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Improving Perinatal Maternal Mental Health Starts With Addressing Structural Inequities

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Psychological distress during the perinatal period has increased during the COVID-19 pandemic. A systematic review of 81 studies (N = 132 917 pregnant or postpartum women; research published prior to January 31, 2021) reported prevalence of depression and anxiety ranging from 20% to 64% during the ongoing pandemic.¹ Although there is still a need to examine more representative samples, a large cross-sectional study¹ of mostly US women corroborated these findings, reporting clinical levels of depression in 36% of perinatal women compared with an estimated prepandemic prevalence of 11% to 17%. Changes in prenatal care and childbirth experiences, including lack of support during delivery and recovery, may also contribute to heightened feelings of distress. Women who gave birth during the pandemic reported an increased acute stress response to childbirth (odds ratio, 1.38; 95% CI, 1.01–1.89), correlating with increased posttraumatic stress disorder symptoms and maternal bonding or breastfeeding problems. In this Viewpoint, we focus on the potential consequences of perinatal maternal mental health on child development and highlight structural inequities that need to be addressed to mitigate maternal psychological distress and improve both maternal and child health and well-being.

Potential Effects of Prenatal Maternal Psychological Distress on Child Development

A major question that arises in the context of population-level changes in perinatal maternal mental health is how the added stress of this period may directly influence the developing child. A robust literature within the Developmental Origins of Health and Disease framework has linked prenatal maternal depression, anxiety, and stress to neuropsychiatric sequelae in offspring, likely mediated through both inflammatory and endocrine pathways.

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Observational studies of prior viral outbreaks, such as the 1918 H1N1 influenza pandemic, primarily focused on the associations between in utero viral exposure and increased risk for neuropsychiatric disorders in offspring. However, it is likely that increased prenatal-maternal psychological distress is an additional mechanism underlying these associations. Although the postnatal environment can potentiate or attenuate neuropsychiatric outcomes, prenatal-maternal psychological distress is associated with alterations in fetal neural networks, including protracted development of connectivity between superior frontal and motor regions, and between posterior insula and temporoparietal brain regions.² A recent study³ posted as a preprint that has not been peer reviewed found that interactions between prenatal-maternal depressive symptoms and in utero SARS-CoV-2 exposure were associated with individual differences in infant attentional processing at 6 months of age, with these differences in attention associated with infant socioemotional skills at 12 months of age. Taken together, this evidence suggests that children born during the current pandemic may be at increased risk of neuropsychiatric sequelae owing to increases in perinatal maternal mental health problems.

Removing Obstacles to Perinatal Mental Health Treatment

The US Preventive Services Task Force recommends mental health screening for all pregnant women through at least 1 year post partum, yet even prior to pandemic-related health care disruptions, there were infrastructure barriers in diagnosis and treatment. Many mental health care professionals do not accept Medicaid, resulting in added obstacles for women with low income and racial and ethnic minority women, who report higher rates of postpartum depression and are less likely to receive treatment. The COVID-19 pandemic has exacerbated these existing obstacles, as women of racial and ethnic minority groups are more likely to report that the pandemic has affected their mental health care access compared with non-Hispanic White women (odds ratio, 3.25; 95% CI, 1.23–8.59),⁴ resulting in an amplified need for equitable access to evidence-based maternal mental health services. There are several policies that could significantly improve perinatal psychological distress if implemented, including guaranteed Medicaid coverage through 1 year post partum, enforcement of mental health parity, and expanded coverage of telehealth services.⁴ However, it is important to note that although virtual services have gained popularity during the pandemic, telehealth may not adequately meet the needs of under-resourced communities.⁵ In addition to federal- and state-level policies to improve access, the expansion of perinatal quality collaboratives and population-based intervention programs that emphasize perinatal mental health screening and treatment could effect equitable change at the systems level. Interventions that target individual or community-level factors are limited in their efficacy unless structural determinants of perinatal maternal mental health are first resolved.

Increasing Perinatal Support Through Paid Leave and Affordable Childcare

Even if access to mental health treatment is improved, mothers need the time and resources to seek treatment during the perinatal period. The US is the only high-income country in the world without a federal policy that mandates paid leave to working women who give birth. Furthermore, in the US, 25% of mothers return to work within 2 weeks after

childbirth.⁷ Currently only 15% of workers have access to paid maternity leave, and rates are skewed toward higher socioeconomic status women.⁷ Black and Hispanic mothers are less likely to have access to time off or be financially able to take time off after child birth compared with White mothers. Mandating paid leave to all working mothers could potentially lead to reductions in sociodemographic disparities in maternal and child health, as paid leave is associated with lower likelihood of postpartum depression and maternal stress, as well as increases in breastfeeding, more secure attachment between mother and child, and fewer socioemotional and behavioral problems during toddlerhood.⁶ Emerging evidence from a recent study⁷ posted as a preprint that has not been peer reviewed, also reported that compared with unpaid leave, experiences of paid leave were related to distinct infant neurophysiological profiles, possibly reflecting more mature patterns of brain activity.

Pandemic-related shifts in increased domestic tasks, including childcare and homeschooling, coupled with financial insecurities have exacerbated prepandemic structural inequities. Parental job loss during the pandemic has been linked with parents' depressive symptoms and stress levels, as well as higher maternal and child cortisol concentration levels, with greater maternal cortisol levels associated with increased internalizing symptoms in children.⁸ According to data from the Kaiser Family Foundation, more than half of women who reported COVID-19-related job losses (beginning early in the pandemic and among mothers who quit their jobs) reported school or daycare closures as their rationale. It is important to note that COVID-19-related stressors are not uniformly experienced by all mothers. For women of racial and ethnic minority groups and women from low-income households, prepandemic disparities have been magnified; women who self identify as either Black or Hispanic or with low income were more likely to report quitting or taking unpaid leave compared with higher income or White women. Recent research suggests that mothers without childcare or with informal childcare arrangements have higher depressive symptoms than mothers whose children were enrolled in a free center-based program.⁹ In contrast, several studies have found that access to stable and high-quality center-based early childcare moderates associations between maternal depression and child internalizing problems.¹⁰ In the midst of an unprecedented nationwide childcare shortage in the US, access to affordable childcare for infants and universal free preschool for 3- and 4-year-old children would reduce unnecessary burden on mothers, with the potential to improve rates of maternal psychological distress and downstream effects on child neurobehavior.

Conclusions

It is imperative to address COVID-19–related population-level changes in maternal mental health and the resulting effects on early childhood development. Supporting mothers through specific policy changes that are associated with increasing access to mental health treatment, paid leave, and affordable childcare can improve mental health and well-being for mothers, their children, and generations yet to come.

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