

Impact of the COVID-19 pandemic on maternal mental health

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SUMMARY

The ongoing impact on global mental health of the COVID-19 pandemic and the isolation measures used to combat its spread is increasingly acknowledged. This reflection focuses on the effect the pandemic has had specifically on the mental health of women in the peripartum period, using recent case examples from a busy and diverse south London community perinatal psychiatry service.

KEYWORDS

Perinatal psychiatry; coronavirus; pandemic; lockdown; maternal mental health.

Since the emergence of the novel coronavirus (SARS-CoV-2) in late 2019 and its escalation to global pandemic status (COVID-19), governments and health systems have faced pressure to reduce its impact on people's physical health. As many countries adopt strict quarantine strategies, increasing attention is being given to the impact on mental and emotional well-being (Lima 2020). Meanwhile, the implications for prevalence of psychiatric illness as a consequence of this pandemic are becoming a growing research priority (Holmes 2020). The influence of the pandemic on perinatal mental health and service provision specifically is important to consider, as women in the perinatal period may be particularly vulnerable to the negative effects we are already seeing in the general and psychiatric populations.

Perinatal mental health services encompass the psychological care of women with pre-existing and *de novo* mental disorder from pre-conception until 1 year postpartum; and the impact of mental ill health in this period may extend to partners and the future emotional well-being of offspring. Among the universal features of pregnancy and childbirth are relative uncertainty and loss of control, which may precipitate mental health problems in some women – and as we are now experiencing these features on a global scale, it follows that we might expect an increase in cases in the coming months and possibly years (Royal College of Psychiatrists 2020).

In our perinatal community mental health service in south-east London, we have noted many recent referrals in which it is evident that the current world health crisis has been a key stressor or trigger for the development or deterioration of women's mental health difficulties. Most commonly this has manifested in high levels of anxiety due to uncertainty and fear about the pandemic and its impact on the woman's health and that of her baby. This has been further compounded by reductions in social support from family, friends and professionals, including a change in the delivery of obstetric and perinatal healthcare. Here we consider specific points to note in this high-risk population during each stage of contact with our services.

Pre-conception

It seems likely that measures that increase social isolation may affect fertility rates. For example, barriers to accessing contraception and abortion services, combined with the effects of cohabiting couples spending increased time together, may lead to an increase in unplanned pregnancies (which are a risk factor for maternal mental ill health). Conversely, women planning a pregnancy may be concerned about the current levels of uncertainty, leading to increased stress and anxiety as they consider whether to delay attempts to conceive. For many women with severe mental illness, family planning decisions can be particularly complex if they rely on medication to keep them well. Other women have experienced the devastating impact of the suspension of fertility treatments, including *in vitro* fertilisation (IVF) – in some cases leaving them uncertain whether they may still be able to access care once restrictions are eased and unsure of the effects that this delay may have on their chances of conceiving.

Case 1

A woman with a history of generalised anxiety disorder suffered an acute deterioration in her mental health, triggered by interpersonal difficulties after her partner reneged on plans to try for a second baby because of uncertainty and financial stress during the pandemic. She expressed feelings of hopelessness as she worried about her ability to conceive once the crisis is over.

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Relationship tension in this context may also reduce fertility, while recent evidence shows that domestic violence is increasing globally and is a significant cause for concern requiring urgent action (Bradbury-Jones 2020). Lockdown and other social distancing measures have made victims more vulnerable, with increased couple isolation and fear of exposure to the virus being cited as key inflators of risk of situational violence and coercion (Jarnecke 2020; Yahya 2020). Never has the need for sensitive enquiry into interpersonal difficulties been more important, while at the same time more difficult to navigate.

The antenatal period

One in five women will experience mental illness during the peripartum period, and in these cases, swift and comprehensive assessment and management may reduce the risk of adverse outcomes. Women are currently experiencing considerable changes to their maternity care. Virtual mental health reviews are now the norm for all but the highest-risk patients; and in terms of physical health, partners and other carers in some areas have faced restrictions on attending routine antenatal appointments and scans, and may not be present at invasive and often distressing procedures such as amniocentesis.

Case 2

A woman with a history of emotionally unstable personality disorder and in the first trimester of an unplanned pregnancy experienced worsening anxiety symptoms after being told that her partner would be unable to accompany her to amniocentesis because of coronavirus restrictions.

Antenatal classes have been cancelled or virtually adapted, leaving many women with minimal access to information and some facing their first experience of labour in these unsettling circumstances. The move to virtual services unfortunately discriminates against those from more disadvantaged backgrounds, who may lack the necessary technology to allow access, thus amplifying pre-existing health inequalities. These changes affect the ability of professionals to identify and support women whose mental health may be in decline and result in heightened anxiety in anticipation of what should, in most cases, be a time of joy. Women who are particularly vulnerable include those with a history of sexual abuse, who are at risk of increased trauma symptoms during the delivery.

Pregnant women have been identified as part of the vulnerable/at-risk group for COVID-19 and in many parts of the world have been asked to self-isolate or shield, meaning that they face greater restrictions on their daily lives and may be more

sensitive to the effects of social isolation. This is particularly significant for single parents normally reliant on family and friends for practical and psychological support, including help with caring for existing children.

Wu et al (2020) found an increased incidence of depressive symptoms and thoughts of self-harm in pregnant women assessed during their third trimester directly after the pandemic was declared compared with those seen immediately before it. Corbett et al (2020) found increased maternal health anxiety in a cohort of pregnant women in their second and third trimesters assessed during lockdown.

The postnatal period

Postnatal mental illness is common and ranges from mild depressive symptoms to postpartum psychosis requiring hospital admission and, in some cases, use of the Mental Health Act 1983 to facilitate this. The impact of reduced face-to-face contacts in this period may adversely affect outcomes, since changes in mental state that indicate emerging illness have become more difficult to detect in the virtual medium. We rely on excellent interdisciplinary communication and swift action to safely support women, and this has been disrupted as services struggle to adapt to the confusing new landscape. Difficulty also arises in effectively observing mother–infant interactions, detecting potential physical concerns in the baby, and identifying signs of domestic violence, substance misuse and other safeguarding concerns normally screened for in clinic and on home visits.

Our patient group, like many in the general population, have concerns about exposure to the coronavirus when attending hospital sites, which may limit their willingness to attend for physical or mental health input. It has been noted that all people with mental illness may be at higher risk of acquiring and spreading infection when unwell, if their ability to observe social distancing is compromised (Yao 2020). In the postnatal period, this risk may be significant owing to the potential speed of mental health decline and change in behaviour – particularly in the weeks immediately following delivery, when risks are elevated.

Case 3

A woman with a diagnosis of schizoaffective disorder developed a hypomanic episode at 2 weeks postpartum and travelled extensively on public transport in the days prior to admission. COVID-19 swab on admission was positive and it was commented that she may have put herself at increased risk of both

acquiring and spreading the infection as a result of hypomanic behaviour.

In some instances, clinicians are faced with complex risk/benefit decisions over whether to admit women to mother and baby units, where infections may be difficult to contain. It is noted that different service providers have taken varied approaches, creating further disparities of access. Fear of infection leading to reduced face-to-face communication is likely to extend long after the immediate crisis period is over. Virtual services may become established as the 'new normal', but this will continue to have an impact on women, particularly those who present *de novo* with mental illness postnatally and are not previously known to services.

Longitudinal and service effects

Research continues into the direct effects of COVID-19 infection on unborn babies, but it will be some time before the longer-term implications on those conceived and born during this pandemic, and their families, are fully realised. It seems plausible that the increased stress related to the pandemic could have epigenetic implications; and the established link between influenza infection in pregnancy and increased risk of schizophrenia in offspring leads to speculation about the potential for similar effects on babies *in utero* whose mothers contract COVID-19 (Cowan 2020).

Those of us working in this field during this crisis have seen rapid changes in service provision, as colleagues are deployed to different services, some services have been lost completely and face-to-face contacts are scaled down. Where direct contact has been unavoidable, timely access to effective personal protective equipment (PPE) has been variable, causing confusion and fear among teams. This is a particular dilemma for professionals who are themselves pregnant or have existing health conditions, and fall into both the vulnerable group and essential healthcare role. This problem has been further highlighted as lockdowns begin to ease and advice about returning to work for this population is at best vague and inconsistently interpreted.

Conclusions

In these hugely challenging times for both those working in perinatal mental healthcare and the patients they serve, it is vital that we maintain equality of access to our specialist services and continue to deliver the best care circumstances allow. On a positive note, as we have transitioned towards a new way of working, we have noticed a decrease in non-attendance ('did not attend' or DNA) rates since the introduction of virtual consultations. In the

future, provided that teams are well staffed and resourced, we may be able to better understand and take advantage of this in order to tailor our care to the variable needs of women at different points in the peripartum period and to reach out to more women at their time of need.

Looking ahead, consideration must be given to how the changing landscape of perinatal psychiatry will look once the crisis has subsided. We foresee a need for further investment in this area to meet the evolving and complex needs of our patient group. This would be through appropriately funded and prioritised research and education projects, with a focus on key issues such as longer-term impact of the pandemic on illness burden, equity of access to services, social isolation and interpersonal violence. Future service planning should incorporate social distancing models and virtual contacts with a flexible, individualised patient-centred approach. There should be an emphasis on training and adequately staffing services to ensure that excellent interdisciplinary care is still possible as we adapt to the COVID-19 and post-COVID-19 era. It is incumbent on those working in this field to consider locally the impact that the pandemic has had on their service, first by employing information-gathering techniques such as seeking feedback from both patients and staff, and then updating training and access to information accordingly. In this way, we may ensure that, as we adapt to a new normal in maternal mental healthcare, the most vulnerable do not slip through the net.

Author contributions

E.R., M.M. and J.P. were responsible for brainstorming and planning. E.R. and M.M. conducted the literature search. E.R. created the first draft. M.M. and J.P. made amendments to the first draft and revisions. E.R. made revisions and created the final draft with amendments. E.R. compiled the references and made the submission for publication.

Declaration of interest

None.

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