MMHLA
Maternal Mental Health
LEADERSHIP ALLIANCE

FACT SHEET | NOVEMBER 2023

Maternal Mental Health Overview

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Key Facts: Maternal Mental Health (MMH) Conditions

1 in 5 Mothers are Impacted by Mental Health Conditions

Maternal mental health (MMH) conditions are the **MOST COMMON** complication of pregnancy and birth, affecting 800,000 families each year in the U.S.[1,2]

Most Individuals are Untreated, Increasing Risk of Negative Impacts

75%

75% of individuals impacted by MMH conditions **REMAIN UNTREATED**, increasing the risk of long-term negative impacts on mothers, babies, and families.[4]

Mental Health Conditions are the Leading Cause of Maternal Deaths

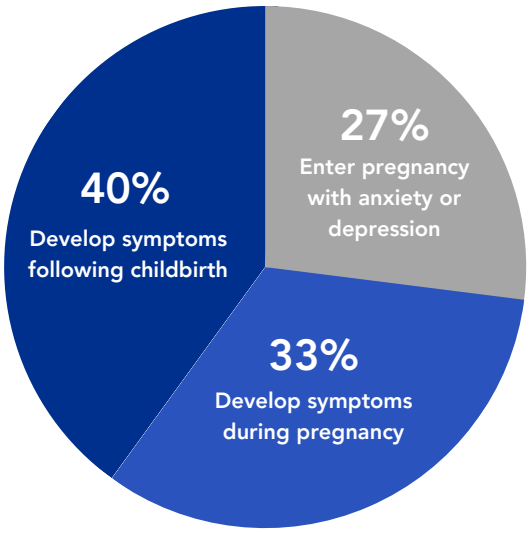
Suicide and overdose are the **LEADING CAUSE** of death for women in the first year following pregnancy.[3]

$14 Billion: The Cost of Untreated MMH Conditions

The cost of not treating MMH conditions is $32,000 per mother-infant pair, or **$14 BILLION** each year in the U.S.[5]

Timing and Onset of Anxiety and Depression

Of women who experience anxiety or depression in the postpartum period.[6]



If untreated, symptoms of MMH conditions can last up to 3 years.[7]

Terminology

Perinatal	From conception through full year postpartum.
Antenatal / prenatal	During pregnancy.
Postpartum / postnatal	First year following pregnancy.
Postpartum Depression / PPD / Postpartum	An umbrella term describing mood changes following pregnancy.
Perinatal mood disorders (PMDs) or perinatal mood and anxiety disorders (PMADs) **Maternal mental health (MMH) or perinatal mental health (PMH) challenges / complications / conditions / disorders / illnesses**	Various terms used to describe mental health conditions during the perinatal timeframe.
Women, mothers, childbearing people, birthing people	MMHLA uses these terms to refer to individuals who are capable of giving birth, and not to refer to gender identity. We strive to use inclusive terms whenever possible.

Range of MMH Conditions, Prevalence, and Symptoms

Baby Blues [20]

- **Up to 85% of childbearing individuals.**
- Normal period of transition.
- Typically include emotional sensitivity, weepiness, and / or feeling overwhelmed.
- Likely associated with the significant changes in hormones in the immediate postpartum period.
- Resolves without treatment within 2-3 weeks following childbirth.

Anxiety Disorders [20, 21]

- **6-8% of childbearing individuals.**
- Feeling easily stressed, worried, overwhelmed, tense.
- Panic attacks, including shortness of breath, rapid pulse, dizziness, chest or stomach pain.
- Fear of going crazy or dying.
- Intrusive or scary thoughts; thoughts of harming self or baby.
- Fear of going outside.
- Sleep disturbances; difficulty falling or staying asleep, even if baby is sleeping.

Obsessive-Compulsive Disorder [20]

- **4% of childbearing individuals.**
- Disturbing, repetitive, intrusive thoughts which may include thoughts of harming self or baby; these thoughts cause the individual great distress (i.e. thoughts are ego-dystonic).
- Compulsive behaviors, such as checking, in response to intrusive thoughts or in an attempt to make the thoughts stop or go away.

Substance Use Disorder (SUD) [22]

- **Often co-morbid.**
- Most-frequently used substances: tobacco, alcohol, marijuana, cocaine, opioids.
- Women are at the highest risk for SUD during reproductive years, especially if access to mental health services is limited.
- Most women who use substances often decrease their use during pregnancy. Those who can quit on their own usually do so, which is the distinguishing factor between substance use and SUD.

Depression [20, 21]

- **14% of childbearing individuals.**
- Change in appetite, sleep, energy, motivation, concentration.
- Negative thinking including guilt, helplessness, hopelessness, worthlessness.
- Irritable, angry, rageful.
- Lack of interest in the baby.
- Low self-care.
- Intrusive or scary thoughts; thoughts of harming self or baby.

Post-Traumatic Stress Disorders [20]

- **9% of childbearing individuals.**
- Change in cognition, mood, arousal associated with traumatic events, typically around childbirth.
- Avoidance of stimuli associated with the traumatic event.
- Feeling constantly keyed up or on guard.
- Learn more about birth trauma and PTSD with MMHLA's Birth Trauma and Maternal Mental Health Fact Sheet.

Bipolar Disorder [20, 21]

- **3% of childbearing individuals.**
- Manic or hypomanic episodes alternate with depressive episodes.
- Unusual shifts in mood, energy, activity levels, and ability to carry out day-to-day tasks.
- NOTE: Women with bipolar disorder are extremely vulnerable to recurrence during pregnancy and have an increased risk for postpartum depression and psychosis.

Psychosis — MEDICAL EMERGENCY [20, 21]

- **1-2 women per 1,000 births.**
- Most significant and least frequent mental health condition occurring during the perinatal period.
- Increases the risk of infanticide and/or suicide.
- Symptoms include delusions, hallucinations, paranoia, rapid mood swings, cognitive impairment, focus on death, reckless behavior.
- Thoughts are ego-syntonic, meaning they do not cause the individual distress.
- Onset is sudden, usually within 1-2 weeks following childbirth.
- The mother should be under the care of a medical provider or taken to the emergency room for assessment and care.
- Learn more with MMHLA's Pregnancy and Postpartum Psychosis Fact Sheet.

Causes of MMH Conditions

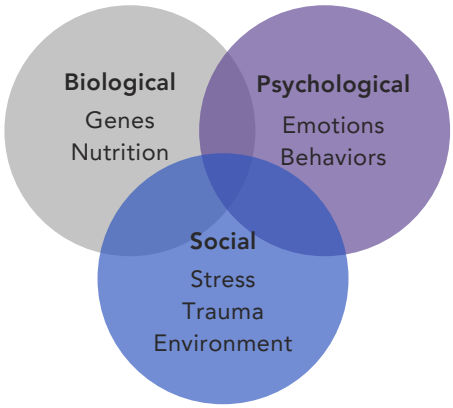
MMH conditions are caused by a combination of bio-psycho-social factors.

Biological: The dramatic change in hormones during pregnancy and in the immediate postpartum period can have a significant impact on mood. [23]

Psychological: Some individuals struggle with changes in roles, relationships, and responsibilities that come with the transition to parenthood. [24]

Social: The childbearing years often include changes in jobs, homes, and finances that can add stress. External factors, such as isolation during the COVID-19 pandemic, can add to or increase feelings of anxiety or depression. [25]

The Biopsychosocial Model



Consequences of Untreated MMH Conditions

On Mothers

Women with untreated MMH conditions during pregnancy are more likely to: [26, 27]

- Have poor prenatal care.
- Use substances such as alcohol, tobacco, or drugs.
- Experience physical, emotional, or sexual abuse.

Women with untreated MMH conditions postpartum are more likely to: [28]

- Be less responsive to their baby's cues.
- Have fewer positive interactions with their baby.
- Experience breastfeeding challenges.
- Question their competences as mothers.

On Children

Infants born to mothers with untreated MMH conditions are at higher risk for:

- Preterm birth, small for gestational size, low birth weight. [27, 29]
- Stillbirth. [27]
- Longer stay in the neonatal intensive care unit. [30]
- Excessive crying. [31]

Untreated MMH conditions in the parent can increase the risk for:

- Impaired parent-child interactions. [31]
- Behavioral, cognitive, emotional delays in the child. [32]
- Adverse childhood experiences. [33]

On Parents

Parents who are depressed or anxious are more likely to: [34, 35]

- Make more trips to the emergency department or doctor's office.
- Find it challenging to manage their child's chronic health conditions.
- Not adhere to guidance for safe infant sleep and car seat usage.

Individuals experiencing MMH conditions might say...

> Having a baby was a mistake.

> I'm such a bad mother, my baby and family would be better off without me.

> I'm exhausted but can't sleep, even when the baby sleeps.

> I feel like I'm drowning.

> I'm afraid to be alone with my baby.

> I want to run away.

> I'm not bonding with my baby.

> I was so embarrassed to say that I have postpartum depression out loud. It felt dirty, like it was a contagious disease.

Individuals at Increased Risk for MMH Conditions

The number one predictor for experiencing a maternal mental health condition is a personal or family history of mental health disorders. [9]

- Individuals with personal or family history of mental illness.[8]
- Individuals of color.[9-11]
- Individuals who live in low-income neighborhoods.[9-11]
- Military servicemembers and their spouses.[12]
- Women veterans.[44]
- Immigrant parents.[13]
- Parents with a baby in the neonatal intensive care unit.[14]
- Individuals who lack social support, especially from their partner.[8]
- Individuals who have experienced birth trauma or previous sexual trauma in their lifetime.[15]

Racial and Cultural Considerations

Increased Risk: Women of color are 3-4 times more likely to experience complications during pregnancy and childbirth and die from these complications than white women.[36]

Intergenerational Trauma: Black women enter pregnancy and childbirth suffering the impacts of intergenerational trauma, including the knowledge that many obstetric and gynecologic procedures were tested on Black women without their consent and without pain medication.[37]

Institutional Racism: Institutional racism in health care settings contributes to Black women receiving lower quality of care – such as giving birth in lower-quality hospitals – as well as being subject to dangerous, demeaning, or humiliating treatment.[36, 37]

Impact on Non-Birthing Parents

Fathers, Partners, Adoptive Parents At-Risk: Non-birthing parents – including fathers, partners, adoptive parents – are also at risk for experiencing mental health conditions related to pregnancy and parenting.[38, 39]

1 in 10 Fathers: As many as 1 in 10 fathers experience postpartum depression, with maternal depression as the #1 predictor of paternal depression.[38]

Grief and Loss: Parents involved in adoption – both the birthing parents and the adopting parents – can also experience strong emotions, including grief and loss.[39]

Barriers to Accessing Care

- Feelings of shame, stigma, guilt.[16]
- Expense and/or lack of access to healthcare.[16]
- Social biases in the healthcare system.[16, 17]
- Logistical challenges, such as lack of transportation or childcare.[17]
- Distrust of the healthcare system.[16]
- Fear that child protective services or immigration agencies will become involved.[18, 19]
- Fear of being considered a "bad mom."[16]
- Racial, cultural, and religious beliefs.[16]

Individuals of color and individuals of low income are MORE LIKELY to experience maternal mental health conditions and LESS LIKELY to be able to access care.[16, 17]

Treatment for Maternal Mental Health (MMH) Conditions

Most MMH conditions are temporary and treatable. Almost all individuals who experience MMH conditions can recover from a combination of self-care, social support, therapy / counseling, and medication. Learn more about treatment options with MMHLA's Steps to Wellness Fact Sheet.

Self-Care	Peer / Social Support [20, 28]
Basic self-care – such as regular and adequate sleep, nutrition and exercise – may be challenging during the first few days and weeks with an infant, but are necessary to recover from the physical and emotional demands of pregnancy and childbirth.[40] • **SLEEP**. Getting 4-5 hours of uninterrupted sleep is one of the most effective, least expensive things a new parent can do to start feeling better.[20, 40] • **NUTRITION**. Lactating parents should eat / drink every time the baby eats to maintain calorie intake and hydration.[40] • **MOVEMENT**. Light exercise (stretching, walking) and getting outdoors every day can have a significant positive impact on mood.[20, 40] • **LIGHT**. Going outdoors for 20-60 minutes or using bright light therapy can help with perinatal depression.[41] • **TIME FOR ONESELF**. Taking even a few minutes to recharge and rejuvenate – such as taking an interrupted shower – can increase feelings of well-being.[20, 40]	New parents can feel isolated and alone during the intense period of caring for a newborn. Social support is vital during this time, and can include emotional support, companionship, information and resources, and tangible support such as preparing meals or running errands. **Mindfulness & Mindful Breathing [20, 42]** Mindfulness-based interventions have shown to be helpful with stress, anxiety, and depression in the perinatal population. **Therapy / Counseling [21]** Counseling during the perinatal period is often short-term, pragmatic, and focused on symptom relief and coping skills. Cognitive behavioral therapy and interpersonal therapy are evidence-based therapeutic techniques proven supportive during the perinatal timeframe. **Medication [21, 43]** Sometimes medication is required to treat MMH conditions; fortunately, there are safe and effective medications to manage mood during pregnancy and lactation. Decisions about medication are best made in consultation with obstetric and psychiatric providers.

Maternal Mental Health Resources

National Maternal Mental Health Hotline HRSA

National Maternal Mental Health Hotline

For individuals who are not in crisis but need real-time support and assistance for maternal mental health conditions.

- 1-833-TLC-MAMA (1-833-852-6262)
- 24 / 7 / 365 response within 5 minutes
- Voice and text
- English and Spanish
- Other languages available via translator

For more resources go to mmhla.org/resource-hub.

PSI POSTPARTUM SUPPORT INTERNATIONAL

Postpartum Support International Helpline

For individuals who are not in crisis but need resources and referrals for maternal mental health conditions.

- 1-800-944-4773
- Online support groups
- Peer mentor program
- Volunteer coordinators in all states
- Provider directory

Special Thanks to Our Funders

This fact sheet was funded by grants from the California Health Care Foundation and the ZOMA Foundation.

Citations

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