sample reflected exhaustion, sleep deprivation, and feeling ill prepared for the shock of becoming a new parent, rather than being a psychological disorder[8]. Subsequent research indicates that the reality is likely to be much more complicated than either of these positions suggest.

Howard and Khalifeh note that measurement of perinatal mental health is hindered by lack of understanding of the importance of somatic symptoms[1]. Well-validated symptom checklists for depression in the general population, such as the Patient Health Questionnaire, have questions on tiredness and sleep disturbance that can be difficult to interpret, as it is unclear if these somatic symptoms are pregnancy-related or mental health-related. This does not mean that such questions are redundant. Rather, they provide a clear rationale for collaborative research and practice to disentangle the unique features of mental health in the perinatal period and in particular what constitutes ill health.

Yonkers et al[9] conducted an observational study of 838 women which aimed to determine if the rates of behavioral and somatic symptoms in pregnant women vary across trimesters and independently of a possible depressive disorder diagnosis. Women completed the Composite International Diagnostic Interview and the Edinburgh Postnatal Depression Scale before 17 weeks of gestation, at 26-30 weeks of pregnancy and 4-12 weeks postpartum. Pregnant women often experienced somatic symptoms in the first trimester of pregnancy, although depressed women still differed from those who were not depressed. Appetite increase, oversleeping and agitation were not informative symptoms in regard to identifying a major depressive disorder in pregnancy. It is important to explore this complex relationship further, as failure to do so could lead to the over-pathologizing of mental health manifestations on the one hand and on the other failure to identify obstetric complications in women with mental disorders, who are at increased risk for a range of obstetric adverse outcomes[1].

Despite perinatal mental disorders being the commonest complication of childbearing, mental health care continues to languish in the shadow of physical health care in the perinatal period. Throughout all the changes in maternity care, women with mental health problems have struggled to have their voices heard. Howard and Khalifeh have documented the considerable progress that has been made in perinatal mental health care, but many challenges remain. Much can and needs to be done to support the psychological well-being of women and their families. Reframing how we conceptualize perinatal mental health to include well-being approaches that acknowledge the complex relationship between pregnancy and mental health provides an opportunity to find effective solutions, so that more women and their families flourish.

Fiona Alderdice
National Perinatal Epidemiology Unit, Nuffield Department of Population Health, University of Oxford, Oxford, UK

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Perinatal mental health and the COVID-19 pandemic

Howard and Khalifeh[1] provide us with an excellent account of the epidemiology of perinatal mental health; the importance of social determinants of mental ill health, such as poverty, racism, and gender-based violence; and the state of current evidence to inform intervention and service delivery models. Their timely and comprehensive review of the current state of evidence identifies critical gaps in knowledge that will be important to address as the COVID-19 pandemic unfolds, particularly with regard to the intersection of individual level and community level interventions.

Once the worst impacts of the COVID-19 pandemic are past, the questions that should concern us are: a) how well prepared were we for an event on this scale; b) what service delivery models and intervention strategies are the most effective in supporting parent mental health when families and communities are faced with such large-scale upheaval; and c) what can be done to guard against events such as COVID-19 further entrenching mental health inequalities, both *within* high income countries, and *between* low, middle and high income countries.

With governments enforcing restrictions on travel, closing schools and workplaces, encouraging people to stay at home and limiting social gatherings, families with young children face a series of multi-faceted and unanticipated challenges. First-time parents are finding themselves caring for a newborn at home with limited or no access to support from extended family and restricted access to primary health care and mental health services. Parents of older children are faced with keeping them occupied at home for an extended (and unknown) period of time, coupled with responsibility for supervision of home schooling.

Millions of people previously employed have lost their jobs, with little chance of finding alternative employment at least in the short term. Those fortunate enough to have ongoing employment are having to navigate ways of maintaining paid work schedules and simultaneously manage the care of children at home. Not surprisingly, by early April 2020, the Australian national helpline for parents experiencing perinatal depression or anxiety (PANDA) had already recorded a 30% increase in calls to its telephone counselling service.

Globally, family violence services are

also gearing up for an escalation of domestic violence in coming months. Governments everywhere are struggling to manage both the economic and social fallout of containment measures, and what this means for citizens. In the past few months, the Australian government has announced an additional $150m for domestic violence services and free child care for working parents with children under five years of age.

These measures are welcome and, in the case of free child care, represent a huge turnaround in Australian government policy. However, other public health measures that normally provide support to families have been drastically curtailed. For example, publicly funded maternal and child health services can no longer provide new mothers groups or home visiting services. Programs specifically designed to provide culturally appropriate care and support to socially disadvantaged populations, such as group pregnancy care for families of refugee background, have also been wound back[2]. In low and middle income countries, evidence suggests there will be even more stark consequences of containment measures for children and families who are already vulnerable[3].

It has long been recognized that perinatal mental ill health has a complex etiology with both biological and social determinants[4]. The contribution of social and environmental factors such as gender-based violence, racism and forced migration is reflected in the higher prevalence of perinatal mental health disorders among women experiencing intimate partner violence and other adverse life circumstances[5,6]. In a longitudinal study of over 1,500 first-time mothers conducted by our group, one in three women experienced depressive symptoms during the first 12 months postpartum, and of these, two fifths (40%) had experienced emotional and/or physical violence by a current or former intimate partner in the first year after childbirth[6].

Gender-based violence, racism and other forms of human rights abuse have their roots in institutions and systems that fail to give all citizens equitable access to social and economic resources. Consideration of these contextual factors in framing service delivery responses is a critical element of high-quality mental health care, clearly articulated in the United Nations Sustainable Development Goals. As Howard and Khalifeh argue, public health interventions are also needed to tackle social determinants of risk for poor perinatal mental health at a systems and community level.

The COVID-19 pandemic necessitates worldwide action to strengthen both public health interventions promoting perinatal mental health and the capacity of mental health care services to support and enable the resilience of families dealing with cumulative social and economic stresses at times of crisis[7]. Howard and Khalifeh identify significant evidence gaps related to treatment efficacy, especially for women facing difficulties related to poverty, racism, stigma and interpersonal violence. They also draw attention to the paucity of evidence regarding large scale community-level interventions tackling system change with local contextual solutions. Strategies that work for particular communities and contexts may not work in others. In the Australian setting, this is most evident in relation to First Nations people, who experience markedly worse perinatal mental health outcomes than non-Indigenous Australians[8].

Mental health clinicians, health services and communities all have important roles to play in the development of rapid responses to limit the escalation and persistence of perinatal and other mental health disorders as a result of the COVID-19 pandemic. It is critical that the opportunity is not lost to ensure that these responses include the development and testing of co-designed strategies that build community-level resilience, foster strengths-based, trauma informed approaches, and tackle the sources of mental health inequalities globally. Better tailoring of individual level responses, taking account of social, economic and cultural contexts and engaging consumers and communities in the co-design of local primary health care and mental health services, is also needed to avoid further entrenchment of health inequalities[9].

Stephanie Brown
Intergenerational Health, Murdoch Children's Research Institute, Parkville, VIC, Australia; Departments of General Practice and of Paediatrics, University of Melbourne, Parkville, VIC, Australia; Women and Kids Theme, South Australian Health and Medical Research Institute, Adelaide, SA, Australia

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Postpartum psychosis: an important clue to the etiology of mental illness

Howard and Khalifeh[1] masterfully review the epidemiology of perinatal mental health conditions and the evidence base for their management. Here I address a further issue and exciting opportunity: the role that the study of severe perinatal mental illness can play in advancing our understanding of the etiology of mental health conditions.

The close relationship of severe episodes of mental illness to childbirth, episodes labelled postpartum psychosis, has been observed for hundreds, if not thousands, of years, and more recently this link has received support from clinical and ep-