

Perinatal mental health in Singapore: Implementation opportunities and relevance of gender-carer roles in screening

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In this issue of the *Annals*, the consensus statement on perinatal mental health by Chen et al. covers the handling of depression and anxiety symptoms in pregnancy, childbirth and the postnatal period.¹ The guidelines were developed by a workgroup involving experts in perinatal mental health and obstetrics using a consensus process consisting of a literature review and consensus meetings involving a range of related professionals in family medicine, paediatrics, psychiatry, social services and the Health Promotion Board in Singapore. Ten consensus statements were developed with particular consideration for adolescent mothers, women with special needs, and women who suffered severe maternity events.

Perinatal mental health is an important theme in population health because the perinatal physical healthcare processes provide an important opportunity for mental health screening for child-bearing women in the population. This is in line with the awareness that mental health challenges such as depression and anxiety are more common in women than men and the risk of mental health disruption is particularly high around pregnancy. Maternal mental conditions have impacts not only on the mother but also on the infant. Many of them respond well to timely psychosocial and pharmacological management.

For easy reference, the statements are presented in sections organised to cover the preconception period, the antenatal period, and the postnatal periods; followed by attention to special groups and situations. The statements provide over-arching directions, which can be adopted for specific implementation details in a range of settings in primary care and maternity care. It also provides suggestions as to when more specialised care should be sought.

Given that common mental disorders (e.g. mood and anxiety disorders) have a high point prevalence around pregnancy, the substantial community treatment gap found

in most studies suggests that insufficient attention has been focused on public education and the detection of common disorders.

It is important to note that the current guidelines do not cover mothers with existing “severe mental disorders” (such as psychosis and bipolar disorder) as specialist psychiatrist input would likely have been involved. It is important to screen for symptoms of undiagnosed severe mental disorders during antenatal care. As the boundaries between “common disorders” and “serious mental disorders” can be ambiguous, it is important that the screening and guidelines recommended be applied broadly and whenever there is doubt, specialist psychiatric input should be sought as additional measures.

In providing guideline-based perinatal care in diverse service settings, it is important to develop an appreciation of the psychosocial roles in emerging motherhood in different cultures. This awareness is crucial in facilitating engagement and help-seeking of women of childbearing age. One of the reasons for women often neglecting their mental health is related to their assuming a caring role in the family (for example, caring for elderly relatives and young children). The caring role is constructed socially from a combination of one’s anticipation, as well as from others’ expectations. It is well known that taking up a caring role is associated with the under-recognition of one’s own needs.² When the role is associated with a consuming sense of self-denial, it may divert attention away from concerns for one’s well-being. This underrecognition applies also to the attention of people around the women (e.g. the husband and the extended family).

The perinatal period provides a unique scenario during the life stages of women in that attention can be focused on both the child and the mother at the same time as the mother and the baby are closely connected physically during pregnancy and the postnatal period. The perinatal experience therefore provides a unique opportunity for women to strengthen a sense of self-compassion. Even women who habitually focus more on others’ needs are compelled to care more for themselves as their own physical and mental health are intricately related to fetal and newborn health. The perinatal period is therefore a good time window for women to learn that “to look after others in the family well, one needs to first attend properly to one’s well-being.” It is a time

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window that is likely to close with increased infant care duties.

In implementing services, it is important to take into consideration the many traditional confinement period rituals (such as bathing, food and herbal infusions), which may serve mental health needs in reinforcing psychosocial support for mothers in a diversity of cultures.³ However, in modern societies, these rituals may have become expensive optional extras. Integrating these practices wisely and flexibly with contemporary healthcare may play a cost-effective role in the prevention of perinatal mental health issues.

Given there are ongoing rapid changes in gender roles in contemporary societies, it may be opportune to develop more awareness of gender-specific issues for the mental well-being of expectant fathers, which would need to be

included more in future initiatives in perinatal mental health. Involvement of other members of the family such as parents in-law may also be important as in-law conflicts have been identified as one of the most important sources of post-natal depression in mothers.⁴

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