# Hospital Psychological Care Protocol for Mental Health Crises in the Perinatal Period

**Protocolo de Atenção Psicológica Hospitalar à Crise em Saúde Mental no Período Perinatal**
**Protocolo de Atención Psicológica Hospitalaria para Crisis de Salud Mental en el Periodo Perinatal**


## RESUMO

**Objetivo:** Apresentar propositura de protocolo de atenção psicológica à crise em saúde mental de gestantes e puérperas hospitalizadas. **Método:** Estudo descritivo, qualitivo, sobre um protocolo assistencial construído, como produto derivado do trabalho da psicóloga em Hospital-Maternidade. **Resultados:** O protocolo compõe nove etapas: acolhimento focal emergencial; conduzir a paciente para ambiente calmo, seguro; escuta ativa, atenta, compreensiva; exame psíquico, avaliação psicológica; identificar/adotar estratégias de enfrentamento adaptativas; não deixar a paciente sozinha, tentar mantê-la em segurança até estabilizar; escuta sensível do acompanhante/familiar; discussão do caso com equipe de saúde; registro no prontuário eletrônico e notificação da violência. **Conclusão:** A atenção à crise em saúde mental no período perinatal conclama: visão caleidoscópica, holística, integral; postura ética-estética-ativa-crítica-sensível-empática; legitimar sofrimento, idiossincrasias invisibilizadas, experiência sui generis, tríade paciente-equipe-acompanhante/familiar; coprodução em rede.

**DESCRITORES:** Protocolo de tratamento; Intervenção em crise; Assistência em saúde mental; Cuidado perinatal; Hospital Maternidade.


## ABSTRACT

**Objective:** To present a proposal for a psychological care protocol for the mental health crisis of hospitalized pregnant and postpartum women. **Method:** A descriptive, qualitative study of a care protocol developed as a product of the psychologist's work in a maternity hospital. **Results:** The protocol comprises nine stages: emergency focal reception; taking the patient to a calm, safe environment; active, attentive, understanding listening; psychic examination, psychological assessment; identifying/adopting adaptive coping strategies; not leaving the patient alone, trying to keep her safe until she stabilizes; sensitive listening to the companion/family member; discussion of the case with the health team; recording in the electronic medical record and notification of the violence. **Conclusion:** Attention to the mental health crisis in the perinatal period calls for: a kaleidoscopic, holistic, integral vision; an ethical-aesthetic-active-critical-sensitive-empathetic stance; legitimizing suffering, invisible idiosyncrasies, a sui generis experience, a patient-team-accompanying person/family triad; co-production in a network.

**DESCRIPTORS:** Clinical protocols; Crisis intervention; Mental health assistance; Perinatal care; Hospitals.


## RESUMEN

**Objetivo:** Presentar propuesta de protocolo de atención psicológica a la crisis de salud mental de gestantes y puérperas hospitalizadas. **Método:** Estudio descriptivo y cualitativo de un protocolo de atención desarrollado como producto del trabajo de la psicóloga en un hospital de maternidad. **Resultados:** El protocolo consta de nueve etapas: recepción focal de emergencia; llevar a la paciente a un ambiente tranquilo y seguro; escucha activa, atenta y comprensiva; exploración psicológica, valoración psicológica; identificación/adopción de estrategias adaptativas de afrontamiento; no dejar sola a la paciente, intentar mantenerla a salvo hasta que se estabilice; escucha sensible al acompañante/familiar; discusión del caso con el equipo sanitario; registro en la historia clínica electrónica y notificación de la violencia. **Conclusión:** La atención a la crisis de salud mental en el periodo perinatal requiere: visión caleidoscópica, holística, integral; postura ética-estética-activa-crítica-sensible-empática; legitimar el sufrimiento, la idiosincrasia invisible, una experiencia sui generis, una tríada paciente-equipo-acompañante/familia; coproducción en red.

**DESCRIPTORES:** Protocolos clínicos; Intervención en la crisis; Atención a la salud mental; Atención perinatal; Maternidades.


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## INTRODUCTION

Mental health crisis engenders a concept widely used in clinical practice and scientific research, hegemonically in the literature on mental health and in various disciplines in the fields of health and social sciences. Complex and multifaceted in nature, influenced by social and structural factors, it is a phenomenon that requires a systemic, intersectional, holistic approach [(1)], in providing assistance in urgent/emergency situations and producing care in a network (RAPS). [(2)]

Situations of mental health crisis, mental disorder, use of alcohol and/or other drugs, self-harm without suicidal intent, attempted suicide and victimization by interpersonal violence, circumscribe serious risk factors in the pregnancy-puerperal cycle for the mother-baby binomial. [(3)] In this sense, they stand out as the most common mental disorders in the perinatal period [(4)], adjustment disorder, depressive and anxiety disorders, obsessive-compulsive disorder, schizophrenia, personality disorder, bipolar affective disorder, puerperal psychosis. [(5)] In fact, mental disorders and substance use disorders are the main cause of preventable maternal death during pregnancy, up to the first year postpartum[(6)]; while they significantly contribute to adverse neonatal, infant and child outcomes. [(4)]

A combination of biological, psychological and social factors make the perinatal period particularly challenging for the high risk of mental disorders. Perinatal mental disorders may result from the worsening of a pre-existing mental illness; emerge during pregnancy or the puerperium as a relapse of a previous condition; or be the first episode of a psychiatric condition. [(7)]

Widespread evidence attests to the burden and impact of mental disorders on patients, caregivers, and society. [(8)] Therefore, pregnant and postpartum women with moderate to severe mental health conditions require interventions supervised by mental health specialists. [(9)] However, fear of referral to these services can make them feel inhibited, afraid to seek help and reveal their mental illness. [(5)]

In this complex landscape, the integration of maternal and child health services is crucial to ensure that women receive timely care. This means creating clear pathways for care for pregnant and postpartum women who require mental health care; managing cases and referring such patients to specialized mental health services, whether formal or informal. [(9)] Incidentally, technologies, techniques and practices for addressing mental health crises are powerful for creating new agencies, social responses and plural movements of approach built in networks, based on the perspective of the transversalization of knowledge-power between professionals and users. To this end, the involvement of community health services, mental health beds in general hospitals, primary care, emergency/urgent care networks and intersectoral networks is essential. [(2)]

Protocols are notable as tools for systematizing the use of health technologies (including procedures, medicines, equipment and health resources), for organizing care practices, with an emphasis on the guidelines of the Unified Health System (SUS) and that best fit the specific demands of the services (10); whose applicability produces social, clinical, and political effects on care processes. [(2)] Consequently, psychological care for mental health crises requires well-defined work plans in protocol, such as care interventions adapted to emergency contexts and care promotion. [(11)] Therefore, this study aims to present the proposal of a psychological care protocol for the mental health crisis of pregnant and postpartum women hospitalized in mental health beds.

## METHOD

Descriptive, qualitative study, referring to the construction of a psychological care protocol for the mental health crisis in the perinatal period, as an innovative product, derived from the individual professional work of the psychologist, member of the technical reference team for spe-

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cialized care for pregnant and postpartum women admitted to mental health beds, in a public teaching and high complexity Maternity Hospital, located in Teresina, Piauí, Brazil, since 2022.

## RESULTS

The protocol for psychological care for mental health crises in the perinatal period consists of nine stages, which are listed in Figure 1, which outlines and summarizes the resulting product. The graphic element was created with the help of Microsoft Word. The relevant details are shown below.

**Figure 1 - Psychological care protocol for mental health crises in the perinatal period, in a high complexity maternity hospital, located in Teresina, Piauí, Brazil.**

1. Emergency focal support, through empathetic, kind, respectful and non-judgmental psychological contact.
2. Take the patient to a calm, safe and quiet environment (whenever possible), where she can feel protected and supported..
3. Active, attentive and understanding listening, with a non-confrontational approach; encouraging speech about distressing content.
4. Psychiatric examination and psychological evaluation, based on multiaxial diagnosis (reactional, medical, situational and transferential).
5. Help identify and adopt adaptive coping strategies in the face of the psychological crisis situation that has arisen:

| Psychosocial Crisis | Psychiatric Crisis | Psychosomatic Crisis | Craving Crisis | Crisis correlated with Interpersonal/Self-Inflicted Violence |
|---|---|---|---|---|
| ▪ Assist in the expression and validation of emotions;<br>▪ Facilitate insights into the stressful event associated with the outbreak of the crisis;<br>▪ Focus on autonomy and coping strategies in the face of suffering, difficult news about loss and/or death. | Act patiently and firmly, without sudden movements. Use the Verbal De-escalation Technique [12]:<br>1. Respect the patient and her personal space;<br>2. Do not provoke the patient;<br>3. Establish verbal contact;<br>4. Be concise;<br>5. Observe desires and feelings;<br>6. Listen carefully;<br>7. Agree in principle (you can disagree later);<br>8. Adopt clear rules and limits;<br>9. Offer options and optimism;<br>10. Inform the patient and the team. | ▪ Holistic approach, valuing verbal and non-verbal communication;<br>▪ Assistance in the expression of emerging cognitions, perceptions, emotions, psychic and physical pain;<br>▪ Investigate precipitating stressors;<br>▪ Focus on real and symbolic losses. | ▪ Keep the environment well-lit and noise-free;<br>▪ Empathic validation of suffering;<br>▪ Diaphragmatic breathing;<br>▪ Maintain vigilance, manage fear, anxiety and reassurance. | ▪ Encourage the expression of suffering related to the violence experienced;<br>▪ Reflect on cognitions and ambivalent feelings;<br>▪ Tolerate ambivalence and explore alternatives for coping, valuing life and preventing suicide;<br>▪ Reduce access to lethal means. |

6. Ensure that the patient is not left alone and try to keep her safe until her mental health stabilizes.
7. Sensitive listening by the companion/family member, for psycho-emotional support, psychoeducation, and encouragement of active participation in care.
8. Discussion of the clinical case with the health team, with an emphasis on the Singular Therapeutic Project and longitudinal care.
9. Recording in the electronic medical record and notification of interpersonal/self-inflicted violence (in the event of suspicion or confirmation).

Source: Barbosa (2025).

The first stage involves emergency focal support, through empathetic, gentle, respectful, non-judgmental psychological contact. The aim is to create an environment that is conducive to making the patient feel comfortable and understood. Consequently, the collaborative relationship and mutual trust that are inherent to the therapeutic alliance are fostered.

The second stage consists of taking the patient to a calm, safe, and quiet environment (whenever possible), where she can feel protected and supported. As a result, trust is fostered, allowing her to share information about the suffering she is experiencing.

The third stage involves active, attentive, understanding, and reflective listening, with a non-confrontational approach, encouraging the patient to talk about distressing content. Therefore, communication guided by a calm and non-threatening tone of voice is essential in order to encourage the pregnant or postpartum woman to share her feelings, suffering, pain, and concerns. Consequently, the information provided by the woman can help to structure a care plan that is appropriate to her real needs.

In the fourth stage, a psychological examination and psychological evaluation are carried out, based on multiaxial diagnosis (reactional, medical, situational, transference) and a holistic approach, focusing on psychological symptoms, coping strategies used in circumstances of mental health crisis, as well as the protagonism, active participation of the patient and their support network in the co-production of mental health care. [13]

The fifth stage is dedicated to help-


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ing the patient identify and adopt adaptive coping strategies in the face of the crisis being experienced, whether related to a psychosocial crisis, psychiatric crisis, psychosomatic crisis, craving crisis, victimization by interpersonal violence or self-inflicted violence.

The sixth stage prioritizes ensuring that the patient is not left alone and trying to keep her safe until the crisis stabilizes. To this end, it is essential to keep her under constant observation, avoiding her being in isolated or unprotected environments. This may include direct monitoring by a psychologist, to provide assertive/sensitive psycho-emotional support and mental health monitoring. Therefore, a calm environment is recommended, free from potential triggers, such as arguments, stressors, and objects that pose a risk of self-harm or interpersonal violence.

In the seventh stage, active, welcoming, and sensitive listening is offered to the companion and/or family member, providing psychoemotional support, psychoeducation, support, psychological counseling, and encouragement for active participation in the co-production of mental health care. Consequently, it is estimated to strengthen the collaborative partnership and mutual support between the patient-team-companion/family member triad, in an empathetic and informed way, which are essential for the success of the treatment.

The eighth stage involves discussing the clinical case with the healthcare team, and is a strategic moment for co-producing a unique, personalized, patient-centered therapeutic project. Its implementation presupposes shared responsibility and a holistic approach; it requires recognition of inherent intersectionalities and psychosocial vulnerabilities, with an emphasis on immediate crisis management and longitudinal care.

The ninth and final stage of the process is intended to record the psychological progress in the patient's electronic medical record, via the MV® System, after the intervention has been completed, with the inclusion of the signature and stamp containing the professional's full name and registration number with the Regional Psychology Council. The printed document is then saved in the physical medical record. In cases of suspected or confirmed victimization by interpersonal or self-inflicted violence, compulsory notification is also recorded.

## DISCUSSION

In our society, and in health facilities themselves, the stigma associated with mental health problems has a negative impact on the willingness of pregnant and postpartum women to seek help for psychological difficulties (14), due to fear of social judgment, which would label them as incapable of caring for their child, or of eventually losing custody of the baby. Aware of these circumstances, it is essential that health services offer a welcoming environment, where these women feel safe, respected, and heard when sharing their anxieties. [15] To this end, they should not adopt rigid, inflexible, decontextualized structures. On the contrary, it is essential that they incorporate culturally sensitive, empathetic, and creative approaches to care for psychological distress, mental disorders, and the use of alcohol and/or other drugs. [16] They must categorically commit to providing more inclusive perinatal mental health care [17] and with the eradication of stigma, which puts the well-being and dignity of patients, their children and their families first. [18]

Considering that patients in the perinatal period have a higher risk of psychological distress, emergence or worsening of mental illnesses, the hospital obstetric environment is a critical space to offer assessment, education and a wide range of evidence-based interventions, especially in crisis situations. [19] Additionally, in the antepartum and postpartum periods, related practices contribute to better mental health and well-being for the woman and the baby. [20]

Mental health crisis situations in the perinatal period require interventions directed at the peculiarities of this phase, with an emphasis on psychoeducation, counseling, strengthening support networks and encouraging participation in activities that promote well-being. [9] Specifically, holistic examination in the context of perinatal mental health care requires consideration of the intricate relationship between mental health diagnoses and psychosocial factors specific to the patient's experience, especially those related to relationship problems, family dynamics, support networks, and environmental stressors. [21] For example, preventing suicide and overdose in the perinatal period requires care based on evidence-based strategies and harm reduction principles. In this context, nuanced assessments tailored to the needs of patients are essential. This implies a comprehensive approach, beyond diagnostic categorization, that is attentive to contextual factors and serious stressors, such as challenges in motherhood, sleep deficit, and intimate partner violence. [22]

In detail, attention to the mental health crisis requires a holistic approach, which values the person in distress and the experiences of their family members. [1] Therefore, the value of collaborative and patient-centered care, the increase in professional qualification programs and the strengthening of policies that prioritize maternal mental health are axiomatic, as are systemic reforms that increase the availability of resources, reduce stigma and promote interdisciplinary teamwork. [14]

The magnitude of the qualification of technical teams and the improvement of care guidelines are attested, incorporating discussions on perinatal mental health, so that patients receive

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clear guidance on the care they need. (23) Furthermore, it is essential that professionals responsible for specialized perinatal mental health care are trained to "think about the family" and to act within the logic of the life course, aware of the impacts of pregnancy and family dynamics. [4]

The relational competence of mental health professionals is an essential attribute for the promotion of high-quality care. Holistic and multifaceted in nature, it incorporates and interconnects four components: (1) capacity for self-reflection and self-regulation; (2) genuine interest in understanding the person; (3) involvement in a reciprocal interaction with the patient; (4) reaching out to the sick person so that he or she feels valued. Its achievement requires skills for open communication with patients, above all, in the decision-making processes; offering human warmth, humor, flexibility, support; and creating a safe atmosphere in stressful situations. Therefore, it denotes that the therapeutic alliance between patients and professionals forms the cornerstone of mental health care processes and is associated with positive therapeutic outcomes. [24]

It is crucial to discuss treatment with patients, providing clear information about uncertainties, risks and benefits for mother and baby. Since women may be less familiar with the risks of not undergoing treatment, this discussion helps to promote an informed decision. Furthermore, prevention of mental illness in the perinatal period is more effective than reactive care, reinforcing the value of ongoing vigilance, which should be shared by health professionals involved in maternal and child care. [7]

That said, changes in the levels of support received are a crucial factor for perinatal mental health, influencing women's choices regarding coping strategies (whether positive or negative), which impacts mental health outcomes. Thus, emotional support demonstrated by health professionals is associated with lower levels of psychological symptoms, as a protective factor and boost to well-being. [25]

## CONCLUSION

Psychological care for the mental health crisis in the perinatal period calls for apprehension under the aegis of intersectionality; a kaleidoscopic, holistic, integral vision; an ethical-aesthetic-active-critical-sensitive-empathetic stance; validation of invisible idiosyncrasies and of the senses/meanings inherent to the patients' unique experience.

After all, the structure and feasibility of the care protocol in the systematization of the psychological management of the mental health crisis are highlighted, as well as the longitudinal care of perinatal psychic demands and the strengthening of scientific research on related themes, in act and in fact, eminently non-stigmatizing; in favor of the political power of the movement, the flourishing and defense of life; that honor the patient-team-companion/family triad and the coproduction in an intersectoral network.

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