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Tip Sheet: Maternal Mental Health

What's the Problem?

Maternal mental health (MMH) disorders (e.g., major depressive disorder, anxiety) are the most common medical complications affecting birthing peopleⁱ during the perinatal period (pregnancy through the infant's first year). Undetected and untreated, these conditions are associated with negative health outcomes for the birthing person and the child's long-term physical, emotional, and developmental health. One in 5 to one in 7 pregnant and postpartum people are affected. Prevalence is higher in some populations. For example, one in four Black and Latina birthing people in California and half of all birthing people living in poverty report depression. Also, maternal suicide is a leading cause of preventable maternal mortality. Finally, the cost of untreated PMH conditions in the U.S. is significant at an estimated \$14.2 billion for 2017 births (\$32,000/birthing person-child pair).

Despite these facts and the existence of highly effective treatments, few birthing people receive appropriate care. A statewide survey of people who gave birth in California in 2016 found that just one in five who screened positive for anxiety or depression during pregnancy reported receiving counseling or treatment for emotional or mental well-being. Just one in three who screened positive for these conditions in the postpartum period reported receiving such treatment.

There are many reasons for lack of treatment, including the fact that basic protocols for systematic identification and tracking of birthing people with these disorders are not widely followed, and implementation of team models of care that improve outcomes is limited. Additionally, a lack of awareness of the problem and understanding among both sufferers and providers causes lack of and/or insufficient diagnosis and treatment.

It is important to note that there are a range of MMH disorders. These include:

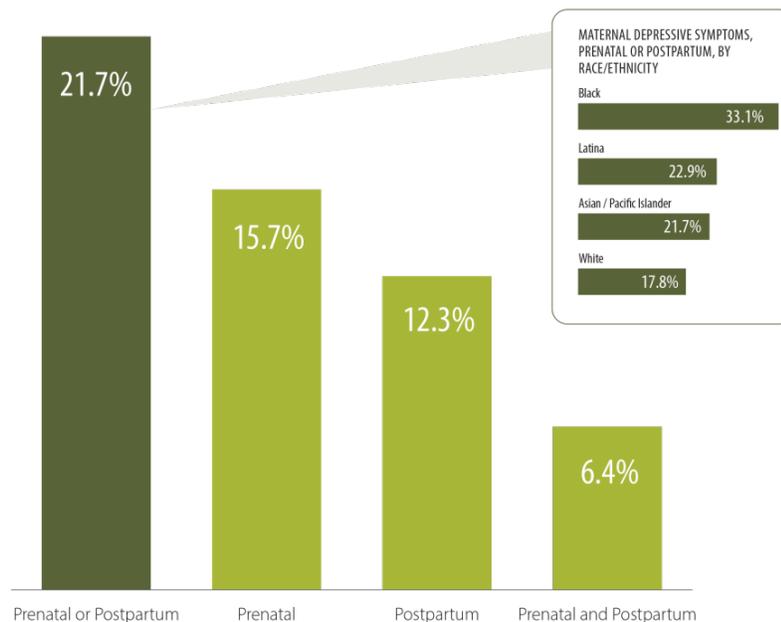
- **Depression:** Often includes intense and persistent sadness, hopelessness, worthlessness, inadequacy or guilt. Physical symptoms may include headaches or muscle tension. Other symptoms may include a lack of energy, focus or motivation, difficulty making decisions, eating too little or too much, obsessing, sleeping too little/too much, no interest in activities previously enjoyed, and withdrawal from friends and family.
- **Anxiety disorders**, such as panic disorder or generalized anxiety disorder: Symptoms of anxiety are very common; they often accompany depression or can exist on their own. Symptoms can include extreme worry, inability to sleep or recurring thoughts of harm coming to the baby, possibly at the birthing person's hands (the latter being a type of anxiety disorder called obsessive compulsive disorder or "OCD").
- **Bipolar disorder:** Can begin or worsen during the perinatal period: In people with bipolar

disorder, episodes of depression are interspersed with episodes of mania or hypomania, which includes elevated or irritable mood, hyperactivity, decreased need for sleep, racing thoughts, fast speech, and uncharacteristically risky behavior.

- **Postpartum psychosis:** An extremely rare psychological emergency requiring hospitalization, far less common than depression and the various forms of anxiety. Psychosis is very serious; symptoms may include visual or auditory delusions, severe paranoia and a catatonic-like state (staring into space). Because of these breaks from reality, birthing people suffering from psychosis are at higher risk of suicide or taking their child's life.

It is very important not to confuse psychosis with depression or OCD as confusion can perpetuate stigma and prevent people from speaking up. Also, symptoms of MMH disorders can vary widely depending on the disorder. It's important to distinguish these consequential conditions from the much more frequent occurrence of "baby blues" shortly after birth. Baby blues can be emotionally distressing but are transient, lasting only up to two weeks.

Maternal Depressive Symptoms, Prenatal and/or Postpartum California, 2016 and 2017



Notes: Data from population-based survey of 13,062 California resident women with a live birth; 2016 and 2017 data were combined.
Source: Custom data request, Maternal and Infant Health Assessment (MIHA), California Dept. of Public Health, received June 19, 2019.

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What are the risk factors?

MMH disorders impact birthing people of every age, culture, income level and race but are more prevalent for underserved populations. Systemic, institutional and interpersonal racism, poverty or other social factors increase the frequency and severity of mental health conditions. Up to 20% of birthing people experience some form of depression and/or anxiety during pregnancy or in the first 12 months after delivery. Risk factors include:

- A history of depression, mood or anxiety disorders
- Mental illness in the family
- Substance use disorders

- Low-income
- Birthing people of color
- Victims of domestic violence
- Single birthing people
- Teenage birthing people
- NICU birthing people
- Birthing people with previous pregnancy or infant loss
- Undocumented immigrants
- Birthing people with high-risk pregnancies
- Birthing people who conceived as a result of fertility treatments
- Birthing people with pregnancy loss, traumatic births and their own or their baby's life-threatening experiences

Stressful events during pregnancy and after delivery, such as death of a loved one, emotional or physical abuse, and poverty can trigger MMH disorders. Birthing people who experience perinatal loss (stillbirth, miscarriage or neonatal death) or severe challenges to their own and/or their newborn's health are at risk for experiencing MMH disorders after birth and during subsequent pregnancies. Other risk factors are the lack of a social support system or access to health insurance coverage and/or health care.

Newborns and children exposed to MMH disorders are also at risk. Untreated MMH disorders can result in a fetus with low birth weight and/or born prematurely. MMH disorders can also reduce the birthing person-infant bond and negatively affect a child's physical and cognitive development, and can cause behavioral problems, attention deficit disorder, lower IQ and/or immunity issues.

Many physicians are unaware of the risk of not treating MMH conditions and the fact that it is possible to safely treat pregnant and breastfeeding people with some psychiatric medications. For example, a 2016 survey by Johns Hopkins University's Task Force to Study Maternal Mental Health Report revealed that one in four OB/GYNs lack confidence in knowledge of MMH disorders and treatment of pregnant and postpartum people. These physicians often incorrectly recommend discontinuing psychiatric medications during and after pregnancy, exacerbating the situation for the patient. Careful selection of medications is needed during pregnancy to avoid adverse effects on the developing fetus, and an important postpartum consideration is whether the drugs reach infants through breastfeeding. While it is true that some drugs have not been adequately assessed for use in pregnant and breastfeeding people, there are some medications whose risk profiles are well known and safe to use. Additionally, many providers do not know that cognitive behavioral therapy is another approach that has helped birthing people with perinatal mood disorders and/or there is a lack of access to qualified providers who are knowledgeable about MMH treatments.

Finally, there is significant stigma in our society around birthing people and mental health conditions. Having a baby is supposed to be a happy time as it is often portrayed in the media/pop culture. The reality of such challenges as lack of sleep, new demands, and significant life changes is not often discussed and so people who have just given birth are often taken by surprise in feeling worried, anxious, depressed and/or despondent. Birthing people who are struggling can feel embarrassed that they are not feeling happier and so do not feel comfortable speaking up and asking for help.

How Can Maternal Mental Health Disorders Be Treated and Prevented?

Several recommended actions can improve MMH including:

- **Prevention:** Increase awareness through patient education of the risks, need to recognize symptoms, asking for help, the importance of sharing feelings and support; reduce the stigma associated with MMH disorders and change the unrealistic concept of a “good parent” that exists today (e.g., always happy, organized, put-together, never angry or upset).
- **Screening:** Improve early identification through screenings (i.e.: surveying pregnant and people who have just given birth periodically about their mental health); use tests such as Edinburg Postnatal Depression Scale (EPDS) and/or the Patient Health Questionnaire-9 (PHQ9) to identify need for mental health care from professionals. Screenings can take place at prenatal visits, postpartum visits, well child visits, primary care visits, etc.
- **Treatment:** Expand MMH training for maternity care, primary care and pediatric providers; many support personnel can encourage birthing people exhibiting symptoms of MMH disorders to seek help (e.g., childbirth educators, lactation personnel, WIC personnel, doulas); provide guidelines for mental health professionals on medications and treatments for pregnant and postpartum people; create support through telephone support lines; more support groups
- **Reducing Barriers:** Provide access to professional treatment and peer support; offer resources for health care if birthing people are not covered by insurance and support services (such as transportation, childcare) so they can get to MMH appointments. Consider telehealth visits for remote and other birthing people who may have difficulty travelling to mental health services.

Efforts to improve MMH disorders also should address accessing paid family and medical leave, extending Medicaid coverage post birth beyond 60 days, and developing low-cost alternative treatments such as telehealth services and online postpartum depression support groups to make it easier for pregnant and postpartum people to follow through on appointments. Wider use of telehealth during the COVID-19 to provide maternity care services has shown that it is possible to deliver care in this way effectively.

Bottom Line

The significant prevalence of MMH disorders and their impact on birthing people, newborns, children and families demands more attention. While these conditions are common, the good news is that they are often highly treatable. Awareness and appropriate care can reduce risk of harm to birthing people, infants and families and diminish suffering.

Case Study

Jenna lived in a rural town in Pennsylvania. At 34 she gave birth to her third child and felt overwhelmed. Her moods fluctuated with her hormones. She was exhausted from lack of sleep and was easily irritated. Grippled by anxiety and paralyzed with depression, she barely went outside, despite the beautiful summer weather. Too embarrassed to tell friends who seemed happy with all their children, her sense of loneliness and sadness got worse. She felt guilty for not feeling happier about having a healthy baby.

Initially Jenna had handled the demands of a new baby and mothering two young children in stride. But then her new baby daughter struggled with breastfeeding. When her baby couldn't get a good latch on her nipple, Jenna grew frustrated and stressed. She felt like a failure. When her baby cried to be fed, she couldn't stop crying either. Fearful her daughter wasn't getting nutrition; Jenna lost her appetite. She felt panicky about neglecting her two other boys. Her mood took a dive.

She felt she had no one to turn to. There were few resources in town, and her doctor was 45 minutes away. When she called his office asking for help with breastfeeding, the nurse suggested a lactation specialist. Jenna languished as she tried to find someone. As her condition grew critical, her husband jumped in, insisting that she follow through for their kids' sake. He assured her he'd borrow money, since insurance didn't cover it.

After connecting with La Leche League, Jenna felt relief that her daughter was breastfeeding, but still couldn't shake her depression. Though the medical professionals hadn't recognized her depression, the breastfeeding instructor suspected Jenna's was experiencing an episode of depression. She recommended a free online support group for birthing people suffering from depression. This helped Jenna realize she wasn't alone. One woman in the group, who lived in a nearby county, spoke about how medication helped. Jenna hadn't taken antidepressants since college and feared the effects on her milk might harm her baby. But a psychiatrist understood the appropriate drugs and doses for pregnant and breastfeeding people. With the right prescription, care and support from her husband, her fog finally lifted.

Resources

- National Institute for Health Care Management “Identifying and Treating Maternal Depression”: https://www.nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf
- Delivering Moms from the Most Common Childbirth Complications: Depression and Anxiety: <https://www.chcf.org/blog/delivering-moms-from-the-most-common-childbirth-complications-depression-and-anxiety/>
- Postpartum Depression: <https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression>
- Maternal Depression: <https://www.cdc.gov/features/maternal-depression/index.html>
- Report of the Task Force to Study Maternal Mental Health: <https://www.calhospital.org/sites/main/files/file-attachments/report-cataskforce-proofv7.pdf>
- Postpartum Support International: www.postpartum.net
- New Study Uncovers the Heavy Financial Toll of Untreated Maternal Mental Health Conditions: <https://www.mathematica.org/news/new-study-uncovers-the-heavy-financial-toll-of-untreated-maternal-mental-health-conditions>
- Perinatal Depression / Preventive Interventions: <https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/perinatal-depression-preventive-interventions>
- Efforts to Reduce Black Maternal Mortality Complicated by COVID-19: <https://www.chcf.org/blog/efforts-reduce-black-maternal-mortality-complicated-covid-19/>
- It's Past Time To Provide Continuous Medicaid Coverage For One Year Postpartum: <https://www.healthaffairs.org/doi/10.1377/hblog20200203.639479/full/>

ⁱWe use the term “birthing people” to recognize that not all people who become pregnant and give birth identify as a woman or a mother.