediatrics 2020; World Health Organization 2020). As these fears receded, however, additional concerns arose, both about increased risk for severe illness in pregnant women with COVID and increased rates of preterm birth in infected women (Centers for Disease Control and Prevention 2020b; Woodworth et al. 2020).

For healthy women, these circumstances can be overwhelming and may lead to new symptoms of anxiety. For the one in five women who suffer from perinatal mood and anxiety disorders (Gavin et al. 2005), they may be crippling. When the whole country is consumed with thoughts of ventilators, inadequate personal protective equipment, and political wars about masks and vaccines, it's easy to forget that childbirth even outside a pandemic can be dangerous. This is especially true for women of color, with Black women already dying at three times the rate of white women in the U.S. and Black communities and Latinx communities now disproportionately affected by COVID-19 (Evelyn 2020; Martin and Montagne 2017; Vahidy et al. 2020). Social support is a crucial factor in healthy pregnancy and in the postpartum period, with its lack associated with increased rates of preterm birth and postpartum depressive symptoms (Hetherington et al. 2015; Surkan et al. 2006). With suicide as a leading cause of death for women in the first year postpartum even at the best of times (Shadigian and Bauer 2005), what happens when health care systems' attention turns even further away from this vulnerable population?

Mental health treatment has changed radically in the last nine months since the beginning of social distancing precautions. At our hospitals, outpatient psychiatry has shifted entirely to telehealth (Johns Hopkins Medicine 2020). Partial hospital programs for more severely ill patients are now virtual, and at UNC the first inpatient psychiatry service dedicated to perinatal women, which one of us directs, closed temporarily in the face of an overwhelming need for hospital beds. As physicians treating pregnant women in this setting, we have heard from many of our patients that they feel isolated at home, without the usual supports of extended family, and our office staff have reported that many women who call for initial appointments have later cancelled or postponed because they fear meeting a new provider over a video connection (or in some cases do not have internet access). This isolation is especially problematic in communities also facing job losses, food insecurity, dense housing and neighborhoods, and increased rates of intimate partner violence (Taub 2020). The result for women will likely be higher stress and lower rates of treatment – and we know from previous natural disasters that these pregnancies will be at higher risk of preterm birth and these children will be at higher risk of developmental and psychiatric disorders (Franzek et al. 2008; Harville et al. 2010; McLean et al. 2018). We are already seeing increased rates of almost

40% with clinically relevant symptoms of depression and almost 60% with clinically relevant symptoms of anxiety (Lebel et al. 2020). This is only the beginning as the social and psychological effects continue, but also as we better understand the effects of infection with COVID-19 itself and the impacts of Posttraumatic Stress Disorder.

What can we do? State medical boards, the Drug Enforcement Administration (DEA), and Medicaid and Medicare have made a good start by loosening regulatory requirements for telehealth provision and reimbursement (U.S. Department of Health and Human Services 2020), but they (and commercial insurers) need to acknowledge the extra time needed and improve reimbursement for remote mental health treatment. Hospitals and health systems need to think creatively about how to enable healthcare teams to support patients that have even higher amounts of stress. Neighborhoods and local institutions should extend and develop support networks to include pregnant women and those suffering from mental illness, not just the elderly. Women and their families can work to maintain existing social support networks, by video or phone or drive-by visits conducted from six feet away. And research is urgently needed to understand the impact that added stress and immune system reactions to the virus will have on this generation of perinatal women and their children.

While the challenges are many, there is opportunity as well – to harness the expanded power of internet connectedness to reach this vulnerable group. Convincing depressed postpartum women to show up to the hospital with their newborns has always been a struggle, a struggle that is even greater for low-income women who may lack childcare or access to transportation. With our expanded capacity for video and telephone visits, we may have found a new way for previously reluctant women to access care. Programs such as NC Maternal Mental Health MATTERS represent a growing number of states that have perinatal mental health consultation lines that provide provider-to-provider consultation, telehealth assessments for patients, and resource and referral (Kimmel 2020). NC MATTERS has seen a dramatic increase in its use during the pandemic. Let's take that as a silver lining and think of other ways to use our altered norms to improve care not only now but for the future of women, their children, and their families.

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Compliance with Ethical Standards

Conflict of interest The authors declare no potential conflicts of interest with respect to the research, authorship, or publication of this article.

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