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Perinatal Mood and Anxiety Disorders

Recognizing Signs and Symptoms



About Me

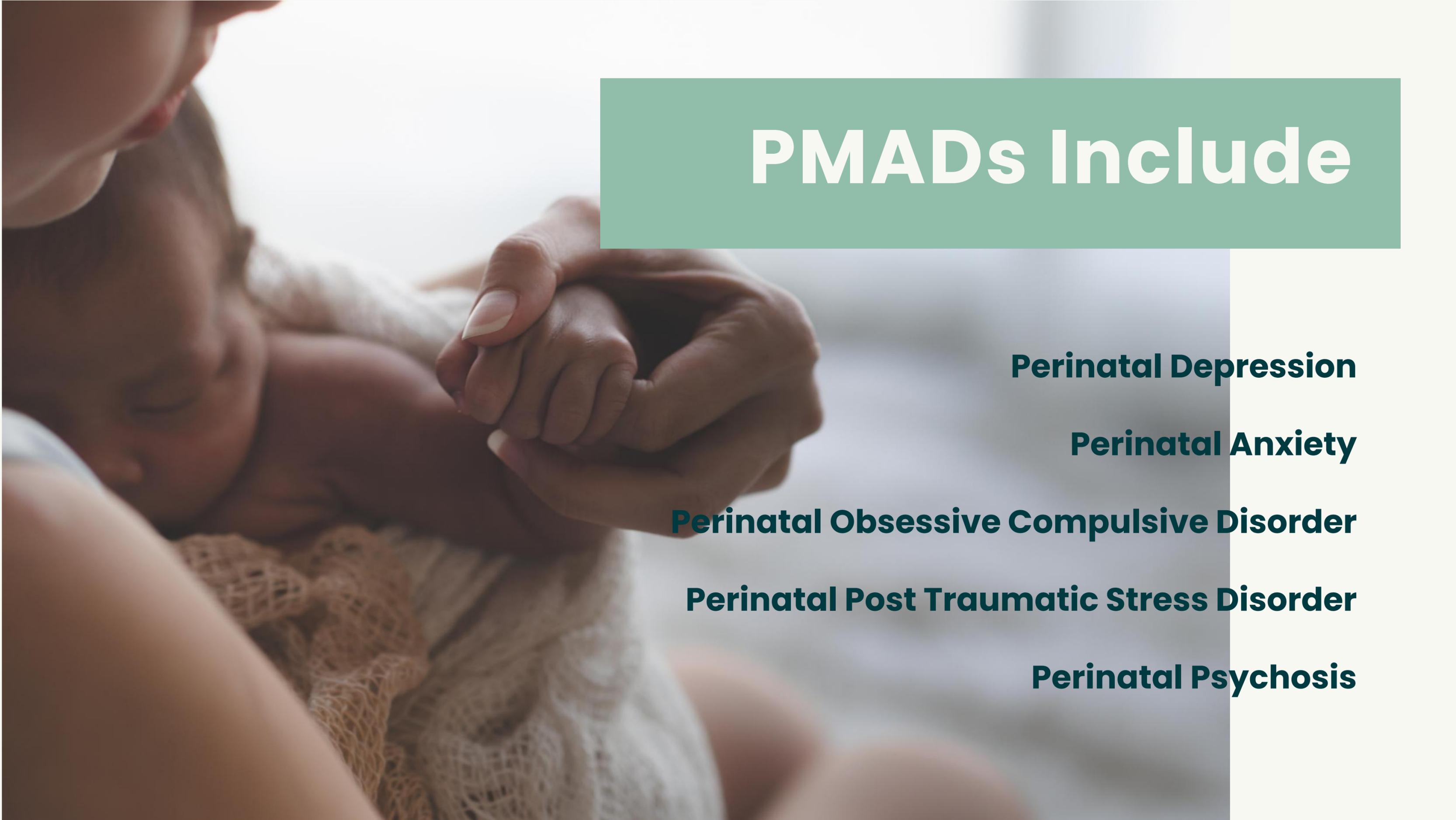
- LCSW, PMH-C (NY & VT)
- 20 years working with pregnant and postpartum people
- Lived experience
- 2014 Legislation
- The Motherhood Center
- ACS, DOHMH, NYS OMH
- Adjunct Professor, Silberman School of Social Work, Hunter College
- Advanced Psychotherapy Trainer, PSI
- Clinician



PMADs, or perinatal mood and anxiety disorders, are a group of illnesses that affect at least 1 in 5 women/birthing people during pregnancy and the postpartum period.

PMADs cause emotional and physical problems that make it hard for women to function adequately (i.e., care for themselves, babies, and family).

What are Perinatal Mood and Anxiety Disorders?

A close-up photograph of a woman holding a baby. The woman's face is partially visible on the left, looking down at the baby. The baby is wrapped in a light-colored, textured blanket and is holding the woman's hand. The background is softly blurred, suggesting an indoor setting with natural light.

PMADs Include

Perinatal Depression

Perinatal Anxiety

Perinatal Obsessive Compulsive Disorder

Perinatal Post Traumatic Stress Disorder

Perinatal Psychosis

Affirming and Inclusive Perinatal Terms

Heteronormative terms are frequently used to label and describe parental roles and practices. In this class we will alternate between binary and non-binary terms to ensure the full range of the client experience. These terms include but are not limited to:

- **Mother / Father**
- **Birthing Person/Birthing Parent**
- **Non-birthing Person / Non-birthing Parent**
- **Pregnant Person / Postpartum Person**
- **Partner**
- **Primary Caregiver / Caregiver**
- **Maternal / Paternal / Parental / Perinatal**
- **Breastfeeding / Chestfeeding / Bodyfeeding**

What is most important is to meet our clients where they are and to use language that best captures their identity.

PMAD Statistics

1 in 5

New and expecting mothers suffer from a PMAD

80%

Of cases go undiagnosed or untreated

50%

Of cases develop during pregnancy

#1

Complication associated with childbirth

Leading Cause of Maternal Mortality

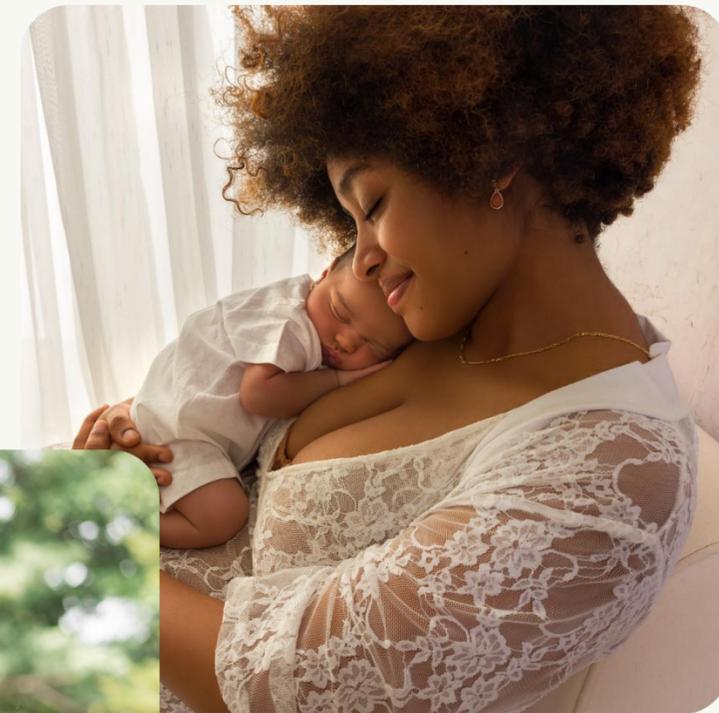
PMADs are a leading cause of maternal death in the United States.

- **CDC findings – mental health/substance use makes up 23% of all maternal deaths**
 - 82% of pregnancy-related deaths are preventable
- **NYC MMRC 2021 Report – mental health/substance use makes up 36.2% of all maternal deaths**
 - 74% of pregnancy-related deaths are preventable

The Transition to Parenthood: Expectations

There is a “romanticized” version of motherhood & parenthood that is reinforced everywhere we look:

- *History*
- *Social Media*
- *Magazines*
- *Movies*
- *Commercials*
- *Baby products*
- *Other parents sharing only their good experience*



It makes a lot of sense that people enter parenthood with a certain set of expectations

The Transition to Parenthood: Reality

Becoming a parent is messy, chaotic, disorganized, and feels very overwhelming. This is what **normal** parenting looks like



The Both / And of Becoming a Parent

Becoming a parent is one of the most **amazing, beautiful and wonderful** things that someone will ever do....

AND -

It can feel like the hardest.

- A “dialectical experience” is having two or more feelings at the same time – and **both can be true**
- “**Ambivalence**” is at the heart of motherhood / parenthood

I will be **glowing and excited** throughout my entire pregnancy

I will experience my **exact birth plan**

I will automatically feel **unconditional love and bonding** towards my baby after birth

Breastfeeding/chestfeeding is easy and natural, **all good mothers / birthing people breastfeed / chestfeed**

Aiming to be a “good enough” mother/parent is not good enough it is better to **strive to be perfect.**

The love a new parent has for their baby overrides their **longing for their previous identity / sense of self**

A good mother/parent knows how to **instinctively** care for their baby

Parents in a partnered relationship quickly figure out how to create **equal roles and responsibilities** around caring for baby and other responsibilities

Perinatal depression and anxiety are rare – and won't happen to me.

Common “Myths” of Motherhood / Parenthood

The Parental Safety Net in Other Countries

- In the *Netherlands and Belgium*, birthing parents will have a **maternity nurse** who comes to the home to provide a minimum of **24 hours of care within the first 8 days after discharge**.
- In *China* a birthing parent has a **month of confinement** or sitting the month where they **build up their strength and bond with their baby** after childbirth by staying at home.
- In *Guatemala* a birthing parent **rests for 40 days** while people in the community do **household chores and bring hot health soups** to eat.
- In *South Korea*, a birthing parent goes to a **postpartum care center for 2 weeks** after they leave the hospital where they are **pampered with massages**, and a full staff catering to their needs including **meals, laundry, and housekeeping**. Infants can room with mom or **stay in the nursery** so mom can rest.
- In the *Middle East including Jordan, Lebanon, Egypt, and Palestine* there is a **40-day period of rest** after childbirth, with **someone taking care of the mother, baby, and household**.

The Parental Safety Net in the U.S.

- The United States is **ranked last in family-friendly policies.**
- Overall, the U.S. spends the **most money in the world on healthcare per person**, however, in regard to **maternal outcomes**, we typically **rank last** when compared to other wealthy nations.
- Only **14%** of American workers have **access to paid leave**. An additional surprise to many is that the Family and Medical Leave Act is not universal — **40 percent of Americans do not qualify.**
- Perhaps more significantly, due to economic hardship and employer constraints, **1 in 4 women return to work just 10 days after giving birth.**
- Parental leave has become very political, but facts are facts: **It is instrumental in creating positive maternal and infant outcomes.**

The Parental Safety Net in the U.S.

Top 10 Countries with the Longest Minimum Maternity Leave

Country	Minimum Leave (in weeks)
Bulgaria	58.6
Greece	43
United Kingdom	39
Slovakia	34
Croatia	30
Chile	30
Czech Republic	28
Ireland	26
Hungary	24
New Zealand	22
United States	0

Salary requirements during leave

Country	Salary during leave
Austria	100%
Chile	100%
Costa Rica	100%
Croatia	100%
Germany	100%
Israel	100%
Lithuania	100%
Netherlands	100%
Poland	100%
Slovenia	100%
Spain	100%
Norway	94%
France	90%
United States	0

Maternity Care in the Postpartum Period

- Birthing people typically return home **2 – 3 days post caesarean section** which is a major surgery. Those who deliver vaginally can return home – 1 to 2 days post birth.
- Most postpartum people only receive **one 6 week visit** with their OBGYN for follow up obstetric or gynecological care, and **60% of all new birthing people miss this appointment.**
- There is little to no emphasis on supporting **a new parents mental health during** this overwhelming transition.
- Most of the focus **is on the baby** – not the new mother/birthing person.



Black Mothers /Birthing People and PMADs

Black Mothers & Birthing People and PMADs

40%

Of all black mothers will experience a PMAD

- Compared to white women, Black women are **twice as likely** to experience PMADs but half as likely to receive treatment.
- Among women who reported postpartum MH concerns, Black women are **far less likely to receive follow-up treatment** than white women.
- Black women are one of **the most undertreated groups** for depression in the U.S.
- Single Black mothers are **6 x's more likely** than the general population to experience depressive symptoms
- Black women experience maternal mortality rates **3 – 4 times the rate** of white women.

Factors that Increase MMH Conditions for Black Women & Birthing People

- Systemic Racism
- Adverse Childhood Experiences
- Socioeconomic Status
- Lack of Representation in the Medical Care System
- Exposure to Violence and Trauma
- Higher Risk of Pregnancy and Childbirth Complications
- Gaps in Medical Insurance
- Lack of Access to High Quality Medical and Mental Health Care



Factors Impacting Black Mothers & Birthing People

Weathering

Black women experience physical “weathering,” meaning their bodies age faster than white women due to exposure to chronic stress linked to socioeconomic disadvantage and discrimination over the life course. Weathering can make pregnancy riskier for Black women at an earlier age and can also lead to Black women experiencing more chronic health conditions, such as diabetes and obesity.

The Superwoman Schema

The Superwoman Schema is a conceptual framework that states that certain socio, cultural, and historical perspectives in the United States have impacted how Black women experience and handle stress, with Black women taking on the following coping characteristics: obligations to manifest strength, suppress emotions, and help others, even to the detriment of personal health; resistance to being vulnerable or dependent; and a determination to succeed despite limited resources.



Barriers to Care for Black Mothers & Birthing People

Shame and Stigma

The pressure of social stigma can encourage Black women to keep their problems private to avoid appearing weak or lacking faith. Having to be a “strong Black Woman” prevents many from seeking help.

Fear of Child Protective Services

Black mothers may be fearful that if they tell anyone what they are thinking or feeling, their baby will be taken. In the 20 most populous counties in the country, the mean rate of CPS investigations was 34%, but ranged from 40% to 70% for Black children.

Barriers to Care for Black Mothers & Birthing People

Systemic and Interpersonal Racism

The cumulative effect of systemic and interpersonal racism takes a toll on the physical and emotional health of black women. Stress, anxiety, and fear all increase the likelihood of developing MMH conditions.

Distrust of the Health Care System

Historically, many Black people have been mistreated and harmed by medical providers, creating deep mistrust of the healthcare system.

Logistical Barriers

Issues such as transportation, time off work, and childcare can prevent women from seeking care.



PMAD RISK FACTORS

PMAD Risk Factors

- **History of mental illness** (personal or familial)
- **Complications** in pregnancy, birth, or breastfeeding
- **Previous PMAD** (50 – 75% chance of repeat)
- **Unplanned or unwanted** pregnancy
- Mothers of **multiples**
- Mothers who have gone through **infertility treatments**
- **NICU** experience
- **Perinatal loss** (miscarriage, abortion, stillbirth, SIDS or other loss of baby)
- **Social isolation or poor support**
- **Individuals of color**
- **IPV**
- Individuals that live in **low-income neighborhoods**
- **Stopping psychiatric medication**



TYPES OF PMADS

What you Might Hear from Birthing People

I don't feel like myself

I can't sleep even when the baby is sleeping

I don't have an appetite, I forget to eat all day

I'm afraid to be alone with my baby

I feel like I am drowning

I don't feel connected or bonded with my baby

Having a baby was a mistake, I wish I never did it

I want to run away and not come back

I can't turn off my brain, it keeps racing all the time

I feel like a failure

I feel like my baby and my family would be better off without me

The Baby Blues (are not a PMAD)

- 80% of all new mothers and birthing people experience the baby blues
- They can last anywhere from a few days to 2 weeks postpartum

Mild Symptoms include:

- Moodiness
- Crying
- Sadness
- Worry
- Lack of Concentration
- Forgetfulness
- Feelings of Dependency

Causes:

- Rapid Hormonal changes
- Drop in estrogen / progesterone
- Physical and emotional stress of birth
- Physical discomforts
- Emotional letdown after pregnancy and birth
- Awareness and fear about increased responsibility
- Fatigue and sleep deprivation
- Disappointment including birth, partner support, nursing and baby

Perinatal Depression



- Low mood, sadness, and tearfulness
- Feeling overwhelmed and unable to cope
- Hopelessness /helplessness
- Loss of interest, joy, or pleasure in things you used to enjoy
- Agitation/irritability
- Lack of energy or feeling slowed down physically
- Difficulty concentrating or making decisions
- Appetite or sleep disturbance
- Feelings of guilt, shame, failure
- **Suicidal ideation**

Perinatal Anxiety

- **Constant worry** – catastrophizing / all or nothing thinking / worst case scenario
- Feeling like something bad is going to happen – **a sense of dread**
- Feeling like you **can't turn your brain off** – the hamster wheel
- Disturbances of **sleep and appetite**
- **Physical symptoms**, like dizziness, heart palpitations, nausea, or panic attacks
- Fear of being **left alone** with the infant
- Hypervigilance in **protecting** the infant

Perinatal Obsessive Compulsive Disorder

- Doing certain things over and over **to reduce fears** and obsessions – excessive washing of clothes, toys, or bottles (compulsions/rituals)
- Repeatedly **checking baby** during the night to make sure they are breathing
- Repeatedly **asking others for reassurance** that the baby hasn't been hurt or abused
- **Not feeding the baby** for fear of poisoning them
- Not consuming certain foods or medications out of **fear of harming the baby**.
- **Recurrent and persistent thoughts**; urges or images that are intrusive and unwanted (obsession); and the thought, urge, or image is neutralized by a repetitive behavior (compulsion). The obsessions and/or compulsions must be time-consuming, cause distress to the individual, and impair functioning
- **Ego-dystonic – thoughts that are distressing and inconsistent with a person's self concept, values and beliefs, desire to change**

Perinatal PTSD

- Intrusive **re-experiencing of a past traumatic event** (which may have been childbirth itself or previous physical/sexual trauma)
- **Recurrent** flashbacks, nightmares or distressing recollections of the event
- **Avoidance of stimuli** associated with the event, including thoughts, feelings, people, places, and details
- Feeling **hypervigilant or on guard** or feeling easily irritated or on edge
- Feeling **restless or having difficulty sleeping**
- Anxiety and **panic attacks**

Perinatal Psychosis

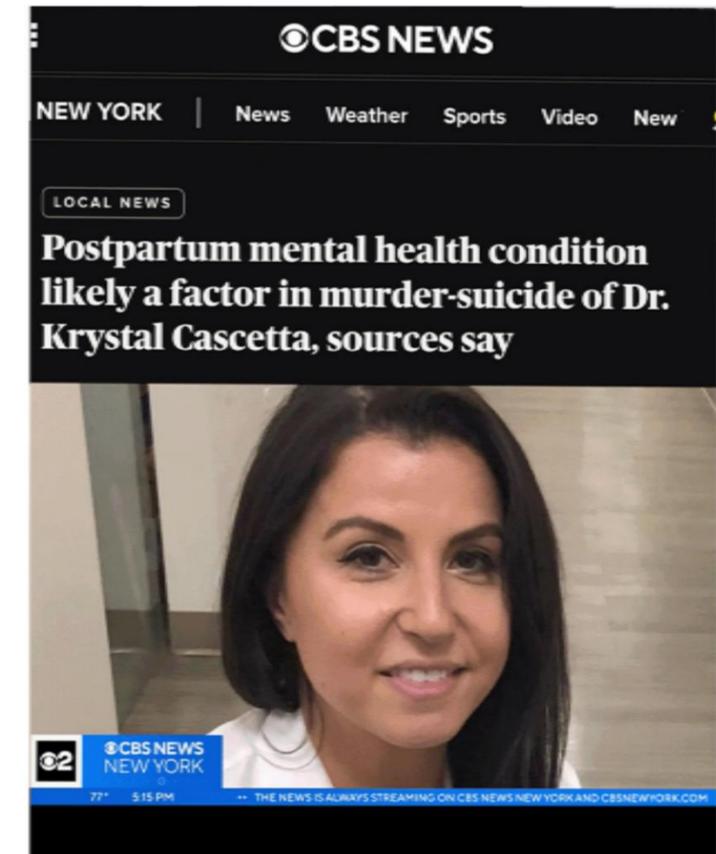
- Delusions or strange beliefs that **feel real but are not** (about the infant death, denial of birth, or need to kill the baby)
- **Hallucinations** (seeing or hearing things that others do not – hearing the voice of God, or the devil, or getting secret messages from the TV)
- **Ego-syntonic** – thoughts/behaviors in line with a person's beliefs – someone who steals may not feel guilty or have conflict with the act)
- Mania – **Decreased need for or inability to sleep**
- **Feeling confused and disorganized** – saying things that don't make sense
- Feeling **disconnected from reality**
- **Paranoia and suspiciousness**
- Symptoms that come and go **or waxing and waning** (may seem normal one minute then hearing voices the next)
- **Psychosis is a 911 EMERGENCY and requires hospitalization!**

Risk Factors for Perinatal Psychosis

- Personal or family history of psychosis or bipolar disorder = **40% – 50% increased risk**
- **Schizophrenia** (diagnosed or not)
- Previous **postpartum psychotic or bipolar episode**
- Hormone shifts, **sleep deprivation**, and increased environmental stress
- Postpartum psychosis is **NOT postpartum depression**
- **STOPPING MEDICATION**

Untreated Perinatal Psychosis

- 1 to 2 per 1,000 births
- 4% of women experiencing postpartum psychosis **will commit infanticide**
- 5% of women experiencing psychosis **will commit suicide**



Societal Costs of Untreated PMADs

A close-up photograph of a woman with dark hair, looking down at a baby she is holding. The woman's expression is somber and weary. The baby is wrapped in a light-colored cloth. The background is dark, creating a dramatic and intimate atmosphere.

When left untreated, PMADs can become a multigenerational issue, negatively affecting the mother and child's long-term physical, emotional, and developmental health

- Pregnancy and birth complication
- Maternal health expenditures
- Obstetric-specific health expenditures
- Productivity losses in the workforce
- Child outcomes

Estimated cost of Untreated PMADs Annually

\$14.2 Billion

Untreated PMADs During Pregnancy

High preeclampsia rates

Higher C-section rates

Higher preterm birth rates

Lower birth weight

Higher NICU admission rates



Untreated PMADs in the Initial Postpartum

- Higher SIDS rates

- Infant failure to thrive

- Frequent ER visits

- Limited bonding and attachment between mother and baby

 - This offers a host of neurological and behavioral development issues*

- Inability to care for self and/or for the child



Untreated PMADs Later in the Postpartum

- Feelings of inadequacy as a mother
- Chronic substance abuse and relapse
- Weight problems leading to diabetes and heart issues
- Impaired social relationships/relationship with partner
- Worse physical health status
- Self-injurious behavior
- Suicide and infanticide



Untreated PMADs and the Impact on Children

- Excessive crying or colic
- Temperament difficulties
- Poor affect regulation
- Behavioral & developmental disorders
- Attention difficulties
- Lower cognition
- Difficulties with peer relationships
- Higher rates of externalizing behaviors
 - ADHD, ODD, CD
- Reduced educational attainment
- Higher rates of substance dependence
- Worse long-term health implications
- Increased rates of mental illness

The Benefits of PMAD Treatment

- Reduce long-term physical/mental health implications for mother and baby.
- Stabilize acute symptoms that put mothers and families at risk of harm.
- Increase effective coping skills.
- Address attachment/bonding between mother and baby.
- Stabilize the family system.
- Strengthen communication skills between mothers and partners.

○ **SAVES LIVES**





SCREENING AND ASSESSMENT

Why Screen for PMADs?

- **Screening can increase the identification of those who are experiencing MMH conditions.**
- **Screening is the first step to identifying a problem so mothers/birthing people can receive treatment and care to reduce symptoms and adverse maternal and infant outcomes.**
- **Additionally, screening provides an opportunity for healthcare providers to:**
 - Indicate that these disorders are common and treatable
 - Inform mothers of the signs and symptoms
 - Identify those at-risk
 - Share that these disorders are often preventable with the right support
 - Note that early detection is important for the health of the mother and baby

States that Passed Screening Legislation by Decade

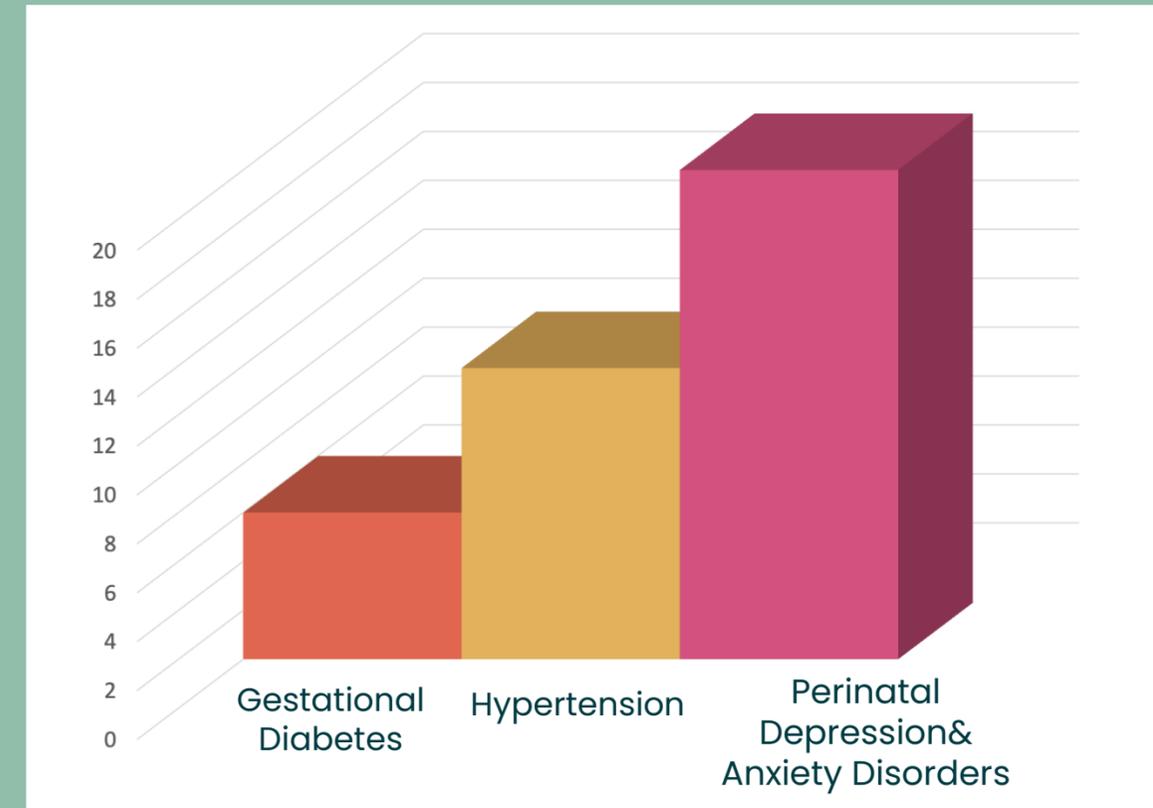
State	2000s	2010s	2020s
New Jersey	2000		
West Virginia	2009		
California		2018	
Florida		2018	
Oklahoma		2019	
Illinois		2019	
Louisiana			2022
Arkansas			2023
Nevada			2023
Washington			2023

How Frequently are We Screening?

The first data set from this **HEDIS (Healthcare Effectiveness Data and Information Set)** measure was reported in 2022. This data was sourced from 50% case management systems, 40% electronic health records, and 10% health information exchanges.

Notably, the HEDIS screening measures included components for both screening and follow-up.

- **The Medicaid Screening and follow-up rates were 16% during pregnancy and 17% in the postpartum period.**
- **For private insurers, screening rates were lower, at 9% during pregnancy and 11% in the postpartum.**



Mandatory testing is required to detect the prevalence of many conditions that are far less likely to occur.

PMAD screening is not mandatory.

—● **Edinburgh Pregnancy/Postnatal Depression Scale (EPDS)** is a 10-question survey specific to the perinatal period, to detect depression which also includes two questions about anxiety.

—● **Patient Health Questionnaire (PHQ 2 or 9)** offers both a short (2-question) and long (9-question) screener used to detect depression.

—● **Generalized Anxiety Disorder (GAD 7)** offers a 7-question screener to detect generalized anxiety and worry associated with other anxiety-related disorders.

Most Commonly Used PMAD Screening Tools

- **Perinatal Anxiety Screening Scale (PASS)** a 31-question perinatal anxiety screener.
- **Mood Disorder Questionnaire (MDQ)** a 15-question bipolar disorder screener.
- **Obsessive Compulsive Inventory (OCI 12 or 4)** 12- or 4-question screeners that rank intrusive thoughts and OCD symptoms on a four-point scale of symptom distress.
- **Columbia-Suicide Severity Rating Scale (C-SSRS)** a 6-question screener to assess for suicidal ideation.
- **Posttraumatic Stress Disorder Checklist (PCL-5)** a 20-question screener to assess for PTSD

Less Commonly Used PMAD Screening Tools

Obstacles to Screening

Screening is not a failsafe, standalone mechanism. Research suggests that screening as a single approach may not be adequate due to cultural mental health stigma and a variance of risk factors in racial/ethnic groups.

The EPDS was developed in 1987 – and many questions are outdated and hard to understand – especially when English is not the primary language.

People don't answer honestly out of fear/lack of psychoeducation.

A positive screening result is not a diagnosis, rather, it tells clinicians that they need to look for further signs and symptoms to confirm whether or not a patient truly has depression or another mental health disorder. When depression or general anxiety is suspected, this assessment can be done by the primary care or front-line treating provider. When symptoms are complex or when multiple diagnoses are present or suspected, further assessment is ideally performed in a timely manner by a mental health professional.

Screening Best Practices



- **Start talking to women/birthing people before conception** about their mental health history— provide them with the risk factors for developing PMADs
- **Integrate PMAD education from the beginning of pregnancy,** throughout, and up to one year postpartum.

- Provide PMAD psycho-education **when partners/family members are present.**
- Integrate routine screening practices **throughout pregnancy and up to one year postpartum.**

- **Deliver screens privately with the client and** ask them to answer the questions as honestly as possible so that you can connect them to care that will help them feel better if they need it.

A woman with long dark hair, wearing a white dress, is holding a baby in a white dress. They are outdoors in a grassy area with trees in the background. The woman is kissing the baby on the cheek.

PMAD Resources

The Suicide and Crisis Lifeline – 988

National Maternal Mental Health Hotline: 833-TLC-MAMA

Postpartum Support International:

www.postpartum.net/

Helpline: 800-944-4773

The Postpartum Resource Center of NY:

www.postpartumny.org/

Helpline: 855-631-0001

New York Project Teach: (855) 227-7272

www.projectteachny.org/maternal-mental-health/

Macari Perinatal Intensive Outpatient Program:

www.childcenterny.org/macari-perinatal-intensive-outpatient-program/

Q and A

Thank You!

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**I provide Perinatal Mental Health
Quality Improvement services to
non-profits including:**

- Evidence-based program design and implementation
- Data Collection
- Training and Education
- Strategic Assessment
- Enhancements to Service Delivery
- Operational Efficiency