July 15, 2020

Meeting Maternal Mental Health Needs During the COVID-19 Pandemic

Alison Hermann, MD1; Elizabeth M. Fitelson, MD2; Veerle Bergink, MD, PhD3,4
JAMA Psychiatry. Published online July 15, 2020. doi:10.1001/jamapsychiatry.2020.1947

The coronavirus disease 2019 (COVID-19) pandemic presents the largest public health threat the medical profession has faced in at least a century. In responding to this crisis, we must acknowledge the unnerving reality that we must weigh the relative risks of COVID-19 infection against the mental health risks associated with infection control. Pregnant and postpartum women, already vulnerable owing to mood and anxiety disorders, have faced intensified harms as public health measures have interfered with crucial psychosocial needs specific to the peripartum period. In this Viewpoint, we will describe the challenges of maternal mental health care in obstetric and psychiatric settings during this pandemic in New York City. We suggest strategies to mitigate maternal mental health risk and increase resiliency in women and the clinicians caring for them.

Changes in Obstetric Practice Affecting Perinatal Mental Health

Infection control procedures for maternity wards now rely on use of isolation rooms, clinicians and others shrouded in personal protective equipment, and donning of surgical masks during active labor. Partners and personal labor supports have been unable to attend some hospital births owing to active infection or quarantine, visitor restrictions, or the need to care for other children or elderly individuals. This bewildering experience increases fear and alienation for women in labor and may increase risk for birth-related posttraumatic stress disorder, especially for women with preexisting trauma.

Because having a partner, supportive family member, or continuously present birth professional is known to improve psychological and obstetric outcomes for women in labor and their newborns,1 particularly for racial minorities,2 obstetric departments should adjust staffing to add in-house doulas or medical assistants and arrange for partners to attend labor and childbirth via video conference when they cannot be physically present.

Maternity hospitalizations postdelivery have been truncated to as little as 24 hours, limiting the opportunity for staff-supported labor recovery, breastfeeding support, education in infant care, and planning for postpartum mental health management. Postpartum women need compensatory engagement with nursing, social work, and lactation specialists within days of discharge. Telehealth check-ins via telephone or video conference can work well; however, women experiencing intimate partner violence and poverty may require additional or alternative resources such as in-person clinics, education about and access to telehealth platforms, expanded Wi-Fi access, and home visits when appropriate.

Some women are pursuing rushed alternative birth plans, including home delivery, because they fear COVID-19 infection and the associated psychological conditions on maternity wards. This places many women at higher risk of obstetric complications already known to be associated with home births3 and additional risks if the 911 response is delayed and emergency departments overwhelmed. Women should be discouraged from making anxiety-driven changes to their obstetric care team and delivery setting based solely on pandemic-related fears.

Obstetric professionals have the primary responsibility for responding to maternal distress at the time of delivery and have struggled with this during the pandemic. Attempting to comfort patients while also facing staffing shortages and fearing COVID-19 infection and transmission to loved ones has at times been excruciating. Clinicians have been confronted with significant expressed anger from patients and their families, especially when enforcing rapidly changing infection control policies.

Obstetric clinicians may require additional training and supervision in short-term distress tolerance and deescalation techniques. In addition, hospital systems need to provide clinicians with resources for healthy coping, stress management, and psychological support. Psychiatry liaison roles may need to be broadened to meet additional staff and departmental needs. In tandem with intensive care unit expansions, mental health services must be expanded for patients and clinicians alike.

Changes in Mental Health Services Affecting Perinatal Mental Health

Perinatal outpatient clinics, partial hospitals, and day programs have converted to telehealth for consultation, medication management, individual and group psychotherapy, support groups, and targeted parent webinars. Telehealth platforms have been leveraged for virtual inpatient consults and psychotherapy to conserve personal protective equipment and support stringent infection control. Despite the regulatory, legal, and economic challenges associated with these efforts, they have been successful overall. They may even serve as an important springboard for future maternal mental health care, especially in the early postpartum period when cloistering at home is normative.

Nonetheless, further strategic adjustments are required, as many previously reliable interventions for postpartum mood regulation have not been available or are severely compromised. Grandparents and overnight infant caregivers are frequently unavailable for in-person assistance, necessitating creative sleep-shifting arrangements to protect maternal sleep. Privacy concerns have been challenging and have demanded increased flexibility, especially when interpersonal interventions focus on conflicts with others in the home.

Pregnant and postpartum women often self-impose more severe social distancing practices that are inherently in conflict with behavioral activation and other standard-of-care interventions for depression and anxiety. Women and clinicians may be hesitant to access the safety net of psychiatric emergency departments and inpatient hospitals, and there may be fewer beds available owing to reallocation of psychiatric units for medical purposes. Units that remain have altered milieus to accommodate infection control measures. In this context, more severe illness is being managed on an outpatient and often virtual basis, with fewer resources for monitoring and support.

For women already engaged with mental health treatment, it is essential to provide robust preventive care and immediate treatment of emerging symptoms. Clinicians need to make special efforts to anticipate and plan for destabilizing circumstances, especially related to postpartum sleep and separation from personal supports. Clinicians should discuss with patients and their families a plan for symptom monitoring and pandemic-specific contingency responses, including safety planning that considers temporary relocations for women avoiding crowded urban areas or seeking to coquarantine with personal supports.

Women with histories of mood or anxiety disorders should use preventive psychotherapies such as cognitive behavior therapy or interpersonal psychotherapy via virtual health platforms where possible. In approaching assessments for use of psychoactive medication during pregnancy and lactation, the risk of untreated or undertreated illness must loom larger than in nonpandemic conditions and the discontinuation of successful medication maintenance treatment is discouraged for most medications. For women taking medication that requires blood monitoring, prescribers need to make extra efforts to coordinate blood draws with other planned in-person medical appointments.

It is encouraging that many professional societies and treatment centers are developing written, web-based, or app-based psychoeducational materials, which may be particularly important for women not yet engaged with treatment. However, a significant amount of effort is being unnecessarily duplicated. It is essential that these groups coordinate effectively and streamline these efforts so local health care systems can focus on efficient implementation.

Maternal mental health is a bellwether in the COVID-19 pandemic, and we must address it expeditiously. Solutions are required on all levels, and systemwide efforts must be well organized and strategic. Maternal mental health clinicians need to focus their efforts on prevention, psychoeducation, and symptom monitoring, given widened gaps in short-term mental health services. Safety planning must be proactive, specific, and responsive to changing pandemic conditions. Hospital systems, in addition to supporting telehealth expansion, must allocate resources to improve the milieu on maternity wards and expand mental health supports for patients and staff. With appropriate coordination as well as robust institutional and collegial investment, we can build resiliency and meaningfully support our patients and each other as health care clinicians in the midst of this crisis.

Article Information

Corresponding Author: Alison Hermann, MD, NewYork-Presbyterian/Weill Cornell Medical Center, 315 E 62nd St, 5th Floor, New York, NY 10065 (alh9039@med.cornell.edu).

Published Online: July 15, 2020. doi:10.1001/jamapsychiatry.2020.1947

Conflict of Interest Disclosures: Dr Hermann reports consulting fees from Sage Therapeutics and is cofounder and chief medical officer Iris OB Health Inc outside the submitted work. No other disclosures were reported.

Additional Contributions: We thank Katherine Wisner, MD (Northwestern Feinberg School of Medicine, Chicago, Illinois), for editorial input. We also thank Kristina Deligiannidis, MD (Zucker Hillside Hospital, Queens, New York), Catherine Monk, PhD (Columbia University, New York, New York), Thalia Robakis, MD, PhD (Icahn School of Medicine at Mount Sinai, New York, New York), and Catherine Birndorf, MD (NewYork-Presbyterian Weill Cornell Medical, New York), who are reproductive mental health leaders in the greater New York City area and participated in the multicenter work group that inspired this piece. No compensation was received.

References

1. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2017;7:CD003766.PubMedGoogle Scholar
2. Thomas MP, Ammann G, Brazier E, Noyes P, Maybank A. Doula services within a healthy start program: increasing access for an underserved population. Matern Child Health J. 2017;21(suppl 1):59-64. doi:10.1007/s10995-017-2402-0PubMedGoogle ScholarCrossref
3. van der Kooy J, Birnie E, Denktas S, Steegers EAP, Bonsel GJ. Planned home compared with planned hospital births: mode of delivery and Perinatal mortality rates, an observational study. BMC Pregnancy Childbirth. 2017;17(1):177. doi:10.1186/s12884-017-1348-y