Significance / Epidemiology

Pregnancy implies emotional, physical and social changes for the mother, her partner and the rest of the family, but while many mothers greatly enjoy these changes and adapt well to them, others react with severe distress. Women’s socio-economic and cultural context modulates the adaptive responses to the pregnancy and unfavorable economic conditions or specific social circumstances make adjustment more difficult.

Generally, psychological morbidity is considerably high in women of reproductive age (1). In particular, mood and anxiety disorders are a common, even if often unrecognized and still tabooed problem in pregnant women, and at least as frequent during pregnancy as in the postpartum period (2). The prevalence of mental disorders generally increases between the first and the third trimester of pregnancy (3). The stress related to the physiological changes that occur during pregnancy can also exacerbate the symptoms.

Perinatal depression

Depression has an impact on both the pregnant woman and the child. Depressed pregnant women may experience loss of appetite and weight, they are more prone to nicotine, drug and alcohol consumption and they often do not attend for the recommended antenatal care. Low birth weight is more prevalent in children of depressed women; there is a higher risk for prematurity and for complications during delivery as well as for caesarean section (3). Untreated depression may result in dysfunction in the mother-child relationship, impairment of the child’s neuro-behavioural development and negative long-term socioemotional consequences (4). Although it is well established that good mental health care in the perinatal period may be crucial for the mental health of future generations, such care provision remains fragmented and often difficult to access in many geographical settings including Europe.

Early detection and screening for perinatal depression

In order to prevent a negative impact on the course of the pregnancy and the development of the child, early detection of mental health problems during pregnancy is crucial. Health care professionals should be alert to the possibility of depression among pregnant and postpartum women and should attend to symptoms that may suggest depression. With the Whooley questions in combination with the Edinburgh Postnatal Depression Scale (EPDS) there exists a valid strategy to screen for perinatal depression, even if there is currently no evidence from high-quality clinical trials that screening improves health outcome (5). Attention should also be paid to experience of intimate partner violence and symptoms of posttraumatic stress disorder (PTSD). Many women are reluctant to disclose psychological distress to others, including caregivers, because of the stigma of mental illness. This is particularly problematic at this life stage because of concerns about being regarded as a ‘bad mother’. Attention should therefore be paid to providing a safe environment and access to non-stigmatizing support that is regarded by women as appropriate to their needs. The availability and acceptability of appropriate referral pathways are also necessary components of ethical screening programmes.

Perinatal care

Considering the consequences of untreated mental health problems during pregnancy, routine antenatal care should include optimization of the woman’s psychological well-being and the provision of psychosocial support. Interdisciplinary care is necessary in cases of depression and appropriate antidepressant medication should be started, if psychosocial support and/or psychotherapy are not sufficient and the severity of the depressive symptoms affords it. No consistent association between use of antidepressant medication during pregnancy and negative long-term effects on the child has been demonstrated and the potential impact of maternal psychiatric illness on the child should be taken into account when considering drug use during pregnancy (6).

In women with known depressive disorder or at risk for developing perinatal depression, care should start when a pregnancy is intended, be maintained throughout pregnancy and extend beyond delivery. Continuity of care and support should be provided beyond the early postpartum period.

Best Practice Advice

The National Institute for Health and Care Excellence (NICE) guideline “Antenatal and postnatal mental health: clinical management and service guidance” provides excellent pathways and defined quality standards for the care of women with mental health problems from preconception counseling through pregnancy to the postpartum period (available at https://www.nice.org.uk/guidance/cg192). Furthermore the International Marcé Society for Perinatal Mental Health, an organization of mainly psychiatrists and psychologists dedicated to supporting research and assistance surrounding prenatal and postpartum mental health for mothers, fathers and their babies (http://marcesociety.com/), promotes and disseminates knowledge which could inform health care policy. Its Position Statement 2013 provides guidance for clinicians, policy makers and health services for undertaking universal psychosocial assessment of women during the perinatal period.

Implications for Training

There is a need for health professionals to be adequately trained in the recognition and management of mental health disorders in pregnancy. This need is largely unmet, and many doctors, midwives and allied professionals lack the confidence and knowledge required for effective, woman-centred care. The National Health System of Scotland Perinatal Mental Health Curricular Framework provides the content and learning outcomes for a comprehensive training programme in the prevention, identification and
management of perinatal mental health disorders and the pertinent professional, ethical and legal issues. It is an exemplar template that can be adapted to suit local training needs at various levels.

European Board and College of Obstetrics and Gynaecology (EBCOG) Standards of Care

EBCOG has also developed standards of care for pregnant women with mental health disorders (available at http://www.ebcog.eu/index.php?view=list&slug=standard-of-care&option=com_docman&an=181). These standards are meant to provide health care providers and the women they care for with up-to-date evidence-based strategies to minimize risk and optimize outcomes during and after pregnancy for both mother and newborn.

The Way Forward

Health policy makers should make appropriate specialty services accessible to pregnant women with mental health disorders. Training and education on preventing, identifying and managing perinatal mental health disorders should be provided as part of national specialist training curricula and all the health professionals involved should be trained to be aware of risk factors and of the impact of mental health disorders. There is a need for policy makers to ensure that clear protocols and standards of care are in place, are rigorously applied and are updated as appropriate. Multi-disciplinary care must be coordinated and clear referral pathways should be in place. The roles and responsibilities of all the staff concerned should be explicit. Women with mental health disorders should be treated sensitively and with respect. Governments and policy makers should actively strive to educate and raise the awareness of society in general about mental illness and thus reduce the stigma, promoting more open communication and better service provision. Crucially, they should commit the appropriate funding to support perinatal mental health care services.

Implications for health care policies

Health care policies should consider these strategies, providing health professionals all the appropriate means to assure assessment of women’s mental status during pregnancy. Also, health professionals should be aware of maternal mental health, paying attention to the way that women face the different stages of the pregnancy, including maternal or fetal medical complications that may arise.

Health care policies should identify and address barriers and facilitators to both service provision and service uptake. These aspects have been considered in various national and regional policy papers in the United States, Canada, Australia and the United Kingdom but to the best of our knowledge, no national or supra-national policies have been articulated in mainland Europe. This gap needs to be bridged as soon as possible.

We urge governments to ensure that health policy on perinatal mental health is backed up by implementation strategies and guidelines for the commissioning of services and ensure that the policy is fully supported by dedicated and adequate funding. Together with other UN agencies, such as WHO and UNFPA, the International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) and EBCOG would be pleased to set up a joint working group to develop European wide guidance for the care of these vulnerable women.

Tahir Mahmood, CBE, MD, FRCP, FRCOG, FFSRH, MBA, FRCP, President, EBCOG

Charlotte Mercer, Chief Administrator, EBCOG

Sibil Tschudin, PhD, Professor, Gynaecology, Social Medicine and Psychosomatics, University Hospital of Basel, Switzerland

References