



ORAL ABSTRACTS



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Perinatal Mental Health

UBUNTU: Umuntu Ngumuntu Ngabantu
I Am Because We Are



The International
Marcé Society
for Perinatal Mental Health

Diversity, Rights, and Global Inclusion in Perinatal Mental Health

136: Severe Perinatal Mental Illness in the UAE: Insights from Psychiatric Inpatient Admissions

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Background: Perinatal mental illness, including postpartum psychosis and severe mood disorders, is a significant contributor to maternal morbidity globally. Early identification and access to specialist care are known to improve outcomes for both mothers and infants. However, in the United Arab Emirates (UAE), there is a lack of published data on perinatal psychiatric admissions. This study aimed to establish baseline data by examining the prevalence, demographic trends, and clinical characteristics of perinatal psychiatric admissions at the only inpatient psychiatric hospital serving Dubai and the Northern Emirates.

Methodology: A retrospective quantitative study was conducted over an 18-month period using hospital admission records. Women admitted within the postpartum period were identified through manual review of clinical records. Data collected included maternal age, infant age, nationality, primary diagnosis, length of stay, admission and discharge dates, and discharge outcomes, including outpatient follow-up. The lead investigator's managerial role on the female acute wards supported case identification and data accuracy. Descriptive statistics were used to summarize prevalence and clinical and demographic patterns.

Results: When considered alongside national birth rates and known global epidemiology of perinatal mental illness—particularly postpartum psychosis—the number of admissions was lower than expected. This suggests that some women with severe perinatal mental illness may not be accessing inpatient psychiatric care. Most admissions involved severe psychiatric conditions, particularly psychotic disorders. The sample reflected the UAE's highly diverse population, with women from a wide range of nationalities represented. While many women engaged in follow-up care after discharge, a proportion did not, raising concerns about continuity of care. Vulnerable groups—including women without health coverage, those facing language barriers, or those affected by stigma—were likely underrepresented.

Conclusion: This study provides the first baseline data on perinatal psychiatric admissions in the UAE and highlights the complexity of delivering care within a highly multicultural population. The wide range of nationalities represented reflects the UAE's unique demographic landscape and reinforces the need for culturally responsive perinatal mental health services.

The discrepancy between expected prevalence based on birth rates and global epidemiology, and the lower number of observed admissions, suggests potential unmet need and under-detection of severe perinatal mental illness.

This study offers critical early evidence to inform the development of specialist perinatal mental health services in the UAE. Future models of care must be evidence-based, inclusive, and culturally attuned to meet the needs of the country's diverse maternal population.

Category: *Perinatal Refugee and Immigrant Women's Health*

254: Resources, Inspiration, Support and Empowerment (R.I.S.E.) for Black Maternal Mental Health; Preliminary Findings from a Randomized Control Trial

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Background: While 13% of women experience Perinatal Mood and Anxiety Disorders (PMADs), the rate triples in Black women, a health disparity that may be partially explained by medical discrimination. Thus, interventions

are urgently needed that address facilitators and barriers to equitable healthcare access and health outcomes. Our ongoing NIH funded R.I.S.E. study (5R21MD017396-02) investigates the effectiveness of a culturally relevant mobile Health (mHealth) intervention in improving outcomes among Black pregnant women. Community advocates for Black women (Candlelit Care) and PMAD education (Maternal Mental Health NOW) created content for the intervention and control group, respectively.

Methodology: Using baseline enrollment data, we examined the prevalence of medical discrimination and childhood trauma, and their associations with PMAD risk, with the goal of improving perinatal care of Black women. We hypothesized that both forms of trauma would correlate with PMAD symptoms. Participants completed the Medical Discrimination Scale (MDS) and the Adverse Childhood Experiences (ACEs) Questionnaire. Symptoms of PTSD were assessed via the Impact of Events Scale (IES), anxiety via the Overall Anxiety Severity and Impairment Scale (OASIS), and depression via the Edinburgh Postnatal Depression Scale (EPDS). Spearman rank correlations were computed to evaluate associations with PMAD.

Results: Participants (N=152) were on average 33.3 years old (SD=5.7 years). Nearly half (41.2%) of the participants reported medical discrimination, and forty-two (27.8%) reported a high ACEs score (ACEs $\geq$ 4). Forty-two (27.8%) participants met PTSD risk (IES $\geq$ 26); forty-two (27.8%) met anxiety risk (OASIS $>$ 7); and forty-four (29.1%) met depression risk (EPDS $\geq$ 10). Bivariate correlations revealed small but significant positive associations between medical discrimination and symptoms of PTSD ($r=0.19$, $p=0.02$), with more moderate associations with anxiety ($r=0.33$, $p<0.01$), and depression ($r=0.33$, $p<0.01$). Childhood trauma was also moderately positively associated with symptoms of PTSD ($r=0.35$, $p<0.01$), but not depression or anxiety.

Conclusion: Sixty Black women reported experiencing medical discrimination, which was associated with PMAD symptoms. Participants' experiences of childhood trauma were moderately associated with PTSD symptoms. Overall, a third reported clinically relevant levels of PMADs, which is consistent with previous estimates. Future analyses will investigate whether mHealth content tailored to Black patients may mitigate the effects of trauma on their health.

Category: *Sexual and Gender Minorities*

324: More Than Words: The Importance of Relational Communication in Interpreted Perinatal Mental Health Conversations

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Background: Equitable perinatal mental health care relies on women being able to participate in safe, trusting conversations about emotional wellbeing. For women with limited English proficiency using UK services, professional interpreters are essential; however, little is known about how interpreted communication shapes the relational conditions required for mental health disclosure within routine maternity care. The MIND MH project examined these dynamics to inform the longer-term development of culturally safe, inclusive practice.

Methodology: This research aimed to explore how midwives and interpreters navigate perinatal mental health discussions with women requiring language support, and to identify communication practices that reduce inequities and create relationally safe appointments.

Individual semi-structured interviews were conducted with 17 midwives and 17 interpreters across UK maternity services. Framework analysis, informed by an intersectional lens, was used to examine how social and structural determinants influenced communication practices during conversations involving mental health in interpreted maternity care conversations.

Results: While interpreted communication enabled access to care, it also subtly reshaped the relational tone and flow of mental health conversations. Interactions were frequently described as task-centred, limiting the informal brief non-clinical discussions about everyday life that facilitate relationship-building and trust, affecting likelihood of mental health disclosure.

Disruptions to non-verbal communication further affected relational connection, such as midwives and interpreters speaking to each other rather than directly with the woman, or, in online/telephone appointments, all parties focusing on the screen or device rather than each other. Participants described midwives needing to focus on documentation completion, using structured forms and questions, with little opportunity for open

discussion.

Both midwives and interpreters highlighted limited training in working together collaboratively and some participants identified practical relational strategies for improving conversations including pre-appointment briefings, shared conversational goals, explicit discussion of communication preferences to support culturally safe perinatal mental health discussions.

Conclusion: Improving equity in perinatal mental health care requires attention not only to language access but to the relational environment in which interpreted conversations occur. Strengthening interdisciplinary collaboration and providing targeted relational communication training for midwives are actionable opportunities to enhance culturally safe care and support earlier mental health disclosure among women with language barriers.

Category: *Perinatal Refugee and Immigrant Women's Health*

325: Vicarious Trauma and Emotional Labour Among Interpreters Supporting Perinatal Mental Health Conversations

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Background: Professional interpreters play an essential role in ensuring equitable access to perinatal mental health care for women with limited English proficiency using UK services. Yet the emotional and psychological impact of supporting these conversations remains under-examined.

Methodology: The MIND MH project aimed to examine how midwives and interpreters navigate perinatal mental health discussions with women requiring language support. Individual semi-structured interviews were conducted with 17 professional interpreters and 17 midwives across UK maternity services. Framework analysis, informed by an intersectional perspective, was used to explore factors which improved or impeded their collaborative practice.

Results: Although it was not the intended focus of the research, important findings were generated regarding the emotional labour and vicarious trauma experienced by interpreters when supporting perinatal mental health conversations, which was heightened when interpreting for forced migrant women and those who disclosed trauma.

Structural features of an interpreter's working day intensified experiences; including back-to-back appointments, rapid switching between emotionally charged and routine consultations and expectations of neutrality without any outlet for processing distress.

Interpreters described practising in a liminal space. Most health providers subcontracted language support to external agencies, and interpreters commonly worked across several. This fragmented, lone-working model left them vulnerable, isolated, and without formal organisational support. A minority accessed supervision; where available, it was usually self-funded. Some interpreters intentionally avoided maternity appointments due to personal triggers, while others cancelled work when emotional load became unmanageable. Midwives often recognised interpreters' distress but felt powerless to act, citing an absence of support pathways within health organisations and lacking the resources to follow up with interpreters after appointments. Interpreters were positioned between systems, with no clear organisational home or trauma-management infrastructure to protect their wellbeing.

Conclusion: Interpreters supporting perinatal mental health conversations in maternity care encounter substantial risks of vicarious trauma without commensurate support mechanisms. System-level solutions across both the employer and host organisation including trauma-informed training for all staff, supervision pathways which are accessible to agency staff, protected decompression time and improvements in collaborative working practices are urgently needed to support interpreters as integral partners in culturally safe perinatal mental health communication.

Category: *Perinatal Refugee and Immigrant Women's Health*

479: Perinatal depression and migration: a systematic review

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Background: The influence of migration on the development of perinatal depression has demonstrated mixed findings. Migration has been divided into “forced” migration (refugees or asylum seekers) and “voluntary” with higher rates of perinatal depression amongst forced migrants but few systematic reviews have included disaggregated data by reason for migration or included within the analysis the covariates of perinatal depression. This systematic review examines studies where reason for migration is described, a comparison group of women from the host country are included, and >1 covariate for depression is included.

Methodology: Search strategy using PubMed, PsycINFO, MEDLINE, Scopus and EMBASE to 1st July 2024. Search terms included depression AND perinatal OR pregnancy OR postpartum AND migration OR migrant OR refugee OR Culturally and Linguistically Diverse (CaLD). Evaluation of study quality and risk of bias (ROB) was performed utilising the Newcastle-Ottawa Scale for observational studies.

Results: We included 20 studies (n= 48,883) both refugees and voluntary migrants and 16 studies demonstrated an increase in perinatal depression in migrants with 4 studies demonstrating no difference between the two groups. 55% were cross-sectional studies, representing lower quality evidence; most studies utilised self-report measures for depression (EPDS) and there was limited recording of >1 covariates of depression, with only 50% of studies including 2 or more covariates

Conclusion: Future prospective studies are needed which incorporate clinical diagnostic measures for perinatal depression, not only self-report, and clearly stratify reason for migration and time since migration

Category: *Perinatal Refugee and Immigrant Women's Health*

Early Career Perinatal Mental Health Research

220: "The first time I laid eyes on my baby": A qualitative exploration of maternal experiences following neonatal admission

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Background: The maternal postpartum period is marked by physical trauma and psychological distress and often involves the involuntary separation from preterm or very low birth weight (VLBW) infants. The early maternal-infant bond is disrupted by vulnerability and the critical medical care required by neonates, influencing mothers' initial caregiving experiences. We describe the journey and psychosocial stressors of mothers of the VLBW population born at Rahima Moosa Mother and Child Hospital (RMMCH).

Methodology: In this reflective phenomenological analysis, comprehensive interviews were conducted with mothers (13 of 50 enrolled in a larger prospective study) of hospitalised neonates to document their experiences with initial encounters and early postpartum adaptation. The data were examined thematically through a reflective methodology.

Results: Mothers described their initial interaction with their infants as including significant distress, confusion, pain and psychological trauma. A quick transition to the neonatal unit after birth meant there was no physical touch, only a brief show of the neonate's face. Driven by the intense resolve to see their infants, necessitating transition through different hospital floors, mothers described excruciating pain and psychological distress. The limited visiting hours and the presence of security personnel heightened mothers' feelings of helplessness when accessing newborns in the neonatal unit. Experiencing their infants' fragility caused anxiety and emotional turmoil, as one mother described her child as "the size of a television remote." Many mothers felt overwhelmed, grappling with the stark reality versus their expectations, often interrupted by nurses' caregiving instructions. Their immediate reactions revealed emotional unpreparedness, marked by expressions of fear and uncertainty.

Conclusion: Maternal initial and visual contact represent a critical and vulnerable moment. The intersection of physical pain, psychological trauma, and premature infants' fragility may hinder early confidence and attachment. Support that is trauma-informed and relationally attuned is crucial throughout the transition period to promote postpartum adjustment and the commencement of caregiving and lactogenesis in the context of prematurity requiring admission.

380: "With or Without My Child, I Am Still A Mother": Lived Experience and Treatment Needs of Indian Women Survivors of Perinatal Loss

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Background: Perinatal grief affects a striking 20% of Indian women, persisting for even over a decade (Roberts et al., 2021). Women's grief is entangled with multiple social factors, however, their subjective experience and perceived expectations from the healthcare system are minimally explored. We aim to understand the lived experience and treatment needs of Indian women who have survived perinatal loss.

Methodology: The study adopted a qualitative design informed by phenomenology to explore women's lived experience through in-depth interviews. The criteria for inclusion comprised Indian cis-women between the ages of 19 to 45 years, speaking English or Tamil (regional language), with a history of pregnancy loss, who were psychologically stable to participate. The sample was drawn from the perinatal psychiatry clinic of a tertiary mental health care hospital, and two maternity hospitals. Ten eligible women were approached through convenience sampling, six consented to participate. Analysis used Braun and Clarke's reflexive thematic analysis. Qualitative rigor was maintained using an audit trail, researcher's reflexive memos, peer debriefing and triangulation.

Results: The sample included married women, with a mean age of 33 years. Time since loss ranged from 5 to 60 months (median = 23.5 months). Four of them had survived more than one pregnancy loss; across participants,

stillbirth was reported by one, miscarriages by four, and terminated pregnancies by four. Three women were diagnosed with a common mental health condition, and one was in remission from bipolar affective disorder. Findings from the ongoing iterative thematic analysis indicate the salient theme of “Grief hurts yet heals: negotiating identity, support, and meaning after perinatal loss”. Subthemes include maternal attachment and continuing bonds, shifts and growth in self-identity, relational-cultural experiences of strain and support, and treatment needs; including family-inclusive treatment, individual psychotherapy, incorporating Indian cultural practices. Detailed thematic analysis is provided, and interpreted in the light of relevant theories such as narrative-constructivist, attachment and feminist perspectives.

Conclusion: The study highlights the voice of experts-by-experience, improves the understanding of disenfranchised perinatal grief, and enumerates vital recommendations for varying levels of care in India; psychotherapy, family bereavement support, and the broader healthcare system’s response, including key stakeholders such as doctors and nurses.

427: A research Informed Mother–Infant Dyadic Intervention for HIV-Exposed Infants and Maternal Mental Health in South African Primary Care

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Background: South Africa continues to face a quadruple burden of disease, with HIV and maternal mental health contributing significantly to risks for mothers and infants. Although the widespread rollout of antiretroviral therapy (ART) has significantly reduced vertical transmission, infants remain exposed to HIV and ART in utero, with emerging evidence suggesting subtle neurobehavioural vulnerabilities. Developmental surveillance at routine vaccination visits often lacks sensitivity to detect early challenges in autonomic stability, state regulation, motor control, and social interaction. Guided by the African philosophy of Ubuntu, recognising that wellbeing emerges through relationships, this study highlights the interconnected health of mothers and infants and the need for relational, community-oriented early interventions within primary healthcare.

Methodology: A multimethod research design was used to examine neurobehavioural functioning among HIV-exposed neonates and maternal mental health in a state hospital in South Africa. Findings from this initial phase informed the development of an early intervention programme. A nominal group process with healthcare stakeholders was used to generate intervention components addressing infant neurobehaviour and maternal mental health, followed by the development of implementation guidelines suitable for primary healthcare delivery.

Results: HIV-exposed neonates demonstrated comparatively poorer neurobehavioural functioning than unexposed infants, particularly in domains of regulation and motor functioning. High levels of maternal depressive symptoms were also identified. In response, a four-week mother–infant dyadic group intervention was developed, integrating support for infant neurobehavioural organisation with maternal mental health care within a relational and community-oriented framework.

Conclusion: Grounded in the principles of Ubuntu, this brief primary healthcare intervention centres the mother–infant dyad as a unit of care and emphasises collective support for early development and maternal wellbeing. The programme is ready for pilot testing and offers a potentially scalable model for strengthening early relational health in resource-constrained settings.

Neuroscience, Treatment, and Innovation

100: Prenatal maternal depression affects infant autonomic regulation of sleep.

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Background: Prenatal maternal depression (PMD) affects up to 20% of pregnant people and is associated with adverse developmental and behavioral outcomes in the offspring. One proposed mechanism underlying these associations involves alterations of the autonomic nervous system originating in the fetal period, which may lead to subsequent atypical stress responsivity. Sleep may provide a unique window into neurodevelopment, as the emergence and differentiation of sleep states reflect rapid maturation of central and autonomic nervous system organization. Characterizing autonomic physiology within and across sleep states may therefore offer important insights into how exposure to prenatal depression shapes early developmental trajectories.

Methodology: Participants were 1,545 full-term born infants from the NIH PASS cohort without prenatal exposure to alcohol or tobacco. Diagnosis of PMD was abstracted from medical records, with 160 (10.4%) mothers classified as depressed. Infant physiology was assessed via electrocardiogram (ECG) during natural sleep at one month of age. Mean heart rate (HR) and a measure of heart rate variability (HRV), specifically Standard Deviation of Normal-to-Normal intervals (SDNN), were derived by sleep state (active (AS) and quiet (QS)). Linear mixed-effects models examined the effect of PMD on HR and SDNN. Models controlled for sleep state, infant sex (M/F), gestational age at recording, and recording site (South Africa/United States).

Results: HR: significant main effects were observed for sleep state ($p=.009$), PMD ($p=.028$), and infant sex ($p=.024$). Infants exposed to PMD exhibited higher HR ($M=128$ bpm) compared to unexposed infants ($M=124$ bpm). SDNN: significant main effects were observed for sleep state ($p<.001$), PMD ($p=.039$), and gestational age at assessment ($p=.020$). Infants exposed to PMD showed lower SDNN ($M=.021$) compared to unexposed infants ($M=.024$), consistent with altered autonomic regulation.

Conclusion: Sleep-based autonomic markers may serve as early, sensitive indicators of neurodevelopmental risk, relevant to pediatric sleep health, prevention, and early intervention. Our findings indicate that prenatal exposure to PMD is associated with differences in autonomic physiology within a critical developmental window. These results underscore the importance of considering PMD as a relevant developmental exposure capable of shaping early autonomic trajectories.

Category: *Clinical Trends in Perinatal Mental Health*

116: It takes a whole village of support: Evaluation of a Reproductive Trauma Service in North-West UK

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Background: There has been significant investment in developing Maternal Mental Health Services (MMHSs) across the UK. These aim to provide integrated maternity and mental health support for women who have experienced tokophobia, birth trauma, or perinatal loss. However, there is little evidence of their efficacy. This study presents insights from a mixed-methods evaluation of an MMH service in North-West UK, which operated across a large geographical area (including four maternity Trusts), named the Reproductive Trauma Service (RTS). The RTS offers a unique approach by combining midwifery, mental health practitioners, peer support, and psychological therapists into a single integrated service.

Methodology: Methods included analysis of routinely collected data (demographics, referral information, outcomes) from 622 service users and 64 interviews with service users, providers, or wider stakeholders. Quantitative data were analysed using descriptive and inferential statistics. Qualitative data were analysed thematically.

Results: The evaluation highlighted strengths (e.g., compassionate leadership, flexibility) and challenges (e.g., service demand, long waits). However, a key finding was the value of the integrated holistic multidisciplinary

approach, with benefits for both service users and providers. Regression analysis found that combining psychological therapy with other support types (midwifery, mental health, and peer support) enhanced its impact on trauma responses. Qualitative data indicated that staff valued team cohesion and integrated care, with careful consideration given to introducing different forms of support in response to service user needs. For many service users, the support was transformative, fostering empowerment, restoring mental well-being, strengthening interpersonal relationships, and reshaping expectations about future childbearing. **Conclusion:** This study highlights how an integrated multidisciplinary approach can facilitate holistic support for women and foster a sense of ownership and development for providers. Recommendations include expanding the RTS provision, as demand exceeds resources, addressing inequalities, and prioritising preventive approaches, such as antenatal education and trauma-informed training.

Category: *Novel Interventions in Perinatal Mental Health*

137: Infant crying, maternal well being, and the early microbiome: A pilot study of interconnected pathways in early life

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Background: Emerging evidence highlights the interconnectedness of parental mental health, early parent-infant interactions, and infant biological stress responses. Consistent with the Ubuntu principle “I am because we are,” maternal distress may shape infant development through relational and physiological pathways, including the infant gastrointestinal microbiome. This pilot study examined associations between the infant gastrointestinal microbiome and infant distress, parent-infant interactions, and maternal depressive symptoms.

Methodology: In a longitudinal observational design, 31 mother-infant dyads were assessed at 2 and 4 months during well-child visits. Mothers completed the PHQ-9 at both timepoints and the Parenting Stress Index-Short Form at 4 months. Infant cries during 4-month immunization were recorded and analyzed for high-frequency band power and high-to-mid frequency ratios. Caregiver and infant behaviors were coded using the Measure of Adult and Infant Soothing and Distress. Infant stool collected at 4 months underwent whole-genome shotgun sequencing. Alpha diversity (Shannon, Inverse Simpson), beta diversity (Bray-Curtis, Jaccard; PERMANOVA), and differential abundance (LinDA; false discovery rate <0.1) were evaluated.

Results: Nineteen phyla, 417 genera, and 1,246 species were identified. Higher maternal PHQ-9 scores at 2 months were associated with infant beta diversity (Bray-Curtis $p=0.006$; Jaccard $p=0.005$) and differential abundance of four species: *Ruminococcus flavefaciens*, *Actinomyces johnsonii*, *Clostridium dakarense*, and *Bilophila wadsworthia*. Infant cries with greater high-frequency band power ($p<0.03$) and higher high-to-mid ratios ($p<0.05$) were associated with lower alpha diversity. *Bibersteinia trehalosi* was uniquely enriched with high-frequency power. PHQ-9 at 4 months and PSI-4-SF indices showed no associations with diversity metrics. Maternal kissing (18 species) and distraction behaviors (10 species) were linked to taxa-level differences.

Conclusion: Findings from this pilot study suggest that infant distress, as reflected in cry acoustics, is associated with lower microbiome diversity. Early maternal depressive symptoms may influence infant microbiome composition and diversity. This interconnected network linking maternal mental health, infant physiological stress signals, parenting behaviors, and microbiome development represents potential modifiable targets for perinatal interventions. Larger cohorts are needed to validate these exploratory findings and to advance preventive interventions grounded in the Ubuntu vision of shared humanity and interconnected care.

Category: *Novel Interventions in Perinatal Mental Health*

180: The impact of stress on iron stores in pregnant Black American women

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Background: Exposure to stress during pregnancy has significant health consequences. In the U.S., Black women are exposed to a wide range of stressors and are at high risk for pregnancy and delivery complications. Depression, one potential source of prenatal stress, is now commonly assessed among pregnant women and has become part of standard prenatal care in many high income countries (Dadi et al., 2020). We have previously reported that depression screening may not be sufficient for capturing high stress exposure and risk for perinatal complications among Black American women (Sroka et al., 2023). In this presentation we extend that research by testing whether stress exposure and depression are associated with prenatal iron deficiency. Iron deficiency is associated with adverse maternal and child health outcomes including infection, perinatal hemorrhage, low birth weight, and preterm birth. We test whether increasing stress exposure and depression is associated with iron levels in the third trimester, when deficiency is most likely to be observed (Siu, 2015), in a sample of Black American women with uncomplicated pregnancies.

Methodology: Data were from the Nutrition and Pregnancy Study (NAPS), which included 168 Black American women with Medicaid insurance living in under-resourced, urban environments. Women had healthy pregnancy and low sea fish intake. Self-reported stress was measured using the Perceived Stress Scale (PSS; Cohen et al., 1983). The PSS is a 10-item self-report measure that assesses participants' thoughts and feelings over the past month using a 5-point Likert scale. Prenatal depression was measured via the 10-item, self-report Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987). We calculated change scores in perceived stress and depression from the second to the third trimesters. Venous blood samples were collected during study visits. Frozen serum samples were transported to the Clinical Research Center at the University of Chicago for analysis. Iron status was quantified by serum ferritin, using the Sigma-Aldrich Human Ferritin Elisa Kit. Data from the second and third trimesters were used for this analysis.

Results: Increasing levels of perceived across the second and third trimesters were associated with lower levels of serum ferritin during the third trimester ($t = -2.10$, $p = .039$), this effect of stress on ferritin was maintained after controlling for second trimester ferritin levels and maternal age (Overall $F [3, 86] = 13.22$, $p < .001$). Depression scores were not associated with ferritin levels in either trimester, nor was the change in depression from the second to the third trimesters.

Conclusion: Iron deficiency during pregnancy is a global health concern that confers significant risk to maternal and child health (Obeagu & Obeagu, 2025). Effective intervention requires early identification as reversal of the deficiency in late pregnancy is challenging (Pfeiffer et al., 2025). Our data suggest that a brief self-report measure of perceived stress can be useful for risk stratification, wherein women reporting high levels of perceived stress would receive increased surveillance via more frequent blood work and dietary support to prevent iron deficiency later in pregnancy. Adding an assessment of stress to the current standard of prenatal care is indicated.

Category: *Clinical Trends in Perinatal Mental Health*

285: Bearing Witness and Bearing Life: Exploring the Dual Role of Perinatal Psychologists in High-Acuity Settings through Collaborative Autoethnography

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Background: Perinatal psychologists routinely provide mental health care to individuals experiencing high-risk pregnancies, severe psychiatric symptoms, pregnancy loss, and complex fetal or neonatal diagnoses. For those who are themselves birthing people, this work unfolds alongside their own experiences of pregnancy, birth, and the postpartum period. Despite growing attention to provider well-being, little research has examined how clinicians' lived reproductive experiences intersect with their professional roles in high-acuity perinatal settings. This study examines how these lived experiences shape and are shaped by clinical work, with implications for

supervision, support, and workforce sustainability.

Methodology: This study uses collaborative autoethnography, a qualitative method in which multiple researchers analyze and interpret their own lived experiences through structured dialogue with one another. Using this approach, we examine the two-way relationship between being a birthing person and providing perinatal psychological care to individuals navigating medically complex situations, such as families receiving fetal diagnoses of genetic or neurological conditions or parents with infants admitted to the NICU or CICU.

Ten members of a perinatal psychology clinical team served as both researchers and participants. Using semi-structured interviews, participants described ways in which their reproductive or motherhood journeys reshaped their clinical presence, therapeutic boundaries, and approaches to uncertainty and loss, while also reflecting on the impact of working with high-acuity families on their own well-being during the perinatal period. Interviews were audio-recorded and transcribed.

This study is currently in the analysis phase. Team members are currently engaging in individual reflexive analyses of all interviews except their own; when complete, the team will meet to develop iterative, shared interpretations of their lived experiences, emphasizing co-construction of meaning.

Results: Emergent themes will be situated within existing literature on perinatal countertransference, occupational exposure to reproductive trauma, and feminist and relational theories of care to contextualize findings and highlight gaps identified in this study. Practice-, supervision-, and systems-level recommendations aimed at supporting perinatal psychologists who are birthing people and promoting sustainability in the perinatal mental health workforce will be provided.

Conclusion: This study underscores the need to intentionally integrate clinicians' lived reproductive experiences into conversations about supervision, workforce sustainability, and the ethics of care within high-acuity perinatal mental health settings.

Category: *Perinatal Psychotherapy*

368: Time-and-motion study of a stepped care intervention for screening and treatment of Perinatal Mood and Anxiety Disorders in maternal-child health clinics in Western Kenya

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Background: Despite high burden of perinatal mood and anxiety disorders (PMAD), most affected women remain undiagnosed and untreated in Kenya. The Integrated Perinatal Mental Health (IPMH) project implements three evidence-based interventions combined with implementation strategies to improve perinatal mental health in Kenya. We conducted time-and-motion studies to estimate the time necessary to provide IPMH compared to standard care.

Methodology: We conducted prospective time-and-motion studies at IPMH study sites (N=20) in Western Kenya (June 2025-March 2026). Trained data collectors observed 284 patient encounters at intervention sites (n=140) and control sites (n=148) recording waiting and service times. We assessed time for 1) screening:_PHQ-2 and GAD-2 across all the sites and PHQ-9 and GAD-7 in intervention sites, 2) standard antenatal consultation, 3) Problem Management Plus (PM+) psychotherapy for women experiencing PMAD (five weekly sessions), and 4) telepsychiatry for women with severe symptoms_(PHQ-9/GAD-7 scores ≥ 15), suicidality or no response to PM+ in intervention facilities. In all sites, we measured time for implementation strategies, including audit and feedback, health talks, and PM+ supervision in intervention sites.

Results: Mental health screening required 20 minutes_(SD:54.3) per person on average at intervention sites (using PHQ-9 and GAD-7) versus 3.7 minutes_(SD:4.2) at control sites (using PHQ-2 and GAD-2). Antenatal consultations averaged 17.1 minutes_(SD:16.1) in intervention sites and 30.4 minutes_(SD:35.1) in control sites ($p < 0.001$). PM+ and telepsychiatry each contributed a mean of 79.1_(SD:22.3) and 85.6 minutes_(SD:33.9) among 6% and 2% of patient encounters, respectively. At the facility-level, audit and feedback activities took a mean of 70.6 minutes_(SD:29.6) versus 52.4 minutes_(SD:28.7) per month at intervention and control sites ($p = 0.012$). Health talks required a mean of 35.9 minutes_(SD:18.0) versus 32 minutes_(SD:29.6) per day at

intervention and control sites ($p=0.064$). PM+ supervision contributed an additional 80.1 minutes (SD:25.9) per month at intervention sites.

Conclusion: Integrating a stepped care model for maternal mental health into routine care is feasible. PMAD screening adds 16 minutes during standard ANC visits, while mothers requiring higher-level support can receive PM+ and telepsychiatry in approximately 80 minutes. These time estimates provide essential inputs for future cost-effectiveness analyses and workforce planning.

Category: *Novel Interventions in Perinatal Mental Health*

369: Epigenetic Studies in Postpartum Psychosis: Implications for Reproductive Mood Disorders

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Background: We previously identified epigenetic biomarker patterns at three genes that are predictive of "reproductive" mood disorders including postpartum depression (PPD) and premenstrual dysphoric disorder (PMDD). Postpartum psychosis (PP) is another disorder which presents with manic, depressive or mixed symptoms with psychosis shortly after delivery. We sought to determine if our previously identified biomarkers are present in women with PP and to identify unique methylation patterns in PP that were associated with symptomatology and recurrence of psychiatric illness within or outside of the postpartum time-period.

Methodology: Blood samples were collected during the acute phase of the PP episode and postpartum Controls had no psychiatric history/symptoms. Samples were matched on age, ethnicity, education, parity, medication use and days after delivery. Genome wide epigenetic analyses used the Illumina MethyEPIC beadchip. The established biomarker algorithm for PPD was run and an epigenome wide association study (EWAS) was conducted to determine epigenetic differences between cases and controls.

Results: 301 participants included 152 cases and 149 matched controls. Average age was 31.1 years, a majority were Dutch and married/committed, and 55.4% were college-educated. In the cases, 19 experienced a depressive-psychotic episode, 93 a manic- psychotic episode, 23 a mixed-psychotic episode and 17 experienced pure psychosis. Our previously identified biomarkers of PPD and PMDD were NOT present in samples from participants with PP. EWAS in PPP focused on symptomatology found no statistically significant methylation associations with manic or psychotic symptoms but 912 statistically significant methylation sites associated with depressive symptoms ($FDR<0.02$). An EWAS model focused on predicting recurrence risk generated an AUC=0.64.

Conclusion: Although our previously identified epigenetic biomarkers associated with PPD and PMDD are likely markers of central nervous system sensitivity to reproductive hormone fluctuations, they are not present in PP indicating a separate and unique underlying biological basis for PP from other types of reproductive mood disorders. Our finding that 912 methylation sites were significantly associated with depressive symptoms underscores the role of epigenetic changes in depressive disorders. Our EWAS model focused on predicting recurrence risk was modestly able to predict recurrence outside of the postpartum time. This model was limited by time of follow-up (4 years).

Category: *Novel Interventions in Perinatal Mental Health*

448: Postpartum depression and birthing parent–infant interactions assessed using the coding Interactive behavior instrument: a systematic review

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Background: Postpartum depression (PPD) affects up to one in five birthing parents and can interfere with parent-infant bonding and attachment, as well as disrupt offspring socioemotional development. The Coding Interactive Behavior (CIB) instrument is a validated observational coding system comprised of 43 global rating scales across parent, child, and dyadic domains. This systematic review examines the impact of PPD on the quality of birthing parent-infant behavioural interactions including sensitivity and attunement, as measured by the CIB instrument.

Methodology: Searches were conducted using five electronic databases from their inception until August 27, 2025: MEDLINE, EMBASE, CINAHL, PsycINFO and Web of Science. The search strategy captured key concepts including postpartum depression, birthing parent-infant behavioural interactions, and the CIB. Studies included pregnant people and/or birthing parents who were ≥ 18 years of age and experiencing PPD with an infant between the ages of two and 36 months. In all studies, PPD was defined using structured clinical interviews, clinician diagnosis, validated cut-off scores on standardized self-report questionnaires, and/or continuous measures of depressive symptom severity. Data were extracted on birthing parent, infant, and dyadic interaction outcomes. Risk of bias was assessed, and findings were synthesized using narrative synthesis and meta-analysis when possible.

Results: Twenty-two studies met inclusion criteria. They used a range of task types (e.g., free play, structured play) to assess CIB domains. While fewer positive behaviours (e.g., parent sensitivity, infant positive affect) and higher levels of negative behaviours (e.g., parent intrusiveness, infant withdrawal) were seen in dyads where birthing parents had PPD, only half of studies reported statistically significant differences. Few dyadic outcomes differed between dyads exposed to PPD and those who were not.

Conclusion: Postpartum depression is associated with disruptions in birthing parent and infant interactions though findings generated by the CIB remain inconsistent across behavioural domains and observational contexts. These results highlight the need for further research using larger samples, standardized observational methods, and longitudinal designs to clarify how depressive symptoms shape early birthing parent-infant interactions and inform interventions to strengthen parent-infant relationships in those with PPD.

Category: *Clinical Trends in Perinatal Mental Health*

463: The impact of peer-delivered cognitive behavioral therapy for postpartum depression on affectionate touch in birthing parent-infant interactions

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Background: Postpartum depression (PPD) affects up to one in five birthing parents and is associated with an increased risk of adverse outcomes for children, including impaired attachment and socioemotional development. Disruptions in early parent-infant interactions, particularly reduced affectionate touch, are hypothesized to mediate PPD's adverse effects on offspring and to increase following treatment. This study aims to: (1) characterize affectionate touch by those with PPD with their infants using the Coding Interactive Behavior (CIB) instrument, a validated observational coding system assessing parent, infant, and dyadic behaviours, and (2) examine changes in affectionate touch following receipt of group cognitive behavioral therapy (CBT).

Methodology: Data were drawn from a randomized controlled trial of a 9-week group CBT for PPD intervention where treatment was delivered by individuals who had previously recovered from PPD (i.e., peers). Seventy-three birthing parents were randomized to the intervention (n=37) or control (n=36) group, and 50 birthing parents and their infants provided data for this study. Parent-infant interactions were assessed at two timepoints (baseline and 9 weeks later) on changes in affectionate touch (warm, gentle physical contact) during a structured play task where parents were instructed to guide their infant in a brief play activity. Interactions were coded using the CIB instrument. Twenty percent of videos were double-coded, and good inter-rater reliability was achieved for the affectionate touch scale.

Results: A statistically significant group by visit interaction was observed for affectionate touch in birthing parents, with those in the intervention group showing greater increases at 9-weeks post-intervention ($p = .015$) compared to those in the waitlist control group during the structured play task. This indicates that birthing

parents in the peer-delivered CBT group engaged in warmer, more responsive physical contact with their infants. **Conclusion:** Findings suggest that birthing parents with PPD who received peer-delivered CBT showed increased affectionate touch during parent–infant interactions compared to those in the waitlist control group. These findings support the potential for peer-delivered interventions to improve aspects of early parenting behaviour. Future research should examine whether changes in affectionate touch may influence offspring developmental outcomes. Replication in larger samples is needed to determine whether treatments targeting parent–infant dyads affect specific parenting behaviours.

Category: *Perinatal Psychotherapy*

Perinatal Mental Health Across Clinical, Social, and Community Contexts

69: The Inclusion of Grandparents in Perinatal Mental Health

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Background: Grandparents are the parents of mothers and fathers. They can be genetically linked to their offspring or through remarriage and be called step-grandparents. Becoming a grandparent is based on luck and life expectancy. It is part of one's life course, and an extension of parenthood. It is about aging and birthing another generation. The perinatal period is the ideal time to engage individuals from different generations to discover and develop a common ground in their families. There is a need to build bridges between the old and the young during pregnancy. The postpartum period is not time limited. There are mental health challenges facing grandparents that are often overlooked.

Since the start of humanity, the number of humans who lived to be grandparents has increased. Longevity is largely the result of improved medical technology genetics, and healthy living standards. By the end of the 20th century men and women were spending almost half of their lives as grandparents. They witnessed their grandchildren becoming adults.

Grandparents and their well being are important. Their role is to pass down family knowledge, information, and wisdom. It is believed that the reason to have three generations living together is survival. Research reveals that early family relationships play a pivotal role in protecting young adults against mental health risks.

Methodology: Academic and peer-reviewed journals that publish articles about grandparents are part of psychology, gerontology, sociology, and family studies. This presentation is based on twenty evidence-based research articles from public health, social science, nursing, medical and family therapy journals.

Results: The results reveal why and how grandparents play a major role in rearing the next generation. They explain the differences between grand-parenting and parenting, how lineage, gender or marital status influence grand-parenting.

Conclusion: Inter generational communication is critical to healthy family dynamics. From the moment a pregnancy is confirmed it impacts on the emotional well-being of grandparents-to-be. This presentation provides an opportunity to explore the research of this vulnerable population and discuss the challenges they face.

Category: *The Inclusion of Grandparents in Perinatal Mental Health*

103: Baby2Home and Parental Mental Health: A Randomized Trial

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Background: Despite improvements in maternal and infant somatic health outcomes in recent decades, the psychosocial needs of postpartum families remain unmet. This randomized controlled trial (RCT) evaluated the effect of Baby2Home, a digitally-augmented perinatal collaborative care model (pCCM), on mental health and wellness outcomes for new parents over the first postpartum year.

Methodology: In this multicenter, pragmatic RCT, parents of first-born, term infants were randomized to Baby2Home or usual care. The intervention integrated app-based education, mental health symptom tracking, and care manager support for both parents. Patient-reported outcomes across six domains (i.e., stress, depression, anxiety, global health, relationship quality, and self-efficacy) were collected at five timepoints. Analyses used mixed-effects models to estimate overall effects. Secondary analyses evaluated treatment effect modifiers.

Results: The RCT enrolled 642 families, including 642 birthing and 324 non-birthing parents. Birthing parents randomized to Baby2Home (n=321) reported reduced stress ($\beta=-4.0$; 95% CI: -5.0, -3.1), depression ($\beta=-1.4$; 95%

CI: -1.9, -0.9), and anxiety (β = -0.9; 95% CI: -1.5, -0.3), alongside improvements in global health, relationship quality, and self-efficacy, compared with usual care. Non-birthing parents randomized to Baby2Home (n=151) reported significantly lower stress (β = -2.7; 95% CI: -4.1, -1.3) compared with usual care. Prespecified analyses showed no evidence of differential treatment effects by race, ethnicity, or insurance type, with larger effects observed among lower-income families.

Conclusion: Baby2Home, a digitally-augmented pCCM, improved mental health and wellness outcomes for parents during the first postpartum year. (Funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, ClinicalTrials.gov number NCT05595486)

Category: *Digital mental health*

107: Prevalence of Mental Disorders in Parents with Intellectual Disabilities: Systematic Review and Meta-Analysis

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Background: Research indicates that increasing numbers of people with intellectual disabilities (ID) are becoming parents. Parents with ID face multiple contextual factors that elevate mental health risks during the perinatal period. Mental disorders in this period can significantly impact parents, their child, and wider support network. An awareness of the prevalence of mental disorders improves detection and personalised care, enabling policies that support early recognition and prevention and reduce health inequities for parents with ID. Thus this systematic review summarises the prevalence of mental disorders in parents with ID during pregnancy, post-partum, and parenthood, comparing rates with the general population and non-parents with ID.

Methodology: The review was conducted following PRISMA 2020 guidance and registered with PROSPERO. Studies were identified with individuals with clinically diagnosed ID who had experienced pregnancy or parenthood and reported prevalence of specific mental disorders. Searches of MEDLINE, APA PsycINFO, EMBASE, and grey literature were conducted up to May 2025. Risk of bias was assessed using the Mixed Methods Appraisal Tool. Findings were synthesised narratively, with meta-analysis where possible.

Results: Ten studies involving 42,207 individuals aged 18–58 years were included. Two studies focused on the perinatal period, the rest on parents with children aged 0–21 years. Across studies, about half of parents with ID experienced a psychiatric disorder. Depression was most common, affecting 38% (95% CI: 26–50%) mothers, anxiety 26% (95% CI: 26–26%), and psychosis 9% (95% CI: 3–14%). Rates are higher than in the general population and non-parent individuals with ID.

Conclusion: This review is the first to document elevated mental health risks among parents with ID. Findings highlight the need for tailored screening and support in reproductive healthcare, addressing stigma, and guiding further research to inform targeted interventions.

142: Healthcare teachers' knowledge, skills, and attitudes related to perinatal mental health in Namibia, Malawi, and Zambia – perspectives on teaching and its development

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Background: Perinatal mental health (PMH) disorders significantly affect the well-being of mothers and children, yet their recognition and treatment vary globally. Prevalence rates are highest in low- and middle-income regions such as sub-Saharan Africa, where PMH disorders often remain underdiagnosed due to the absence of systematic screening and limited knowledge among healthcare professionals. Evidence-based treatment is also

largely inaccessible. This qualitative study explores healthcare teachers' knowledge, skills, and attitudes regarding perinatal mental health and its teaching across Namibia, Malawi, and Zambia.

Methodology: Focus group discussions (FGDs) were conducted with healthcare teachers from Higher Education Institutions (HEIs) in Namibia, Malawi, and Zambia (two per country; total N = 6). Participants were recruited based on their expertise in PMH care or their involvement in PMH teaching. FGDs followed structured protocols to ensure consistency. All discussions were audio-recorded, transcribed verbatim, and analysed thematically.

Results: Healthcare teachers identified several risk factors for PMH disorders, including poverty, inadequate social and financial support, and previous traumatic experiences. Stigma and culturally rooted misconceptions were described as persistent barriers that prevent women from seeking help. Teachers emphasized the absence of systematic screening practices and the limited availability of treatment options, both of which weaken the quality of care. Participants stressed the urgent need for educational initiatives as essential for changing societal attitudes and reducing stigma. Strengthening PMH education within HEIs by ensuring that perinatal mental health is systematically and consistently embedded across teaching programmes and increasing community-level awareness were viewed as vital steps toward improving maternal mental health outcomes in these regions.

Conclusion: Improving PMH education in healthcare training is essential for addressing the significant human suffering associated with PMH disorders and their long-term consequences for women, children, families, and communities. Enhanced educational approaches, combined with broader community awareness, can promote early identification and reduce stigma. Failure to recognise or treat PMH disorders may lead to substantial national economic costs, including increased healthcare utilisation, reduced productivity, and intergenerational impacts. These findings can guide the development of educational strategies, clinical practices, policy measures, and community-level initiatives to advance maternal mental health outcomes in Namibia, Malawi, and Zambia.

Category: *Perinatal mental health competence in Healthcare Higher Education*

147: Stability and change in perinatal depressive symptom trajectories: The role of social support and community green space

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Background: Research typically shows a reduction in depressive symptoms from the prenatal to postpartum period, yet the variability underlying this population-level trend has not been well characterized. Furthermore, limited attention has been paid to multi-level, strengths-based factors that may support peripartum mental health and inform intervention targets. This study examined stability and change in depressive symptoms from pregnancy through 24 months postpartum, and investigated whether prenatal social support and residential exposure to community green space were associated with improving symptom trajectories.

Methodology: Participants (N=6,896; Mean age=29.9 years; 65% White, 18% Black, 17% other/multiple race or minoritized groups) were enrolled in the Environmental influences on Child Health Outcomes (ECHO) cohort across multiple sites in the United States. Depressive symptoms were assessed using the Edinburgh Postnatal Depression Scale administered at least once per period and aligned by trimester and in 3-month groups through 24-months postpartum. Participants self-reported prenatal social support; residential addresses were geocoded and linked to the health and environment domain of the Child Opportunity Index as an indicator of neighborhood green space exposure.

Results: Latent class analysis identified a three-class solution for both prenatal symptom profiles (Class1: 14.9% 'moderate', Class 2: 55.2% 'low', and Class 3: 29.9% 'very low') and postpartum symptom profiles (Class

1: 10.9%, 'moderate'; Class 2: 49.9%, 'low'; Class 3: 39.2%, 'very low'). Within-person stability across the transition was high. Latent transition analyses indicated that individuals with 'moderate' depressive symptoms during pregnancy had a 39% probability of transitioning to a lower symptom class postpartum. Neither prenatal social support nor green space exposure was associated with this symptom improvement.

Conclusion: Depressive symptom trajectories were largely stable across the perinatal period, although a clinically meaningful minority of individuals shifted to a lower symptom trajectory postpartum. The lack of modification by social support and green space exposure suggests that these factors may be insufficient to drive symptom change at a population level. These findings highlight an ongoing need to identify modifiable multilevel determinants, across individual, interpersonal and structural domains, that can be leveraged in scalable interventions to support the mental health of childbearing individuals and their families.

Category: *Multi-level promotive factors*

265: Polyhydramnios as a Clinical Clue in Lithium Exposed Pregnancies: Findings from a Retrospective Cohort

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Background: Lithium is a first line mood stabilizer for perinatal bipolar disorder and is primarily eliminated through renal excretion. Pregnancy induces substantial physiological adaptations—including plasma volume expansion and altered renal function—that can modify lithium disposition. Polyhydramnios, defined as an abnormal increase in amniotic fluid volume, may further influence maternal fluid balance and renal perfusion, potentially affecting lithium pharmacokinetics.

Objectives:

To determine whether polyhydramnios impacts maternal serum lithium concentrations and to explore the implications for therapeutic monitoring and maternal–fetal safety.

Methodology: We conducted a retrospective observational cohort study of women treated with lithium, either as monotherapy or in combination therapy, during the perinatal period at the perinatal psychiatry outpatient clinic of a tertiary university hospital (November 2006–December 2020; HCB/2020/1305). Demographic, psychiatric, obstetric, and serum lithium data were extracted from electronic medical records. Lithium levels were measured using an AVL 9180 electrolyte analyzer with ion selective electrode technology (LoQ 0.20 mEq/L; LoD 0.10 mEq/L). Longitudinal changes in serum lithium concentrations across pregnancy and postpartum were analyzed using linear mixed models.

Results: A total of 1,260 serum lithium measurements were obtained from 109 pregnancies in 95 women. Polyhydramnios occurred in 11 pregnancies (10%) between gestational weeks 28–36; two cases were severe (amniotic fluid index >35 cm), and one required amnioreduction. Etiological evaluations were negative for all cases.

In pregnancies without polyhydramnios (n=98), serum lithium concentrations (standardized to 1000 mg/day) decreased by 32.9% in the first trimester, 32.2% in the second, and 21.0% in the third trimester, followed by a 0.3% increase in early postpartum. Pregnancies with polyhydramnios (n=11) showed slightly higher absolute serum levels, although trimester to trimester patterns were comparable. In the adjusted linear mixed model

(controlling for perinatal period and lithium dose), the difference in serum lithium concentrations between pregnancies with and without polyhydramnios was not statistically significant ($p = 0.144$).

Conclusion: In this cohort, polyhydramnios did not significantly affect maternal serum lithium concentrations during pregnancy. Prospective studies are needed to refine individualized lithium monitoring strategies throughout the perinatal period, with a focus on maternal–fetal safety.

Category: *Perinatal psychopharmacology*

421: The Antenatal Risk Questionnaire: Its psychometric properties and comparison with EPDS and DASS for use in Iceland for prevention of mental health problems

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Background: The Antenatal risk questionnaire (ANRQ) was developed for clinical and research use. It is a short scale probing mental health history, adverse life experience, partner relationships, and social support. It therefore includes important information regarding psychosocial risk factors not addressed by the main mental health scales used during pregnancy such as EPDS and The Depression, Anxiety Stress Scales (DASS). We aimed to evaluate the psychometric properties of the Icelandic ANRQ translation to determine its suitability for antenatal use and to support more personalized pregnancy care.

Methodology: A sample of 625 pregnant women participated in this cross-sectional study and answered the ANRQ-R, EPDS and The DASS-21, and questions concerning background variables. The participants were recruited when coming for a sonogram at various gestational weeks. Data analysis included comparing results of ANRQ with EPDS and DASS to establish reliability and correlation, and exploratory factor analysis and regression to assess the psychosocial properties of ANRQ.

Results: Approximately 47% of respondents scored above-threshold on the ANRQ whereas 27% scored above-threshold on the EPDS. Analogous values for the DASS were 29% on the Depression scale, 26% for Anxiety and 23% for Stress. Pearson's correlations between ANRQ and EPDS total scores was $r=.55$. Between ANRQ and DASS Depression the Pearson's correlation was $r=.48$, $r=.39$ between ANRQ and DASS anxiety, and $r=.50$ between the ANRQ and DASS Stress scale. A 5-factor solution provided the best account of the ANRQ data [$\chi^2(16) = 24.365$, CFI=.998, RMSEA = .029]. Our exploratory analysis of ANRQ scores by different gestation times showed an unanticipated pattern, with respondents completing the questionnaire between weeks 28 and 32 reporting higher scores than those who completed it later.

Conclusion: The results show that ANRQ shares some conceptual overlap with EPDS and DASS scales but may also provide novel insights into history-related psychosocial risk factors not fully reflected in symptom-focused measures such as EPDS and DASS. Results from the 5-factor solution support the purpose of the questionnaire as a measure of conceptually independent variables relating to the expectant mother's background. Findings suggest that the ANRQ may add useful insight to improve early identification of women at increased risk during pregnancy.

Category: *Prevention of Perinatal Mental Health Disorders*

477: Characterization of Reproductive Health Among Black Birthing Canadians

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Background: Evidence from high-income countries suggest that Black women experience a higher burden of mental health symptoms during pregnancy and postpartum. However, Black women are less likely to engage in outpatient mental health services resulting in worsening of symptoms and a greater reliance on emergency and inpatient psychiatric care. This study provides a rare examination of mental health-related healthcare utilization among Black perinatal people in Ontario, Canada.

Methodology: This population-based cohort study utilized health administrative databases from ICES Institute for Clinical Evaluative Sciences and the Better Outcomes and Registry Network. All Ontario in-hospital livebirth and stillbirths, conceived between 2012 and 2021 to residents aged 13-55 years, were considered for inclusion. Modified Poisson regression models were used to compare Asian and Caucasian vs. Black birthing persons on mental health service outcomes between conception and 365 days postpartum, overall and for specific psychiatric diagnoses. Mental health outcomes were any mental health contact, psychiatric emergency department visits, and psychiatric hospital admissions. Models were adjusted for covariates including maternal age, parity, year of delivery, immigration status, neighborhood income, infant sex, location of residence, and Ontario marginalization.

Results: Of 760,611 birthing people, 55,605 (7.3%) identified as Black. Among Black birthing Ontarians, 26.6% had a perinatal mental healthcare contact, anxiety and related disorders being the most common diagnoses (20.6%). Their Caucasian counterparts were more likely to have a contact (31.26%, aRR 1.12, 95%CI 1.11-1.14) and their Asian counterparts were less likely to have a contact (18.72%, aRR 0.87, 95%CI 0.86-0.89). This pattern held for outpatient mental health visits, and most specific diagnoses, with two exceptions. Both Asian and Caucasians were less likely than Black perinatal persons to have (1) a psychotic disorder diagnosis (0.21% and 0.34% vs. 0.63%, corresponding to aRRs of 0.58, 95%CI 0.50-0.69 and 0.60, 95%CI 0.52-0.69, respectively), and (2) a psychiatric admission (0.17% and 0.38% vs. 0.50%, corresponding to aRRs of 0.67, 0.56-0.89 and 0.77, 0.67-0.88, respectively).

Conclusion: Black perinatal persons may be less likely to utilize/access outpatient healthcare for mental health disorders unless symptoms are severe or emergent. Early and strategic interventions are critical to prevent poor mental health outcomes.

Category: *Healthcare utilization for mental health among perinatal people of African descent who identify as Black and reside in Canada*

Preconception, Perinatal and Early Postnatal Interventions

130: What makes perinatal depression screening acceptable? A systematic review mapping women's views, measurement practices, and implementation gaps

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Background: Routine screening for perinatal depression (PND) is widely recommended, however, its effectiveness depends on women's acceptability of the screening process, an implementation construct that remains inconsistently operationalized. Since the last comprehensive review on the topic in 2014, screening recommendations and approaches have evolved. This systematic review aims to synthesize recent evidence on women's acceptability of PND screening, focusing on how the construct is defined, measured and experienced.

Methodology: Five databases were searched for studies published between 2014 and 2025. Studies reporting any indicator relevant to acceptability or closely related constructs were included. Two reviewers independently screened, extracted and appraised the studies. Quantitative and qualitative findings were synthesized separately and examined in parallel across key screening dimensions (provider, tool and mode, setting, timing).

Results: 43 studies were included, revealing heterogeneity in measurement and reporting. Acceptability was rarely assessed directly and was most often inferred through proxies, such as comfort, ease, usefulness, or completion rate. Despite this variability, trends could be detected by combining quantitative and qualitative evidence. Quantitative evidence indicated overall high acceptability, particularly when screening was embedded in routine care and facilitated by trusted providers. Qualitative findings helped explain these patterns by identifying empathic communication, perceived relevance, and clarity of follow-up as key mechanisms shaping acceptability.

Conclusion: Overall, PND screening appeared acceptable when delivered in a relational and well-integrated manner. Future policies should focus on designing and implementing non-judgmental, culturally sensitive screening processes with a clear purpose and accountable follow-up, and on promoting the adoption of shared frameworks and measures in research.

Category: *Prevention of Perinatal Mental Health Disorders*

196: Gestational Choline Buffers Stress, Preterm Birth Risk and Child Neurodevelopment in African American Women

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Background: African American (AA) women have increased cortisol levels during pregnancy, increased risks of preterm birth, and higher rates of children with mental illnesses with prenatal origins. All of these conditions have known complex relationships to systemic racism and inequalities that exist in the US. Choline has multiple roles in development, including cell membrane phospholipid synthesis, one-carbon metabolism and methylation, and agonism at cholinergic receptors before their innervation by acetylcholinergic synapses. Increased maternal dietary choline and choline supplements have been associated with improved cognitive ability, attention, and social behavior in children up to 7 years old. The objective of this study was to investigate how prenatal maternal choline interacts with maternal mood and stress, cortisol levels as a biomarker of the stress, pregnancy outcomes, and child neurodevelopment in pregnancies of AA participants compared with other races and ethnicities.

Methodology: Pregnant women were enrolled in two randomized clinical trials of gestational phosphatidylcholine supplementation versus placebo. In addition, participants from a prospective cohort study of prenatal stressors and interactions with prenatal choline were also included as study timelines and

measures were identical. All 3 studies were initiated at 16 weeks gestation, between 2010 and 2021, in Denver, Colorado, USA. In all studies, participants underwent a 16-week hair cut for cortisol extraction and a blood draw to assess serum choline. The primary outcomes were: gestational age at delivery, birthweight, and the Infant Behavior Questionnaire-R-SF (IBQ-R) at 3 months. Secondary outcomes were measures of depressive symptoms, anxiety, stress, pregnancy & birth outcomes, and inhibition of the P50 component of the cerebral evoked response to paired sounds (P50).

Results: There were 403 total participants in the combined studies, with 48 identifying as AA. Lower 16-week maternal plasma choline was noted in AA vs White participants. Lower 16-week choline was associated with: higher hair cortisol, indicative of higher stress for ($\beta = -.477$, $P = .045$); gestational age at birth, indicative of an increased risk for preterm birth ($\beta = .335$, $P = .044$); lower infant IBQ-R Orienting/Regulation, indicating decreased attention and relation to caregivers ($\beta = .417$, $P = .050$); and with decreased auditory P50 inhibition, a marker of inhibitory neuron development ($\beta = -.447$, $P = .021$). No relationship was found between choline and BMI, lower household income or different choline metabolism genotypes.

Conclusion: In AA participants, higher 16-week maternal choline appeared to buffer higher hair cortisol levels, and lengthen gestation compared to AA participants with lower choline. In addition, inhibitory and behavioral deficits associated with lower prenatal choline in the children of AA participants in this study indicate potential developmental predispositions to later mental illnesses. Prenatal choline supplementation may be beneficial in reducing health care disparities in both birth and neurodevelopmental outcomes in African American women and their children.

Category: *Prevention of Perinatal Mental Health Disorders*

216: “You say this is my baby...well, ok then”: Parental experiences and postnatal mental health following general anaesthetic caesarean section

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Background: General anaesthetic (GA) caesarean birth accounts for approximately 4-8% of all caesarean sections in the UK. Although relatively uncommon, it may be associated with complex emotional and psychological challenges for mothers and fathers/partners. GA caesarean often occurs in acute emergency contexts, where fathers/partners are typically not permitted into the operating theatre. Consequently, neither parent is present at the point of birth. The potential implications for postnatal mental health and early newborn bonding in parents' following GA caesarean remain underexplored.

Methodology: This mixed-methods research included two studies. The first analysed data from over 18,000 caesarean section cases within the Early-Life Cross-Linkage in Research (eLIXIR) database, which links maternity, neonatal, GP and mental health records for births across South London. This dataset was used to examine mental health outcomes, such as depression, PTSD and anxiety in the first postnatal year. The second study used a grounded theory approach, involving separate interviews with mothers and fathers/partners, to explore the impact of GA caesarean in the first 2 years after birth.

Results: Postnatal (PN) depression was defined using GP-recorded diagnostic codes in the first year after birth. Among complete cases, PN depression occurred in 216/4,337 (5.0%) of epidural-spinal caesareans and 15/193 (7.8%) of GA caesareans. Interviews contextualised these findings. Mothers reported escalating fear and panic at the point of general anaesthesia, often centred on concerns for their baby's survival, alongside distress at missing the birth itself. Many described an immediate sense of disconnection from their baby, which for some persisted for weeks or months, alongside temporary doubt about whether the baby was their child and feelings of guilt, failure and isolation. Mothers also described symptoms consistent with depression and post-traumatic stress. Fathers reported profound distress and anxiety while separated from their partner during the emergency.

Conclusion: This is the first large-scale study to use linked administrative data to examine GA caesarean birth and postnatal mental health, integrating qualitative interviews with mothers and fathers/partners. Together, these findings indicate that GA caesarean birth represents a distinct psychological context that warrants targeted recognition and trauma-informed support within postnatal services.

237: Pilot evaluation of a co-designed adolescent perinatal mental health intervention in Kenya and Mozambique: The INSPIRE project

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Background: Despite the high prevalence of teenage pregnancy in low- and middle-income countries, few interventions focus on adolescent perinatal mental health. The co-designed Thriving Mamas Programme (TMP) focuses on improving mental health outcomes for adolescent girls. TMP is a nine-session antenatal course which supports girls to look after themselves and their babies, strengthen life skills and plan for the future. We aimed to assess the implementation and impact of TMP in Kenya and Mozambique.

Methodology: A mixed-method pilot randomised control trial was conducted in Kilifi County, Kenya and Tete District, Mozambique. Pregnant adolescents (aged 15-19 years) were recruited from health facilities to receive standard antenatal care plus the TMP (n=40) or standard care alone (n=30). Implementation data on acceptability, appropriateness, and feasibility of the programme were collected from providers (n=31), adolescents (n=70), and friends/family members attending TMP meetings (n= 46) throughout the study. The impact of the intervention on girls' mental health, perceived social support, health behaviours and parenting competencies were also assessed.

Results: TMP was found to be highly feasible, appropriate and acceptable to all participants. The intervention resulted in an 85% reduction in the number of girls experiencing moderate to serious symptoms of depression and anxiety. While there was no difference in intention to vaccinate or breastfeed, adolescents receiving the intervention attended more antenatal appointments. Participants described TMP as giving them hope for their futures and the futures of their babies. The relationships participants developed with providers and other adolescents were described as reasons for adhering to the intervention and feeling competent in their abilities to maintain a healthy pregnancy and care for their babies.

Conclusion: INSPIRE has demonstrated that co-design approaches can be successfully used to develop mental health interventions. The results of this pilot trial support TMP's potential for integration, effectiveness and generalisability. In addition, the intervention drew significant support from girls, their families, health care workers and governmental and healthcare officials in both countries.

Category: *Prevention of Perinatal Mental Health Disorders*

251: Gestational Choline in the Second and Third Trimesters of Pregnancy Improves Child Neurodevelopment

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Background: Choline has multiple roles in development, including cell membrane phospholipid synthesis, one-carbon metabolism and methylation, and agonism at cholinergic receptors before their innervation by acetylcholinergic synapses. Increased maternal dietary choline and choline supplements have been associated with improved fetal brain development and subsequent cognitive ability, attention, and social behavior in children up to 7 years old.

The objective of this study was to determine whether gestational choline supplementation begun at 16 weeks of gestation, compared with placebo, improves childhood behavior problems and cognitive abilities.

Methodology: This randomized placebo-controlled trial compared 9000mg phosphatidylcholine daily or placebo, initiated at 16 weeks' gestation, between 2018 and 2021 in Denver, Colorado, USA. The primary

outcome measure was the Child Behavior Checklist 1.5-5yr (CBCL) and Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV). Secondary outcomes were measures of maternal mental health and stress, pregnancy & birth outcomes, inhibition of the P50 component of the cerebral evoked response to paired sounds (P50), and individual CBCL components including social withdrawal and attention problems. This trial is registered on ClinicalTrials.gov NCT03028857

Results: The trial randomized 211 pregnant women, 157 continued through childbirth, 142 completed infant assessments, and 124 children were assessed by CBCL at 4 years of age. The COVID19 pandemic affected 58 pregnancies with 17 reporting symptoms and 1 participant hospitalized with COVID pneumonia who experienced a fetal demise at 33 weeks. Maternal plasma IL-6 increased during the pandemic (2.99 ± 5.07 pg/ml, $N=58$, compared to other times, 1.71 ± 1.65 pg/ml, $N=98$, mean difference 1.28 pg/ml, 95% CI 0.189 to 2.3). Males whose mothers were pregnant and received placebo during the COVID19 pandemic had higher CBCL T-scores (more problems) than males whose mothers received placebo at other times, 60.4 ± 2.4 (SE), $N=8$, compared to 52.2 ± 1.8 (SE), $N=21$, mean difference 8.25 , 95% CI 3.9 to 12.6 , and higher T-scores than males whose mothers received phosphatidylcholine during the pandemic, 51.6 ± 2.0 (SE), $N=14$, mean difference 8.8 , 95% CI 4.3 to 13.3 . Of the tripartite primary outcomes, phosphatidylcholine supplementation decreased Withdrawn Problems T-score (mean difference = -2.6 , 95% Confidence Interval (CI) -4.0 to -0.6) and Attention Problems Tscore (mean difference = -3.2 , 95% CI -6.4 to -0.6), and increased Full Scale IQ (mean difference = 6.7 , 95% CI 2.0 to 11.4). Phosphatidylcholine had no significant adverse effects.

Conclusion: Prenatal phosphatidylcholine improved 4-year-olds' Withdrawn Problems and Full Scale IQ and decreased Attention Problems as measured by the CBCL. COVID19 infection negatively impacted male fetuses in the group of participants who received placebo compared to those who received phosphatidylcholine supplementation. Choline supplementation during gestation appears to buffer the fetal brain from avoidable and unavoidable exposures during pregnancy and, thus, should be a recommendation for all pregnant patients.

Category: *Prevention of Perinatal Mental Health Disorders*

310: A complex, community-based, task-shifting perinatal mental health intervention in rural India: a RE-AIM and realist mixed-methods evaluation of the PRAMH phase 2 pilot

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Background: Common perinatal mental disorders are highly prevalent in low- and middle-income countries, where detection and treatment gaps remain substantial. In rural India, stigma, gender inequity and limited specialist services further restrict access to care. The Perinatal Mental Health (PRAMH) phase 2 study co-developed and piloted a complex, community-based intervention for perinatal mental health in two Indian states, Haryana and Telangana.

Methodology: We conducted a single-arm mixed-methods feasibility pilot study across four primary health centres in two districts in Haryana and Telangana. Evaluation was structured using the RE-AIM framework (reach, effectiveness, adoption, implementation, maintenance) and informed by realist evaluation and Kabeer's empowerment framework. The PRAMH intervention comprised: 1) digital screening, and referral by Accredited Social Health Activists (ASHAs), 2) Ten 1-hour peer-led group sessions drawing on and integrating components from WHO's Thinking Healthy Programme, Group Problem Management Plus and related psychosocial interventions, adapted through local co-development, 3) community engagement on social determinants, and 4) development of a community anti-stigma campaign. 200 women were screened and 100 were enrolled with baseline and four-month follow-up assessments. Quantitative outcomes were PHQ-9, GAD-7, SIDAS, WHO-5, stigma; qualitative interviews explored acceptability and mechanisms.

Results: Depressive and anxiety symptoms significantly decreased in both states ($p \leq 0.01$), with reductions in suicidal ideation ($p \leq 0.05$) and improved wellbeing ($p < 0.001$). Reach and adoption were high, with sustained engagement of ASHAs and peer leads. Preliminary qualitative findings suggest that peer groups may have activated relational processes including recognition, emotional validation and normalisation of distress. Women

highlighted the value of connection and shared experience, describing reduced self-stigma and greater confidence to seek support. Participants also reported emerging shifts in gendered beliefs, including greater acceptance of having a girl child. Interpreted through realist and empowerment lenses, peer groups appear to function as social resources that may strengthen agency and connection, contributing to improved mental health outcomes.

Conclusion: This pilot suggests that a task-shifting, community-based perinatal mental health intervention is feasible and associated with improved symptoms in rural India. Emerging qualitative findings indicate that relational and empowerment processes within gendered social contexts may contribute to change. These results support progression to a controlled effectiveness trial.

Category: *Prevention of Perinatal Mental Health Disorders*

316: Embedding attachment-informed strategies in a primary-care perinatal mental health service in Cape Town: a case series

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Background: Common perinatal mental health conditions can disrupt mother-infant attachment. However, improving maternal psychological wellbeing, together with attachment-strengthening interventions, may enhance responsive, nurturing caregiving.

At Hanover Park Midwife Obstetric Unit (Cape Town), the Maternal Support Service of the Perinatal Mental Health Project delivers perinatal psychosocial care using a collaborative, stepped-care model. Registered counsellors provide tailored psychosocial counselling on-site, which imbeds infant-focused therapeutic strategies during the postnatal period.

The aim is to illustrate the use of therapeutic interventions tailored to the maternal-infant relationship, in supporting early outcomes of maternal attachment in service-users.

Methodology: A service-based evaluation and illustrative case series were used to describe implementation and early outcomes of infant-focused interventions. Maternal-infant therapeutic components included facilitating maternal mentalisation of the infant's experience, maternal attunement, emotional regulation and co-regulation, developmental processes, and attachment-focused reflection.

Proxy indicators of the mother-infant relationship were selected for feasibility in low-resource clinical sessions, including, maternal sensitivity and responsiveness to infant cues, shared pleasure, and eye contact. We summarised baseline antenatal and postnatal assessment (PNA) outcomes for eight cases to illustrate the breadth of infant-focused intervention strategies and to report on their feasibility in resource-constrained settings.

Results: The age of the women ranged from 16-45 years old with infants ~2-11 months at PNA; most were unemployed, with varied to no support from partners or family.

Counselling spanned 6-19 sessions per case, combining antenatal and postnatal work delivered in-person and remotely (telephonic or WhatsApp). Presenting problems include unplanned pregnancy, anxiety and or depression, trauma or grief, relationship and socioeconomic stressors. A combination of interventions was facilitated, including psychoeducation, cognitive-behavioural techniques, emotional regulation, problem-solving, grief, and/or bereavement and trauma-focused care, and relationship interventions.

Mothers described improvements in functioning. Counsellors observed infant-related outcomes, including strengthened bonding and maternal responsiveness (e.g., observed eye contact, shared pleasure, sensitive responding, and maternal psychological flexibility and capacity to mentalise the infant's internal world).

Conclusion: Embedding feasible, infant-focused therapeutic strategies within a stepped-care perinatal mental health service appears practicable in a primary-care, low-resource setting and may strengthen mother-infant attachment-related processes while supporting maternal mental health. Ongoing monitoring using pragmatic proxy indicators and strengthened routine data systems will support more robust evaluation of impact and guide scale-up.

Category: *Prevention of Perinatal Mental Health Disorders*

317: Psychiatric vulnerability and consultations for perceived reduced fetal movement: an opportunity to identify and address maternal mental illness during pregnancy?

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Background: Psychiatric vulnerabilities during pregnancy may influence fetal activity, but also the perception of fetal movements. Perceived reduced fetal movements (RFM) are a common reason for obstetric consultation. This study explored the association between psychiatric vulnerability and the occurrence of ≥ 1 RFM consultation during pregnancy.

Methodology: This retrospective cohort study included women aged ≥ 18 years, with a singleton pregnancy who gave birth between 2015 and 2020 in a large hospital in Amsterdam, The Netherlands. The association between psychiatric vulnerability and ≥ 1 RFM consultation was performed with logistic regression, while negative binomial regression examined the relationship with the number of RFM consultations per individual. Sensitivity analyses evaluated the link with depressive and anxiety disorders and ≥ 1 RFM consultation.

Results: Among 2311 women, psychiatric vulnerability was both associated with a higher likelihood of ≥ 1 RFM consultation (OR = 1.30, 95% CI 1.058-1.595) as well as a higher number of RFM consultations per individual after adjusting for confounders (IRR = 1.26, 95% CI 1.081-1.477). Both associations remained significant after exclusion of women with identified somatic explanation for RFM (OR = 1.25, 95% CI 1.002-1.569; IRR 1.29, 95% CI 1.107-1.561). Anxiety disorders were significantly associated with increased RFM consultations (OR = 1.32, 95% CI 1.005 – 1.733) whereas depressive disorders were not (OR = 1.16, 95% CI 0.916-1.457).

Conclusion: Psychiatric vulnerability, specifically anxiety disorders, was associated with increased presentations for perceived RFM. These findings suggest that RFM consultations may offer an opportunity to identify and support women with psychiatric vulnerability.

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366: Admission to the Kangaroo Mother Care Ward and Maternal Postpartum Depression: a Randomized Controlled Trial

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Background: Postpartum depression (PPD) is a serious public health problem affecting ~17% of women globally, with higher rates recorded in southern Africa – ~40%. Admission to the neonatal intensive care unit (NICU) is a risk factor for PPD. We aimed to determine whether initiation of kangaroo mother care (KMC) at the NICU, followed by admission to the KMC ward as part of stepdown care, reduces maternal PPD.

Methodology: We conducted an individual randomized controlled trial of newly delivered mothers whose preterm newborns, weighing 1000-2000g at birth, were admitted to the Women and Newborn Hospital – University Teaching Hospitals (WNH-UTH) NICU between November 2024 and February 2026. Mother-infant dyads were randomized with a 1:1 parallel allocation to those admitted to the KMC ward for up to 2 days (control) or for more than 2 days (intervention) as part of stepdown care before discharge home. Mothers were screened for PPD using the Edinburgh Postnatal Depression Scale (EPDS) screening tool at 2-weeks. Mothers who scored 11+ were categorized as having PPD.

Results: We recruited 514 mothers, of which 508 were screened for PPD at 2 weeks postpartum, pooled from

253 in the intervention and 255 from the control arm. Women aged 40 and above have a significantly higher risk of developing PPD, compared to those aged 16-19 (p-value 0.009). Additionally, women who reported alcohol consumption during the post-partum period had a significantly higher risk for developing PPD (p-value 0.031). Women in the intervention arm had a significantly lower rate of developing PPD at 2 weeks postpartum. **Conclusion:** Longer stay at the KMC ward was associated with a significantly lower rate of maternal PPD at 2 weeks postpartum. Tailored follow-up interventions may be necessary during the postpartum period, especially for older mothers and those who consume alcohol.

Category: *Prevention of Perinatal Mental Health Disorders*

376: An evaluation of the UNICEF Caring for the caregiver (CFC) intervention against the routine standard of care in Northern Uganda: a quasi-experimental prospective cohort study

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Background: In adversity, many perinatal women are at risk of mental and social distress. Controlled studies provide evidence that task-shifting perinatal mental health interventions reduces the treatment gap, but larger-scale delivery remains challenging. The UNICEF Caring for the caregiver (CFC) intervention has been shown to reduce parenting stress, depression, anxiety and to increase self-efficacy and social support in six low-and-middle income countries. We aimed to evaluate its benefits, relative to routine standard of care, in Northern Uganda.

Methodology: In this quasi-experimental prospective cohort study we recruited a community sample of pregnant women and caregivers of children 0-24 months, in two districts. To test the validity of the intervention in adversity, selected districts had limited health care and high levels of poverty. Community health workers delivered 10 sessions, over 6 months, as part of their routine home visiting. Outcomes, including depression (PHQ-9), anxiety (GAD-7), self-efficacy (GSE) social support (MSPSS) and parenting stress (Parenting Stress Index SF-36) scores were assessed 6-8 months post enrolment. Data analysis used a mixed-effects regression model adjusting for caregiver age, financial status, and education level, to assess change over time, interactions with intervention exposure, and district.

Results: We recruited n=502 caregivers (n=243 intervention; n=259 comparison) and 87.8% completed endline. Fidelity ($\geq 75\%$) was acceptable. The intervention groups showing greater improvements in mental health and social support outcome scores: depression ($\beta = -7.05$, $p < 0.001$), anxiety ($\beta = -3.89$, $p < 0.001$), self-efficacy ($\beta = 9.55$, $p < 0.001$) and social support ($\beta = 9.57$, $p < 0.001$). Overall, parenting stress increased in the comparison groups, and decreased only slightly in the intervention group, with district-level variations. In one district, it decreased in the intervention group ($\beta = -23.99$, $p < 0.001$) while in the other it increased in both, although less steeply in the intervention group. Financial insecurity was significantly associated with higher parent stress.

Conclusion: The CFC intervention has important mental and social benefits for caregivers relative to routine care, but its ability to mitigate parent stress may be limited by socio-economic deprivation. Integrating parenting support with poverty alleviation programmes in highly adverse contexts is important.

Category: *Prevention of Perinatal Mental Health Disorders*

422: Exploring Differences in Perceptions in the Transition to Parenthood: A Perinatal Study Using Narrative and Embodied Methods

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Background: The transition to parenthood represents a major developmental shift in the family life cycle, particularly during the perinatal period when the first child is born. During this stage, partners undergo psychological and social adjustments that are not always explicitly communicated or mutually understood, often creating perceptual gaps within the family system. These gaps can lead partners to form differing interpretations of shared experiences, shaping how they perceive stress, support, and relational dynamics. Despite its clinical relevance, these intra-family differences remain insufficiently understood. This study examined how such differences emerge using the Clinical Ethnographic Narrative Interview (CENI), a visual and narrative method designed to elicit thoughts, emotions, and embodied experiences.

Methodology: This qualitative study used CENI to explore partners' interpretations of early parenting. Participants were eight employed couples in their 20s to 40s navigating first-time parenthood. Each partner completed a 90-minute interview involving social network mapping, body mapping, lifeline construction, and card sorting. These procedures facilitated the distress points, emotional and physical states, and help-seeking tendencies, allowing implicit meanings and relational patterns to be externalized. Independently generated narratives were integrated at the couple level and analyzed using reflexive thematic analysis to identify patterns in how partners interpret and adapt to early parenting dynamics.

Results: Discrepancies emerged in five domains: perceived fairness of childcare involvement, emotional sharing and expressiveness, career aspirations relative to time constraints, expectations and evaluations of parental roles, and the quantity and quality of family social engagement. These differences were shaped not only by situational demands but also by how each partner interpreted shared events through developmental histories and attachment-related tendencies. Participants with heightened approval needs, difficulty seeking support, or early experiences of inconsistent caregiving often perceived partner behaviors in ways that intensified misalignment.

Conclusion: This study identified key domains of partner perceptual discrepancies. These findings suggest that such discrepancies reflect deeper psychological processes rather than simple communication failures or structural burdens. Understanding how partners construct meaning, regulate emotions, and seek support highlights the need for future research to examine these mechanisms across diverse family contexts. These findings offer clinical implications for developing tailored perinatal interventions to strengthen couple understanding and support healthier family adaptation.

Category: *Prevention of Perinatal Mental Health Disorders*

467: Transcutaneous Vagus Nerve Stimulation for Postpartum Mental Health: An Integrative Randomized Controlled Trial

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Background: Perinatal mental health issues such as depression and anxiety disorder affect around 20% of women postpartum, highlighting the need for accessible interventions. Mental health problems in the peripartum phase are often undertreated, particularly among those wishing to avoid pharmacotherapy. Transcutaneous auricular vagus nerve stimulation (tVNS) is a promising non pharmacological neuromodulation approach, but its effects on postpartum mood trajectories in real world settings remain unclear.

Methodology: In an ongoing randomized controlled trial (target N = 120), women enrolled in late pregnancy are randomized after childbirth to high-intensity tVNS, low-intensity tVNS, or treatment-as-usual for 6 weeks, followed by a protocol switch for another 6 weeks. Depressive symptoms are assessed at eight timepoints from pregnancy to 3 months postpartum using the Edinburgh Postnatal Depression Scale (EPDS), alongside daily ecological momentary assessment of affect and wearable-derived sleep indices. Linear mixed-effects models with random intercepts test main and interactive effects of group and time on EPDS and daily mood and examine whether affect and sleep dynamics predict depressive symptom trajectories.

Results: Interim data (n= 40 complete; 35 ongoing) show a transient EPDS peak around 3 weeks postpartum (mean 8.41) followed by a decline by 5 weeks (mean 8.00). Group specific means showed similar trajectories and preliminary linear mixed effects models did not provide clear evidence for main effects of group or group by time interactions on EPDS scores (all $p > .30$). Daily EMA models reveal coupling between negative affect and depressive symptoms, and between poorer sleep and higher negative affect, indicating that short term fluctuations in affect and sleep might be linked to symptom severity.

Conclusion: This trial is among the first to combine dense mood assessments with physiological and psychosocial markers to evaluate tVNS for postpartum mental health in everyday life. Current analyses, based on roughly one third of the planned sample and marked individual heterogeneity, do not yet permit firm conclusions about tVNS effects on depressive symptoms, although daily affect and sleep dynamics appear central to symptom trajectories. Final analyses in the full sample will clarify whether tVNS is a safe, acceptable, and clinically meaningful non-pharmacological option for postpartum women and which women are most likely to benefit.

Category: *Prevention of Perinatal Mental Health Disorders*

468: Preventing Perinatal Depression, Substance Use, and Self-Harm Ideation in Nurse-Family Partnership Program to Design Injury Related Early Warning Systems and Reduce Maternal Morbidity and Mortality

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Background: Pregnancy-associated injury-related deaths due to overdose, homicide and suicide continue increasing in the U.S. However, limited studies address their precursors maternal depression (MD), substance use (SU), and self-harm ideation (SHI), which are common and co-occurring in injury-related maternal early warning systems to reduce maternal morbidity and mortality as obstetrical causes have been. Relationship education teaches the concepts, processes, and skills for healthy romantic relationships and reduces relationship distress and breakdown. To design home visiting programs augmented with relationship education addressing MD, SU, and SHI, we performed secondary data analyses of a three-wave longitudinal randomized controlled trial of the Nurse-Family Partnership (NFP) program.

Methodology: In Oregon, 238 low-income, first-time pregnant mothers were randomized to a standard or augmented program where trained nurses integrated the Within My Reach curriculum and intimate partner violence screening and referral with the NFP workflow one-on-one at home visits. At pregnancy, 1-year, and 2-year follow-ups, research assistants interviewed mothers with the Edinburgh Postnatal Depression Scale (including an SHI item), Alcohol Use Disorder Identification Test, and Drug Abuse Screening Test. Multilevel models and generalized estimating equations with the wave-intervention interactions were performed, adjusting for race/ethnicity, age, education level, and nativity status.

Results: Depressive symptoms (25%), SU (36%), and SHI (8%) were common. Compared with the standard program, the augmented program indicated stable partner relationships (66% vs. 50%, $p=0.01$) and reduced depressive symptoms at the 1-year follow-up ($p=0.02$) but did not reduce depressive symptoms, SHI, or SU over

the two years. Building a consortium with experts, providers, payers, and families to implement a type 2 hybrid effectiveness-implementation pilot trial of injury-related maternal early warning systems might address injury-related disparities and promote safe motherhood.

Conclusion: These results can inform the design of large pragmatic transdisciplinary studies regarding mechanisms of change and integrating strategies (e.g., engage fathers, include co-parenting, and target SHI and SU). Our transdisciplinary teamwork has engaged stakeholders in evaluation, adoption, and integration of injury precursors into systems and models of care throughout settings. We will pilot test and scale them up in diverse settings culturally and linguistically tailored toward marginalized populations, thereby setting the stage for improving equity in safe motherhood.

Category: *Prevention of Perinatal Mental Health Disorders*

482: A cluster randomised trial of an integrated behavioural activation and parenting intervention for perinatal depression and child development in HIV-positive women in South Africa

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Background: HIV and depression in the perinatal period are major global public health challenges. Almost a third of perinatal women living with HIV in Africa also experience depression but intervention evidence remains limited. We aimed to test the effectiveness of an integrated behavioural activation and parenting intervention to treat perinatal depression and improve child cognition.

Methodology: We conducted a 2-arm, assessor-blind, cluster randomised controlled trial in HIV-positive perinatally depressed women, in South Africa. The trial evaluated combined behavioural activation and parenting support compared to enhanced standard of care (ESOC) which included routine care and telephonic support, all delivered by lay counsellors. Primary outcomes were depression at 12 months postnatal (Edinburgh Postnatal Depression Scale) and child cognition at 24 months (Cognitive Subscale, Bayley Scales of Infant Development). A randomly selected sub-sample of 60 women (30 per arm) completed qualitative interviews. Analysis was at individual level. The trial is registered ISRCTN #11284870 (14/11/2017); SANCTR #DOH-27-102020-9097 (17/11/2017).

Results: 320 pregnant women were enrolled (155 intervention; 165 ESOC). Preliminary findings showed that, compared to ESOC group, there was a significant reduction in depression at 12 months postnatal in the intervention group; there was no evidence of a difference in child cognition at 24 months. Perception and qualitative data found that both arms were highly acceptable and helpful. Intervention participants appeared to benefit from skills transfer and the ability to use behavioural activation strategies in day-to-day life. In the ESOC group, calls provided a confidante which was beneficial, although a number of ESOC participants would have liked additional sessions.

Conclusion: Behavioural activation for perinatal depression in HIV-positive women resulted in reductions in depression, although there were no evident effects on child development. This intervention, delivered at home by lay-counsellors, is a feasible way to treat depression and increase coping capacities of women living with HIV.

Category: *Prevention of Perinatal Mental Health Disorders*

Systems of Care/Policy and Advocacy

124: Between Fatalism and Resilience: Lived Experiences of Perinatal Mental Health of Women in the Village of Taki, Ivory Coast in 2025

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Background: Up to 15% of women experience mental disorders during the perinatal period (World Health Organisation, Guide for integration of perinatal mental health in maternal and child health services. Genève : OMS ; 2022) , yet maternal mental health in rural West Africa remains under-recognized. Local idioms of distress intersect with religious fatalism, gendered expectations, and economic precarity. This qualitative study explores women's lived experiences and sociocultural factors shaping perinatal mental health in Taki (Ivory Coast).

Methodology: A focus group discussion grounded in a socio-anthropological approach, complemented by post-session individual interviews, was conducted with 24 women (two group sittings). All participants came from low socio-economic backgrounds and most were non-literate. The semi-structured interview guide addressed mental health during pregnancy, the postpartum period, perinatal loss, social reactions, and adaptation strategies. Data (notes and audio recordings) were subjected to inductive thematic analysis, attentive to emic idioms of distress (e.g., “heart” metaphors), multiple forms of violence (physical, psychological, structural, and symbolic) and the moral economies of care.

Results: Four major themes:

1. Frequent and normalized perinatal loss. Nearly all participants reported miscarriages, stillbirths, or neonatal deaths, described through religious registers (“It is God’s will”) and bodily idioms (“my heart was cut”). Symptoms strongly resembled those of depression, generalized anxiety, and post-traumatic stress disorder, without being labeled as such.
2. Maternal responsibility and conjugal solitude. Women bore heightened mental burdens due to absent fathers, injunctions to “be strong,” and systematic blame when pregnancy or childbirth went wrong.
3. Layered oppressions and plural violences. Accounts highlighted intimate partner violence, obstetric mistreatment, economic precarity, and lack of communication within health facilities, combining into cumulative harms.
4. Low mental health literacy. Painful emotions were often expressed through somatic complaints or metaphors, reflecting both the scarcity of opportunities to verbalize suffering and a rich cultural expressiveness.

Conclusion: Results revealed a “silence of suffering” rooted in normalized loss, gendered norms, and institutional neglect. Addressing this requires culturally grounded, gender-sensitive interventions that integrate perinatal grief and mental health into primary care, engage men as allies, and create collective psychosocial spaces to empower women and reform maternal care pathways

Category: *Perinatal Mental Health in Resource-Limited Settings*

154: A longitudinal study on maternal and child outcome among mothers with postpartum psychosis admitted to the mother-baby unit in India

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Background: While majority of mothers with postpartum psychosis (PPP) shows good clinical outcome of the index episode, a small proportion may have a recurrence or residual symptoms. The current study aimed to

evaluate five-year course of PPP and child outcome among mothers admitted to mother baby unit (MBU) in India.

Methodology: Forty-three mothers with PPP admitted during the years 2016-17 in MBU were systematically evaluated using the Brief Psychiatric Rating Scale (BPRS), Young Mania Rating Scale (YMRS) and Clinical Global Impression-Improvement (CGI-I) at admission & discharge, at 3-month follow-up and at 5 years. The Being-a-Mother-13 (BaM-13) scale and the Developmental Screening test were used to assess maternal parenting efficacy and the child's development at the 5-year follow-up (2021-22).

Results: At admission, the mean age of the mothers was 27.3 ± 6.2 years. The first episode of postpartum SMI was observed in 27 (62.8%) mothers. Affective disorders and acute psychotic disorders were the most common diagnoses. Mothers with a first episode had higher BPRS scores ($W_s=309.5$, $P=0.02$) than the others. The average duration of stay in MBU was 25 days. All mothers showed significant improvement in BPRS, YMRS and CGI-I at discharge,

At 3 months following discharge, all mothers sustained the improvement.

At the 5-year follow-up, 40 mothers could be contacted. Seven (18%) mothers had recurrence of psychiatric illness; amongst them, five women (71%) had episodes during the postpartum period, and two women (29%) had episodes outside the postpartum period. N9(23%) mothers were nonadherent to treatment. The mean BaM-13 score for mothers was 16.4 ± 4.66 [cut-off score = 9 on the BaM-13 scale], indicating a significant level of distress in maternal self-efficacy. The Mean Developmental Quotient (DQ) of the recruited children was 87.4 ± 2.08 , suggesting average development. A higher BaM-13 score (poor maternal parenting efficacy) was associated with lower DQ (poor development) in the child ($p<0.05$).

Conclusion: Mothers with PPP admitted to an MBU showed significant clinical improvement at discharge and 3 months following discharge. Longitudinal course indicates that a small proportion of women do experience postpartum and non-postpartum recurrences. PPP can affect maternal self-efficacy and, in turn, the development of the child.

Category: *Mother-Baby Units*

205: Towards a standard costing approach and interactive decision-support tool for perinatal mental health in low and middle-income countries: Application in Thailand

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Background: Perinatal mental health problems are highly prevalent and generate substantial health, social, and economic consequences for mothers and children. Despite growing recognition of their burden, many countries lack locally relevant economic evidence to inform prioritisation. We developed a standardised, transferable costing approach and interactive tool to estimate the societal cost of perinatal mental health problems, designed for application in low- and middle income country settings and demonstrated using Thailand as a case study.

Methodology: We constructed an economic model in Microsoft Excel from a societal perspective, incorporating healthcare costs, productivity losses, and disability-adjusted life years (DALYs). The model follows established economic evaluation principles and allows country-specific epidemiological, demographic, and economic parameters to be incorporated. Maternal and child cohorts were modelled over 10- and 40-year time horizons, respectively. The Microsoft Excel model was translated into a web-based interactive decision-support tool developed in Python using Streamlit, enabling users to modify key parameters, update inputs, and explore uncertainty in real time.

Results: Applied to Thailand, untreated perinatal mental health problems were estimated to cost around USD 3,000 to USD 3,500 per woman giving birth, equivalent to USD 2.2 billion for a single annual birth cohort. Indirect costs—productivity and DALY losses—accounted for the majority of the burden. Beyond these country-specific findings, the model demonstrated feasibility of generating transparent, disaggregated, and updateable cost estimates adaptable to other low- and middle income country contexts.

Conclusion: This study provides both new evidence on the economic burden of perinatal mental health problems in Thailand and a transferable standard costing methodology with an accompanying interactive decision-support tool. The approach enables decision makers in low- and middle income countries to generate context-specific estimates, explore alternative assumptions, and strengthen the economic case for integrating perinatal mental health into maternal and child health policy.

Category: *Perinatal Mental Health in Resource-Limited Settings*

211: Hidden pregnancies, hidden systems: Perinatal mental health and (dis)respectful maternity care in institutional mothers' homes – a scoping review for low- and middle-income countries

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Background: Women and girls may conceal socially unsanctioned pregnancies due to stigma, shame, fear of violence and/or abandonment. Globally and historically, residential institutions housed perinatal women and girls when family care was infeasible or inappropriate. These institutions operate outside mainstream sexual and reproductive health systems including perinatal mental health services. The extent, nature, and quality of care provided, particularly in low- and middle-income countries where unplanned and adolescent pregnancies are most prevalent, remains poorly documented. Understanding available mental health care pathways and psychosocial support is critical for perinatal mental health equity and reproductive justice.

Methodology: This scoping review maps evidence on residential institutional models for perinatal women/girls in low- and middle-income countries. Searches included scholarly and regional databases, grey literature, and human rights documentation. Data extraction addresses: institutional characteristics (nomenclature, governance, funding); demographics; entry/exit pathways; ante- through postnatal care; mental health service integration; evidence of (mal)treatment; mental health and psychosocial needs and outcomes. Analysis characterises available evidence and critical knowledge gaps.

Results: Preliminary findings reveal a profound evidence vacuum. Available evidence predominantly comprises organisational websites emphasising rescue narratives and moral rehabilitation, with limited scholarly research. Institutions may be more prevalent in abortion-restrictive settings. Language frequently invokes sin, correction, and second chances, potentially (re)entrenching stigma. Care is often conditional on carrying pregnancies to term, raising concerns about reproductive coercion. The pipeline for perinatal mental health care remains opaque while connections to mainstream services appear minimal or absent. Some institutions facilitate adoption or orphanage placement, creating intergenerational institutional care. This review systematically documents these patterns and highlights future research priorities for residents' mental health and psychosocial assistance.

Conclusion: Residential institutions for hidden pregnancies represent an invisible parallel system operating beyond mainstream health services and regulation. The lack of evidence on mental health provisions, trauma-informed care, or psychosocial outcomes for highly vulnerable women and girls represents a critical gap in perinatal mental health systems. Institutional frameworks may compound psychological harm through stigmatisation and shame. This scoping review provides the first evidence mapping advocating for mental health integration, trauma-informed care standards, and safeguarding for women and girls navigating clandestine pregnancies in low-resource settings.

Category: *Perinatal Mental Health in Resource-Limited Settings*

212: Violence, maternal homicide, and suicide in the perinatal period: Lessons from Mexico as a call to action for perinatal mental health

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Background: Violent deaths in pregnancy and the postpartum represent a critical yet overlooked challenge for perinatal mental health stakeholders. These deaths, from self-harm, homicide, and femi(ni)cide, demand that perinatal mental health practitioners develop specialised competencies in violence identification and response. Mexico's maternal mortality data offer a compelling case study highlighting current surveillance shortcomings that fail to capture the true burden of violence-related deaths, with implications for violence and perinatal mental health research and practice worldwide.

Methodology: We analysed deaths in Mexico of pregnant and postpartum women up to 11 months post-pregnancy from ICD-10 implementation (1998–2024), comparing violent deaths to maternal and late maternal causes using ICD-Maternal Mortality groupings. We identified existing gaps in surveillance with implications for (clinical) case recognition and intervention.

Results: Between 1998 and 2024, Mexico recorded 36,662 pregnancy-related deaths among women aged 10–54, including 1,855 violent deaths: 1,287 from external violence (154 undetermined intent) and 568 self-inflicted. Violence-related deaths have risen since 2010, now surpassing or equalling leading obstetric causes including pregnancy-related infection (n=929). Firearm-related death (n=639) was the predominant homicide modality; hanging/strangulation (n=423) was most common in suicides, followed by self-poisoning (n=104). These data demonstrate that substantial numbers of perinatal women die from preventable violence, yet these deaths remain invisible within standard maternal health and mortality frameworks.

Conclusion: For perinatal mental health stakeholders, these findings underscore an urgent practice imperative: violence during pregnancy and postpartum is not a peripheral concern but a leading cause of maternal death. Practitioners must develop tailored knowledge and skills integrating evidence on violence with women's mental health to improve prevention, identification, and intervention. Future practice-orientated research should advance: (1) effective approaches to trauma-informed violence and self-harm assessment; (2) homicide/femi(ni)cide and suicide risk management strategies; and (3) advocacy for revised maternal mortality definitions and concomitant surveillance systems that explicitly capture perinatal homicides and better-capture suicides as maternal deaths. Mexico's robust vital statistics reveal what current maternal health frameworks obscure. Perinatal mental health practitioners are uniquely positioned to identify at-risk women and girls, but only if equipped with violence-specific knowledge and integrated care pathways that address both mental health and safety.

Category: *Advocacy and Policy in Maternal Mental Health*

229: Provider- and facility-level correlates of non-specialist provider competence in perinatal mental health skills in Western Kenya: a cross-sectional study

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Background: Perinatal mood and anxiety disorders are undertreated globally, particularly in low- and middle-income countries, partly due to shortages of mental health providers. The World Health Organization and Kenya Mental Health Action Plan recommend training non-specialist providers with little or no prior experience delivering mental health interventions to perinatal women. We examined how individual- and facility-level

factors relate to competence in delivering Problem Management Plus (PM+) among non-specialist providers in Western Kenya.

Methodology: Lay providers (N = 85), including HIV testing service (HTS) counselors and mentor mothers living with HIV (n = 33), and non-specialist healthcare providers (nurses and clinical officers, n = 52) in 10 facilities, were trained in PM+. Competence was evaluated by the research study team using the Ensuring Quality in Psychological Support (EQUIP; range 0-44) scale completed during a mock roleplay. Using linear Generalized Estimating Equations to account for clustering by facility, we determined univariate and multivariate associations of EQUIP score with provider and facility characteristics. The multivariate model included all predictors with $p < 0.1$ in univariate analysis.

Results: In multivariate analysis, provider education was significantly associated with competence: providers with a bachelor's degree or higher scored 3.99 points higher on the EQUIP scale than those with a high school diploma or less (95% CI [2.22, 5.77], $p < 0.001$). Provider cadre was also independently associated, with nurses scoring 1.97 points lower than HTS counselors (95% CI [-3.86, -0.08], $p = 0.04$), despite HTS counselors having lower education levels than nurses. No significant associations were observed between competence and individual-level characteristics (provider age, gender, work experience, stigma, facility organizational readiness for change) or facility-level characteristics (new patient volume and mental healthcare integration level).

Conclusion: This cross-sectional study provides support for non-specialist provider delivery of PM+ in maternal child health facilities in Western Kenya. However, training may need to account for educational differences among providers to ensure training is tailored to education level and provider type, as these variables were independently associated with competence.

Category: *Perinatal Mental Health in Resource-Limited Settings*

260: Global Mapping of Perinatal Mental Health Services for Women Suffering Severe and Complex Perinatal Mental Health Disorders

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Background: Severe perinatal mental health disorders, such as postpartum psychosis, severe depression, and suicide remain major causes of maternal morbidity and mortality worldwide. Timely and precise treatment of these disorders is crucial for the prognosis of mothers, babies, families, and communities. The effectiveness of Mother-Baby Units in treating these conditions is demonstrated in countries such as: United Kingdom, France, Australia, India, the United States, and Germany. Yet limited information exists on organization, admission criteria, or integration with community services. This lack of comparative data constrains equitable, culturally adapted models of perinatal mental healthcare.

Methodology: This international project, initiated by the Mother-Baby Unit Special Interest Group of the International Marcé Society for Perinatal Mental Health, aims to map perinatal mental health services worldwide, by identifying MBUs, day-care programs, and alternative models for managing severe and complex perinatal conditions, while documenting challenges, innovations, and resource disparities. A cross-sectional online survey was collaboratively developed within the MBU SIG. The survey is open to multidisciplinary professionals working with women and families affected by acute perinatal mental health conditions. Data collection is ongoing and will be analyzed descriptively to identify regional patterns, inequities, and best practices.

Results: To date, 172 participants have completed the survey. Preliminary findings reflect an international,

multidisciplinary sample (e.g., psychiatrists, obstetricians, psychologists, social workers, nurses, researchers). Admission without the baby to a general psychiatric ward is the most common model of care for severe perinatal conditions, and nearly half of participants report limited access to MBU services in their country. Postpartum psychosis and suicidality are the most frequent admission criteria. Inpatient MBUs are typically led by perinatal psychiatrists with multidisciplinary consultation, and day care teams commonly include psychotherapists, social workers, perinatal psychiatrists, and nurses. Across both models, pharmacotherapy and disorder-specific individual therapy are the most common interventions.

Conclusion: This project provides the first global mapping of perinatal mental health services, highlighting disparities, admission criteria, staffing models, and innovations in diverse contexts. These findings stress the global lack of specialized MBU. Consequently, the management of severe perinatal conditions remains fragmented, relying on general wards that require mother-baby separation and limit the capacity for integrated, joint clinical care.

Category: *Mother-Baby Units*

272: Identification of psychosocial problems in routine antenatal care in Ethiopia: a facility-based cross-sectional study

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Background: High quality person-centred maternal care includes recognition of, and response to, psychosocial problems. However, little is known about the extent to which routine antenatal care (ANC) meets women's psychosocial needs in low- and middle-income countries.

Methodology: In this facility-based cross-sectional survey in primary health care centres in southern Ethiopia, women attending for ANC were screened for depression (PHQ-9; score ≥ 5 and functionally impaired), anxiety symptoms (GAD-7; score ≥ 10), post-traumatic stress disorder (PTSD; PCL-5 score ≥ 31), intimate partner violence (IPV; non-graphic language screening test) and risky substance use (ASSIST). Clinical notes were reviewed post-consultation for evidence of health worker recognition of psychosocial concerns and actions taken. Descriptive statistics were used to calculate prevalence and co-morbidity. Poisson regression models were used to calculate prevalence ratios between enquiry about women's emotional wellbeing and demographic and clinical characteristics, adjusting for facility clustering.

Results: Of the 2079 interviewed women, 24.9% of women had at least one psychosocial problem and 7.3% had two or more problems. The most common psychosocial problem was probable IPV (n=289; 13.9%, 95% Confidence Interval (CI) (12.57-15.25)), followed by risky khat use (n=134; 6.5%, 95% CI (3.72-10.94)) and depression (n=110; 5.3%, 95% CI(3.98-7.00)). Co-occurrence of psychosocial problems was common, but identification by ANC professionals was low: psychosocial problems were documented for 2.7% of women with probable depression (3/110) and in none of the women with probable IPV (0/289). History of mental health or substance use problems was not documented in 99.7% and 98.3% of the sample, respectively. Despite, 98.4% of women that reporting they were comfortable being asked about psychosocial problems; only 47.3% (n=938) of women reported being asked how they were feeling emotionally in ANC.

Conclusion: Despite the high prevalence of psychosocial problems and their co-occurrence in antenatal care

in rural Ethiopia, recognition by health professionals is very low. Further research is required to understand what systemic changes can promote person-centred maternal care and improve recognition, documentation and response to psychosocial problems, to improve outcomes for all women.

Category: *Perinatal Mental Health in Resource-Limited Settings*

281: Integrating perinatal mental health into maternal and child health services in Ethiopia and Guinea: a complex systems analysis of policy and implementation

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Background: The burden of perinatal mental health conditions in Africa is substantial, with diverse impacts impeding the achievement of the Sustainable Development Goals. However, perinatal mental health continues to be neglected. The aim of this study was to identify bottlenecks in the health system that hinder the promotion of perinatal mental health, and to propose policy and implementation considerations.

Methodology: As part of a broader, prospective, longitudinal, mixed methods study (MISPOD Study), we conducted 70 in depth interviews with women with symptoms suggestive of postpartum depression and 50 interviews with health system informants in Ethiopia and Guinea. Data were analysed stepwise, beginning with the interviews with the women, followed by those with frontline health workers and health system informants at sub-city, city, and national levels. We used the theoretical framework of complex adaptive systems to guide our analysis.

Results: Perinatal mental health is barely integrated into maternal and child health services within the Ethiopian and Guinean health systems. This challenge is exacerbated by interconnected barriers at the macro, meso and micro levels of these systems. These barriers include underinvestment in health systems, staff shortages, heavy reliance on task-shifted maternal (mental) health services, a lack of training for maternal health workers in perinatal mental health, a lack of respectful care throughout the maternity process, the externalisation of stewardship of perinatal mental health to non-communicable diseases, diverse sociocultural expectations of care and societal factors such as high levels of gender-based violence and a lack of awareness and stigmatisation surrounding mental health conditions. The interaction between these system hardware and system software components was complex, highlighting the need for multi-pronged and coordinated interventions. In Ethiopia, the experience of integrating the prevention and control of non-communicable diseases (including mental, neurological and substance use disorders) into primary care was identified as a solid basis for replicating similar approaches to integrating perinatal mental health into maternal and child health services.

Conclusion: To overcome these complex bottlenecks, efforts to integrate perinatal mental health interventions into maternal health services at the macro, meso, and micro levels of health system should be (re)imagined based on the tenets of woman-centred approaches. We propose a simultaneous from bottom up approach, testing the effectiveness of context-appropriate models, and a top-down approach, implementing actionable policies and strategies.

Category: *Perinatal Mental Health in Resource-Limited Settings*

286: Perinatal outcomes of patients attending a Maternal Mental Health Clinic at a tertiary hospital in Johannesburg

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Background: Perinatal mental illness contributes substantially to maternal morbidity and may adversely influence obstetric and neonatal outcomes. Data on perinatal and neonatal outcomes in women with mental illness remains limited in the South African context.

Methodology: The study compared the perinatal outcomes of women with psychiatric illness attending the Maternal Mental Health Clinic (MMHC) at Chris Hani Baragwanath Academic Hospital (CHBAH) with the perinatal outcomes of obstetric patients without diagnosed mental illness attending the Obstetrics Antenatal Clinic at CHBAH. A retrospective file review from 01 January to 30 June 2024 included 74 psychiatric patients and 72 obstetric patients. Demographic, clinical, obstetric, and neonatal variables were extracted and analysed using R v4.4.2. Categorical data were analysed with χ^2 or Fisher's exact tests and continuous data with non-parametric equivalents.

Results: There were no significant differences between the psychiatric and obstetric patients in predefined primary obstetric or neonatal outcomes, including preterm delivery, low birth weight, Apgar score < 7, stillbirth or neonatal intensive care unit admission. Women attending the MMHC had higher unemployment rates and presented earlier in pregnancy. Planned and wanted pregnancies were more common in the psychiatry cohort. Elective caesarean section occurred more frequently among psychiatry patients. Clinical comorbidities and substance use did not differ between groups, except for epilepsy, which was more frequent in the psychiatry cohort.

Conclusion: Despite a higher burden of psychiatric illness, women managed through a specialised perinatal psychiatry service demonstrated obstetric and neonatal outcomes comparable with obstetric controls. Earlier antenatal presentation, regular follow-up within an integrated multidisciplinary service, and proactive psychiatric management may have mitigated risks typically associated with perinatal mental illness. These findings suggest that structured, integrated perinatal psychiatric care within tertiary services may contribute to optimising maternal and neonatal outcomes.

Category: *Perinatal Mental Health in Resource-Limited Settings*

377: Community health worker stress, self-efficacy, mental health, and social support following training and delivery of a perinatal intervention in Uganda

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Background: Task-shifting perinatal interventions to community health care workers (CHWs) could reduce the treatment gap. Community embedded CHWs experience similar stressors as the caregivers they work with, yet less is known about their own coping or the potential impact of interventions on their well-being. We aimed to investigate whether training and delivery of the UNICEF Caring for the Caregiver (CFC) intervention increased CHWs' coping and well-being, or whether, instead, intervention delivery had detrimental effects.

Methodology: This research, in northern Uganda, trained government-employed Village Health Teams to deliver the UNICEF CFC intervention as part of a larger intervention study (n=502 caregivers). CHWs (n=49) attended 5 days of training and delivered 10 home visits to n=243 intervention group caregivers, over 6 months, with supervisors (n=4) providing monthly supervision. Our process evaluation included assessments of CHW perceived stress (PSS), self-efficacy (GSE), depression (PHQ-9), anxiety (GAD-7), and social support (MSPSS) at 3 time points (baseline n=49, midline n=48, endline n=47) as well as focus group discussions with CHWs and semi-structured interviews with supervisors. Descriptive statistics were restricted to complete-case analysis for CHWs (n=46), and thematic framework analysis was used for qualitative data.

Results: The proportion of CHWs reporting moderate to high stress decreased at endline (n=36/46, 78.3%; n=20/46, 43.5% p<0.001). Likewise, the proportion of CHWs reporting mild to moderate depression reduced (n=22/46, 47.8%; n=10/46, 21.7% p=0.006) as did proportions of CHWs reporting mild to moderate anxiety

(n=17/46, 37%; n=7/46, 15.2% p=0.016). CHWs' self-efficacy ($\beta = 5.9$, [CI 4.08, 7.72], $p < 0.001$) and social support also increased over time ($\beta = 5.59$, [CI 1.67, 10.23], $p = 0.007$). The number of CHWs reporting partner conflict also decreased over time ($\beta = -1.12$, [CI -2.02, -0.21], $p = 0.016$). Qualitative findings supported the observed changes, with CHWs reporting high skill transfer and application of CFC skills at home and in their own relationships, leading to improved confidence, communication, and emotional awareness. Supervision was critical to managing complex cases.

Conclusion: CHWs reported lower stress and improved mental health, self-efficacy, and social support during CFC implementation and supervision. This highlights that interventions provide important opportunities to support both caregivers and CHWs. Larger-scale longitudinal research is required to investigate this further.

Category: *Perinatal Mental Health in Resource-Limited Settings*

416: Building compassionate systems for maternal care: Perinatal Mental Health Project strategies to reduce obstetric violence and support healthcare providers

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Background: South Africa's sociopolitical landscape, shaped by Apartheid and colonial legacies, contributes to high rates of mental health conditions, with one in three perinatal women experiencing depression or anxiety. The sociopolitical context also impacts the national healthcare system, with implications for providers working within this system. Maternity healthcare providers face high levels of compassion fatigue and burnout. This is linked to systemic obstetric violence, poor care quality and staff attrition, which are themselves, drivers of perinatal distress and mental ill-health. The Perinatal Mental Health Project (PMHP) has developed interventions to address provider burnout, disrespect and abuse, and to strengthen selfcare skills of staff.

These interventions aim to address healthcare system challenges, while also setting up sustainable multi-level care systems for providers.

Methodology: We describe four selected PMHP interventions, outlining our rationale, development processes, the content and method of delivery, and available evaluation data.

Results: Nyamekela4Care: A manualised, peer-facilitated, meeting model that enhances team functioning by integrating skills development, case sharing and structured selfcare. A mixed methods feasibility study showed improvements in work-related knowledge, selfcare practices and team collaboration.

Secret History Training: An interactive narrative-based provider training method using staged disclosures, informed by 'Theatre of the Oppressed' techniques. The approach facilitates support staff reflection on power dynamics, "othering," and emotional responses and needs. Evaluation showed shifts in staff perspectives, adoption of communication tools and improved attention to mental health. This approach has been adapted into a mobile application using a branching narrative format.

Engagements with maternity staff at the PMHP's Maternal Support Service (MSS): Participatory training and codesign workshops using accessible garden space, kindness sessions, mindfulness, yoga, and celebratory activities to foster connection and wellbeing.

Support for mental health staff at the MSS: Structured support, including weekly clinical supervision, technical assistance, mental health days, professional development and peer support mechanisms.

Conclusion: Obstetric violence and burnout are intersectional, system-level challenges that require system-level interventions. The PMHP addresses these through strategies that build compassionate practices by supporting providers, strengthening peer networks and embedding wellbeing and supervision into maternity service design.

Category: *Perinatal Mental Health in Resource-Limited Settings*

417: Substance use and abuse among perinatal women in Africa: An integrated literature review

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Background: Substance use and abuse remain a critical global health concern, disproportionately affecting marginalized populations with limited access to healthcare. Rising substance use among women, influenced by shifting gender roles and sociocultural changes, has made perinatal substance use an emerging issue with serious implications for maternal and child health. In Africa, where healthcare disparities and cultural stigma persist, the factors driving perinatal substance use are understudied and under-addressed, highlighting the need for focused research.

Methodology: An integrated literature review was conducted using multiple databases, including PubMed, EBSCOhost, CINAHL, Ovid EMBASE, Web of Science, African Journals Online, and Google Scholar. Peer-reviewed studies accessible in English published between 2021 to 2025 were included. The quality of included studies was assessed using Mixed Methods Appraisal Tool (MMAT) and the Critical Appraisal Skills Programme (CASP). The PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) checklist was utilized. Relevant data were extracted and organized using Microsoft Excel. The findings were then categorized using the Biopsychosocial (BPS) model and the 4P Factor Model.

Results: A total of 28 studies from seven African countries met the inclusion criteria, with South Africa contributing the most studies. Substances identified included alcohol, tobacco, khat, caffeine, hookah, and polysubstance use, with alcohol being the most frequently reported. Factors influencing perinatal substance use spanned across biological, psychological, and social domains. Key social risk factors included low education, residential area, intimate partner substance use, and sociocultural norms, while protective factors involved formal education, antenatal care attendance, and awareness of health risks. Psychological contributors included lack of knowledge, stress, anxiety, depression, trauma, and prior substance use. Biologically, chronic illness, obstetric history, and older maternal age were identified as risk factors, while previous adverse pregnancy outcomes acted as deterrents.

Conclusion: Substance use among perinatal women in Africa is shaped by biological, psychological, and social factors, including trauma, poverty, and limited access to care. Effective responses require culturally sensitive, multifaceted interventions that integrate screening, education, harm reduction, and support for vulnerable groups while addressing structural inequities. Greater understanding of cultural practices, underreported substances, and broader regional research is essential to inform sustainable and targeted strategies.

Category: *Perinatal Mental Health in Resource-Limited Settings*

435: A matter of life and death: A scoping review of the relationship between induced abortion and women's self-harm and suicide

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Background: Globally, 65 countries ban abortion entirely or permit it only to save a woman's life; only 25/47 countries permitting abortion on health grounds explicitly include mental health in legislation. Restrictive abortion policies are expanding, including in previously protective contexts like the United States. Whether suicidal risk to life qualifies under existing life-saving legal exceptions, and whether any health system acts on this, remains under-investigated. Literature linking abortion to suicide/self-harm is fragmented, methodologically inconsistent, and vulnerable to ideological distortion, warranting systematic mapping.

Methodology: This scoping review will map evidence on the association between induced abortion and suicide/self-harm in women and girls across four dimensions: (i) women who accessed a wanted abortion; (ii) women denied/unable to access abortion, including those pregnant following violence, and minors; (iii) women who experienced reproductive coercion to undergo an unwanted abortion; and (iv) whether any jurisdiction recognises suicide/self-harm risk under life-saving legal exceptions de jure, and whether such terminations are documented in clinical practice de facto.

Following PRISMA-ScR guidelines, we will search scholarly and legal databases (e.g., MEDLINE, PsychInfo) (1990-2026) for studies reporting original data on reproductive age women, with no language restrictions,

alongside legislative texts and grey literature, charting data by study design, legal/geographic contexts, outcome, and confounding approach.

Results: Legal mapping conducted prior to the scoping review identified no jurisdiction that explicitly outlines suicide/self-harm risk within life-saving abortion exemptions, and no documentation of terminations granted on psychiatric grounds in any published source. Preliminary scoping indicates that the broader evidence base is concentrated in high-income, legislatively permissive settings, systematically excluding populations at greatest risk, including women in criminalised contexts and those pregnant following sexual violence.

Conclusion: The absence of any de jure recognition or de facto documentation of abortion access for suicidal women – even where life-saving exceptions formally exist – flags a critical and underexamined policy failure. As restrictive abortion legislation expands, those disproportionately affected include sexual violence survivors and minors. Whether legislative and institutional actors who foreseeably obstruct care for suicidal women bear moral and legal accountability emerges as an urgent interdisciplinary question. This scoping review will provide the first systematic map of the evidence needed to pursue it.

Category: *Advocacy and Policy in Maternal Mental Health*