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Supporting Maternal Mental Health and Reducing Stigma

Collaborating for Change: Building a Stronger System of Maternal Mental Health Support in New York

By Dr. Ann M. Sullivan
Commissioner
New York State Office of Mental Health

Effectively addressing maternal mental health requires a comprehensive public health solution that targets risk and protective factors. These include social determinants of health, clinical care, community support, culturally responsive interventions, and policy changes. This is why the New York State Office of Mental Health (OMH) is leading efforts to develop and support programs to help birthing people address their mental well-being and get the necessary help when needed. We are trying to eliminate the stigma and cultural obstructions that prevent some from seeking help and ensuring they are treated with dignity when they do reach out for assistance.

The prevalence of mental health challenges – particularly among people of color – has reached alarming levels in New York State and in the United States. Nationally, an estimated one in five birthing people experience perinatal mood and anxiety disorder during their pregnancy or in the first year postpartum. Approximately 75 percent of these individuals are not diagnosed or treated, can lead to potentially grave consequences that range from high-risk pregnancies and poor childhood cognitive development to substance use, self-harm, and even suicide.

Ann M. Sullivan, MD

Stigma poses a formidable barrier to maternal mental health care. Some may feel they are being judged or treated differently following a diagnosis such as perinatal mood and anxiety disorder, and it may lead some to opt out of screenings or treatment – even if they are experiencing symptoms. Those with a history of substance use may also worry about repercussions of a mental health diagnosis, such as their children being removed from their care.

Education and awareness are crucial. By helping birthing people understand the benefits of screening during all phases of pregnancy, we can help reduce this stigma, promote available assistance, and encourage these individuals to accept help.

OMH convened a Maternal Mental Health Workgroup to develop recommendations for perinatal and postpartum mood and anxiety disorders. The workgroup diligently gathered information from subject matter experts and individuals with lived experience and discussed the complex issues facing vulnerable, underrepresented birthing people. The findings are being summarized into a final report that includes proposed recommendations, considerations, and aspirations for improving maternal mental health.

Studies emphasize the importance of utilizing screening tools in pediatric primary care settings as a method to identify and provide support for postpartum mood and anxiety disorders. This year's budget includes funding to integrate behavioral health in OB-GYN offices in underserved communities to improve maternal mental health, providing for vital screenings and access to treatment for pregnant people and new parents through the New York State Collaborative Care Medicaid Program. Like the Collaborative Care approach in primary care, implementing measurement-based mental health and substance abuse treatment in OB-GYN offices is critical. Currently, there are 24 OB-GYN practices enrolled in the New York State Collaborative Care Medicaid Program for which OMH provides technical implementation assistance and training to practices

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Expanding Perinatal Mental Health Care in NYC: Advancing Equity and Family Well-Being

By Fatima Kadik, MA,
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Perinatal and Early Childhood Mental Health Programs, NY City Department of Health and Mental Hygiene

Perinatal mental health—the emotional and psychological well-being of individuals during pregnancy and the postpartum period—is a growing public health concern. In New York City, behavioral health conditions are among the leading underlying causes of pregnancy-related deaths.

According to the New York City Maternal Mortality Review Committee (MMRC), mental health conditions (defined as including overdose and suicide) accounted for 18.7% of pregnancy-associated deaths in NYC from 2016-2020 (Pregnancy-Associated Mortality in New York City, 2016-2020). Of these deaths, overdose accounted for 75.6% of pregnancy-associated deaths, with more than 76% involving opioids. This underscores the urgent need for early identification, intervention, and treatment of perinatal mental health and substance use disorders.

To address some of these challenges, the New York City Department of Health and Mental Hygiene is expanding access to perinatal mental health care through its Perinatal + Early Childhood Mental Health (P+ECMH) Network clinics and its Training and Technical Assistance Center (TTAC). These efforts aim to improve early support for parents and reduce health disparities, building upon broader initiatives like New York City's HealthyNYC campaign, which targets reducing drug overdose, suicide, and maternal mortality.

Prioritizing Health Equity in Perinatal Mental Health Services

Too often, racial and socioeconomic disparities shape who receives care (Krishnamoorthi et al., 2023). Black and Latina women and birthing people are more likely to experience higher rates of perinatal mood and anxiety disorders but are less likely to receive adequate treatment (Kozhimannil et al., 2011). The Health Department's expanded services aim to change that by focusing on four key strategies:

- **Expanding Outpatient Clinics** – Additional perinatal mental health supports are being integrated into outpatient clinics across all five boroughs through the NYC P + ECHM Network. These clinics will provide culturally competent and linguistically inclusive care to ensure accessibility for pregnant and parenting people and their partners.

- **Increasing Workforce Training** – Through the TTAC perinatal expansion, the Health Department is funding

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Confronting Racial Inequalities in Maternal Mental Health in Indigenous Women

By Mary Banahan, MS, PA-C
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It is well known that Indigenous populations such as Native Americans (N.A.) often have limited access to healthcare and suffer from health disparities and inequities in care. This is especially true of N.A. women suffering from maternal mental health issues such as postpartum depression (PPD) (Margerison et al., 2021). According to the CDC, PPD occurs in approximately 1 in 8 women, with the incidence increasing to 1 in 5 depending on the state and race/ ethnicity of the mother ("Depression Among Women", 2020). It is also the most common complication associated with childbirth. While the prevalence of PPD in all women in the U.S. is about 11%, the prevalence of PPD in American Indian/ Alaska Native women is much higher at 14%-29.7% (Heck, 2021). Maternal suicide is also a significant issue with increasing rates over the last several years, and these deaths have been more commonly found than those from maternal hypertensive disorders or from postpartum hemorrhage (Palladino et al., 2011). Deaths from maternal suicide also demonstrate ethnic and racial disparities, with N.A./Alaska Native women at much higher risk-almost 3x higher- than non-Hispanic white women who are also at higher risk compared to their Hispanic, non-Hispanic Black and non-Hispanic Asian/ Pacific Islander counterparts (Margerison et al., 2021). With the effects of PPD on the mother to include issues with physical and mental health, relationship issues including mother-infant bonding, and infant effects to include problems with growth and development and cognitive and behavioural issues, recognizing and treating these mothers before lasting effects occur is imperative (Slomian et al., 2019). O'Connor et al. (2019) found that screening for perinatal depression may help decrease symptoms of depression and decrease depression prevalence, and that treatment (including medication, counseling, and behavioral therapy) increases the chances of remission in women with PPD.

Increased awareness of perinatal mood and anxiety disorders (PMADs) is vital to changing these statistics. Connecting to Indigenous populations (especially their healthcare providers) can open a dialogue about the importance of supporting new mothers within their communities. Providing knowledge about signs and symptoms, risk factors, screening tools, support

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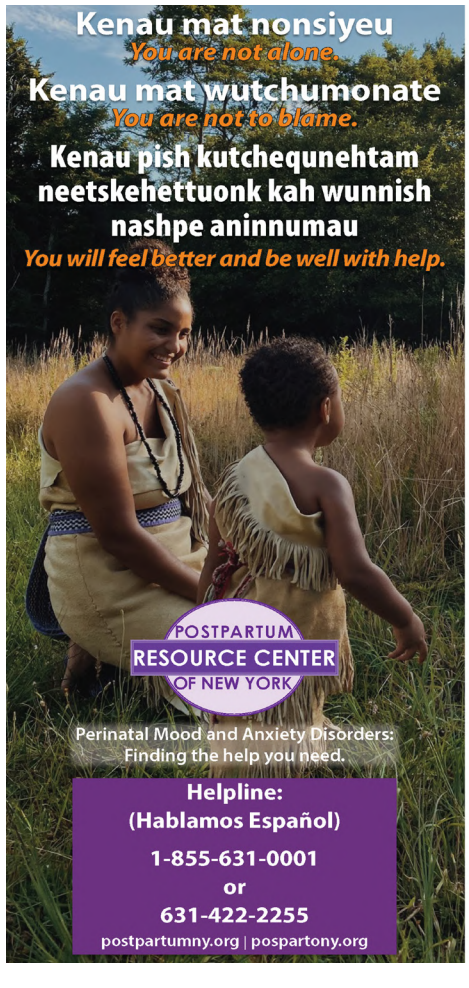

From Silence to Support: How Doula Care Can Destigmatize Maternal Mental Health

By Isabella Hou, MPH
New York State Office of Mental Health

Motherhood is often framed using this narrative of a "strong mother"—of self-sacrifice, resilience, perseverance, and unwavering devotion. They are expected to give endlessly, to find joy in every sleepless night, and to cope quietly with the unexpected realities of their new identity. While this narrative is often celebrated and even romanticized, it leaves little room for acknowledging the very real mental health challenges that many birthing people face.

In reality, maternal mental health conditions are incredibly common, with one in five birthing people experiencing a perinatal mood and anxiety disorder (PMAD) such as depression, anxiety, post-traumatic stress disorder, and psychosis.[1] Among communities of color, these numbers are even more alarming, as Black and Indigenous individuals are more likely to experience maternal mental health issues but less likely to receive care.[2] Despite its prevalence, maternal mental health remains shrouded in silence and shame. New parents are expected to push through their struggles, perpetuating this harmful belief that seeking help is a sign of weakness or failure.

Recently, there has been a shift towards integrating maternal mental health support in non-traditional healthcare settings. In particular, doulas have become powerful allies in improving maternal outcomes by providing emotional, educational, and physical support during pregnancy, childbirth, and the postpartum period. In fact, a 2022 study by Falconi et al. showed that women who received doula care during childbirth had roughly half the odds of postpartum depression or anxiety compared to those who did not receive doula care.[3] As non-clinical professionals, doulas are uniquely positioned to close gaps in maternal mental health care by destigmatizing conversations and normalizing help-seeking.

How Doulas Can Help Destigmatize Mental Health[4]

- **Creating safe spaces for expressing vulnerability:** Oftentimes, birthing individuals are reluctant to admit that they're struggling out of fear of being dismissed or labeled as a "bad parent." By building close, trusting relationships that are rooted in open communication and respect, doulas create spaces where birthing individuals feel supported enough to share their fears and worries without judgment.

- **Raising awareness and providing education:** Doulas can help address myths and misconceptions around maternal mental health conditions by educating birthing individuals on what to expect during the perinatal period. For example, hormonal dips following childbirth can lead to mood swings, exhaustion, and feeling overwhelmed—commonly known as the "baby blues." These changes are typical during the first two weeks, although they can escalate into serious mental health conditions.[5] Especially in communities of color where conversations around mental health can be taboo, doulas can normalize these

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Project TEACH: A Perinatal Psychiatry Access Program Transforming Maternal Mental Healthcare in New York State

By Kristina M. Deligiannidis, MD
Medical Director, Reproductive Psychiatry, Project TEACH NY

Maternal mental health conditions are one of the most common complications of pregnancy and birth, affecting one in five perinatal individuals (1,2) and 800,000 families annually in the United States, with 75% of those affected remaining untreated or undertreated (2). Mental health conditions are the leading cause of maternal mortality in the United States, accounting for 22% of pregnancy-related deaths, with suicide and overdose being the leading causes of death in the first year following pregnancy (3). In New York State, 15% of all pregnancy-related deaths were due to mental health conditions, with 12.2% of all pregnancy-related deaths due to suicide; all pregnancy-related deaths due to mental health conditions were considered preventable (4). The economic impact is also staggering, with untreated maternal mental health conditions costing an estimated $32,000 per mother-infant pair, totaling at least $14 billion annually in the United States (5) and an estimated $997 million in New York State (inclusive of all maternal mental health conditions) of which $598 million is from untreated/undertreated perinatal depression alone (3,5,6).

Untreated maternal mental health conditions are associated with poor prenatal self-care and increased rates of gestational diabetes (7), hypertensive disorders of pregnancy (8) and surgical delivery interventions (9), inadequate maternal-infant bonding (10), poor infant-feeding outcomes (11), and impaired child cognitive, behavioral and emotional development (12). Perinatal individuals of color and those with low incomes are both more likely to experience maternal mental health conditions and less likely to access treatment. High-risk populations include military service members and their spouses, immigrant women, and those lacking social support (2). These disparities underscore the critical need for accessible, culturally responsive care delivery models. The provider shortage worsens these challenges dramatically. Fewer than 500 psychiatrists in the United States are trained in reproductive/perinatal mental health to serve the 800,000 individuals who experience maternal mental health complications annually.

This treatment gap has created an urgent public health crisis that demands innovative, scalable solutions. Perinatal Psychiatry Access Programs have appeared as a transformative approach to bridging the gap, with programs like New York State's Project TEACH leading the way in expanding access to essential mental healthcare services.

Understanding Perinatal Psychiatry Access Programs

Nationally, Perinatal Psychiatry Access Programs are population-based interventions designed to increase the ability of frontline healthcare providers—including obstetrical providers, pediatricians, family physicians, and even psychiatrists—to effectively identify, assess, and treat maternal mental health conditions. These programs recognize a fundamental reality: pregnant and postpartum individuals have

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The Silent Barrier: How Fear of Judgment from Healthcare Providers Keeps People from Seeking Help

By Michiko B. Andrade
Bailey Andrade Consulting, LLC.

When stigma enters the exam room, patients can feel judged, dismissed, or misunderstood by their providers—creating barriers to honest conversations and quality care.

What if the person meant to help you was the one you feared most? Imagine sitting in an exam room, fidgeting with your cell phone, scrolling through apps, and trying to distract yourself from the anxiety building inside. You are aware of the antiseptic smell lingering in the air, but it's drowned out by the voice in your head rehearsing how to describe the new medication side effects, without sounding non-compliant. Across the room, the medical provider's fingers peck at the keyboard and eyes fixed on the screen, while you continue with 'unfocused swipes' on the cell phone. When the medical provider finally turns from the computer and asks how you are feeling, you hesitate. The words feel heavy, and instead of voicing your genuine concerns, you nod and say you are fine, letting the moment—and your chance for help—slip *quietly* by.

This moment is more than uncomfortable—it is a pivotal moment that affects not just your health, but the well-being of families, communities, and the entire public health system. When fear of judgment silences patients, illnesses go undiagnosed, treatments are delayed, and the ripple effects can touch everyone. Stigma—*those negative attitudes and stereotypes*—can turn a place of healing into a source of anxiety and silence, with consequences that reach far beyond the exam room.

What Stigma Looks Like in Healthcare

Stigma in healthcare is not always obvious. It can be as subtle as a dismissive glance or as overt as a harsh comment about a patient's beliefs or lifestyle. Research from 2024 reveals that patients who share health misconceptions or non-mainstream beliefs with their doctors often feel judged, and with good reason. A study from the Stevens Institute of Technology found that both doctors and laypeople tend to view patients more negatively when they express mistaken health beliefs, leading many to withhold even reasonable concerns out of fear of being looked down on (News-Medical, 2024).

The negative judgment or stigma from healthcare providers does not only happen to people who have uncommon or unconventional health beliefs. It also happens to people with common but stigmatized health conditions. People with mental health conditions, substance use disorders, or eating disorders often report feeling devalued, dismissed, or dehumanized by healthcare professionals. The result? Many choose silence over honesty and delay or avoid seeking care altogether.

The Real-World Impact: Statistics from 2024–2025

The consequences of stigma and fear of judgment are measurable and something to think about:

- **30% of adults with eating disorders** reported seeking medical help, with perceived stigma from healthcare professionals strongly linked to more severe illness (Marlais et al., 2025).

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* These services will launch in August, 2025.

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Project TEACH is funded by NYS OMH

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Improving Safety with Technologies in Maternal Mental Health

By InvisALERT Solutions

Maternal mental health is increasingly recognized as a cornerstone of family well-being and a critical area for innovation in modern healthcare. Each year, thousands of women experience perinatal mood and anxiety disorders (PMADs), including postpartum depression, anxiety, and postpartum psychosis. These conditions don't just affect mothers- they can influence infant development, partner relationships, and long-term family dynamics.

While healthcare staff have long focused on the physical aspects of childbirth, the mental health component is gaining long-overdue attention. As healthcare systems seek to provide more modern maternal care, data-driven tools and hospital safety technologies are playing an expanding role in identifying risk, supporting early intervention, and improving outcomes.

Understanding the Scope of Maternal Mental Health

According to the Centers for Disease Control and Prevention (*CDC, 2024*), about 1 in 8 women with a recent birth report experiencing symptoms of postpartum depression. While postpartum depression is the most discussed, conditions range from generalized anxiety and obsessive-compulsive behaviors to more acute disorders like postpartum psychosis. Postpartum psychosis requires immediate clinical attention due to its severity and potential risks to both the mother and infant (ACOG, 2023a; 2023b).

Left untreated, these conditions can significantly impact a mother's ability to bond with her infant, increase the risk of complications like substance misuse or suicide, and create long-term developmental risks for children. Early detection and proactive, compassionate intervention are vital.

Ensuring Mental and Physical Safety in Postpartum Care

Physical health and mental health are deeply interconnected, particularly in the postpartum period. Women recovering from childbirth often deal with fatigue, pain, and hormonal fluctuations that increase both the risk of emotional distress and physical accidents, such as falls.

Innovative safety technologies originally developed for psychiatric and high-risk units are now being adapted to support postpartum care. SMARTsense, a sensor-based monitoring system, detects patient movements like getting out of bed or entering the bathroom. The system alerts staff to movement that may signal a fall risk, especially important at night or for mothers recovering from cesarean sections. All accomplished without using intrusive cameras,

For patients navigating both physical recovery and PMAD symptoms, this kind of discrete, non-invasive monitoring is more than a safety measure. It promotes privacy, dignity, and swift staff response – all of which can reduce stress, anxiety, and support emotional recovery.

Real-Time Observations for High-Risk Situations

In critical cases, mothers may enter a mental health crisis during or after childbirth. Conditions like postpartum psychosis require urgent, around-the-clock monitoring to ensure the safety of the mother and her infant.

Here, technologies such as ObservSMART360 provide real-time patient observation and alerts. This system gives you access to patient location, monitors for unsafe behaviors like elopement or aggression, and alerts supervisors for a prompt, immediate staff response when someone enters restricted areas or demonstrates high-risk behaviors.

Though ObservSMART was not originally designed for maternity units, its use in the mental health and behavioral care settings has direct applications in postpartum safety. Hospitals can apply similar tools to ensure timely intervention for mothers exhibiting symptoms of acute distress, delusion, or disorientation.

Standardizing Care with Protocol-Based Support

Consistency is key when managing complex conditions like PMADs, especially across different shifts and staffing levels. The Protocols application enhances hospital workflows by embedding prompts and reminders into the care routine, ensuring that mental health screenings, fall risk assessments, and behavioral observations aren't skipped or delayed.

These checklists are particularly useful in postpartum units, where the line between physical recovery and psychological need is often blurred. By managing healthcare compliance and alerting nurse managers to deviations or delays, Protocols supports early action and reinforces a culture of accountability and comprehensive care.

Combining Behavioral Data with Dashboard Insights

The potential to integrate safety technologies like ObservSMART, 360, SMARTsense, and protocols with maternal health dashboards is an exciting frontier. By feeding real-time behavioral observations into predictive systems, hospitals can develop a data-driven view of each patient's risk profile.

Imagine a dashboard that not only notes a mother's reported mood, but also includes sleep disruptions detected by sensors, missed meals, or pacing behaviors – all possible early indicators of postpartum anxiety or depression. These nuanced signals, often missed in routine assessments, could trigger early outreach from mental health staff or social workers.

Such integration aligns with the broader goal of proactive rather than reactive care, addressing maternal mental health needs before symptoms escalate into emergencies.

Looking Ahead: A Smarter, Safer Postpartum Future

Maternal mental health is not a niche concern – it's central to the health of families and communities. As awareness of PMADs continues to grow, so does the opportunity for healthcare innovation. Data dashboards, predictive analytics, and integrated safety technologies represent a new frontier in postpartum care – one that is smart, safer, and more attuned to the full spectrum of maternal needs.

While platforms like ObservSMART, 360, SMARTsense, and Protocols may have originated in behavioral and psychiatric units, their capabilities are increasingly relevant in acute care, including maternity care. When combined with thoughtful protocols and compassionate human interaction, these tools can transform how we support mothers, helping to identify mental health challenges earlier and respond more effectively to promote healing.

For additional information or questions regarding this topic, visit www.obsservsmart.com.

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Findings from New York State's Report on Postpartum Depression Screening

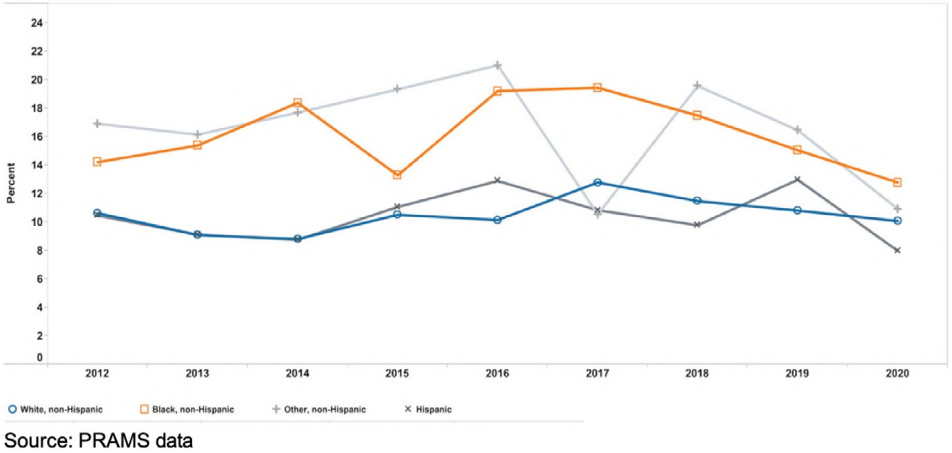
By Amy Ehntholt, ScD
Research Scientist
NYS Office of Mental Health

Postpartum depression (PPD)—the most common perinatal mood and anxiety disorder—is a debilitating condition affecting at least one in eight people who give birth. PPD is more than just the "baby blues." It is a more severe mood disorder that can last for many months. PPD may impair a person's ability to function, care for their baby, or maintain their health and relationships. Despite longstanding screening recommendations and available treatments, postpartum depression remains underdiagnosed and undertreated, particularly for marginalized populations.

Postpartum Depression in New York State

A recent legislatively mandated report from the New York State (NYS) Office of Mental Health (OMH) and Department of Health (DOH) provides a review of postpartum depression prevalence, screening, and risk factors in NYS. Its findings expose disparities in prevalence as well as gaps in postpartum screening and care, and opportunities for improvement.

The report relies heavily on PRAMS (Pregnancy Risk Assessment Monitoring System) data for estimates of PPD prevalence, screening, and provider identification. The CDC-sponsored PRAMS has been a valuable population-based risk factor surveillance program since the 1980s, surveying a representative sample of individuals who recently delivered a live-born infant, asking respondents about their experiences before, during, and after pregnancy.



Source: PRAMS data

Figure 1. Percentage of women reporting depressive symptoms after giving birth, by race and ethnicity (NYS, 2012-2020)

According to NYS PRAMS data for 2020 (the most recent year available at the time of OMH-DOH report publication), roughly 10% of postpartum New Yorkers reported depressive symptoms. Consistently since 2012, higher percentages of self-reported PPD have been seen among racial and ethnic minoritized populations (see Figure 1) and among people of lower socioeconomic status.

Of the New Yorkers reporting PPD in 2020, only 34% indicated that they were told by a healthcare provider that they had depression—an alarming gap that signals missed opportunities for care.

A recent analysis of PRAMS data from the years 2017-2022, published in the journal *Psychiatric Services*, allowed for a deeper exploration, examining this discrepancy by race and ethnicity (Figure 2). Among over 12,500 New Yorkers who had recently given birth, self-reported depressive symptoms were significantly higher for those identifying as non-Hispanic Black (17%) or non-Hispanic "other" (17%) compared to non-Hispanic White (11%) and Hispanic (10%) individuals. Provider identification of PPD among depressed individuals was even more skewed: Just 17% of Hispanic respondents and 19% of non-Hispanic "other" respondents who self-reported PPD symptoms said a provider had diagnosed them, compared to 36% of non-Hispanic White respondents.

This mismatch between symptom reporting and clinical identification suggests systemic shortcomings in how PPD is assessed and might reflect broader social and structural factors, including socioeconomic status, access to care, provider bias, and historic mistrust in the healthcare system.

Disparities in Postpartum Mental Health Care

This analysis of NYS PRAMS data also exposes inequities in postpartum mental

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Confronting Mental Health Stigma in Maternal Care

By Karin Wagner, PhD
Lead, Strategic Plan for
Mental Health Stigma Reduction
NYS Office of Mental Health

Mental health stigma—those persistent negative attitudes, beliefs, and stereotypes about mental illness—remains a powerful barrier to care. When these perceptions translate into actions in our society, they become discrimination, and this limits opportunities for healing. Even though mental health conditions are common, stigma and misinformation continue to fuel judgment, silence, and shame, particularly around maternal mental health.

This stigma can delay or even prevent individuals from seeking help, whether from loved ones or from community-based programs. It can also lead people to abandon treatment prematurely. While stigma is a widespread issue, it can be especially pronounced in rural areas, where privacy is harder to maintain and support systems may be limited.

Understanding the Forms of Stigma

To effectively address mental health stigma, it's important to recognize the different ways it can manifest:

- **Structural stigma** refers to systemic barriers that are embedded in our laws, policies, and institutional practices. These can limit opportunities for people with mental health conditions, particularly in healthcare, housing, and employment settings.
- **Public stigma** encompasses the general population's beliefs about people with mental health conditions, their families, and even the professionals who support them. These beliefs often portray individuals as weak or flawed, reinforcing discrimination and discouraging help-seeking.
- **Self-stigma** occurs when individuals internalize these public attitudes, leading to feelings of shame, self-blame, and diminished hope for their own recovery.

New York State's Commitment to Change

The New York State Office of Mental Health (OMH) is actively working to reduce—and ultimately eliminate—mental health stigma across the state. Through its *Strategic Plan for Mental Health Stigma Reduction*, OMH funds and implements community-based initiatives and collaborates across agencies to support evidence-based approaches. Much of this work is supported by the Mental Health Stigma Tax Check-off Fund.

OMH's mission is clear: stigma undermines the effectiveness of mental health and housing programs by making communities less receptive to services and discouraging individuals from seeking care. Reducing stigma is essential to building inclusive, supportive environments where recovery is possible.

What Works: Evidence-Based Approaches

Research shows that the most effective stigma-reduction strategies are "contact-based" - that is, they involve real people sharing their lived experiences with mental health challenges and recovery. These personal stories humanize mental illness and foster empathy. Other approaches include:

- **Educational campaigns**, which are widely used but may have limited long-term impact unless paired with deeper engagement.
- **Advocacy and protest**, especially when tied to specific events or policy changes, can shift public perception and lead to systemic reform.

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Dismantling Structural Stigmatization Through Organizational Transparency, Accountability, and Leadership

By Gretchen Grappone, LICSW
Training Consultant

In the Summer 2022 edition of Behavioral Health News, my colleague, Jayden Carr, BS, and I wrote an article reviewing the most common forms of stigmatization and their negative effects on people with mental illness and substance use disorders (MI/SUD). The term "stigmatization" rather than "stigma" is used because stigma focuses on and views the person(s) experiencing the discrimination as tainted, while addressing stigmatization focuses on dismantling the harmful behavior of the perpetrator(s) of discrimination (Bowleg, 2022). The article highlights the importance of acknowledging the social injustices that can create and maintain both MI/SUD stigmatization and the inequities in accessing and receiving treatment for MI/SUD (Shim & Vinson, 2021). Three years later, it remains crucial to address stigmatization through an intersectional lens. Recent data (NYC Epi Data Brief, 2024) show that while overdose deaths decreased among White New Yorkers, they continued to increase among Black residents of New York and remain high among Latinx individuals. Rates of overdose deaths also differ by gender, as indicated by a decrease in men's overdose death rate and an increase in women's deaths (no data was available on non-binary or intersex New Yorkers). Among adults in NYC, those who identify as lesbian, gay, or bisexual report more psychological distress than straight individuals and people who identify as non-binary, transgender, or another gender identity are two- to three- times more likely to report psychological distress than cisgender New Yorkers (NYC Epi Data Brief, 2025). This underscores the need for organizations to intentionally attend to LGBTQ+-affirming care.

From my work with health care agencies and hospitals over the past decade, what I perceive to be the biggest barrier to addressing stigmatization that causes health inequities is resistance to implementing current best practices for dismantling structural stigmatization. The Mental Health Commission of Canada (MHCC) (2023) has an excellent implementation guide that includes a summary of the key principles for dismantling structural stigmatization. These research-backed principles include acknowledging the intersectional nature of structural stigmatization; avoiding performative actions and tokenism; modeling change from within to spread influence; centering the voices of people with lived experience; embedding change and sustainable results via policy and ongoing training; and redistributing power relationships. There are three additional key principles in the guide that I suggest organizations reflect upon first as they consider strategies to effectively address stigmatization:

1. Get Explicit Support From Senior Leadership

Effectively dismantling stigmatization requires commitment from leadership and a multi-level approach (Knaak et al., 2017) because, as Sievwright et al. (2022) state, "systems of power perpetuate intersectional stigma." This difficult work of addressing institutional and policy-level stigmatization requires organizations to assess

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Supporting Maternal Mental Health and Reducing Stigma: A Clinical Perspective

By Glen P. Davis, MD
Chief Medical Officer
Institute for Community Living (ICL)

Becoming a mother is a beautiful and rewarding experience, but it comes with a set of challenges that often go unrecognized. Maternal mental health is a critical dimension of perinatal care that is often overlooked amid the focus on the physical aspect of pregnancy. During the perinatal period, expecting mothers are presented with biopsychosocial challenges and are sometimes more vulnerable to mental health disorders such as anxiety, mood disorders, and, in the most extreme cases, postpartum psychosis or mania. Although there is a growing understanding of perinatal psychiatric illness, many women continue to face stigma when seeking treatment that hinders identification and treatment of perinatal mental health disorders. Mental health professionals must enhance support for maternal mental health and actively dismantle stigma that adversely affects both mothers and children.

Maternal Mental Health and Clinical Implications

Maternal mental health challenges can significantly impact maternal functioning, trajectories of child development, and family dynamics more broadly. According to Gavin et al., postpartum depression ranges from 10% to 20% across the globe, yet underreporting surely underestimates an accurate prevalence of this condition. Hormonal fluctuations, sleep deprivation, psychosocial stress of new parenthood, and previous psychiatric history can all contribute to the complexities of perinatal mental illness. Stein et al. have shown that untreated perinatal depression can impair maternal-infant bonding, contributing to negative cognitive and emotional outcomes in newborns. Early recognition and intervention are imperative for maternal recovery and to ensure positive long-term outcomes for offspring.

Stigma as a Barrier to Perinatal Mental Health Care

As with all mental health disorders, stigma is a pervasive barrier for mothers seeking treatment for perinatal mental health disorders. Thornicroft and colleagues have pointed out that the inherently joyful idealization of motherhood by society sometimes invalidates the distress that many mothers may experience during pregnancy and after childbirth. Some mothers may internalize feelings of shame and fear judgment by others. Fear of punitive consequences such as custody concerns may pervade the consciousness of mothers who are suffering symptoms of mental illness related to pregnancy and motherhood.

Unfortunately, as Letourneau and colleagues have pointed out, even healthcare systems can perpetuate stigma surrounding perinatal mental health concerns. It is essential for mental health professionals to foster a nonjudgmental rapport with expecting mothers and new mothers, normalizing screenings for mental health as standard practice to reduce stigma.

Interventions and Approaches to Support Maternal Mental Health

1. **Universal screening and assessment** for mood and anxiety symptoms should be administered during every prenatal and postpartum visit (Gaynes et al., 2005). Valid, reliable tools such as the Edinburgh Postnatal Depression Scale (EPDS) can help with early detection, appropriate triage, and treatment.

2. **Integrating mental health services into primary care treatment**, with collaboration among obstetricians, psychiatric providers, and social workers, can improve access to mental health services for mothers both pre- and post-labor.

3. **Psychotherapeutic interventions** such as cognitive behavioral therapy (CBT), interpersonal therapy, and mindfulness-based methods have been shown to be effective in treatment for perinatal depression and anxiety (Dennis and Chung-Lee, 2005). Psychotropic medication may be helpful for moderate to severe cases with careful, balanced consideration given to the risks and benefits of medication and their potential fetal and neonatal effects.

4. **Peer specialist involvement** in maternal mental health treatment can help reduce feelings of isolation. Including family in treatment can strengthen support networks for new mothers (Leach et al., 2016).

5. **Advocacy** by mental health clinicians for policies like sufficient paid parental health and workplace accommodation can support the well-being of new mothers.

Professional Responsibility to Reduce Stigma

Mental health professionals must approach evaluation and treatment of perinatal and postnatal mental health care through a trauma-informed lens. Language matters, and providers should validate patients' experiences without reinforcing stereotypes that perpetuate stigma. Educational programs within healthcare delivery systems can enhance providers' knowledge, attitudes, and practices with regard to perinatal mental illness. Vigilant self-reflection on implicit bias can also improve patient-provider relationships and improve outcomes for mothers and newborns (Corrigan et al., 2012).

Effect of Maternal Mental Health on Child Mental Health

Peri-natal and post-natal mental health challenges can have intergenerational consequences, as lack of treatment can contribute to increased risks of psychiatric conditions in children (Stein et al., 2014). Addressing maternal mental health is of clinical importance as a population health priority, potentially mitigating downstream burdens on society.

Conclusions

Effectively addressing maternal mental health requires a multidisciplinary, evidence-based approach. Integration of routine, standardized screening for mental health conditions during the pre-natal and post-natal periods, offering evidence-based interventions to treat maternal mental health disorders, and advocating to reduce stigma surrounding perinatal mental health care can improve maternal and child outcomes. Reduction of stigma is essential to foster recovery, contributing to healthy families and communities.

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ICL's Emerson-Davis Family Center

Institute for Community Living's (ICL) Emerson-Davis Family Center is an innovative program that offers permanent and transitional housing to parents who have experienced homelessness, are experiencing mental health issues, and who are at risk of losing custody or are seeking to be reunified with their children.

Emerson-Davis provides 24/7 support, including

- *Comprehensive case management services*
- *Trauma-informed, in-home family support services to promote independent living skills*
- *Tutoring*

By offering stable, affordable housing and on-site supportive services, ICL has helped more than 74% of our clients in this program reunify or remain with their children.

"I Should Be Able to Handle This": How Internalized Stigma Silences Moms

By Ashley Womble, MPH, PMHC
Sr. Director, Marketing & Public Affairs
Brave Health

There's a shared assumption in health care that if we make services more accessible, patients will use them.

It's the foundation of many well-intentioned interventions: Add depression screening to the six-week postpartum visit, embed a therapist in the OB/GYN clinic, expand access through telehealth—and mothers will use these services.

But when it comes to maternal mental health, access is only half the battle. Even when screening tools flag symptoms. Even when a therapist is just a few clicks away. Even when a provider offers help in a warm, nonjudgmental way—internalized stigma can stop a mother from saying yes.

It's Not Just Stigma—It's Identity

When we talk about stigma, we usually think of external judgment. Internalized stigma happens when we absorb cultural narratives about mental illness and motherhood—and turn them inward. It's different from the fear of being judged by others. It's the fear that those judgments are *true*.

For mothers, that lie hits especially hard—because it messes with our core identity. We've been taught that a "good mom" takes care of everyone in her orbit, selfless and emotionally bulletproof. Social media has created distorted windows into the lives of effortlessly perfect moms—and punishes those who fall short. For every mom influencer with a picture-perfect feed, there's a comment thread somewhere tearing her down.

So when anxiety, depression, or rage show up—alongside sleep deprivation, hormonal chaos, and identity whiplash—it doesn't feel like an illness. It feels like a personal failing.

As a mother who works in mental health, I know this kind of thinking is irrational. And yet, I've had it myself.

I've lived with major depression most of my adult life, and when I became pregnant, I felt a different, deeper kind of shame—not because I needed help, but because I needed to *stay* on antidepressants. Even though I knew the science, even though I trusted my psychiatrist, part of me still believed that a "good mother" should be able to go without.

That's the cruel power of internalized stigma. It doesn't matter how much we know. It's what we *believe* about ourselves that shapes our decisions.

We're Making Progress—But Mothers Can't Wait

Over the past few years, the federal government has taken critical steps to finally start treating maternal mental health like the public health crisis it is. The launch of the National Maternal Mental Health Hotline in 2022 was a turning point—finally, there was a free, 24/7 resource where mothers could reach out and hear, "What you're feeling is real, and you're not alone."

But we can't afford to let this progress unfold slowly. Maternal mental health conditions—including suicide and overdose—are now the *leading* causes of pregnancy-related death in the United States, responsible for nearly 20% of maternal

see Internalized Stigma on page 36

NYSPA Report - Biomarkers for Perinatal Mood and Anxiety Disorders: A Way to Reduce Stigma

By Lauren M. Osborne, MD
Associate Professor of Obstetrics & Gynecology and of Psychiatry, Vice Chair of Clinical Research in OB-GYN
Weill Cornell Medical College

The numbers are so depressing. The United States has the worst maternal mortality of any developed country, with a racial disparity that is shocking.[1] Mental health conditions are one of the leading causes of pregnancy-related death – in some places, THE leading cause.[2] We do a dismal job of identifying, evaluating, diagnosing, and treating mental health disorders, with the dispiriting estimate that only 3-6% of women with perinatal depression are treated to remission.[3]

There are many reasons for this grim picture. Insurance reimburses poorly for mental healthcare, and screening for perinatal mood and anxiety disorders (PMADs) is often overlooked in the reimbursement landscape.[4] Clinicians in both obstetrics and psychiatry are insufficiently trained to recognize and treat reproductive psychiatric disorders.[5] Systemic and structural racism, and the uneven resources that result, lead to imbalances in care.[6] And pregnant and postpartum women themselves are often reluctant to acknowledge their symptoms and to seek treatment – in part out of a desire to protect their infants from harm (though we now know that most psychiatric treatments, including medication, can be compatible with pregnancy and lactation).[7]

Looming large in each of these problem areas is the issue of stigma. Clinicians and patients alike are affected by societal standards assuming that pregnancy should be a happy time, and that women are bad mothers or failures if their mental health is less than ideal in this period.[8] Stigmatizing attitudes are perhaps an even more difficult issue to tackle than insurance issues, lack of education, and uneven resources, as they are often connected to long-held views that are based on belief and not evidence, and can thus become entrenched. While there are many tools to combat stigma (including making substantial changes to all of the issues mentioned above), one that is less dwelt on is the potential role of biomarkers and increased understanding of the pathophysiology of PMADs.

For many medical conditions, advances in our scientific understanding of disease have already reduced stigma and increased acceptance. Epilepsy is one such example – a disease that used to lead to shunning and ostracism and that is now much more likely to be accepted as a neurological disorder that can be effectively treated. [9] The advance of EEG and MRI technologies has given us the tools to find reliable biological signatures of seizure disorders, in turn leading to increased acceptance. But what do we have for PMADs? Differential EEG signatures have not been explored, though there are increasing attempts to do so in non-perinatal disorders. Brain imaging reveals consistent differences between the postpartum brain and that of non-perinatal women, but we are only beginning to tie this to psychiatric disorders, and the logistics of enrolling pregnant women in imaging studies are complicated. [10] Genetic studies have yielded some signatures of postpartum depression, but only in those whose illness begins in the first few weeks postpartum.[11]

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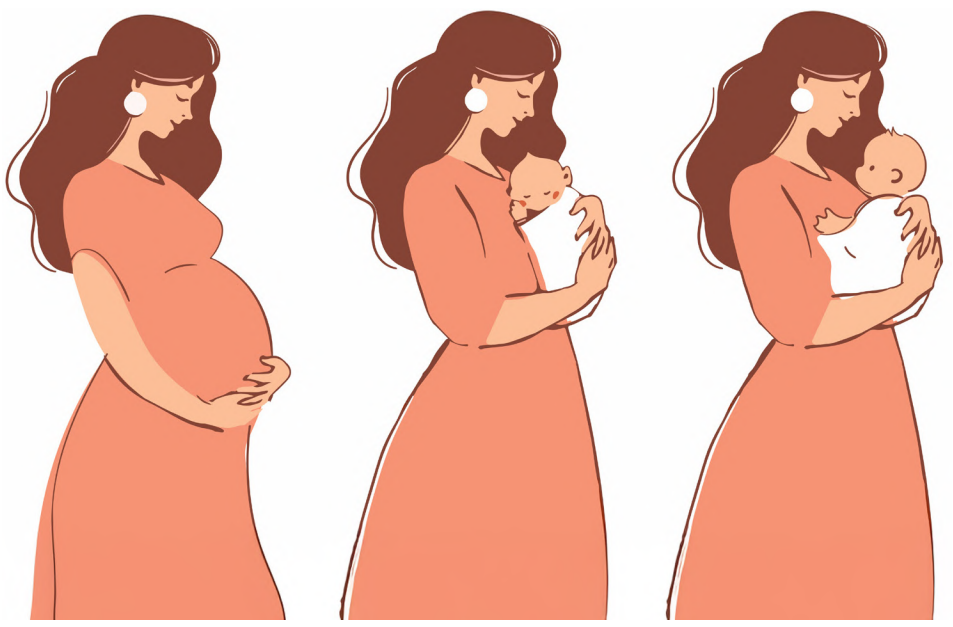
Generations of Motherhood: How Mental Health Changes Over Time

By Libby Erickson, DO
Psychiatrist
Family Care Center



One in five mothers is affected by a mental health condition, and 75% of women impacted by maternal mental health conditions remain untreated, increasing the risk of long-term negative impacts on mothers, babies, and families. [1] The effects aren't just heartbreaking; they're far-reaching. When a mother is struggling, her well-being and her child's development can both be at risk.

Yet, when we talk about maternal mental health, the focus is usually limited to the postpartum period. But for many women, the emotional roller coaster begins long before a baby arrives and continues long after.

Motherhood isn't a single chapter; it's a lifelong journey. From trying to conceive to raising children to becoming an empty nester, each stage brings its own challenges. Yet most mental health support is centered on the weeks and months after birth, leaving many women unseen and unsupported.

While postpartum depression and anxiety deserve urgent attention, they're only part of the picture. A mother's journey may begin with the stress of infertility, miscarriage, or even the pressure to become a mother. It can continue through the daily demands of parenting, the complex emotions of watching children grow up, and the identity shifts that come after the kids leave home.

It's time to recognize maternal mental health for what it truly is: a lifelong journey. Each stage brings its own set of challenges, and every phase deserves to be seen, heard, and supported.

Before Motherhood: The Silent Struggles

For many women, mental health challenges connected to motherhood start before the baby is born. Some face pressure to get pregnant by a certain age, especially in their late 20s or 30s. Others wrestle with infertility, pregnancy loss, or the emotional toll of fertility treatments. Those unsure about becoming parents may feel guilt or shame in a culture that values traditional family roles. All of these experiences can trigger anxiety, depression, and deep stress. But because they happen before birth—or even before pregnancy—they're often overlooked.

Mental health needs during this phase are often complex and deeply personal. Women may need space to grieve a loss, process conflicting emotions, or simply talk through their feelings without judgment. The pressure to make the "right" decision or follow a certain timeline can be isolating, especially when it feels like everyone else is moving forward effortlessly.

Talking to a therapist, joining a support group, or connecting with a provider who understands reproductive and perinatal mental health can help offer meaningful guidance during this time.

Navigating Pregnancy, Childbirth, and Caring for a Baby

Pregnancy is often described as a joyful time, but it can also be deeply overwhelming. Concerns about the baby's health, fears around childbirth, and intense physical and hormonal changes can leave many women feeling emotionally depleted. For some, pregnancy may worsen pre-existing mental health conditions such as anxiety, OCD, or bipolar disorder.

Even in a healthy pregnancy, the pressure to feel constantly happy can make it difficult to talk about emotional struggles. Many women hesitate to share symptoms of depression or anxiety for fear of being judged—so they stay silent. However, the reality is that maternal depression occurs as frequently during pregnancy as it does during the postpartum period.[2]

Then, once the baby arrives, new challenges emerge. Hormonal shifts, sleep deprivation, and the demands of caring for a newborn can trigger or intensify mental health symptoms. While the "baby blues" are common and usually resolve within a couple of weeks, more serious conditions - like postpartum depression, anxiety, or intrusive thoughts - often require professional support.

Postpartum depression (PPD) alone affects an estimated 10–20% of new mothers worldwide. Characterized by persistent sadness, hopelessness, and a loss of interest or joy, PPD can begin within the first few weeks after childbirth but may surface anytime within the first year.

What many people don't realize is that pregnancy-related depression can start as early as conception and persist long after birth. It's not always talked about, but it should be. No one should suffer in silence. When a woman feels safe to speak up—without shame, fear, or judgment—she's much more likely to get the help she needs.

Early intervention and a well-rounded care plan can enhance maternal outcomes, strengthen the parent-child bond, and foster a healthier, more resilient family foundation.

Comprehensive care plans that include therapy, medication when appropriate, and targeted mental health interventions—not only support a mother's mental health but also address psychiatric factors that impact mother-infant bonding and outcomes. More advanced treatments, such as transcranial magnetic stimulation (TMS), are also available when these approaches are ineffective.

Middle Motherhood: The Mental Load of the School-Aged Years

The school-aged or "middle years" bring a different kind of exhaustion—one that's harder to name and even harder to shake. As children grow, so do their academic, emotional, and social needs. Mothers are not just juggling daily tasks; they are often trying to anticipate them and even head problems off before they happen.

Outside of parenting, this "middle" stage often overlaps with a mother's peak professional years, which adds pressure to succeed at work while staying fully involved at home. The constant planning, organizing, and worrying can often lead to burnout.

Emotional challenges can also arise. Kids may struggle in school, face friendship troubles, or show early signs of anxiety or depression. For moms—especially those with more than one child—the emotional load can be heavy. They're not just holding it together for themselves but for everyone else, too.

Mental health support during this phase isn't just about surviving the chaos. It's about setting boundaries, sharing the load, and rediscovering joy outside of motherhood. Therapy can be especially helpful in this stage—offering a space to process stress, reflect on identity, and develop strategies for both parenting and self-preservation. Support should include not only

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Voices of Hope and Healing: Parental Mental Health Peer Support Program for New York Families

By Sonia Murdock, PMH-C
Executive Director
The Postpartum Resource Center of New York, Inc.

Perinatal mood and anxiety disorders, including postpartum depression (PMADs), are the most frequent complication related to childbearing and a leading cause of maternal mortality in New York State.[1] PMADs affect up to 20% of birthing persons and new mothers. Also, up to 13% of fathers may experience paternal depression.

In the United States, 50%–70% of women with AND (antenatal depression) or PPD (postpartum depression) are undetected and undiagnosed, and nearly 85% go untreated.[2] While undetected, untreated, and under-treated postpartum depression can have a devastating impact on mothers, their infants and children may also be affected. Infants are at increased risk for developmental and motor developmental delays. Untreated, PMADs increase the risk of suicide and infanticide.

Research has shown that women living in poverty are more likely to experience postpartum depression and less likely to receive care. Women of color are at higher risk for postpartum depression due to racism, social determinants of health, and cultural stigma.[3] Underserved families, such as refugees/immigrants and other racial groups, are in need of culturally sensitive, quality maternal mental health resources.

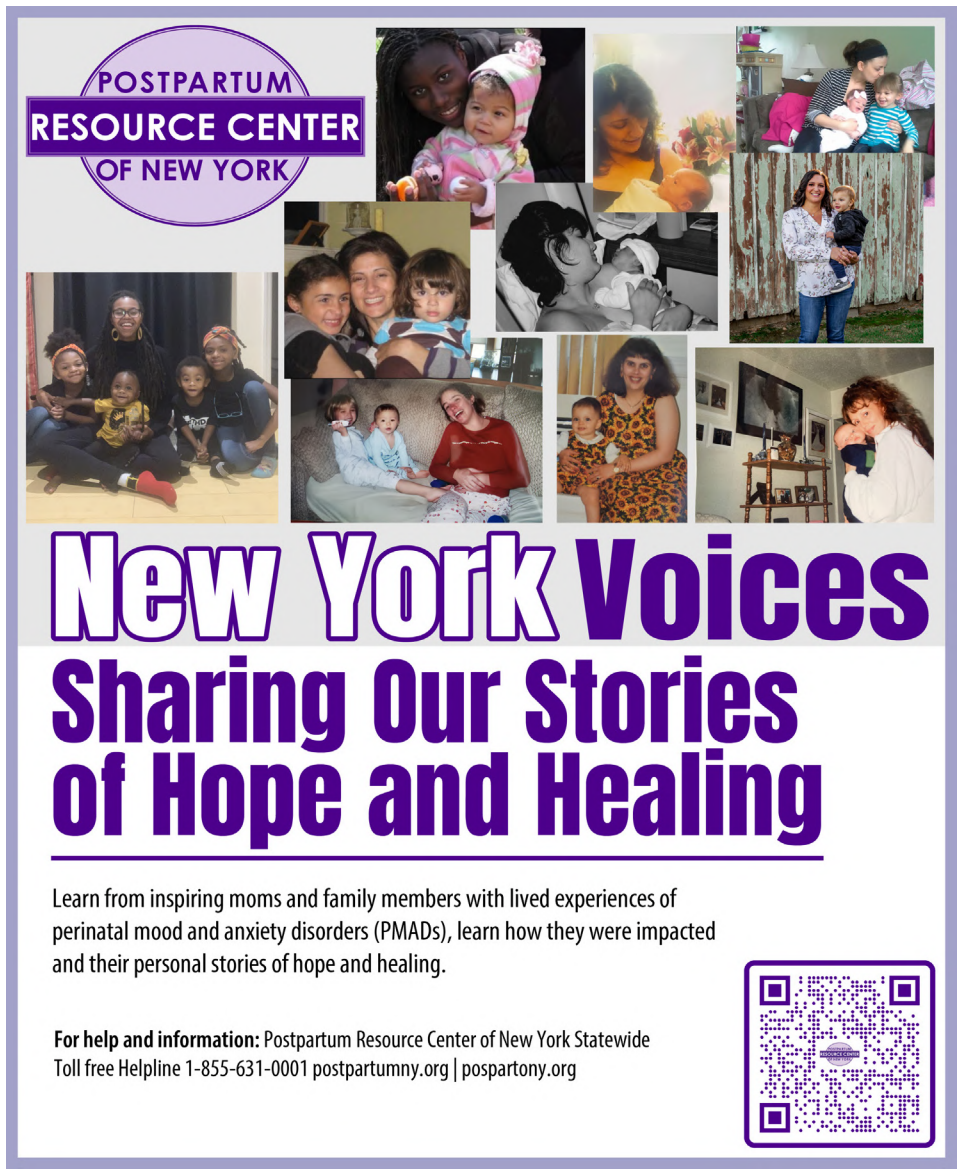
Children of mothers with PMADs are more likely to experience mental health concerns, learning disabilities, cognitive impairment, conduct/behavioral issues, and/or developmental delays. Mothers are reluctant to discuss changes in mental health due to shame, fear that their child(ren) will be removed from their care, substance and alcohol abuse, trauma, and distressing interactions with professionals. The availability of peer support and education lessens stigma and increases help-seeking behaviors.

In an effort to decrease and eliminate preventable maternal mortality and the adverse effects of untreated parental mental illness on parents and their infants and children and our society, it is critical to increase New York State families getting to the help they need for the prevention and early identification and treatment for the recovery of perinatal mood and anxiety disorders (PMADs).

Furthermore, for the prevention of the detrimental effects of undetected, untreated, and undertreated perinatal mental health conditions, the inclusion of peer support should be considered.[4]

The Parental Mental Health Peer Support Program, developed by the Postpartum Resource Center of New York, was created to address the critical need for the availability of peer support for families at risk for or experiencing perinatal mental health conditions. PRCNY's peer support program leverages a team of trained Peer Coaches with lived experience of PMADs who offer multiple channels of peer support to parents-to-be, parents, and their families. The result is that barriers of stigma are reduced and access to quality care is increased.

see Voices of Hope on page 40



Confronting Stigma from page 10

Maternal Mental Health: A Hidden Crisis

Mental health stigma is particularly harmful in the context of maternal health. In fact, the leading complication of childbirth is not physical - it's mental. Perinatal Mood and Anxiety Disorders (PMADs) affect approximately 1 in 5 pregnant and postpartum individuals. Among Black and Brown birthing people, that number rises to 40%.

Despite the prevalence, an estimated 75% of those experiencing PMADs go undiagnosed and untreated—largely due to stigma. The consequences are profound: untreated PMADs can lead to prolonged suffering for the parent, child, and family, and in severe cases, may result in suicide or infanticide.

PMADs encompass a range of conditions, including:

- Depression
- Anxiety
- Panic disorders
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Postpartum psychosis

The economic cost of untreated PMADs

Karin Wagner, PhD

in the U.S. is conservatively estimated at $14 billion annually. Beyond the financial burden, the human cost is immeasurable, impacting families, healthcare systems, and communities.

Reducing Stigma, Expanding Access

So, how can we reduce stigma and improve access to maternal mental health care? Promising strategies include:

- **Educating partners and families** about PMADs and their symptoms to foster early recognition and support. Partners can be an important missing link in engagement.
- **Encouraging active listening and validation** in all maternal care settings—from doulas and lactation consultants to OB/GYNs, community medical practices, and midwives.
- **Integrating mental health services** directly into medical practices to normalize care and increase accessibility.
- **Offering patient navigation services**, which help individuals move through complex healthcare systems and connect with appropriate resources.
- **Embedding mental health screening and counseling** into routine prenatal and postpartum visits.
- **Training the healthcare workforce** across disciplines to recognize and respond to maternal mental health needs wherever they present.
- **Engaging family members and community partners** in care and recovery efforts.

Community Programs Making a Difference

Community-based programs play a vital role in reducing maternal mental health stigma by meeting individuals where they are—both literally and emotionally. Successful models include peer-led support groups that focus on lived experience, home-visiting initiatives like Suffolk County's *Healthy Baby and Me*, and comprehensive treatment centers such as *The Motherhood Center of New York*, which offers a unique Perinatal Day Program, therapy, and support groups for birthing people experiencing PMADs. These initiatives normalize mental health care, foster trust, and increase access—especially when services are culturally responsive and embedded in routine maternal care.

Yet stigma remains a formidable barrier: nearly two-thirds of people with a known mental health condition worldwide do not seek help from professionals, and stigma is associated with a measurable reduction in clinic visits and treatment adherence. On a systemic level, stigma contributes to underinvestment in mental health infrastructure and community resistance to new programs. Public awareness campaigns and statewide collaboratives, such as Perinatal Quality Collaboratives, help shift these perceptions by training providers, promoting screening, and advocating for policy change. Together, these efforts create a more compassionate and stigma-free environment for pregnant and postpartum individuals.

Karin Wagner, PhD, is the Lead for the NYS Office of Mental Health's Strategic Plan for Mental Health Stigma Reduction.

Maternal Mental Health Is Societal Health

By Ashley Brody
Chief Executive Officer
Search for Change, Inc.

An emerging crisis in maternal mental health may be attributed to innumerable causes, many of which have been implicated in other behavioral health crises. Recent epidemics of Suicidality and Substance Use Disorder are the most notable and tragic manifestations of human distress that attend the modern era, and the stressors of motherhood render many women uniquely susceptible to these conditions. Studies of maternal mental health and well-being have revealed significant declines in concert with sociopolitical upheaval, economic volatility, and the Coronavirus pandemic that have dominated the global landscape of the past decade. According to one investigation, 5% of mothers surveyed in 2016 described their mental health as "fair" or "poor." By 2023, this percentage had increased to 8.3%. Only 4.5% of fathers surveyed in 2023 described their mental health in such terms, suggesting mothers bear a disproportionate share of stress related to child rearing, as affirmed by countless studies and widely accepted anecdotal evidence (Pearson, 2025). To balance the demands of employment, motherhood, and countless other responsibilities modern life levies upon women requires exceptional fortitude, even under relatively favorable conditions. For many women, however, conditions for childrearing are decidedly unfavorable. R.D. Laing's depiction of insanity as a sane response to an insane world is perhaps the most apt explanation for the decline in maternal mental health. It also contains a clue to potential correctives that would ameliorate the suffering of women who elect to pursue motherhood and all the joys and challenges it entails.

The U.S. offers a paltry package of publicly funded support services for parents in comparison to other industrialized nations. It ranks 33rd out of the 38 member nations of the Organization for Economic Cooperation and Development (OECD) in spending on childcare and early childhood education, and its parental workplace leave policies are similarly parsimonious (Organization for Economic Cooperation and Development, 2023). Although the Family and Medical Leave Act (FMLA) guarantees parents unpaid leave following the birth of a child and related events, many parents cannot afford to go unpaid, nor can they adapt to the seismic lifestyle changes that accompany the birth or adoption of a child within the 12-week period stipulated in the FMLA. Furthermore, women who manage to balance the competing demands of work and parenthood receive less compensation than their male counterparts and do not enjoy financial returns commensurate with their efforts. Women earn 16% less than men by some estimates, and this economic inequity is demoralizing to many women and compounds the financial stress of parenthood, particularly in the absence of a robust publicly funded safety net (Institute for Women's Policy Research, 2024).

European and other industrialized nations generally offer extensive parental support benefits relative to the U.S., and these benefits are not limited to parents or to employees with caregiving responsibilities. Women in the United Kingdom are statutorily entitled to 52 weeks of leave from their employment following the birth of a child, and their counterparts in Estonia and Croatia enjoy even more generous offerings at 68 and 52 weeks, respectively (Engage Employee, 2025). Other nations' paternity leave policies are similarly progressive and yield proven benefits for fathers and mothers alike. A study of Swedish households revealed a statistically significant correlation between paternity leave and maternal mental health during the first six months of parenthood. It revealed a 14 percent decrease in the likelihood of a mother having an inpatient or specialist outpatient visit for complications related to childbirth and a 26 percent decrease in the likelihood a mother would require anxiolytic medication when their male partners availed themselves of paternity leave policies that enabled them to assume a larger share of childcare responsibilities than would be possible in the absence of these policies (Khan, 2020). Another study of Israeli households revealed a positive relationship between paternity leave and maternal sleep hygiene. This study examined 57 families in which fathers of newborns assumed childcare duties that would otherwise devolve to mothers, presumably as a result of paternal leave policies that permitted greater paternal engagement. Mothers who participated in this study experienced improved sleep hygiene relative to control group participants (Tikotzky et al., 2015). Insofar as sleep hygiene is both predictive of and highly correlated with an array of behavioral health conditions, the salutary emotional and psychological effects of improved sleep are axiomatic.

To segregate the psychological and physical effects of motherhood is to entertain a false dichotomy that has persisted since René Descartes advanced a dualistic view of the human condition several centuries ago. Recent advances in biology, psychology, and related fields of scientific inquiry have largely discredited the concept of dualism, and this is similarly evident in studies of maternal health and mortality. Simply put, maternal mortality rates are correlated with other indicators of maternal health and well-being and are similarly influenced by public policy. The U.S. ranks 55th in the world in maternal mortality, the lowest of any developed nation (World Health Organization, 2023). The state of maternal health and mortality among Black, American Indian, and Alaskan women is particularly dire. Maternal mortality among American Indian and Alaskan women is double that of white, non-Hispanic women, and Black women are three times more likely than white, non-Hispanic women to die of obstetric-related causes or within one year of the end of their pregnancy (Peterson et al., 2019). Such racial disparities are widely attributed to enduring inequities in access to healthcare and social determinants of health among women of diverse racial and socioeconomic status.

Improvements in maternal health and longevity require a reevaluation of public policies that address mothers' economic and social welfare and the countless factors that perpetuate health disparities among women of diverse racial and ethnic backgrounds. The benefits of affordable childcare, ample paid leave, primary and behavioral healthcare services, and quality health insurance are not limited to mothers. They promote the healthy development of children and familial stability. Initiatives that address the Health-Related Social Needs of vulnerable individuals and correct inequities in health outcomes offer considerable promise, provided they do not perish at the hands of policymakers and elected officials on whom they depend.

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America's Hidden Maternal Mental Health Crisis

By Jorge R. Petit, MD
Quality Healthcare Solutions, LLC

There is a quiet but growing crisis unfolding in America. It is the steady erosion of maternal mental health. New national data underscore what so many families and clinicians already know: U.S. mothers are struggling, and the supports meant to sustain them are lagging behind.

A recently published study in JAMA Internal Medicine offers a sweeping, sobering view: between 2016 and 2023, the percentage of U.S. mothers reporting "excellent" mental health dropped by more than 12 percentage points—from 38.4% to just 25.8%. Meanwhile, rates of fair or poor mental health saw a relative increase of 64% during the same period.

Much of the national conversation on maternal health has focused on pregnancy and delivery. But this new study, along with the 2024 U.S. Surgeon General's advisory titled Parents Under Pressure, argues for a more expansive view—one that tracks parental health and well-being long after the postpartum period ends.

We know that the drivers of this crisis are many: limited access to affordable mental health care, chronic stress, economic instability, rising cost of living, racial and gender inequities, and a national shortage of perinatal mental health specialists. Compounding this further are the isolating effects of modern parenting—particularly for Gen Z and millennial mothers—and the disconnecting role of social media in shaping expectations and comparisons.

The COVID-19 pandemic did not cause this cliff, but it did accelerate the descent. According to the study in JAMA, mental health scores were already declining pre-2020, but the pandemic years saw a sharper increase in the proportion of mothers reporting poor or fair mental health.

Notably, mental health deterioration among mothers occurred across racial, socioeconomic, and insurance groups. But, the burden is especially heavy for single mothers, those with lower educational attainment, and those caring for children with public or no health insurance.

Key Findings and Disparities

- Maternal mental health disorders (MMHD) - ranging from postpartum depression and anxiety to OCD, bipolar disorder, and psychosis - affect roughly 1 in 5 women.
  - Shockingly, almost 75% go undiagnosed and untreated, and rates of depression have doubled since 2010.
- Black and Indigenous mothers are disproportionately affected and less likely to receive treatment.
- Untreated MMHDs are linked to poor birth outcomes, higher healthcare costs, and increased risk of maternal mortality
- Data from the CDC's Maternal Mortality Review Committees show that maternal mental health conditions, including suicide and overdose, are now the leading cause of pregnancy-related death in the U.S.
- Risk factors extend beyond clinical symptoms: intimate partner violence, food insecurity, and overwhelming childcare burdens all amplify the risks.

These trends demand our attention—not just as a mental health concern but as a public health emergency.

Intergenerational Stakes

Poor maternal mental health has

see Hidden Crisis on page 43

Supporting Maternal Mental Health in the Workplace: Policies, Practices, and Culture Change

By Nichole Renadette, LCSW
Senior Program Administrator
New York Psychotherapy and Counseling Center (NYPCC)

As more women navigate pregnancy and early motherhood while continuing their careers, organizations must recognize that mental health support during the perinatal period is critical to employee wellness, engagement, and retention. Untreated perinatal mental health conditions, including depression, anxiety, and postpartum disorders, affect at least 1 in 5 women, and these challenges are often exacerbated by unsupportive work environments (Maternal Mental Health Leadership Alliance, 2023).

As a mother with a full-time career as a program administrator at a community mental health center, I know firsthand the challenges that often come with balancing motherhood and work. I remember the anxiety of returning to the office when my baby was just 2 months old. I still felt like I did not know what to expect and was still waiting for my life to go back to "normal". However, I quickly discovered that when I became a mother, I joined a new community; a community of women that support each other. While the adjustment back to work took time, having the support from my colleagues and other mothers made a difference.

At New York Psychotherapy and Counseling Center (NYPCC), we believe that mental health support should begin not just in the clinic and the community we serve, but in the workplace. It is crucial that employers not only abide by federal and state policies and protections but also work individually with staff to account for their unique needs. Employers need to be flexible to encourage staff to take advantage of maternity/paternity leave to build a family-friendly culture.

This article explores the landscape of maternal mental health in the workplace, current U.S. policies, best practices from the field, and how implementing these strategies can transform organizational culture for the better.

Becoming a mother is life-changing, but for working women, this transition often brings emotional strain rather than celebration. Between managing hormonal shifts, childcare responsibilities, and professional expectations, many mothers experience increased stress, depression, or anxiety, conditions that, if unsupported, can have profound consequences for both employee and employer. An average of 1 out of 4 women exits the workforce during the first year of motherhood (Time, June 2025).

A 2022 study by the American College of Obstetricians and Gynecologists reported that only 15% of new mothers in the U.S. receive adequate screening or treatment for postpartum mental health issues. "Post Partum Depression is the most common mental disorder diagnosed among women during the perinatal period, with an estimated prevalence of 13-19%" (Costa et al, 2021). These women are also more likely to leave the workforce, either temporarily or permanently, due to burnout, lack of accommodations, or stigma (ACOG, 2022). Such attrition costs U.S. businesses billions annually in lost productivity, training, and turnover-related expenses.

While the United States still lags behind many developed nations in maternal support, recent federal and state initiatives are helping to bridge the gap:

The Family & Medical Leave Act (FMLA)

FMLA provides eligible employees with 12 weeks of unpaid, job-protected leave for family or medical reasons, including childbirth and mental health conditions. However, only about 60% of US workers are eligible, and the unpaid nature of the leave is often a barrier (U.S. Department of Labor, 2023). Women who are not able to take the 12-week leave have an increased risk of postpartum depression, with a reported 1 out of 4 mothers returning to work within ten days of giving birth (Policy Center for Maternal Mental Health, 2025).

NY State Paid Family Leave (PFL)

Starting in 2021, all eligible workers in New York State can take up to 12 weeks of paid time off for bonding following the birth of a child in their first year, adoption, or foster placement. Workers can get paid up to 67% of their salary, and immigration status does not affect eligibility (paidfamilyleave.ny.gov, 2025)

The Pregnant Workers Fairness Act (PWFA)

Effective as of June 2023, the PWFA requires employers with 15+ employees to provide reasonable accommodation for known limitations related to pregnancy, childbirth, or related conditions, including mental health (EEOC, 2023).

The Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act

Expanded in 2023, this law now ensures break time and private space for lactating employees, promoting a more supportive postnatal environment.

These policies form a foundation, but real change requires going beyond compliance.

Paid Medical Leave During Pregnancy

New York launched a mandate requiring at least 20 hours of paid prenatal leave for all private-sector employees to attend medical appointments while pregnant, spotlighting practical steps toward better maternal workplace support. (AP News, Jan 2025)

At NYPCC, we are committed to moving from reactive to proactive. Below are evidence-based best practices we recommend and implement:

Extended and Paid Parental Leave

Paid leave is a proven buffer against postpartum depression. A 2021 study from Harvard's T.H. Chan School of Public Health found that women who received 12 weeks or more of paid leave were 30% less likely

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She Carries More Than a Child: The Psychological Burden of Unhealed Trauma

By Keiley Pfeiffer, EdD
Program Manager, Healthy Families Montgomery and Schoharie County
Integrated Community Alternative Network (ICAN)

Motherhood starts way before a woman discovers that she is pregnant. Rather, research suggests that a person's projected pathway into motherhood starts as soon as their own infancy. The type of attachment, connection, and personal experiences that a child is exposed to during their first five years of life have been proven to have a significant impact on their future ability to create secure attachment with their own offspring. More specifically, the type of relationship between mother and child has been identified as a significant catalyst for overall well-being and development of future generations. This article explores the intergenerational transmission of maternal trauma to their children.

According to Babcock, Fenerci, and DePrince (2018), intergenerational trauma survivors who become mothers often directly and indirectly transmit their own negative views to their children starting in infancy. John Bowlby, the founder of maternal attachment, discovered that there was a significant link between mother and child attachment, which is directly linked to the emotional and mental well-being of the mother at the time of birth (Iyengar et. al., 2019). A mother's maternal responsiveness and care to her own child are often a reflection of her own childhood. For example, if a mother was raised by a parent who was often dismissive, unpredictable, and disengaged in daily interactions, these same mothering behaviors are carried into the next generation of child-rearing (Iyengar et. al., 2019; Powers et. al., 2022).

These behavioral patterns and trends are most commonly related to the mother's model behaviors and inability to establish a secure attachment with their child. Research suggests that the dysfunctional connection between mother and child is linked to post-traumatic stress and inappropriate behavioral responses to "triggers" (Babcock Fenerci & DePrince, 2018; Power et al., 2022). Babcock, Fenerci, and DePrince (2018) studied mothers between the ages of 23 and 47 who experienced significant traumatic events. These traumatic experiences were defined as "childhood maltreatment": "physical abuse, sexual abuse, emotional abuse, witnessing domestic abuse, or neglect". The women who participated in this study revealed that their post-traumatic appraisals of themselves were defined by six different categories: "betrayal, self-blame, fear, alienation, anger, and shame". These post-traumatic feelings and behavioral responses, unless addressed, explored, and replaced, become a survivor mother's identity. Future generations of children of survivor mothers are often exposed to more negative interactions. These behaviors are described as physical and verbal hostility, avoidant attachment, and less nurturing than those mothers who do not carry unhealed wounds (Iyengar et. al., 2019; Powers et. al., 2022).

When mothers do not address their "ghosts" or explore the "baggage" that they bring from their past, the impact on their child can lead to behavioral and mental health concerns. Children of survivor mothers often view the world as

see Unhealed Trauma on page 42

Beyond the Baby Blues: Understanding the Impact of Codependency in Maternal Mental Health

By Anne Dranitsaris, PhD
Psychotherapist, Leadership Coach, and Author

Have you ever found yourself lying awake at night wondering if you're doing enough as a mother, even after giving everything you had that day?

Do you constantly second-guess your parenting decisions, compare yourself to other moms, or feel like you're falling short, no matter how hard you try?

If you've ever felt this way, you're not alone—and you're not broken. What you're experiencing may not just be anxiety or exhaustion. It may be something deeper, something that's rarely talked about in maternal mental health conversations: the reactivation of old emotional wounds and patterns that began long before motherhood.

Aspiring to be a "Good Mother"

Most women begin their parenting journey determined to be "good" mothers. They read all the how-to-parent books and prepare themselves to be attuned, selfless, responsive, and nurturing mothers. Too often, they set themselves up with a criterion that they have to live up to and end up feeling that, because they are tired, irritable, and want a break, there is something wrong with them.

Unknowingly, they have triggered their unconscious fear that they don't have what it takes to be a "good" mother. Their fear of not being good enough manifests in pushing themselves harder and neglecting their own needs. For those with unhealed attachment wounds, motherhood hasn't just brought sleepless nights and feeding schedules. It has stirred up deep-seated insecurities rooted in childhood experiences where love was conditional, needs were minimized, or emotional expression was unsafe.

These women often fall into familiar codependent patterns, such as perfectionism, over-functioning, and people-pleasing, that once helped them survive emotionally in their family of origin. As mothers, they become hypervigilant and anxious, interpreting every cry, sleep regression, or tantrum as a sign of their failure. They compare themselves constantly to other mothers, convinced they are falling short. In trying to prove their worth through flawless parenting, they develop a codependent dynamic with their child, relying on their child's behavior to affirm their adequacy as a mother.

What results is not the nurturing, secure bond they intend to create but a high-pressure performance of motherhood that depletes them emotionally and distances them from their Authentic Self. This self-abandonment, masked as devotion, fuels anxiety and burnout and too often goes unrecognized by medical providers, therapists, and even other mothers.

What Is Codependency, Really?

Codependency is traditionally linked to addiction and dysfunctional relationships and is often misunderstood as a personality flaw. However, when viewed through the lens of attachment and developmental psychology, it's clear how codependent behaviors are actually survival strategies that become unconscious behavioral patterns

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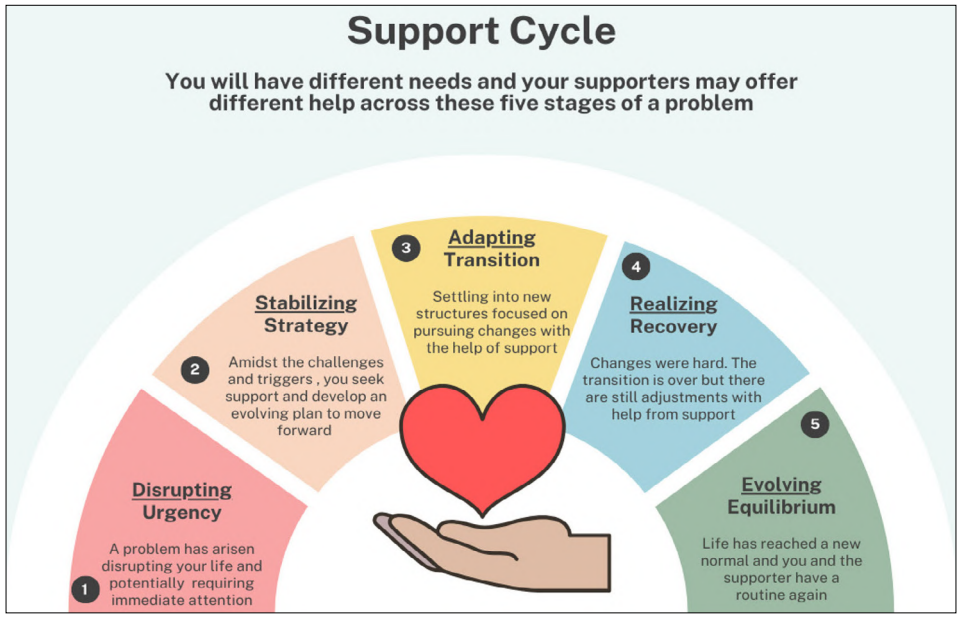
Overcome Stigma with Resources for Support, Rejection, and Accommodations

By Dan Berstein, MHS
Founder
MH Mediate

Mental illness stigma might mean folks inappropriately assume someone living with a mental health condition is dangerous, incapable, or socially undesirable. When those negative attitudes translate into harmful actions, the results can be devastating. Stigma often leads to friends or family pulling away from offering support, coworkers or colleagues rejecting someone from social and professional opportunities, and organizations dismissing reasonable requests for needed disability accommodations to access schools, workplaces, or the community.



The "Nurturing Relationships" tipsheet includes the Support Cycle diagram, to help users understand that there are different times when someone who needs support has different needs and expectations from their supporters. It also includes a chart of "Your Needs and Your Supporter's Needs" to help explore what everybody needs during each of these stages, in order to structure a mutually beneficial support relationship.

What Can Be Done to
Address These Challenges?

The Stigma and Conflict Resolution Resource Group is a free resource hub being shared with the New York behavioral health community and beyond. It was produced by MH Mediate's Mindquity platform, with support from the New York State Office of Mental Health via New York State's Mental Illness Anti-Stigma Fund Tax Check-off Program and from the New York City Department of Health and Mental Hygiene's Office of Consumer Affairs. The Resource Group is designed specifically to help users apply conflict resolution best practices when navigating challenges they face across three key situations: seeking support, overcoming rejection, and pursuing accommodations.

Tools for seeking support include:

- Appreciating Supporter Needs
- Deciding on an Outreach Strategy
- Asking with Gratitude
- Nurturing Relationships
- Adjusting to Changes

Resources for overcoming rejection include:

- Clarifying Whether Rejection Occurred
- Deciding Whether to Speak Up
- Seeking Support
- Reorienting After Rejection
- Addressing Stigma and Discrimination

Guides for pursuing accommodation include:

- Addressing Self-Stigma
- Deciding Disclosure
- Navigating Logistical Burdens

see Resources on page 44

The Role of Partners in Supporting Mothers with Postpartum Depression

By Richard Anemone, MPS, LMHC
Behavioral Mental Health Counseling PLLC

Postpartum depression (PPD) is classified by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* as a major depressive disorder with peripartum onset. It is characterized by persistent sadness, anxiety, fatigue, and difficulties in emotional bonding with the newborn. Unlike transient postpartum mood disturbances - commonly known as "baby blues" - PPD is more severe and enduring, potentially impairing maternal functioning and overall well-being.

PPD has an estimated prevalence of 10–20% worldwide, with research indicating that one in seven women in the United States experience PPD. Despite its high incidence, nearly 50% of cases remain undiagnosed, limiting access to appropriate interventions. Furthermore, approximately 10% of partners of individuals with PPD report experiencing paternal postpartum depression, highlighting the interconnected nature of familial mental health dynamics.

Given the substantial impact of PPD on maternal and family well-being, this article examines the role of partners in supporting affected individuals, identifies key challenges, and outlines evidence-based strategies for fostering recovery.

Challenges Faced by Partners

Despite their critical role, partners often encounter barriers to effective support, including:

- **Limited Awareness:** A lack of knowledge regarding PPD symptomatology and treatment can result in delayed intervention.
- **Restricted Involvement in Care:** Partners are frequently excluded from formal treatment plans, leaving them ill-equipped to assist effectively.
- **Psychological Burden:** The emotional toll of witnessing a loved one struggle with PPD may contribute to distress, burnout, or even the onset of depressive symptoms in partners themselves.

The Importance of Partner Support

Empirical research underscores the protective role of a supportive partner in mitigating the severity of PPD:

- A study published in PubMed demonstrated that mothers who engaged in psychoeducational sessions alongside their partners reported a significant reduction in depressive symptoms.
- Findings from the American Journal of Obstetrics & Gynecology indicate that partnered mothers exhibited a 71% lower risk of developing severe PPD, reinforcing the buffering effects of emotional support.
- John Gottman's longitudinal research highlights that strong relational bonds function as protective factors against psychological distress during the postpartum period.

Evidence-Based Strategies
for Partner Engagement

1. Enhance Awareness and Knowledge

Partner education is fundamental to effective

see Partners on page 45

The Generational Transmission of Untreated or Unresolved Relational Trauma

By Victoria Sanders, LMFT 52610, PhD
Licensed Marriage and
Family Therapist, CEO
VMS Family Counseling Services

She leaned in close to me, whispering as if we were girlfriends rather than therapist and client: "I'm trying to get pregnant because then I'll have someone who will love me forever and never leave me."

How do I, as a compassionate therapist, gently explain to this 13-year-old girl that babies do not come into the world loving their mothers? That, in truth, it is mothers who must unconditionally love their babies—despite the fact that she herself has offered unwavering love to a mother who has never been able to give her what she so desperately needs.

Understanding Relational Trauma

Relational trauma refers to the repeated disruption of safe, supportive interpersonal relationships—most often between parent and child—during key developmental periods (Gilson & Abela, 2021). While widely discussed in both literature and therapeutic contexts, relational trauma is not formally recognized in the *DSM-5*, which presents a diagnostic challenge. Without accurate recognition, effective treatment is often delayed or misdirected.

Two key elements form the foundation of healthy development in infancy: secure attachment and attunement.

- **Attachment** describes the emotional bond between caregiver and child. Four primary attachment styles have been identified: secure, avoidant, ambivalent, and disorganized (Suneel et al., 2022). These patterns often carry into adulthood if not addressed early (Jacobsen et al., 2024).
- **Attunement**, on the other hand, refers to the caregiver's ability to be emotionally in sync with the child—responding to their internal and external states in a way that feels seen and understood (Passaquindici et al., 2024). This emotional "meeting place" is only possible when the caregiver can regulate their own emotions, especially when the child is distressed.

The Weight of Motherhood

Motherhood is inherently challenging. The body has undergone a profound physical transformation, hormonal shifts are ongoing, and the demands of caring for a newborn are relentless. The mother must not only survive but also serve as the emotional regulator for her child—ensuring secure attachment and attunement, even when she herself feels depleted.

Many mothers aim to be better than their own parents—a commendable goal. But if a mother has never experienced secure attachment or emotional safety, how can she be expected to offer what she never received? When early caregiving relationships were marked by fear, neglect, or inconsistency, the mother may lack the internal framework needed to tolerate her child's difficult behaviors or emotional needs.

Unresolved relational trauma can manifest in many ways: a mother may appear overly controlling or emotionally absent,

see Relational Trauma on page 43

Addressing the Stigma of Perinatal Mood and Anxiety Disorders

By Jeridith Lord, LCPC, BCBA
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Institute for Applied Behavioral
Science, Endicott College

When I had my son in 2024, I had more than a few medical professionals warn me that due to my anxiety pre-pregnancy, I was at greater risk for developing a perinatal mood disorder (PMD), specifically postpartum anxiety (PPA) and/or postpartum depression (PPD). I was warned to contact someone if I ever felt like harming myself or the baby, but that the "baby blues" were also a totally normal experience. As a clinical mental health professional, I knew this. I was confident. I was ready.

I think it's easy to give abstract warning signs based on the worst-case scenario; given the severity, I don't think it's a bad strategy… but I do think that it's not a completely accurate representation of what these mood disorders can look like for different people. These medical professionals had a hunch and were right: I went on to develop PPA. The thing is, I never wanted to hurt myself or my baby. Instead, I had painful, intrusive thoughts that the Walmart we were in would suddenly burn down. I also refused to bathe the baby for months because "what if I sneeze and I close my eyes, and then he drowns?" I was used to anxiety, and I have a wide range of coping mechanisms, but this was a level that I was not prepared for. How do you cope with your brain telling you that you will be responsible for this baby's death because you can't control your allergies?

Things got better, and medication helped me greatly. I am grateful for the support that I received from all of those professionals, but I wish that they had expanded my understanding of PPA/PPD beyond the worst-case scenario. I was afraid to reach out because I knew in my heart that these were ridiculous catastrophes that had a VERY limited probability of occurring. There is a stigma against moms struggling with mental health, and I felt foolish feeling these things on top of having no idea how to be a parent, which ultimately spiraled into what I now see was probably a sprinkling of PPD on top of the PPA.

Knowing what I now know from first-hand experience has absolutely changed how I approach PPA/PPD from a clinical perspective. Addressing these issues is a challenge that requires a collaborative effort. I have included four recommendations for any clinician working with parents and soon-to-be parents, along with how to address any outstanding mental health stigma.

First, let's talk about how the presentation of PPA/PPD can look different for everyone. Specifically, let's educate families on how it's more than thoughts of harming yourself or your baby. Some families feel educated about PPD, but PPA is still a relatively unknown disorder in young families (Ponzini et al., 2021). A lot of the stigma surrounding these disorders comes from a natural discomfort in the idea that a parent would ever do anything to hurt their baby, but PPA/PPD is so much more than that. Furthermore, the fear of judgment is often a limitation for so many new families who may need help but fear reaching out.

Second, mental health professionals should prioritize talking about the wide range of symptoms associated with postpartum mood disorders, prevalence, and latency. In addition, cultural and contextual factors should be considered when supporting these families. There is a known disparity in mental health support for racial and ethnic minorities when it comes to PPA/PPD, a disparity that is often exacerbated by socioeconomic status and stigma. Mental health professionals play a critical

see Addressing Stigma on page 39

No One Forgotten: Sharing Love with Hospitalized Mental Health Patients

By Katherine Ponte, JD, MBA, CPRP
Mental Health Advocate, Author,
and Nonprofit Leader
Psych Ward Greeting Cards

The psych ward can be an unbearably lonely place. We're often alone with our thoughts and reflections on relapses, struggles, disappointments, and hopelessness. I know. I've been there. I've suffered from severe bipolar I disorder with psychosis for over 25 years. Mental health crises landed me in the psych ward involuntarily three times. In the psych ward, there are rarely well wishes or flowers on the window ledges. Many of us have no visitors at all. We feel forgotten and abandoned—I did and was. I felt unloved. I was heartbroken. These were the lows of my struggles, of my life. I have since reached recovery, but the pain of those hospitalizations never seems to go away. After I reached recovery, I wanted to share comfort, support, and hope with my hospitalized peers. I created a program called Psych Ward Greeting Cards. The program is simple. It is based on kind gestures. Wonderful people, very often with mental illness, donate beautiful greeting cards. Our amazing giving partners and I contribute chocolate and small gifts. We have caring financial contributors who help with the special extras. I distribute the cards and gifts through in-person hospital visits and shipments throughout the year.

Our program was inspired by my experiences living with severe bipolar I disorder, including three hospitalizations. I wanted to share an inspiring message of recovery in a simple, caring approach. Since I returned home from my last stay and until this day, my Mom and Dad have sent me the most loving cards every week. They make me feel loved and cared for, remembered and needed. I want to share these same feelings with all psychiatric patients.

We also meet patients at the time of discharge. The time following discharge is critically important. One study found that the suicide rate during the first 3 months after discharge is approximately 100 to nearly 200 times that of global suicide rates. We meet patients when they need us most.

I do many things. I am most proud of this program. Anyone who has mental illness knows that hospitalization is the most difficult experience we face. I want to help make that experience better. This year, our program is celebrating our six-year anniversary. In this time, we have reached over 25,000 amazing patients at eight leading hospitals. We are blessed.

Please support our mission by donating greeting cards with heartfelt messages. Your kindness helps remind those in psychiatric hospitals that they are not forgotten—that they are seen, valued, and loved.

Katherine Ponte, JD, MBA, CPRP, is a mental health advocate, author, Assistant Clinical Professor of Psychiatry at the Yale School of Medicine and nonprofit leader and the founder of Psych Ward Greeting Cards.

Teen Mothers: When Stigma Trumps Compassion (and Research)

By Jean Wittenberg, MD
The Group for the Advancement of
Psychiatry Adolescence Committee

Samantha is a first-generation American and middle child of three. She was born and raised in Boston and attended a small high school in Cambridge, where she made the dean's list each semester. During junior year of high school, her mother discovered Samantha was 10 weeks pregnant and kicked her out of their home. In school, her school nurse spread the news of her pregnancy to teachers at school, who then either ignored her entirely or shook their heads in disapproval when she walked by. She was removed from honors classes and discouraged from applying for college.

After her daughter's birth, the school refused to provide Samantha with accommodations to pump breastmilk. They refused to excuse her absences for doctor's appointments and accused her of lying or making up illnesses so she could skip school. At the hospital, one nurse lectured her on teenage pregnancy and warned her not to be like other "welfare girls" who get pregnant back-to-back just for "some free government handouts." At her 6-week postpartum exam, her mental health symptoms were ignored, but she was given a depo birth control shot and told it was a necessary part of postnatal care because the nurse did not want to see her back in the clinic with another pregnancy in a few months.

Sadly, teen mothers are routinely perceived as having physical, psychological, mental, emotional, and social problems and as being poor parents. Many people assume teen mothers are troubled, dependent, promiscuous, exploitive—the list of pejorative adjectives goes on and on. However, these descriptors malign young mothers. Ironically, negative stereotypes people hold about young mothers may make it more likely they will become pregnant again: Pregnancy rates are higher in disadvantaged groups.

However, the last teen mother I met ultimately became an academic child psychiatrist, making a presentation at a major international conference. And Samantha, now an adult, has a career in healthcare technology, has posted her own TED, and has her own consulting company. Both of these women have happy, successful daughters. And they are not unique.

Many would be surprised to know that a significant proportion of young women who have babies in their teens go on to do better in their lives than peers who do not have babies. They have better jobs. They are independent. They move up the social gradient. In fact, a significant number further their education. Researchers have often concluded that teen mothers are disadvantaged relative to their age equivalents, but if we compare those teen mothers to their social equivalents who do not have babies in their teens (i.e., young women of the same ages who come from the same social populations), many do better. If you are surprised, you are not alone, and this stigma can play a role in worsening health care outcomes.

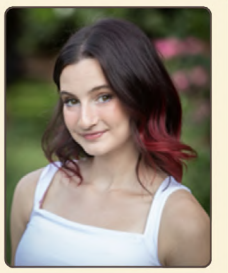
Most teen mothers do come from disadvantaged populations—racialized, marginalized, and traumatized populations that are already stigmatized. Some grow up poor in families that are stressed by food insecurity, divorce, separation, or transient relationships; live with adults who have mental health or substance or alcohol use problems; live on streets that are unsafe and in neighborhoods that are environmentally challenged. They are witnesses to violence. Many are victims of mistreatment themselves. These women are survivors of adverse childhood experiences, which impose stress and threaten health in all

see Teen Mothers on page 40

TRUTH FROM TODAY'S YOUTH

Plugging into youth discourse to inspire intergenerational connection and spark meaningful social change in mental health.

WRITTEN BY YOUTH, FOR THOSE WHO CARE ABOUT YOUTH.



SOPHIE SZEW

Resisting Unjust Algorithms: Lessons from Maternal Health for Youth Mental Health and Education

By Sophie Szew
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In previous installations of this column, I have written about how communities of youth harmed by systemic oppression and inequities rely on peer-to-peer models of care on social media to meet healthcare, safety, and support needs when institutions fail to do so. Namely, queer youth are engaging in life saving harm reduction and suicide prevention through online care networks, and disabled youth engage in organizing that meet their access needs through digital forums. Reliance on the community to meet individual needs is not a resilience and healing tactic that is unique to current generations of youth. In fact, it is a practice we have learned directly from our histories, traditions, and movement elders.

The systemic exclusion and harm enacted by systems that are framed as existing to meet basic needs, such as the healthcare system and education system, are as old as those systems themselves. This harm is perpetuated by the algorithmic frameworks that serve as justifications for these systems' existence in the first place. Given that this quarter's issue of Behavioral Health News is focused on maternal mental health, this column will position such inequities during birth as a case study for how community-based individual needs-meeting can serve as resistance and resilience against systemic injustice. As was discussed during a 2022 roundtable by the National Academy of Science, Engineering, and Medicine, the algorithmic calculations utilized by providers to determine whether birth givers are eligible to deliver vaginally after previous c-sections (an algorithm known as the vaginal birth after cesarean (VBAC) success calculator) systematically discriminates against people of color, as this calculation has a "race coefficient" that deems Black and Latina birth givers ineligible for VBAC. This algorithm was directly derived from slavery medicine used to justify the abuse of Black birth givers who were deemed to have "anthropoid pelvises." While activism by those harmed by these calculations have led to the removal of the "race coefficient" from VBAC success calculations in some healthcare settings, the ongoing racialized pathologization the American healthcare system is constructed on continues to enact violence on communities via its perpetuation of disparities including maternal mortality, which is higher for Black women in the U.S. than in any other high income country. The NASEM roundtable names numerous other healthcare algorithms, including those used to calculate kidney function and lung capacity, as well as diagnostic criteria for mental health conditions, as linked to eugenics and slavery medicine. The inextricability of these inequities form healthcare systems itself points to a need for communities to turn to modes of care that view patients as whole persons in their own contexts with intersecting oppressions, protective factors, and vulnerabilities that all contribute to their overall picture of health, rather than basing treatment on reductive, harmful groupings.

The use of care resources to meet individual needs in their holistic context has been practiced in the education space, which can serve as a blueprint for similar applications to the maternal healthcare and mental healthcare systems. For example, in her book *Black Disability Politics*, disability justice activist and scholar Sami Schalk details the success of the Oakland Community Schools (OCS) organized by the Black Panthers in the 1970s, in which students' needs were individually accommodated for with consideration for their unique conditions, rather than being grouped into assumed ability-levels based on algorithmic criteria for learning disabilities, which itself serves to justify harm against Black disabled students by existing in a grouping landscape that constructs the notion of the "good student" as undeniably White, as explained by Alicia A. Broderick and Zeus Leonardo in their article "What a Good Boy: The Deployment and Distribution of 'Goodness' as Ideological Property in Schools." As youth continue to reject the pathologizing labels placed on us and meet each other's needs without the pretext of racializing, oppressive algorithms, we do so on the foundation built by movement elders like the OCS organizers, and those invested in maternal health equity who advocate against VBAC race coefficients. It is worth centering this framework when discussing how to sustain maternal health and mental health, educational success, youth mental health, and pathways to build more just systems overall.

Sophie Szew (she/they) is a youth mental health advocate, writer, and coterminal master's degree student at Stanford University. She was appointed by the Secretary of Health and Human Services to advise the federal government on mental health policy as the youngest member of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council. Sophie's storytelling first gained national recognition during the MTV Mental Health Youth Action Forum at the White House, where she met with President Biden and his administration to advocate for systemic mental healthcare justice. Sophie's lived experience, expertise, and activism have also led them to advise numerous organizations on youth mental health issues, including Mental Health America, Born This Way Foundation, the National Alliance on Mental Illness, and Project Unloaded. In March of 2023, she testified in front of the California State Senate about the impact of algorithmic injustice on youth, and since, her advocacy has been covered by the Today Show, the LA Times, NBC, CBS News, and has landed her a spot on the 2025 Forbes 30 Under 30 Social Media List. Sophie combines her calls for policy change with poetic storytelling, serving as the inaugural poet for LA Mayor Karen Bass. She has community health partnership experience working with the Mount Sinai Hospital System and views her community-building, artistic, and advocacy work as deeply interconnected.

From Silence to Support: Changing the Story on Maternal Mental Health

By Cara McNulty, DPA
Chief Executive Officer
Vibrant Emotional Health

When I became a mother, I was prepared for a momentous life change. What I did not anticipate was the impact that pregnancy and postpartum could have on my mental health, in addition to my physical recovery. After giving birth to my first daughter, I dismissed my stress and sensitivity as the typical fatigue and chaos of early parenthood. But in reality, I was deeply struggling. Although I knew that something wasn't right, I wasn't ready to face the possibility that I was experiencing mental health challenges. By the time I had my second child, postpartum anxiety had wrapped itself tightly around my daily life.

My breaking point came one afternoon when I found myself sitting on the kitchen floor in tears while holding my second daughter. She had been battling a respiratory syncytial virus (RSV) at five months old. Despite knowing that she was receiving effective medical care and would likely make a full recovery, I was still overcome with constant worry. I couldn't leave her side. What began as a desire to monitor her breathing turned into obsessive behaviors that made me terrified to go to sleep, shower, or even eat. My fear that she would stop breathing while I wasn't holding her was all-consuming.

All I wanted was to make sure she was safe, but in doing so, I began to slowly unravel. In this moment, my husband knelt beside me and said, "This isn't how it's supposed to be. We can get you help." That conversation opened me up to confront my anxiety and practice what I inspired others in my life to do: be brave enough to admit when you're *not* okay.

From there, I began my journey toward healing with the help of an incredibly talented physician who *listened* to me and helped me understand the mental health challenges I was facing. I started to realize that my mental health mattered just as much as my physical health, and that *my* well-being mattered just as much as my daughters'. I saw firsthand how avoiding open conversations about the emotional and psychological impacts of early motherhood can prevent us from addressing a mental health crisis.

This lack of transparency permeates throughout an entire system that fails mothers because of a fragmented approach to care that overlooks mental wellness as a central pillar of postpartum recovery.

The Overlooked Realities of Perinatal Health

The perinatal period, spanning pregnancy through one year postpartum, brings heightened vulnerability to a range of behavioral health conditions. These include generalized anxiety disorder, depression, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and, more rarely but urgently, postpartum psychosis. Women experience dramatic physical, hormonal, and emotional changes while navigating sleep deprivation, recovery from childbirth, and the demands of caring for a newborn. For some, the challenges are magnified by traumatic birth experiences or pre-existing conditions. Yet, the standard six-week postpartum

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Trusted, Trained, and Too Often Overlooked: The Role of Holistic Providers in Maternal Mental Health

By Georgina Dukes-Harris, MHA
Founder & CEO
Swishvo

The perinatal period is a critical window of vulnerability and opportunity. Research shows that up to 20% of women experience a mental health disorder during pregnancy or in the first year postpartum, including depression, anxiety, and post-traumatic stress disorder (Howard et al., 2014). Without timely intervention, these conditions can disrupt maternal-child bonding, impair long-term child development, and increase the likelihood of intergenerational transmission of psychiatric disorders (Stein et al., 2014).

Yet, maternal mental health remains significantly under-addressed in traditional healthcare delivery. Fragmented systems, underdiagnosis, and cultural mistrust of mental health services—especially among historically marginalized communities—have left many mothers without the support they need. An integrative approach that blends licensed behavioral health practitioners with community-based, culturally relevant providers such as doulas, midwives, acupuncturists, and herbalists offers a promising pathway to close this gap.

Why Integration Matters

Children of mothers with untreated perinatal mood disorders are at higher risk for cognitive, emotional, and behavioral challenges—risks that may persist into adolescence and adulthood (O'Connor et al., 2002). Mounting evidence suggests that maternal stress, especially during pregnancy, can influence fetal brain development and epigenetic expression, potentially predisposing children to future psychiatric vulnerability (Glover et al., 2018). The stakes are not just maternal—they are generational.

Combining mental health care with maternal health care has been shown to improve both outcomes and engagement. A recent study by the American College of Obstetricians and Gynecologists (ACOG) emphasized the value of embedding behavioral health within routine prenatal care settings, reducing stigma and making early intervention more accessible (ACOG, 2023). However, system-wide integration requires infrastructure and innovation that most providers don't yet have.

A Community-Centered Innovative Solution

Emerging models that link licensed mental health professionals with alternative and holistic providers—especially those trusted in communities—are beginning to reshape the maternal care landscape. These integrative partnerships allow families to receive care that is wraparound, culturally resonant, and scalable.

Among these trusted providers are doulas, who support birthing people emotionally, physically, and informationally throughout pregnancy, labor, and postpartum. Studies show doula care improves birth outcomes, reduces the risk of postpartum depression, and increases satisfaction with the birthing experience (Gruber et al., 2013). Their non-clinical yet expert support provides a unique layer of psychological safety—especially for women of color who often face implicit bias in

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The Impact of Childhood Separation: Parallels Between Children of Parents with Mental Illness and Children of Incarcerated Parents

By Cheri A. Bragg Acker, BA, MSW,
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Family separation is a traumatic experience for children, regardless of the cause. When separation occurs due to parental mental illness or incarceration, children face unique psychological and systemic challenges that are often overlooked. Both groups experience disenfranchised grief, attachment disruptions, and long-term socioeconomic consequences. However, what's striking is how society treats these separations differently—mental health-related separations are framed as 'protective,' while incarceration-related separations are seen as punitive. This societal framing needs to be critically examined and shifted.

This brief report examines the individual and systemic impacts of childhood separation, comparing the experiences of children of parents with mental illness to those with parents that were incarcerated. Both groups are disproportionately affected by poverty, bias in child welfare systems, and inadequate policy responses. By analyzing these parallels, we underscore the urgent need for comprehensive systemic reforms that prioritize children's developmental needs and provide the necessary support for their families.

Defining Family Separation in Mental Health and Incarceration Contexts

Separation Due to Parental Mental Illness

Children may be separated from parents with mental illness through:

- Involuntary psychiatric hospitalization (Murphy et al., 2017; Reupert et al., 2021; Slade et al., 2022).
- Child welfare interventions (Gambrill & Shlonsky, 2001).
- Informal kinship care arrangements (Reupert et al., 2021).

Unlike previous high-profile cases of border-related family separations (Lobel, 2020), mental health-related separations lack standardized terminology or tracking mechanisms (Acker et al., 2024). The Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998/2019) includes parental mental illness but does not distinguish between co-residence and separation, masking the unique trauma of removal.

Separation Due to Parental Incarceration

An estimated 2.7 million U.S. children have a parent who is incarcerated (Simmons, 2000). Separation occurs through:

- Detention and imprisonment (Rojas-Flores et al., 2017).
- Foster care placement when no caregiver is available (Roberts, 2022).
- Restricted visitation due to carceral policies (Zayas, 2015).

Unlike mental health separations, parental incarceration is explicitly listed in the ACE questionnaire. However, systemic

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Voice and Identity: Daughters and Sons of Parents with Psychiatric Experiences

By Maggie Jarry, M.Div.
Co-Founder
Daughters and Sons Initiative

Daughters and Sons Initiative Pins, created by Cheri Bragg Acker for the Daughters and Sons Initiative booth at the 2009 National Alliance on Mental Illness (NAMI) National Conference in San Francisco.

Parenting with a mental health condition is common, yet widely unsupported. The following statistics may surprise you: according to Joanne Nicholson of Brandeis and Kate Beibel at the University of Massachusetts Medical School, 68% of women and 57% of men with diagnosed psychiatric disorders are parents. The figures are even higher for people (especially fathers) with serious and persistent psychiatric disabilities.[1] To quote Kate Beibel, "women and men with a lifetime prevalence of psychiatric disorder are at least as likely to be parents as are adults without a psychiatric disorder." More than twenty years ago, in 2004, Helena Davis of the Mental Health Association of Albany shared the following statistic with me: 60% of parents with psychiatric disabilities lose custody of their children, many due to stigma against parents with diagnosed mental illness. Yet, persons with psychiatric disabilities play the important societal role of parent in the lives of millions of people (young and old), often called "invisible children."

I was one of the invisible children. As a daughter of a mother, father, and stepfather with psychiatric disabilities (schizo-affective illness, chronic depression, and schizophrenia, respectively), I was raised by my parents, grandparents, two foster care placements, teachers in my schools, and the community at large. My story and the story of others like me are beginning to be told in a small but growing area of research. Until recently, few mental health professionals or advocates were aware of the unique issues faced by the daughters and sons[2] of people with psychiatric disabilities. As a child, it seemed that when people learned about my mom's illness, they would speak to me with apparent admiration, saying, "Oh, you are so strong." Yet in my twenties, I increasingly heard people ask me, "Isn't that hereditary?" I sought out the relevant literature, but all I could find was scientific literature that gave me percentages about my chances of developing my mother's illness or narrative literature that dramatized experiences of daughters and sons. What I lacked was a framework to help me understand the concerns and preoccupations that are typical of daughters and sons of people with psychiatric disabilities.

I now know that daughters and sons of people with psychiatric disabilities routinely experience feelings of isolation, have difficulty forming intimate relationships (because of excessive dependence or avoidance), fear inheriting a parent's illness, can be confused about identity, tend to feel more comfortable living lives that have ongoing chaos and crisis, fear having children, often have difficulty with setting limits or boundaries, are wont to be perfectionist, often grieve as they grow older over never having had a childhood, and

see Daughters and Sons on page 49

Reframing Residential Treatment: Preventing Family Separation and Supporting Women with Substance Use Disorders

By Sarah March, LMHC, MSW, CASAC
Program Director
Samaritan Daytop Village

According to the 2023 National Survey on Drug Use and Health, 70.5 million people used illicit drugs in the past year, and 48.5 million of them met the criteria for a substance use disorder (SUD). In 2022, 32.6 million women reported illicit drug use, and while men have historically shown higher SUD rates, women with addictive disorders often face greater vulnerability (Fonseca et al., 2021). Nearly 16.4 million women with an SUD did not receive treatment because they did not believe they needed it, and only 15.2% of those diagnosed received any form of care (SAMHSA, 2022). These numbers underscore the deep impact of isolation from support and the need to remove barriers to treatment access for women. Fonseca et al. (2021) and Rizzo et al. (2022) highlight systemic, structural, and personal-level challenges—especially addiction stigma—as major obstacles to care. Women often face heightened stigma, more severe social consequences, and additional barriers such as poverty, co-occurring mental illness, and the lack of gender-responsive services. Family responsibilities, fear of legal repercussions, and child welfare concerns further complicate access. Given this complexity, a family-centered, gender-specific residential treatment model may offer an ideal approach to addressing the unique needs of women with substance use disorders.

I am writing as the Program Director at the Samaritan Daytop Village Young Mothers Program (YMP), a residential addiction treatment program where women can live with their young children while working on their recovery. The program is a supportive, structured environment that provides multi-faceted programming to combat alcohol and drug addiction while simultaneously providing prenatal, maternal, and pediatric health care, and adult psychiatric care. Clients have access to individual therapy and case management, attachment and bonding therapy with their children, family therapy, and evidence-based group counseling. Counseling frameworks utilized in the program include Motivational Interviewing, Cognitive Behavioral Therapy, and Dialectical Behavior Therapy, and integrate Community As Method, Trauma Informed Care, and Family Systems Theory. Individuals are often mandated to treatment and find themselves at YMP from a variety of legal systems that include criminal, treatment, or family courts, probation or parole, and child welfare agencies.

Unfortunately, family court referrals to YMP are typically facilitated only after the identified mother has been noncompliant with less-restrictive treatment mandates, and the substance use escalates or continues without resolve, and the legal system then recommends the removal of the child from the care of their parent and frequently begins court proceedings to terminate parental rights. Court-mandated mothers are oftentimes not referred for residential placement until their circumstances have become dire enough to warrant child removal and termination of parental rights proceedings. The removal of the child from the family system because of substance use perpetuates stigma, shame, fear, and

see Residential Treatment on page 47

Addressing America's Silent Crisis: Maternal Mental Health

By Dr. Tom Milam
Chief Medical Officer
Iris Telehealth

Maternal mental health in the U.S. is in crisis. Despite advancements in medicine and growing awareness around mental health, the emotional well-being of mothers has quietly deteriorated. This is particularly true during pregnancy and after childbirth.

A recent study published in JAMA Internal Medicine reveals a nearly twofold increase in depressive symptoms among expectant and new mothers between 2014 and 2018, jumping from 10% to almost 20%. Behind these numbers lies a deeper story of chronic underinvestment in maternal mental health services, postpartum care, and family support infrastructure. This underinvestment comes from federal and state governments, healthcare systems, insurers, and workplaces that fail to provide paid leave or postpartum support.

As a physician who has spent decades working in behavioral health and telehealth services, I have witnessed firsthand how the lack of accessible mental health care creates cascading effects for families. There is an urgent need for comprehensive maternal mental health support that must be met.

Understanding the Postpartum Reality

To understand the urgency, it helps to step back and look at what the postpartum experience involves. Beyond sleepless nights and physical recovery, many mothers face a quiet reckoning: a reshaped identity, new emotional terrain, and the pressure to do it all with a smile. The early weeks and months after birth can be marked by exhaustion, loneliness, and anxiety. Some mothers experience intense mood swings, intrusive thoughts, or feelings of hopelessness and helplessness they are too afraid to name.

Despite this time of great need, many do not have access to mental health care, or do not know where to start. Even when they do speak up, they may be dismissed or told their suffering is simply part of the process. These emotional realities are common and often overlooked in standard medical care.

Mothers encounter significant barriers when seeking mental health care, particularly due to stigma. Studies show that as many as 58% of mothers who experience postpartum depression will not reach out for help, with many stating they were too scared to seek support. Additionally, social determinants like lack of transportation, affordable childcare, and time away from newborns further hinder access to necessary care.

The Broader Impact on American Families

This psychological toll has ripple effects far beyond individual households. The Centers for Disease Control and Prevention (CDC) recently reported that U.S. birth rates have dropped to their lowest levels ever recorded. While economic uncertainty and shifting cultural norms contribute to this trend, declining maternal mental health plays a powerful, often overlooked role. When potential parents witness how unsupported motherhood can feel, many hesitate to take that leap themselves.

Fear of facing postpartum depression alone, fear of being judged for struggling,

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The Silent Struggles of Fertility: Understanding the Emotional Toll

By Maria F. Costantini-Ferrando, MD, PhD, FACOG, IVI RMA North America

When a woman embarks on the journey of fertility care, she enters a world filled with hope, uncertainty, and an emotional burden not always perceptible to others. The medical procedures and clinical visits are only part of the experience—behind closed doors, many face silent struggles that take a profound toll on their emotional wellbeing.

For many, the dream of motherhood is not simply an idea; it is a vision built over a lifetime. It is woven into dreams, expectations, and imagined futures. The expectation that conception will happen naturally, effortlessly, is rarely questioned, until it is. And when fertility challenges arise, they can shake the very foundation of identity, leaving women grappling with feelings of inadequacy, guilt, a sense of failure, and betrayal by the very body they have always trusted.

The emotional strain of infertility does not always present as obvious sadness or anxiety. It does not always announce itself with tears or moments of visible anguish. It may show up as persistent exhaustion, difficulty concentrating, or a growing disinterest in once-comforting social rituals. Invitations to baby showers become sources of anxiety. Scrolling through social media feels like navigating landmines, each pregnancy announcement a sharp reminder of the unfulfilled longing. Some women withdraw from social interactions, not from lack of love, but because being around children or fielding questions about their journey is emotionally taxing. Others experience a quiet grief, mourning expectations that once felt inevitable. The hope attached to each treatment cycle can make every negative result feel like an emotional setback, leaving women to navigate a cycle of optimism and heartbreak that repeats endlessly.

Unpredictability of Fertility Outcomes is a Significant Challenge

One of the most challenging aspects of fertility treatment is the sheer unpredictability of outcomes and the potentially endless waiting. There is no guarantee a procedure will succeed, no timeline for pregnancy. The waiting, the wondering, the hope, the disappointment, followed by more waiting and hoping for something that may never happen, and it all builds an emotional pressure that can be overwhelming and, at times, unbearable.

Some women try to regain control by immersing themselves in research, learning every detail about medical options, nutrition, or alternative treatments. Others turn to support groups, finding solace in the shared understanding of those who walk the same path. But for many, the uncertainty remains, shaping everyday life into something fragmented, caught between hope and fear, between possibility and grief.

The Confusion of Secondary Infertility

The grief of fertility struggles affects even those who have been pregnant before. For mothers who once carried a child, who once gave birth, the realization that conception is no longer coming easily can feel like a betrayal, as if their bodies are failing them in ways they never imagined. Many

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Addressing Maternal Mental Health Through Connection and Care

By Andrea Womack
Chief Content Officer
Psych Hub

Becoming a mother is a profound transition—one that reshapes how a person sees themselves, their priorities, and their relationships. It's a shift that can feel expansive and deeply meaningful, but also disorienting. With so much focus on the baby, it's easy for a mother's own experience to get overlooked. And yet, her identity is in flux. Parts of who she was may feel far away, while who she's becoming hasn't fully taken shape. That emotional recalibration can touch everything: how she feels in her body, how she's seen by others, and what she needs to feel steady.

This period of change is often deeply personal and at times, lonely. Love for a child can be immediate and intense, but adjusting to motherhood or primary caregiving may also bring moments of doubt, disconnection, or grief for a former version of life. Gratitude and struggle often coexist. And for many, having space to name those emotions, whether quietly, with others, or with a therapist, can be a powerful part of settling into this new chapter.

When Loneliness Deepens the Strain

Loneliness isn't just about being alone; it's the ache and distress that comes when meaningful connection is missing. A new parent can be surrounded by people and still feel invisible if her needs go unnoticed or unspoken. When that feeling lingers, it can take a toll. Ongoing loneliness has been linked to increased risk of depression, anxiety, and even cardiovascular disease.

Some mothers feel a shift the moment their baby arrives. Though family and friends may be present, most conversations focus on the baby, and the mother's well-being may fade into the background. If the need for support is greater than what's available, doubts can surface, and many try to push through without help.

This isolation isn't just emotionally difficult—it's also a risk factor. Loneliness can magnify the emotional and physical toll of early motherhood, making it harder to recognize or seek support for maternal mental health symptoms.

Understanding Maternal Mental Health Conditions

It's important to recognize that perinatal mood and anxiety disorders (PMADs) are common, treatable medical conditions, not a reflection of a mother's character or ability to parent. Symptoms can emerge during pregnancy or develop weeks to months after childbirth. PMADs affect up to one in five women and can include major depressive episodes, generalized anxiety disorder, panic disorder, and obsessive-compulsive disorder. In rare cases, postpartum psychosis may occur, requiring urgent medical attention and specialized care.

These conditions are shaped by a combination of factors, including genetics, hormonal changes, sleep deprivation, stress, trauma history, and limited support. Screening for perinatal mood and anxiety disorders (PMADs) is an evidence-based practice endorsed by leading obstetric, gynecologic, and pediatric professional associations. Yet accessing support can be difficult, especially if these experiences are minimized, dismissed, or attributed solely to "just hormones." When symptoms go unacknowledged, isolation often deepens, making it even harder to feel understood or ask for support. Early, compassionate conversations, especially with trusted providers, can make a meaningful difference in

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The Super Mom Myth: Why Resilience Alone Is Not Enough

By Temitope Fabayo, BA, MBA-HR
DMC HomeCare

The baby's cry pierces the morning silence. The coffee's gone cold. It's 6:30 in the morning. Lilly stands in her kitchen, making breakfast. One hand is stirring her oatmeal, while her other hand scrolls through the work messages she has to deal with. A cartoon is playing in the background to keep her baby happy. Her day is full of tasks she handles with no moments of rest.

And yet, she stands like a lighthouse in the storm, resilient but alone. Asking someone for assistance seems like giving up. Naturally, she's a super mom; she must take care of every problem herself.

Still, this image? It is not true. It is quietly unkind to keep teaching the role of a perfect mother to women. Doing it all on her own while overlooking assistance is not heroic—it's very tiring. Worse, it leaves mothers trapped in a cycle of guilt that they're never doing enough.

It's time to challenge this myth and rewrite the story.

Guide to Being a Perfect Mom: Spoiler Alert

Imagine this. You find a Super Mother monthly magazine in your mailbox. Inside, there's a step-by-step guide to becoming a super mom. It goes like this.

Wake up at 5 a.m. Go for a walk. Feed the dog. Clean the house. Prepare breakfast. Send your husband to work and the kids to school. Run errands. Then rush to your job if you're a working mom.

Being a super mom often comes at the cost of your mental and physical well-being. But social media and magazines paint it like a fantasy. You're a supermom if you survive sleepless nights and change diapers many times before dawn. If you cook, clean, do laundry all day, and greet your family with a big smile, you're a supermom again.

Sick? Moms don't get sick. They just push through. Right?

Wrong! This isn't a strength. It's pressure, and it's toxic.

Motherhood is not about being a robot. After all, she's human, pushing through life while deeply caring for her children. She's allowed to feel tired. She's allowed to ask for help. Underneath that brave face, she often hopes someone will support her.

Vulnerability isn't a weakness; it's bravery! It's time to normalize asking for help. It's time to stop chasing the Ideal Super Mom myth and start accepting real motherhood.

Unseen Sacrifices Come at a Real Cost

Back to Lilly! One day, she gets a call from her friend for a meet-up. Deep down, she eagerly wants a girls' day out, but then she realizes who she'll leave her kids with.

Her parents?

But leaving kids with her parents and sipping on a hot cup of coffee with her friend feels like a rebellion. This extra weight of responsibility and not being around her children feels like a curse to Lilly.

It won't be wrong to say that an average woman thinks twice about her children than herself. She puts her wishes and goals on hold for her children. These unseen sacrifices aren't anecdotal but are backed by research showing mothers' real sacrifices.

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Maternal Mental Health: Reducing the Stigma Through AI

By Brett Talbot, PhD
Licensed Psychologist and Co-founder
Videra Health

Maternal depression affects approximately 1 in 5 women in the United States. For many, their struggles go undetected and untreated. It's critical that we acknowledge both the prevalence of this condition and the innovative solutions emerging to address it.

The lack of diagnosis of postpartum depression (PPD) can impact new mothers in what would normally be a joyous time. Often unrecognized and undiagnosed, PPD often slips past providers as new mothers transition from OBGYN in their first few postpartum weeks to their primary care physician for longer-term care. It is in this period of transition between providers that PPD symptoms often appear, and why it is so challenging to identify the symptoms that trigger most screenings for PPD. The gap in care not only impacts mothers but resonates throughout families and communities.

The Hidden Costs of Untreated Maternal Depression

Beyond the emotional toll, untreated postpartum depression costs payors 90% more in healthcare expenses. These costs extend beyond immediate medical care to include long-term impacts on child development and family well-being. Early detection and intervention are essential not just for emotional recovery but also for financial sustainability in our healthcare system.

How AI Is Transforming Maternal Mental Health Care

The traditional approach to maternal mental health screening often falls short. Brief questionnaires during limited check-ups may not capture the full picture of a mother's experience, especially when stigma prevents honest reporting.

A more comprehensive, accessible approach to maternal mental health care includes:

1. **Continuous Monitoring**: Rather than relying solely on point-in-time assessments during medical visits, leverage AI for consistent check-ins throughout the perinatal and postnatal periods.
2. **Multi-Modal Assessment**: Instead of impersonal standard questionnaires like the Edinburgh Postnatal Depression Scale (EPDS), ask patients open-ended questions about how they are doing. Integrate video, text, and audio responses while also gathering additional data points around mood, trauma, or emotional distress. This more personal way for the patient to engage is more enjoyable and thus more likely to have repeat engagement while providing richer data and insights.
3. **Early Risk Detection**: Our platform identifies mothers at higher risk before symptoms escalate to crisis levels. This proactive approach allows for intervention at the earliest signs of struggle.
4. **Seamless Provider Integration**: When our system detects concerning patterns, it automatically alerts healthcare providers, ensuring timely clinical support without requiring additional staffing resources.

Real Impact for Mothers and Families

What makes this approach particularly powerful is its ability to reach mothers

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Transcranial Magnetic Stimulation (TMS) is a Safe, Drug-Free Option for Postpartum Depression Relief

By Mah Mekolle
Regional Nurse Practitioner Lead
Serenity Mental Health Centers

Postpartum depression (PPD) affects one in seven women, yet too many mothers suffer in silence. Stigma, fear of medication side effects, or simply not knowing about effective alternatives often keep them from getting the help they need.

But here's the good news: you don't have to choose between your mental health and your baby's wellbeing. There's another way forward.

Transcranial Magnetic Stimulation (TMS) offers a solution. This innovative, effective treatment has been shown to provide lasting relief from PPD, especially for mothers who haven't found success with traditional treatments or want to avoid medication while breastfeeding.

Serenity Mental Health Centers' TMS technician administers treatment to a patient.

A Breakthrough in PPD Treatment: What is TMS?

It is an approach to maternal mental health where you don't have to compromise your mental health for motherhood.

TMS has been used for over 40 years and treats conditions like depression, anxiety, PTSD, and OCD, all without medication. It works by delivering magnetic pulses, similar to those used in MRI machines, to gently stimulate areas of the brain that regulate mood.

Unlike antidepressants, which affect your whole body, TMS targets specific brain circuits, helping to 'reset' mood regulation in a safe and controlled environment.

How TMS Helps Mothers with PPD

- **Targets the source:** PPD is often tied to underactive brain regions. TMS activates those areas to restore emotional balance.
- **No meds, no downtime:** It's drug-free, requires no anesthesia, and is safe while breastfeeding.
- **Minimal side effects:** Unlike medications, TMS has little to no systemic side effects. The most common is a minor headache, which usually subsides shortly after treatment.
- **Real results:** Many patients start feeling better—more energy, improved mood, and outlook—within just a few weeks of TMS. Unlike medications that can take months, TMS offers faster relief, helping mothers reconnect with daily life and their babies sooner.

What makes TMS particularly compelling is its lasting impact. Studies have shown that the benefits of TMS extend far beyond the treatment period, with many patients continuing to experience positive outcomes for months and, in some cases, years after completing their sessions.

In fact, TMS at Serenity Mental Health Centers has an 84% response rate and a 78% remission rate, with results lasting 3+

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who wish to enroll in the program, including education specific to perinatal health needs.

Primary care physicians can play a crucial role in identifying, managing, and supporting maternal mental health. As trusted sources of information, they can help normalize discussions about mental health and offer nonjudgmental support. These doctors have ongoing contact with birthing people during and after their pregnancy, well-positioning them to screen for mental health symptoms using trusted tools such as the Patient Health Questionnaire Depression Scale and the Edinburgh Postnatal Depression Scale.

Progress in this area is also being driven by investments in last year's budget (Fiscal Year 2025), Governor Hochul increased funding to expand the Project TEACH Maternal Mental Health initiative which educates and supports maternal health providers to screen and treat maternal depression and related mood and anxiety disorders during pregnancy and the postpartum period. Project TEACH is a robust collaborative model originally established in 2010 and committed to strengthening and supporting the ability of primary care providers (PCPs) to provide mental health services to children, adolescents, and their families. In 2022, Project TEACH added reproductive psychiatrists who are available via a warmline to immediately speak with and support an OB-GYN or any prescribing practitioner serving pregnant and post-partum individuals. Project TEACH reproductive psychiatrists can be instrumental in assisting medical professionals in addressing the risks and benefits of continuation of psychiatric medications during pregnancy, a scenario where the risks of untreated mental illness can be as severe as the potential adverse effects of medication. Additionally, the recent expansion of this program allows for a wider range of front-line practitioners – including doulas, midwives, therapists, WIC staff, home visiting nurses, lactation consultants, and others – to get training and support in screening, resource access, and treatment engagement. Providing direct access to Project TEACH for these practitioners who often have longstanding, trusting relationships with perinatal individuals not only can improve immediate care, but also facilitates timely referrals for additional care and promotes better outcomes for individuals and their families.

Additionally, HealthySteps, an evidence-based prevention program that integrates behavioral health specialists in pediatric practices to address the social and emotional well-being of young children and their families, is undergoing significant expansion. OMH sponsors 125 HealthySteps sites, which provide these critical screenings, along with other behavioral health care services and referrals. These sites have collectively conducted more than 28,000 maternal depression screenings.

Still, there is more work to be done. We must continue providing education on maternal mental health issues to healthcare professionals and the public alike to dispel common misconceptions that can contribute to stigma.

For those birthing people who do experience acute mental or behavioral health issues but do not necessarily require inpatient or residential treatment, partial hospitalization and intensive outpatient programs are available. There are programs in the greater New York City and Long Island areas – including the Motherhood Center and The Child Center of NY – that offer specialized prenatal, perinatal, and postpartum treatment. In addition, the Postpartum Resource Center of New York offers a directory of community resources to strengthen the statewide perinatal mental health support network, including educational information, healthcare and peer group services and a Postpartum Resource Center of NY Mom Line, available 7 days a week from 9am-5pm (1-855-631-0001).

Support for maternal mental health is also available from sources outside of OMH. For Instance, the New York State Department of Health's (DOH) New York State Maternal, Infant and Early Childhood Home Visiting Initiative, provides evidence-based family support programs to improve birth outcomes for high-risk individuals and their babies; support children's health and development; and strengthen families.

The Office for Children and Family Services' (OCFS) initiative, Healthy Families New York, through our partners at the state, offers a home-based program focused on building positive parent-child relationships among new parents. Services include helping families access community resources and services, educating families on parenting and child development, connecting families with medical providers, and assessing children for developmental delays.

Likewise, our colleagues at the state Office of Addiction Services and Supports (OASAS) provide programs to support maternal mental recovery and well-being. In addition to prioritizing admission for pregnant and breastfeeding individuals at its certified substance use disorder treatment programs, OASAS offers educational opportunities for the behavioral health workforce supporting this population. The agency also provides harm reduction education focused on high-risk and underserved New Yorkers – including those who are pregnant, parenting, and post-partum – through Project COPE.

These efforts are helping birthing people and families throughout our state to recognize the critical need to address maternal mental health concerns. By providing these New Yorkers with support and education, we can continue to reduce stigma and ensure they receive the best and most appropriate care whenever help is needed.

Dr. Ann M. Sullivan is Commissioner of the New York State Office of Mental Health.

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more training and technical assistance to mental health practitioners and perinatal partners across disciplines. This initiative emphasizes culturally responsive care, trauma- and resilience-informed approaches, and best practices for addressing perinatal mental health conditions, including co-occurring substance use disorders among diverse populations.

- **Strengthening Community-Based Support** – Enhancing peer support groups, home visiting programs, and collaboration with doulas aims to improve engagement and reduce stigma. These community-driven models offer meaningful and accessible support, particularly to historically underserved populations, by fostering a sense of connection and trust.

- **Addressing Structural Barriers** – While not the central focus of this initiative, the Health Department continues to support broader advocacy and policy efforts that enhance access to care, such as expanded Medicaid coverage and workforce capacity building. Reducing systemic barriers and ensuring equitable access to mental health support remain key goals across various health initiatives in NYC.

Strengthening Collaborations for Comprehensive and Coordinated Care

A robust referral system is at the heart of our collaborative approach. Families in need of mental health care must be linked to care. This initiative enhances capacity and coordination among existing NYC Health Department programs serving pregnant people and new families, including the Newborn Home Visiting Program, Nurse-Family Partnership, Citywide Doula Initiative; Family Wellness Suites; Healthy Start Brooklyn; Healthy Women, Healthy Futures; and the Neighborhood Health Action Centers. These programs center on education, empowerment, and culturally responsive services for birthing communities. They are supported by an interdisciplinary team of public health professionals, which may include doulas, social workers, nurses, and health educators who provide timely, critical care to families throughout the perinatal period. Home visitors and doulas are being trained to recognize, screen for, and refer individuals requiring mental health attention to care. Social workers are being trained in evidence-based short-term interventions they can deliver directly to families in need. By

Fatima Kadik, MA

strengthening these internal linkages, the Health Department is creating a comprehensive network of care that wraps around birthing families and addresses their needs.

In recognition of the incredible diversity of our community, the Perinatal + Early Childhood Mental Health (P+ECMH) Network is prioritizing equity-focused and evidence-based workforce development. The Network is intensifying training focused on perinatal mental health and substance use through its P+ECMH Training and Technical Assistance Center (TTAC). This initiative equips mental health practitioners, community health workers, nurses, doulas, and lactation counselors with the knowledge and skills needed to recognize and respond to mental health and substance use needs in an evidence-informed and culturally appropriate way. Together, these efforts are creating an inclusive and supportive ecosystem for families navigating the perinatal period by equipping NYC's workforce with the tools needed to meet them where they are with respect, empathy, and care.

The Goals of the Expansion

By increasing access to perinatal mental health services and centering health equity, this initiative seeks to:

- Reduce the incidence of untreated perinatal depression and anxiety, particularly among communities of color

- Strengthen parent-infant bonding and overall family well-being

- Improve developmental and emotional outcomes for young children

- Address racial disparities in access to maternal mental health supports

Devina Buckshee, MA, MPH

- Build a more resilient and well-trained behavioral health workforce equipped to provide inclusive and equitable care

Conclusion

Perinatal mental health is an essential component of overall maternal and child well-being. The expansion of NYC's Perinatal + Early Childhood Mental Health Network and TTAC's enhanced training efforts mark a critical investment in the future of families, particularly those most impacted by systemic inequalities. By aligning with MMRC recommendations and addressing racial and socioeconomic disparities through early intervention, workforce development, and policy advocacy, this initiative is poised to create lasting positive change for parents and children across the city.

By expanding services, empowering practitioners, and centering equity, NYC's Perinatal + Early Childhood Mental Health Network clinics, and TTAC are working toward a future where every parent is seen, heard, and supported. When we invest in parents, we uplift entire families—and build a healthier and more equitable New York for all.

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For more information on the NYC Perinatal + Early Childhood Mental Health Network and the TTAC training, please visit ttacny.org. For more information about the NYC Department of Health and Mental Hygiene, please visit https://www.nyc.gov/site/doh/index.page.

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services, etc., can enable Indigenous healthcare providers to better care for their mothers who may be suffering in silence. Making the connection with Indigenous communities can be difficult due to their understandable reluctance to engage with outsiders. Locating healthcare providers who may be open to communication, such as social workers, doulas, midwives, and holistic healers in Indigenous communities through websites and community connections, can open the door to a wonderful partnership.

After becoming aware of the startling suicide statistics for Native American and Alaskan Native women during a webinar, I felt the need to act. I consulted with another member of the Hofstra PA faculty, Amy Roberts, and reached out to Sonia Murdock, Executive Director of the Postpartum Resource Center of New York, Inc. (PRCNY), about a potential project with the Shinnecock Indian Nation, our neighbors on the eastern part of Long Island. The PRCNY is a non-profit organization in New York for which I have volunteered for the last 23 years after suffering from a PMAD myself with my younger son. It provides education, support, and resources for mothers and families suffering from PMADs across New York State. We were fortunate enough to connect with Ahna Red Fox, a doula and respected member of the Shinnecock Indian Nation who wanted to learn more about the project. The core group met several times to speak about the goals and objectives of the project. Our ultimate goal was to empower Ahna and other healthcare providers to help the women of their community who would be more comfortable discussing difficult topics with members of their own community.

Amy Roberts and I obtained a "Be the CHANGE" grant from the nccPA Health Foundation to fund the "train the trainer" project of enhancing access to maternal mental health screening, support, and education for the Indigenous women of the Shinnecock Indian Nation. This would be accomplished by providing education and training workshops about PMADs to their healthcare providers. Once trained, these healthcare providers would then be better able to serve the mothers of their community by educating them and their community members about PMADs, identifying those at risk for a PMAD through screening, and providing assistance for those suffering from a PMAD through telephone support, support groups and resources for treatment. First-year didactic Hofstra PA students also benefited from increased awareness about the health disparities that

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exist in this Indigenous population through a 2-hour lecture given by Ahna Red Fox at the end of the project.

We had several anticipated outcomes of the grant project: increased immediate and long-term awareness of PMADs in marginalized populations , specifically Indigenous women; increased immediate and long-term PA student awareness of PMADs and maternal mental health issues in Indigenous women; early, immediate, and long-term identification of PMADs in Indigenous women; increased immediate and long-term access to care for maternal mental health in the Shinnecock Indian Nation population; implementation and access to maternal mental health telephone support immediately and long-term; formulation of maternal mental health support groups for the Shinnecock Indian Nation population immediately and long-term; and lastly to replicate this training and project in order to support and serve other marginalized populations.

To achieve our desired outcomes, we held six training sessions- non-consecutive except for the first 2-day training. All were held virtually via Zoom and included two days of PMAD education, a one-day description and use of screening tools (including the Edinburgh Postnatal Depression Scale), a one-day telephone support workshop, and a two-day support group training workshop. The one-day telephone support workshop was taught by Sonia Murdock and included "Social Support: PMAD: Steps to Wellness" and "The Changing Face of PMADs in the Community: Offering Social Support with Telephone Support" modeled from what is used at the PRCNY. The two-day support group training workshop included how to facilitate support groups for mothers suffering from PMADs, and provided training, support services, and materials to group facilitators so they may offer the PRCNY's *Circle of Caring* support group to the populations they serve in their community. All sessions had an opening welcome and Shinnecock blessing from Ahna Red Fox. Attending the 2-day PMAD Education Workshop from the Shinnecock Indian Nation was Ahna Red Fox, a social worker from the Shinnecock Indian Nation, and several tribal leaders. The subsequent sessions were attended by Ahna Red Fox and the social worker that attended the first sessions.

In addition to the training sessions, the core group also developed a palm card with information about PMADs and resources that was adapted from PRCNY palm cards but tailored for the Shinnecock Indian Nation. Some of the language on the card was in the Shinnecock native language, and the Shinnecock Indian Nation's colors of purple and yellow were also used, as well as a photo of a Shinnecock Indian Nation mother and child in their nation's attire. The informational palm cards were distributed in their community centers, family center, preschool, health clinic, and directly to pregnant and postpartum mothers from their healthcare providers.

Along the way, we had assured Ahna that even at the conclusion of the project, we would continue to support their community as much or as little as she felt necessary. Since completing the project, she has implemented support services for the Shinnecock community's perinatal families and expanded her knowledge about PMADs to further help her community. In September 2023, at the PRCNY's 25th Anniversary Gala, Ahna was the recipient of the Community of Caring Award for her contributions to her community in the fight to raise awareness and support for those suffering from PMADs. We continue to include Ahna in our advocacy to change policy for mothers and families both in New York State and federally, and we have some new projects that we are looking to implement to further combat the racial inequities in maternal mental health in Indigenous populations. Sonia, Amy, and I also learned many things from Ahna and the tribal leaders involved in the training sessions. In many ways, I learned more from them than they did from us. I learned that there are ways of respectfully empowering Indigenous healthcare providers to identify and support mothers suffering from a PMAD in their communities by ensuring that they are stakeholders in the process, and that we were there to learn from them as well and learn about what makes their community unique. I also learned to be aware of avoiding the "White Savior Complex" and to ensure that the people of the Shinnecock Indian Nation knew that we were there for guidance and support in the process, to empower them to help the mothers and families of their community. This project has enriched my life and career as a healthcare provider and fostered in me a desire to continue working with marginalized populations, not only for their benefit but also for my own. To quote Marine Corps 1st Lt. Travis Manion on why he chose to be deployed to Iraq a second time, "If not me, then who?"

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years for most patients. Postpartum depression is real, but so is recovery.

Jenny, a mother who sought TMS treatment at Serenity, shared her experience:

"I always wanted to be a mom. One of the things I was worried about having depression is that, like, what kind of mom am I going to be able to be if I'm not well? TMS has been such a relief because I am so much happier in motherhood than I thought I could be."

Jenny's story is a powerful reminder that while PPD can make mothers feel overwhelmed, hopeless, or disconnected, recovery is possible, and it's life-changing. If you're struggling with postpartum depression, know that you're not alone. You deserve support, compassion, and the right treatment to help you heal and experience the joy of motherhood.

Why Many Moms
Choose Alternatives Like TMS

Despite how common it is, nearly 50% of women with Postpartum depression go untreated. In fact, research shows that nearly 75% of women with PPD symptoms never receive professional care.

That means millions of women each year go without treatment, often because they're unaware of alternatives or feel pressured to 'push through.' But, untreated PPD can have long-term effects on both mother and baby, including delayed child development and strained relationships.

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frequent contact with healthcare providers, seeing them 20-25 times during routine pregnancy and the first year of their baby's life. However, these frontline providers, and even psychiatrists and psychiatric nurse practitioners, often lack the specialized training, knowledge, and resources necessary to address maternal mental health conditions effectively (13).

The programs operate on a workforce development model, providing education, consultation, and support to healthcare professionals rather than trying to treat patients directly. This approach uses existing healthcare infrastructure while maximizing the impact of scarce psychiatric resources. Research has found five core components that these programs may implement: telephone consultation with perinatal psychiatry experts, one-time patient-facing consultations, resource and referral services, training for perinatal professionals, and practice-level technical assistance. Across the United States, programs vary in which components they offer, allowing for customization based on local needs and resources (14).

Project TEACH: A Model for Comprehensive Support

New York State's Project TEACH exemplifies the comprehensive approach that Perinatal Psychiatry Access Programs can provide. Funded by the New York State Office of Mental Health, Project TEACH serves as both a Child Psychiatry Access Program and a Perinatal Psychiatry Access Program. In recognition of the need for expanded maternal mental health services, New York State Governor Kathy Hochul increased Project TEACH funding in 2025. Project TEACH now includes support to allied healthcare professionals such as therapists, lactation consultants, home visiting nurses, staff of the Special Supplemental Nutrition Program for Women, Infants, and Children, and community mental health workers. Any frontline professional who serves pregnant and postpartum individuals can access specialized training and expert consultation to provide mental health support to the perinatal individuals they work with.

Project TEACH provides three primary service categories designed to support New York State professionals in delivering quality mental health care.

First, Project TEACH offers real-time phone consultations with psychiatrists and psychologists, with the potential for telehealth evaluations of patients. This service allows frontline professionals to access expert guidance when faced with complex cases or uncertainty about treatment approaches. For example, the program's team of maternal mental health experts can provide medication reviews and safety recommendations for pregnancy and breastfeeding, aid with mental health assessments, and offer specialty consultations for concerns related to substance use or lactation.

Second, the program helps with referral and linkage services. The program's team of liaison coordinators can help providers and patients connect to therapy and services that support pregnant and postpartum individuals. This component addresses one

Kristina M. Deligiannidis, MD

of the most significant barriers to care: navigating the complex mental healthcare system to find appropriate, available services. By keeping relationships with local providers and understanding community and state resources, Project TEACH can streamline the referral process and, in some cases, work directly with patients, linking them to ongoing care.

Third, Project TEACH provides comprehensive, maternal mental health education through in-person and virtual trainings that offer no-cost continuing medical education and continuing education unit credits. The program also provides scholarships to national perinatal mental health certification programs, investing in long-term workforce development. Maternal mental health trainings can be customized to meet a professional's personal educational development or to meet the training needs of an organization. This multi-faceted access to education ensures relevant and practical application.

All Project TEACH services are provided at no cost to clinicians, allied health professionals, and patients in New York State. The program operates through seven academic medical centers across the State, ensuring broad geographic reach and using the expertise of reproductive psychiatrists, perinatal psychologists, and maternal mental health liaison coordinators. This distributed model allows the program to serve both urban and rural areas effectively, addressing geographic disparities in access to specialized care.

Increasing Access Through Systematic Change

Perinatal Psychiatry Access Programs like Project TEACH increase care for pregnant and postpartum individuals through several key mechanisms. By building provider capacity, these programs enable more healthcare professionals to screen for, assess, and manage maternal mental health conditions confidently. This distributed care model expands the workforce capable of providing evidence-based treatment, thus addressing the shortage of specialized providers. The consultation component provides crucial safety net support, ensuring that frontline providers can access expert guidance when needed while maintaining primary responsibility for patient care. This approach builds provider confidence and competence over time, creating a multiplier effect as trained providers become more skilled and comfortable managing these conditions independently. Practice-level technical assistance helps healthcare systems implement evidence-based screening and treatment protocols systematically. This organizational change approach ensures that maternal mental health becomes integrated into routine care rather than as an add-on service dependent on individual provider initiative. The education and training components create lasting change by building knowledge and skills across the healthcare workforce. By offering continuing education credits and certification opportunities, programs incentivize participation while ensuring that learning translates into improved patient care.

Empowering all providers to transform maternal mental health, Perinatal Psychiatry Access Programs, like Project TEACH, represent a paradigm shift in maternal mental healthcare delivery, moving from a specialist-dependent model to one that empowers the broader healthcare workforce to provide evidence-based care. By addressing systemic barriers, building provider capacity, and ensuring access to expert consultation, these programs offer hope for closing the treatment gap that affects hundreds of thousands of families annually. As these programs continue to evolve and expand, they hold the promise of transforming maternal mental healthcare from a crisis-driven specialty service to an integrated component of routine perinatal care.

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To learn more or request a no-cost service, visit www.ProjectTEACHny.org or call toll-free at (716) 878-2454.

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experiences, reducing fear and shame. Doulas are also knowledgeable about available mental health resources and can connect birthing individuals to licensed professionals, support groups, and crisis interventions, reducing barriers to care.

- **Recognizing early warning signs:** In perinatal settings, screenings for mental health conditions are widely inconsistent and vary in frequency, implementation, and follow-up. Unlike clinical providers who have limited time with patients, doulas interact with birthing individuals longer and more frequently throughout the perinatal period and can assist with identifying early signs of mental health issues, such as intrusive thoughts, loss of interest in activities, and withdrawal from family and friends, as well as referring them to timely, appropriate services.

- **Advocating for culturally responsive, person-centered care:** Doulas play a vital role as advocates for birthing individuals, ensuring that their voices, needs, and concerns are heard and respected. This is especially important for historically marginalized communities, such as Black and Indigenous groups, that have experienced systemic racism, discrimination, and mistrust in medical institutions.[6] Doulas understand that different stigmas affect specific communities, and by providing culturally responsive support, they ensure that an individual's background, beliefs, and lived experiences are recognized and reflected in their care.

- **Supporting partners and families:** In addition to supporting birthing individuals, doulas can also provide education and support to partners and family members. Doulas can offer guidance on how to recognize warning signs, facilitate conversations around mental health, and provide emotional support to their loved ones. By including partners and family members in these discussions, doulas can strengthen a birthing individual's support network, ensuring that they receive the help they need.

The State of Doula Care in the U.S. and New York State

While the benefits of doula care are well-established, there is still much work to be done in making it accessible and affordable for all. As of April 2025, roughly half of U.S. states require or are in the process of implementing doula care coverage for Medicaid members, while several states are working to implement coverage in private insurance plans.[7] In New York, there have been significant strides to increase access to doula services. Launched in 2018, the Doula Services Pilot Program laid the groundwork for Medicaid members to receive doula care at no cost.[8] Currently, all New York State Medicaid enrollees are eligible to receive doula services (up to eight visits) during pregnancy and for 12 months postpartum. In addition, enrolled doulas are reimbursed by fee-for-service up to $1,500 in New York City and $1,350 in the rest of the state. More information regarding the Medicaid doula care benefit can be found here.

Despite recent progress, greater efforts are needed to expand doula services across New York. Nearly half of the births statewide are covered by Medicaid, yet in April 2025, there were only 214 Medicaid-enrolled doulas, most of whom are concentrated within the New York City and Buffalo regions, leaving more rural areas underserved.[9, 10] In addition, policymakers and insurers need to work together to mandate coverage under private plans, ensuring that all birthing individuals—not just those enrolled in Medicaid—have access to doula services. Lastly, all healthcare and social support providers have a duty to educate their patients about doula services, particularly the availability of the NYS Medicaid doula benefit. Doulas are vital in reshaping the current state of maternal mental health, and expanding access is a powerful step towards destigmatizing mental health conditions and improving outcomes for all.

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deaths (CDC, 2004).

If we want these interventions to actually work, we have to stop treating maternal mental health like every other mental health issue. The stigma is different.

We tell people to "speak up" or "ask for help." But many moms don't feel they're *allowed* to do either. They fear they'll be labeled unstable. That they'll be judged. Or worse—deemed unfit to parent.

And for some mothers, especially in rural areas, religious communities, immigrant populations, and communities of color, that fear is well-founded. The shadow of child protective services looms large. So does generational trauma and distrust of medical institutions.

When I served as the Project Director for the National Maternal Mental Health Hotline, we heard over and over from mothers who were told, "It's just the baby blues." In trying to help women understand the emotional shifts that can come after childbirth, we've unintentionally internalized a message that minimizes their pain. That's why we had to start every conversation in a way that made them feel safe—not dismissed—for reaching out.

Ashley Womble, MPH, PMHC

Designing for the Moms Who Say "I'm Fine"

Healthcare leaders have a challenge: How can we design systems for mothers who don't want to be patients?

We're not just asking women to accept treatment—we're asking them to redefine their identity. We're asking them to believe that vulnerability isn't weakness. That being a mother in need isn't the same as being a bad mother. That seeking treatment is a sign of strength, not a red flag.

That's not something a single screening tool or referral can fix. It requires a systemic approach grounded in empathy, trust, and cultural change.

Here are a few key opportunities:

- **Don't Stop at the Screener.** A yes on the Edinburgh Postnatal Depression Scale (EPDS) isn't the finish line—it's the first step. Providers need training to gently challenge stigma. If a mom says "I'm fine" while shaking or crying, it's worth asking again.

- **Make Follow-Up Automatic.** Why put the burden on moms to schedule their own therapy when we know stigma discourages action? Leverage technology to make follow-up the default, not a one-off.

- **Let Peer Voices Lead.** Nothing cuts through shame like hearing another mom say, "I've been there—and I got better." Integrating support groups and peer support specialists into care can normalize the struggle and spotlight the strength it takes to get help.

- **Build with Communities, Not Just For Them.** Stigma thrives in cultures where motherhood is sacred and mental illness is taboo. Tailor interventions with community input, especially in rural, religious, immigrant, and BIPOC communities.

I believe deeply in the power of healthcare to transform lives. But we can't keep operating under the assumption that mothers will speak up when they need help. Many won't. Not because they're hiding—but because they don't believe they're allowed to ask.

The solution isn't just awareness. It's identity-affirming care. It's helping mothers understand that treatment isn't proof they're unfit—it's evidence they're fighting for themselves and their families.

We don't need to tell mothers to be strong. We need to create systems that make it safe for them to be vulnerable.

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- **42% of patients** say they hesitate to share health misconceptions or concerns with their providers due to fear of being judged (News-Medical, 2024).

- **Among healthcare workers**, fear of judgment for seeking behavioral health support increases the risk of suicide and leads many to avoid professional help or even self-care (CDC, 2025).

These numbers highlight a troubling reality: Stigma is not just a matter of hurt feelings—it can worsen health outcomes, prolong suffering, and, in some cases, become a matter of life and death. When individuals are afraid to speak up, entire families and communities can suffer the consequences—diseases spread, mental health crises deepen, and public health resources are strained.

Why Fear of Judgment Blocks Help-Seeking

Stigma creates a cycle of silence and worsening health. People fear being labeled "weak," "crazy," or "difficult," so they keep quiet about symptoms or delay seeking help. This is especially true for mental health and substance use disorders, where negative stereotypes are deeply ingrained, even among healthcare professionals themselves.

The effects are profound:

- **Delayed diagnosis and treatment** for both mental and physical conditions.

- **Lower Trust** between patients and providers, especially among marginalized groups who already face systemic discrimination.

- **Poorer treatment adherence** and higher dropout rates for ongoing care.

When people are afraid to share their truth, not only do they suffer, but the entire system becomes less effective, less compassionate, and less able to protect public health.

Michiko B. Andrade

Building Trust and Reducing Stigma

The solution starts with Trust. Studies show that when patients feel respected and understood, they are more likely to share concerns, follow treatment plans, and seek help early. The Centers for Disease Control and Prevention (CDC) recommends that healthcare leaders and providers:

- Use straightforward and respectful language when discussing sensitive topics, including those relevant to mental health.

- Share personal stories to normalize conversations and reduce shame.

- Lead by example, demonstrating non-judgmental attitudes in every interaction.

Training healthcare workers to recognize their own biases and communicate with empathy is an essential part of delivering quality healthcare. It is essential to foster an organizational culture that reminds providers that self-awareness and empathy are not one-time lessons but ongoing practices necessary to establish trust with patients. Trust is built not just by what providers know but also by how much they demonstrate that they care.

Moving Towards a Stigma-Free Healthcare System

The stakes could not be higher. When fear of judgment keeps people silent, it is not just individuals who pay the price; families, communities, and the entire healthcare system also feel the impact. But change is possible. By transforming the way we discuss health, confronting our own biases, and fostering trust, we can create a healthcare system where everyone feels empowered to speak up and seek help. The path to better health for all starts with compassion, respect, and the courage to listen without judgment. Imagine a world where the doctor's office is not a place of fear but a safe place of understanding—where every voice is heard, and every patient and their concerns are valued.

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ingrained in our brains and nervous systems in response to our early conditioning. These adaptations shape how we connect and protect ourselves. Even if we feel secure in some relationships, the codependent patterns can resurface in unfamiliar situations, especially when we feel vulnerable, judged, or are forming new bonds, pulling us away from our Authentic Self and back into self-protective behaviors.

In homes where love had to be earned through good behavior or where parents were emotionally unavailable, children learned to suppress their own needs and prioritize the needs of others. They became hyper-attuned to the emotions of caregivers, sacrificing authenticity for the sake of some degree of attachment. Over time, this becomes hardwired into the brain's stress response and attachment systems.

These coping strategies often carry into adulthood, and for many women, even those who've done therapy and worked hard to heal attachment patterns, motherhood can reactivate them. The emotional intensity, constant demands, and vulner-

Anne Dranitsaris, PhD

ability of caring for a child can trigger old survival behaviors, making it feel as though all that progress has disappeared.

The Neuropsychology of the "Good Mother" Persona

From a brain-based perspective, codependent behaviors emerge from early disruptions in the development of the limbic and prefrontal systems. When emotional attunement and co-regulation are absent in early childhood, the amygdala, the brain's threat detector, becomes overactive. This type of conditioning creates chronic hypervigilance, anxiety, and difficulty regulating emotions. It also leaves mothers predisposed to reacting to their feelings and the "not good enough" story that accompanies them rather than to their child's needs.

During childhood, the development of the prefrontal cortex is stalled because of the over functioning of the amygdala. This part of the brain, responsible for boundary-setting, perspective-taking, and self-reflection, doesn't fully integrate with the emotional centers, causing us to control our emotions instead of maturing them. When the codependency pattern is reactivated with their child, it causes mothers to prioritize the real or imagined needs and expectations of others over their own, despite knowing they need to rest, say no, or ask for help.

Their nervous system responds as though self-care or boundary-setting is a threat to their survival because, in their early experiences, expressing needs often led to disconnection, punishment, or shame.

In the context of motherhood, this neuropsychological pattern leads to:

- Relentless self-monitoring and anxiety over parenting decisions

- Guilt and shame when trying to meet one's own needs

- Emotional fusion with the child—feeling responsible for the child's every feeling or behavior

- Difficulty asking for or receiving help

- A chronic sense of not being "good enough."

These symptoms are not simply by-products of stress or hormones. They are expressions of an unhealed developmental delay that affects identity, self-worth, and emotional regulation.

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health care by race, ethnicity, and socioeconomic status in New York State. For example, Black and Hispanic women in the State were less likely than their White counterparts to receive postpartum check-ups in 2020—a key opportunity for depression screening. Only 80% of non-Hispanic Black and 78% of Hispanic postpartum New Yorkers reported having such a check-up, compared to 91% of non-Hispanic White individuals. Postpartum New Yorkers who were unmarried, insured by Medicaid, or had attained less than a high school education were also less likely to report having a postpartum check-up.

Even among those diagnosed with depression, follow-up care was inconsistent. In 2020, just 55% of those diagnosed reported receiving counseling. White individuals were much more likely to report using medication to treat postpartum depression (71%) than were their Hispanic peers (38%).

Challenges with Screening Tools

The report identified that postpartum individuals in New York—and nationally—are not universally screened using standardized tools. Among postpartum New Yorkers who reported receiving a postpartum checkup in 2020, 82% reported being asked about depression at that visit, a number in line with the CDC's national estimate for PPD screening. But this is likely an overestimate of how many individuals receive robust screening with a validated instrument, as this survey question serves as a proxy for being screened.

While organizations like the American College of Obstetricians and Gynecologists (ACOG) recommend PPD screening, current guidelines across entities lack clarity and consistency on how, when, and by whom screening should be performed. This has led to significant variation in practice and inequitable implementation of screening.

The Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire-9 (PHQ-9) are two widely used tools. Both have been validated across diverse populations, but the OMH-DOH report notes that challenges remain. It is critical that screening instruments be tested and updated as needed for the unique subgroups of all New Yorkers, as language barriers, literacy, and cultural norms can affect how questions are interpreted and answered. The report strongly recommends that validated PPD screening tools be paired with assessments of social determinants of health (SDOH), which powerfully influence maternal mental health and well-being.

Social and Structural Determinants of Risk

The report highlights the many non-clinical factors that elevate risk for PPD, such as stressors like food insecurity, housing instability, low-quality sleep, intimate partner violence, and limited access to transportation or childcare.

Particularly high-risk groups include:

- Young parents
- LGBTQ+ individuals
- People with a history of mental illness
- Immigrant and refugee populations
- Those experiencing relationship or financial stress

New York State's PRAMS data further demonstrate that postpartum people covered by Medicaid or with lower education levels consistently report higher rates of depressive symptoms, yet are less likely to be diagnosed or treated. For instance, in 2019, self-reported PPD was more than twice as common among those without a high school diploma compared to those with more than a high school education (23% vs. 11%).

Recommendations

In light of these and other findings, the NYS report offers a series of recommendations aimed at standardizing, expanding, and improving postpartum screening and care:

1. **Screening and Follow-up**: Incorporate validated mental health screening tools into routine care from preconception through one year postpartum—not just immediately after birth. Include other perinatal mood and anxiety disorders beyond PPD. Screen for basic social needs using validated tools, including for housing, food, social support, intimate partner violence, and barriers to accessing care.

2. **Provider Training**: Enhance training in cultural competence, implicit bias, trauma-informed care, and communication around mental health and substance use to reduce stigma and improve equity.

3. **Access to Treatment for Mental Health and Substance Use Disorders and to Resources to Meet Social Needs**: Explore ways to improve pathways to care by increasing access and decreasing barriers to services and supports, including through partnerships with other state agencies.

4. **Reimbursement**: Ensure adequate technical support and reimbursement for screening, education, and brief intervention to incentivize greater uptake by primary care and pediatric providers.

5. **Research**: Collaborate with researchers to refine existing screening tools for cultural relevance and study technology-based solutions, like mobile phone-based screenings, which could reach more postpartum individuals in real time. Improve data collection systems to better capture subgroup differences by disaggregating data.

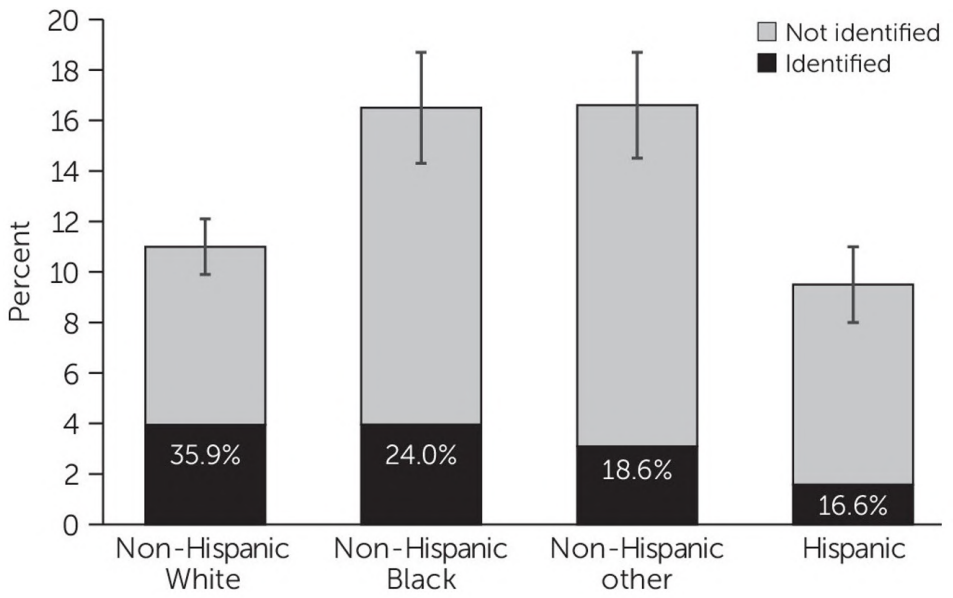

Figure 2. Percentage of respondents (N=12,541) reporting postpartum depressive symptoms who also report being told by a health care provider that they had postpartum depression[1]

1. Data were from the New York State Pregnancy Risk Assessment Monitoring System (PRAMS), 2017–2022. Percentages are weighted to represent New York State's demographic composition. "Non-Hispanic other" includes PRAMS respondents identifying as American Indian, Chinese, Japanese, Filipino, Hawaiian, other Asian, other race, or mixed race; 84% of this group was non-Hispanic Asian. Small sample sizes within this group prevented deeper - and much-needed - analysis. Error bars indicate 95% confidence intervals.

Note: Figure 2 is taken from Ehntholt et al. Psychiatric Services 2025. In original publication, it is labelled Figure 1.

Looking Ahead

These findings add to the mounting evidence of persistent inequities in how postpartum depression is experienced, screened, and treated. Though screening is the first necessary step, it alone is far from sufficient. Systems must be responsive to the complex, intersecting challenges postpartum individuals face, especially those who have been historically marginalized. While awareness of PPD has grown, many of the people most in need—especially Black, Hispanic, low-income, and underserved birthing individuals—are still not being reached by the current system.

New York continues its efforts to understand, to address, and, ideally, to prevent the drivers of disparities, with the goal of providing equitable and effective maternal mental health care. As the United States faces an ongoing maternal health crisis—to which mental health conditions are a major contributor—the urgency of such efforts cannot be overstated.

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Why This Goes Unseen

The most insidious aspect of maternal codependency is how normalized and even praised it becomes. A mother who sacrifices everything, never complains, and is endlessly attentive is seen as devoted and loving. But under the surface, these women are emotionally depleted, anxious, and living from a performative "Imposter Persona" rather than their Authentic Self.

This invisible struggle contributes to the following:

- **Postpartum mood disorders**: Chronic self-abandonment and emotional dysregulation are key features of anxiety and depression in mothers.
- **Parental burnout**: Mothers who are unable to set boundaries or advocate for their own needs become emotionally and physically exhausted.
- **Intergenerational trauma**: Children raised by mothers in codependent patterns often struggle to develop secure attachments and healthy emotional regulation themselves.

Because codependency doesn't always look like a crisis, it's rarely addressed in maternal mental health care. But ignoring these patterns leaves women stuck in survival mode, silently suffering behind a mask of perfection, striving to be a good mother rather than a mother who seeks to meet their child's needs while taking care of themselves.

A New Path Forward

Developing from codependency in motherhood begins with recognizing it not as a character flaw but as an adaptive response that's no longer serving us. We cannot build resilience, emotional regulation, or secure attachment without first acknowledging where we've been developmentally delayed.

Here are three core strategies for ensuring you mother from your Authentic Self:

1. Challenge Your Beliefs

The first step is to identify and unlearn the belief that motherhood means martyrdom. All humans have emotional, physical, and psychological needs, including mothers. When these needs are consistently

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connections between identity, experiences, and systems of power among staff, recipients of services, and community members (Rehman et al., 2023). A lack of ongoing involvement and commitment from leadership prevents this process from happening. Freyd's work researching institutional courage (2022) – "an institution's commitment to seek the truth and engage in moral action, despite unpleasantness, risk, and short-term cost," – emphasizes the importance of including leadership in efforts to educate the organization on the need to "transform institutions into more accountable, equitable, effective places for everyone." I've seen organizations effectively involve leadership in a variety of ways, including:

- leadership attendance at trainings about stigmatization (this allows them to learn about best practices for reducing stigmatization and signals to employees the importance of the topic),
- the CEO attending all onboarding for new employees and discussing the agency's commitment to providing an equity-driven workplace and services,
- adding an ongoing agenda item related to stigmatization at executive meetings, and
- including the board of directors in these efforts (sharing outcomes related to destigmatization work with them and inviting them to trainings).

2. Evaluate Outcomes Through Monitoring and Measurement

Validated self-stigma assessments should be used with clients/patients, and stigma assessments and interventions should be included throughout clinical treatment and programming (O'Toole et al., 2016). It is also important to assess staff members to identify which types of stigmatizations are most in need of addressing and to track the effectiveness over time of the new interventions and policy changes (Modgill et al., 2014). Several of the validated assessments I use with sites are available at the NYS Office of Mental Health (OMH)-funded website. A limitation of most stigma assessments is that they only measure attitudes, so I also encourage the ongoing use of assessment tools that provide ways to

Gretchen Grappone, LICSW

track behaviors related to organizations' responses to reports of intersectional forms of stigmatization (The Center for Institutional Courage has several of those assessment tools that can be accessed). I've also seen organizations add specific questions about experiencing discrimination to their quarterly client/patient surveys, which is an easy way to get behavioral feedback related to staff. Regardless of what outcome measures are tracked, sharing the results with staff, service recipients, and the community is an excellent way to show that an organization is committed to transparency and accountability.

3. Grow Through Tension and Dissonance

Organizations working on the structural and clinical changes needed to address stigmatization must plan for resistance and backlash because it will happen. Sukhera & Knaak's research (2022) emphasizes that dismantling structural stigmatization is "only possible through interventions that were accepting of, and proactively managed disruption as part of their intervention." What causes pushback? The MHCC (2023) states, "In many cases, resistance comes from people in power who feel unmoored or even threatened when their perspectives are no longer the top (or only) priority," and emphasize that it is important to acknowledge that this response makes sense and then "work to support those people through conversations rooted in empathy and curiosity." One community mental health center I worked with that was very successful in addressing structural stigmatization started the process with an email from their CEO to all staff. The message explained the need for change, how certain outcomes would be tracked, and it included a link to an anonymous survey asking for feedback about the topic and any concerns or suggestions staff had for the upcoming changes. We got over a 90% response rate from 300 staff members and were able to share the results with the staff. That data helped guide much-needed discussions about potential changes and helped to identify specific training needs for the organization.

Continuing This Work
in Challenging Times

Last week, I attended a conference addressing strategies for embracing change related to mental health and substance use services in New York in challenging times. Both the directors of Office of Addiction Services and Supports (OASAS) and the Office of Mental Health (OMH) presented at the conference and made themselves available to answer questions about their strategic plans and guiding principles. They embodied several of the key principles to dismantling structural stigmatization described above: leadership guiding change talk, discussion of strategies for evaluation of strategic plan goals (e.g. OASAS goal of reducing racism and stigma surrounding substance use disorder) and responding to the current challenges related to new federal-level policies that may cause conflict with state-level policies. I left the conference feeling more hopeful about this work than I had in several months precisely because it felt like the content of the day was driven by the key principles needed to dismantle the practices and policies that cause harm to New Yorkers who experience MI/SUD, to those who care about them, and sometimes to those of us who provide services in health care settings. It is my hope that these principles will be embraced by all healthcare leadership in the diverse communities of New York and result in equitable care for anyone in need of services.

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role in reducing the internal stigma that may prevent families in need from reaching out for support.

Third, mental health should continue to be prioritized as part of routine pre/perinatal care. I am grateful that my team emphasized my mental health, but that is not necessarily the case for everyone. In addition, these screenings should extend to the father. While not subject to the same hormonal changes, fathers may feel a strain on their relationship, heightened anxiety, and poor mood overall (Kim & Swain, 2007). Fathers (or really, any non-birthing partners) are subject to a different stigma than their partners, but they are not exempt from that pressure.

Fourth and finally, there needs to be greater advocacy for parents in the workplace. While stigma against PMD may not be overt in most workplaces, the covert barriers are strong enough to act as a strong deterrent for those already struggling. This stigma may be perceived as a weakness rooted in shame, fear of negative stereotypes and judgment, or just a lack of institutional policies to help parents as they return to work (Thorsteinsson et al., 2018).

Everyone's postpartum experience is different. One baby may be magical and effortless, while another may leave the family feeling anxious and overwhelmed. Both experiences are valid; the problem lies in the stigma. Combatting this stigma is a multi-faceted approach with a solution that leans heavily into collaboration and advocacy. Education on topography, prevalence, and latency could be extremely helpful in early recognition. Prioritizing mental health for both parents during pre/perinatal care is also critical in identifying problems early and addressing them before they escalate. Finally, advocating for better parental care and acceptance may help reduce the stigma that parents feel when returning to work. I leave you with this note: my own postpartum experience was rocky, with the best support and care. I had a wonderful partner and an excellent care team. If this was my experience, then imagine the difficulties that can arise without this support, and addressing the stigma surrounding PMD is a good place to start.

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The Parental Mental Health Peer Support Program's mission is to increase awareness and improve access to quality care for New York State families at risk or experiencing a perinatal mood and anxiety disorder, including maternal/postpartum depression. Peer support reduces stigma and increases the number of mothers and fathers seeking and receiving help. A special emphasis in this program is on increasing the provision of services to those New York families that are underserved or disadvantaged from various socioeconomic backgrounds.

The Parental Mental Health Peer Support Program is expanding the programs and services of the Postpartum Resource Center of New York statewide. The program includes providing for free to families: peer to peer nonjudgmental emotional support via a 7 day a week, state-wide toll free helpline, numerous weekly virtual support groups and support meetings, twice weekly check-ins, weekly Peer Chat sessions, and educational information/awareness materials to pregnant women, moms, dads and service providers (maternity hospitals and health clinics) and healthcare and support group resources.

The Program includes providing peer support and closing gaps for high-risk populations, including: Finding the Help You Need Support Meeting, and What I Need to Know Virtual Class. For Spanish-speaking families, there is the Seguimos Adelante Groupo de Apoyo (We Keep Moving Forward) support group, for Black/African American moms-to-be and moms there is EMERGE, and for dads-to-be and fathers there is Support for Dads Groups and Dad on Call telephone support. There is also support provided to military families and those impacted by Perinatal Psychosis and Parenting with a psychiatric disability.

Family members are offered to meet with the Peer Team for emotional support, education, and perinatal mental health resources at free virtual Take Care of You Family Support Meetings. Family members have reported back to the Postpartum Resource Center of New York that many times these meetings are a turning point in understanding of PMADs, have increased partner

Sonia Murdock, PMH-C

communication, and have increased getting the help that is needed.

"The Take Care of You family meeting was the turning point for all of us having a better understanding how to support my wife and take care of myself and family as she recovered from postpartum psychosis. I don't want to think where we would be without finding the Postpartum Resource Center of New York." - A grateful new parent

Besides offering support from Peers themselves, there is also an educational component with a growing Learning Collaborative Community. The Postpartum Resource Center of New York had a unique opportunity to continue hosting the well-attended Moving on Maternal Depression Webinar Series (MOMD) that has been offered in collaboration with the Schuyler Center for Analysis and Advocacy. This webinar series is an important part of the Parental Mental Health Peer Support Program. The series helps to make the connection for increasing knowledge on the need for inclusion of Peer Support. Topics addressed include challenges of connecting with perinatal populations due to stigma of mental illness and combating lack of knowledge of perinatal/parental mental health.

The Learning Collaborative Community is also able to engage and learn from each other, closing the gaps in care by highlighting models of treatment and support for perinatal mental health in New York and sharing best practices including on the inclusion of Perinatal Mental Health Peer Support throughout New York State and other states.

The Moving on Maternal Depression Webinar Series is increasing knowledge for the prevention, screening, treatment, and support services for perinatal mental health. The MOMD series is also increasing specialty and culturally appropriate, trauma-informed care resources to reduce health and racial disparities. It is further increasing access to quality care for New York families who are underserved and disadvantaged from varying socioeconomic backgrounds, especially those at high risk or experiencing a perinatal mood and anxiety disorder.

With the identification and development of new resources (including multilingual, culturally and economically appropriate resources), the PRCNY's on-line Statewide Perinatal Mood and Anxiety Disorders Directory continues to be expanded to offer additional resources with special attention to address racial and health equity and access to care.

The availability and support of the Postpartum Resource Center of New York's Parental Mental Health Peer Support Program is enhancing professionals and community support programs to have greater ease in screening and asking of parents-to-be, mothers, and fathers about their mental health.

In conclusion, the need for awareness, prevention, education, and early intervention in perinatal mood and anxiety disorders (PMADs) remains of critical importance to reduce stigma, increase access to care, and to prevent suicide and infanticide. The Postpartum Resource Center of New York's Parental Mental Health Peer Support Program has demonstrated through its statewide implementation and expansion, that through peer support there can be a reduction in stigma, increased access to quality care, and vital tools provided for families and healthcare providers to increase connection to treatment and support for help to save lives.[5,6,7]

"The program in general has been absolutely critical to my healing. The meetup was extremely helpful because I heard other women speaking the thoughts and feelings I was having. I thought these were specific to me and I thought I was alone and broken, but knowing so many were having the same experience was comforting, and I felt so much support and reassurance in that I wasn't alone." - PRCNY Parental Mental Health Peer Support Program Mom

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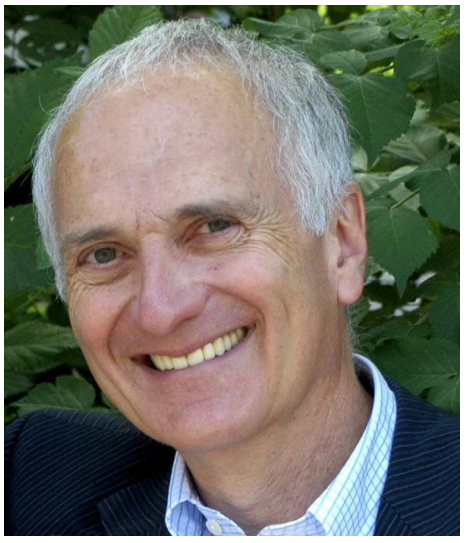
Teen Mothers from page 25

domains. Making things even more difficult for them, these are all groups that are highly stigmatized. Pregnant and mothering teens and their families have spoken about their experiences of stigma. Unfortunately, healthcare professionals all too often share those biases and play a role in perpetuating stigma.

Indisputably, many teen mothers, like those I see in my clinical practice, are struggling, as are their children. Even so, as I sit in my office, I think, "This young woman is smart, but for chance and the fate of being born with profound social disadvantages, she could be as successful as my own kids, the medical trainees I teach, and the colleagues I work alongside." But some young mothers do pull themselves out of the chaos of their childhood, even as more fortunate members of our communities—including healthcare providers, teachers, and policymakers—assume they are where



Jean Wittenberg, MD

they are because they deserve it. We may believe they brought it on themselves, that they are less capable, less smart, lazier, less honest than we are, and these biases change the way professionals view and treat young mothers. That is the essence of stigma—and stigma hurts.

Among other things, stigma causes stress. It piles up on itself and multiplies its impact. It can add to the stress of adverse childhood experiences and continue throughout teen mothers' lives to make every step more difficult for them and their children. Stigma reduces access to resources: Schools, parks, healthcare access, housing, shops, etc., are all better in better neighborhoods. Many teen mothers live in marginalized communities and are victims of discrimination. Stigma is manifested through interpersonal interactions in shops, on public transit, in healthcare offices, and in schools. It acts systemically and is embedded in policy.

In the face of these challenges, it is remarkable that some of these young mothers fashion successful lives for themselves and their children. For many, having a baby becomes a call to setting life goals and organizing their lives. Some, like Samantha, find their new role as an opportunity to examine their purpose and change conditions for their children. Even for them, though, stigma makes it harder to succeed and causes stress that is passed on to their children. All too often, young mothers succeed *despite* the oppression of the stigmatizing beliefs imposed on them by their presumed support system. Undoubtedly, some are defeated by stigma. This is a systemic failure resulting in tragedy for them, their children, and, ultimately, society.

What Society at Large Can Do

- Adopt a more compassionate stance because these are young girls and women who have babies they can love and grow with. Adolescents have always had babies, and we know that they

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Biomarkers from page 15

But there is a promising avenue for biological tests that may help us to pinpoint pathophysiology as well as predict risk, and that is in the area of blood-based biomarkers. Critics of this line of reasoning will point out that PMADs are not solely a biological phenomenon – of course not, as with any psychiatric illness (indeed, any illness period), the causes are biology and environment intertwined. But for a substantial number of women with PMADs, the proximate cause of illness is vulnerability to the hormonal shifts of pregnancy, [12] whether that is mediated directly through hormone levels and receptor conformational change, or indirectly through related systems such as the immune system and the HPA axis. In the last 15 years, research teams have uncovered potential blood-based biomarkers in epigenetics, immune signatures, neuroactive steroids, and extracellular vesicles. [13] With the current crisis in federal grant funding, it is a matter of urgency that those interested in promoting the psychiatric health of today's mothers and tomorrow's children rally to enable continued research of these potentially game-changing lines of research. With a blood test to predict the development of a PMAD, mothers could stop thinking that their illness was "all in their head" or evidence of their unfitness as mothers, and focus instead on the treatment they need to manage their medical conditions in pregnancy and postpartum (just as they now focus on managing gestational diabetes and hypertensive disorders of pregnancy). It's time for both mothers and clinicians to recognize that these are real illnesses, with real causes (both biological and environmental), and that only by identifying – and treating – those at risk can we advance the health of two generations.

Lauren M. Osborne, MD

Lauren M. Osborne, MD, graduated from Weill Cornell Medical College and received her psychiatric training at Columbia University/New York State Psychiatric Institute. She completed both clinical and research fellowships in women's mental health and is an expert on the diagnosis and treatment of mood and anxiety disorders during pregnancy, the postpartum period, the premenstrual period, and perimenopause. Dr. Osborne is an Associate Professor of OB-GYN and of Psychiatry and serves as the Vice Chair of Clinical Research in the Department of Obstetrics & Gynecology at Weill Cornell Medicine. Her research on perinatal mental illness focuses on models of care and on biological mechanisms and biomarkers, with a focus on neurosteroids and the immune system, and she runs the PIPPI Lab – Psychoneuroimmunology in Pregnancy and Postpartum – at Weill Cornell. Dr. Osborne's clinical work consists of collaborative care for perinatal mental health within OB/GYN. She is also the chair of the Education Committee for Marcé of North America; founder and chair of the National Curriculum in Reproductive Psychiatry, a free web-based standardized curriculum; and an editor of The APA Textbook of Women's Reproductive Mental Health. Her work has been supported by the Brain and Behavior Foundation, the Doris Duke Foundation, the American Board of Psychiatry and Neurology, the Department of Defense, the NIMH, and the NICHD.

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tools for managing daily demands but also room to reconnect with the parts of yourself that existed long before motherhood.

The Kids are Grown. Now What?

Becoming an empty nester is another significant life shift. After years of putting children first, their departure can feel both like a proud milestone and a profound loss. Even when expected, this change can stir up grief, loneliness, and a sense of lost identity.

Every woman experiences this stage differently. Some feel free to rediscover themselves, while others are caught off guard by sadness or anxiety. Milestones such as graduations or weddings can bring joy and a quiet ache of being left behind.

This time often overlaps with other challenges. Many women are caring for aging parents and managing their own health changes. Menopause, with its hormonal fluctuations and physical symptoms, can add another layer to the emotional load—exacerbating mood changes, sleep issues, or feelings of vulnerability. Taken together, these transitions can feel overwhelming, even for women who once considered themselves emotionally resilient.

Libby Erickson, DO

But this stage also offers room for rediscovery. After years of tending to others' needs, it can become a season of reflection, reconnection, and growth. Therapy can help process grief, manage anxiety, and reframe identity with clarity and confidence. Relationship counseling may deepen bonds with partners, navigate changing dynamics with adult children, or foster new friendships. With the right support, women aren't just getting through this season—they're growing into it and thriving.

Breaking the Silence:
Every Mother Deserves Ongoing Support

Too often, mothers quietly carry their emotional burdens. Guilt, stigma, and deeply ingrained generational beliefs teach women to push through pain, prioritize others, and equate strength with silence. Mental health concerns may be brushed aside as "just part of the job" or dismissed entirely until they reach a breaking point. This silence can be isolating, as many mothers feel alone in their struggles—even though their experiences are deeply shared.

But maternal mental health isn't just about responding to a crisis. It's about creating space to grow, process, ask hard questions, and rediscover joy. Whether a woman is grappling with infertility, balancing the demands of parenting and career, or redefining herself in an empty home, her emotional needs are real and deserving of care. At every stage of a woman's life, accessing appropriate mental health services should be a priority—whether through therapy, medication, TMS, or other psychiatric interventions—regardless of the stage of motherhood a woman finds herself.

As society expands its understanding of mental health, it's essential to broaden the conversation beyond the postpartum window. The maternal journey doesn't begin or end with a baby—it evolves over time, shaped by love, loss, change, and resilience. And at every stage, women deserve the support, validation, and resources that help them not just survive but thrive.

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to report depressive symptoms than those who did not.

Best Practice: Offer a minimum of 12–16 weeks of paid leave to parents and at least 4–6 weeks for partners, encouraging shared caregiving and reducing stigma.

Flexible Work Arrangements

Return-to-work anxiety is a common trigger for perinatal mental health challenges. Many women feel rushed when returning to work. Flexibility in hours, hybrid models, and task reprioritization ease this transition.

Best Practice: Implement gradual return-to-work programs, such as phased reentry or part-time arrangements during the first three months after leave.

Virtual Mental Health Access

Providing access to Employee Assistance Programs (EAPs) normalizes help-seeking and reduces stigma. It is important for managers to educate and encourage employees to utilize the services available to them. By providing free or subsidized counseling sessions, employers can help reduce financial barriers to help.

Best Practice: Ensure your health plan includes perinatal mental health services. Mindfulness-Based Therapy Groups have proven effective in helping mothers cope with the stressors related to a return to work (Costa et al, 2021).

Manager Support

One of the most common experiences of a working mother is the feeling of being

Nichole Renadette, LCSW

"stretched too thin," a sign of role overload. Adjusting to the new role of "mother" while still performing at work can feel overwhelming. Oftentimes, mothers are forced to fulfill the needs of others (i.e., their employer or families) before taking care of their own wellness needs, due to lack of time or energy. That is why the first line of support is often the manager. As an administrator and a mother myself, I feel sensitive to the needs of a first-time mother returning to work. I think it is important for mothers to know they are not alone, and that as an employer, we want to find the best back-to-work plan and understand it may take up to a year to combine the new role of "mother and employee". The benefit of paid leave is crucial; however, it does not prepare the mother for her new identity, that will come with time.

To effectively change a culture at work, to be more family-friendly, and to meet the needs of our employees, leadership must model empathy, normalize conversations about mental health, and demonstrate flexibility. Support does not end with maternity leave. Employers need to be flexible and accommodate the individual needs of the family. Supporting maternal mental health in the workplace is not only a moral obligation but a strategic advantage. It fosters employee loyalty, improves well-being, enhances productivity, and signals that your organization values the whole person, not just the role they play.

As one of the largest outpatient community mental health organizations in New York, we urge employers to view maternal mental health not as a niche concern but as an essential pillar of any inclusive, forward-thinking workplace. With the right policies, partnerships, and cultural commitment, we can ensure that no mother is forced to choose between her mental health and her career.

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Unhealed Trauma from page 21

frightening, unpredictable, unfriendly, and unsafe (Powers et. al., 2022).

Mothers who come from generations of the same repeat behavioral trends are unable to recognize that their behavior can be changed due to the modeling of their disorganized memory and attachment (Babcock, Fenerci, and DePrince, 2018). The traumatic experiences impede the brain's ability to function properly, and the risk for intergenerational trauma continues in a cyclic pattern. There is a disconnection between the ability of survivor mothers to establish parental cognition. The child of the survivor mother often replicates the negative stress responses due to exposure and a lack of secure attachment. A child of a survivor mother often will externalize the internal feelings of the mother through transmission (Iyengar et. al., 2019; Powers et. al., 2022).

The research shows that maladaptive behaviors displayed by survivor mothers stem from their brain's inability to process these stressful experiences appropriately. Mothers who have experienced trauma are unable to emotionally regulate and find it difficult to connect with their children. This is directly correlated to the mother's inability to cognitively address their post-traumatic experiences.

Keiley Pfeiffer, EdD

When a person experiences chronic stress or traumatic experience(s), the brain naturally shuts down the prefrontal cortex and turns on the amygdala (Iyengar et. al., 2019; Powers et. al., 2022). Neurologists discovered that this is a natural stress response, which triggers the brain to go into survival mode. Power et. al. (2022) identified that women who have gone through trauma often have low self-esteem, a lack of awareness, and empathy to face their own internal struggles.

A recent study completed by the National Institute of Mental Health (2023) explored the brain function of infants raised by survivor mothers. The analysis of these brain scans revealed that the brain of an infant shows a mirrored reflection of the mother's brain, specifically in the amygdala and prefrontal cortex. Therefore, this leads to increased risk for the child of future mental and behavioral health concerns. Research suggests that in order to prevent this type of attachment from being formed, the mother must recognize, treat, and heal from their past traumas. Providing interventions and resources to surviving mothers is critical in order for them to address the triggering event that increases the potential for abuse, neglect, or insecure attachment to take place. Resources should see them through these critical time periods and provide them with appropriate coping mechanisms and modeling of secure attachment in order to put an end to intergenerational trauma (Iyengar et. al., 2019; Powers et. al., 2022). Overall, the teaching of emotional regulation is key in reversing the presence of intergenerational trauma.

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significant and long-lasting ripple effects. It increases the risk of preterm birth, impacts child development, and contributes to behavioral and emotional challenges in children. As the CDC notes, there is a "strong connection" between parental and child mental health.

In clinical and community settings, we see this every day. Mothers who are anxious or depressed often find it harder to manage basic parenting tasks, adhere to pediatric care plans, or maintain employment. In turn, this increases household stress and economic vulnerability—creating a feedback loop that harms both parent and child.

Policy Headwinds

These troubling trends in maternal mental health are unfolding against the backdrop of sweeping federal restructuring efforts that threaten to further destabilize the fragile infrastructure supporting mothers and families. Recent proposed changes at the U.S. Department of Health and Human Services (HHS) include deep budget cuts, workforce reductions, and the consolidation of key public health agencies—most notably, the demotion of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the elimination of several maternal health-specific programs within HRSA and the CDC. Critical surveillance systems like the Pregnancy Risk Assessment Monitoring System (PRAMS) may be at risk, and technical assistance programs that support maternal mental health screening, peer support, and clinical integration are being scaled back. These moves jeopardize the very systems designed to detect, address, and prevent poor outcomes for mothers across the country.

Without immediate course correction,

Jorge R Petit, MD

these cuts can only exacerbate the underlying crisis in maternal mental health—reducing access to data, eroding care coordination, and dismantling the specialized teams and leadership needed to champion perinatal mental health equity.

As suicide, overdose, and untreated mood disorders continue to rise among reproductive-aged women, the elimination of dedicated maternal mental health funding and leadership sends the wrong message at the wrong time. If we are serious about reversing these trends, protecting maternal mental health must become a core priority in federal behavioral health policy. Now more than ever, targeted advocacy is needed to restore, sustain, and scale the programs that make a difference.

What Needs to Happen Now!

Addressing this crisis requires structural changes and upstream investment. Based on the emerging data and evidence-based practices, we should strongly advocate for:

1. Extending Medicaid postpartum coverage to 12 months (now optional for states under the American Rescue Plan), ensuring continuous access to mental health support beyond six weeks.

2. Mandating universal screening for maternal mental health in both prenatal and pediatric care, using standardized tools (e.g., Edinburgh Postnatal Depression Scale (EPDS) or PHQ-9).

3. Scaling culturally and linguistically responsive peer models, such as community-based doulas and lay health workers, to offer trusted support in underserved communities.

4. Integrating behavioral health in OB-GYN and pediatric offices—leveraging collaborative care models and tele-mental health to close access gaps.

5. Leveraging data and digital tools: EHR platforms, mobile apps, and AI-driven tools can prompt screening, monitor progress, and flag risk, enabling more proactive interventions.

From Crisis to Commitment

While many national conversations frequently focus on protecting unborn life, far less attention is paid to ensuring that mothers survive and thrive during and after pregnancy. This disconnect creates a dangerous gap in care and policy—one that contributes directly to preventable suffering and maternal mortality.

We can no longer afford to treat maternal mental health as an afterthought. The data shows us the scope of the problem; the human stories remind us of the cost of inaction. If we are serious about ending preventable maternal mortality, improving early childhood outcomes, and building a healthier society, maternal mental health must become a central focus of behavioral health, reproductive health, and public health policy.

Healthy moms raise healthy kids. It's time to turn awareness into action and ensure that every mother has access to the care, support, and dignity she deserves.

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Diversity & Health Equity at APA. Fall 2024 Update

Relational Trauma from page 24

anxiously hovering, or chronically disengaged. These patterns are often signs of a nervous system still wired for survival. Whether in response to physical or emotional threats, the brain resorts to fight, flight, freeze - or eventually, emotional shutdown.

Healing in the Home and in Therapy

Motherhood is hard. It's exhausting. And there are moments when even the most resilient mother questions whether she can make it through.

The pressures of social media compound this struggle. New mothers are bombarded with filtered images of smiling babies and effortlessly glowing parents. For a mother who hasn't showered in days or feels like she's failing, these images can breed shame and isolation. But they are highlight reels—not the real, raw moments of self-doubt, tears, and uncertainty that every parent experiences.

So, how does one know when to seek professional help? The answer is simple: it's never wrong to ask for support. Therapy offers mothers a safe space to express their needs, explore their history, and restore emotional balance. Often, what a mother truly needs is the presence of others who can offer her the very thing she

Victoria Sanders, LMFT, PhD

must offer her child: secure attachment and compassionate attunement.

Practical Support for New Mothers

Here are a few actionable ways to support new mothers - whether you're a partner, family member, friend, or professional:

1. **Create space for honest conversations.** Validate the mother's feelings. Babies can be both adorable and exhausting - these realities are not mutually exclusive.

2. **Support physical and emotional self-care.** Help the mother tune in to her own needs and prioritize them without guilt.

3. **Model and teach healthy attachment behaviors.** Especially for young mothers or those with histories of trauma, offer concrete guidance: make eye contact, smile, laugh together, and encourage skin-to-skin contact.

Conclusion

Relational trauma doesn't begin—or end—with childhood. It echoes through generations, quietly shaping the way we love, attach, and care for others. But when we name it, recognize it, and address it with compassion, we can begin to break the cycle.

Every mother deserves to feel seen, supported, and emotionally held—just as every child deserves the same. And sometimes, the healing begins with a whisper.

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Resources from page 23

- Overcoming Communication Challenges
- Asking for Adjustments

All tools and videos from the Stigma and Conflict Resolution Resource Group are available for free at www.conflictcompass.com/rg. Organizations, communities, and support groups who would like assistance integrating these resources into their communities can contact MH Mediate for assistance at dan@mhmediate.com.

Below, we highlight six of the tools featured in the Resource Group and share how they support real-life situations involving stigma and conflict.

Anyone can join the Stigma and Conflict Resolution Resource Group to access the fifteen different tools and videos, and four skills sessions, by visiting www.conflictcompass.com/rg.

1. Support: Appreciate Supporter Needs

This tool lays the foundation for seeking support by encouraging users to step back and consider the day-to-day realities facing the people they're reaching out to - people who may be busy or going through problems of their own. It helps users map out possible supporters, their capacity, and their own hopes and fears about asking for help. Users are guided to appreciate their supporters' own stressors, time limitations, and interpersonal dynamics. A structured worksheet prompts people to name potential supporters, assess how much they trust them, identify what kind of support they hope for, and consider the best timing to approach them. This tool promotes empathy and realism—and helps avoid disappointment or resentment.

2. Support: Asking with Gratitude

Once a user identifies potential supporters, this tool helps them plan how to ask for help. It includes templates for outreach messages, planning guides, and reflection exercises. The emphasis is on making "asks" that are thoughtful and flexible, showing appreciation rather than entitlement. The worksheet walks users through each step: what stage of a problem they're in, what kinds of help would be useful, who could offer it, and what level of investment is being asked. This approach reduces the emotional load for both the asker and the supporter, and increases the chance that the help will be sustainable. By being clear about what kind of support is being asked for, it can reduce the chance that the prospective supporter is overwhelmed.

3. Rejection: Clarifying Whether Rejection Occurred

Many people who have experienced trauma or marginalization carry heightened sensitivity to rejection. This tool breaks down ambiguous interactions and helps users assess whether rejection has truly occurred or if something else might be happening. It starts by having the user list observable behaviors (e.g., not responding to messages, avoiding contact). Then it asks what assumptions are being made and whether alternative explanations exist. It concludes by guiding users toward grounded next steps. This can prevent spirals of shame or self-blame and promote clearer, calmer communication. It can also help develop clear evidence of stigmatizing rejection, if that is indeed what is happening.

4. Rejection: Deciding Whether to Speak Up

Sometimes, rejection is real—and the next choice is whether or not to speak up in response. This tool supports thoughtful decision-making by offering a step-by-step process to evaluate how the user feels, what the context is, what the relationship dynamic is, and what the risks and benefits might be. The "Deciding Whether to Speak Up" worksheet provides a checklist of reasons someone might choose to speak up (e.g., seeking closure, restoring trust) and reasons they might hold back (e.g., needing emotional safety, waiting for clarity). It ends with options for how to frame the conversation if they decide to engage.

5. Accommodations: Deciding Disclosure

This tool focuses on what can be a very difficult, personal decision for someone living with an otherwise invisible mental-health-related life impairment: whether to disclose their diagnosis or disability limitation as part of seeking support or accommodations. The worksheet offers legal context, reflection questions, and a list of pros and cons for sharing more or less information. It also helps them understand what kinds of questions or exams may be inappropriate for people to ask for as part of the disclosure process. In considering the choice to share more information, the tool helps users identify their concerns (e.g., stigma, retaliation), emotional reactions (e.g., shame, fear, hope), and past experiences. It reinforces the user's autonomy by making clear that disclosure is a personal choice—and that limited disclosure is often enough.

6. Accommodations: Navigating Logistical Burdens

Even after accommodations are requested, people can face delays, denials, poor implementation, or even retaliation. This tool outlines common post-request obstacles and provides calm, strategic options for responding. The worksheet shares ideas of what to do if a request is ignored, ways to challenge policies respectfully, things to say when implementation is poor, and possible options for handling backlash from others.

Conclusion: A System for Surviving and Thriving Amidst Stigma

Together, these resources provide a system of support for people navigating stigma—not just by naming it, but by offering practical pathways to respond. The full collection of 15 tools, along with videos and skills sessions, is available for free at www.conflictcompass.com/rg.

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dismissed, both mother and child suffer.

***Practice*:** Identify one unmet need each day—rest, solitude, nourishment, connection—and take one small action to meet it without guilt or apology.

2. Respond, Don't React

Rather than reacting to every cry, mood, or perceived need as though it were a life-or-death situation, take a breath and respond to what is happening with clarity and intention. Children need to learn to delay gratification, and it doesn't serve this developmental requirement when you jump to attention at the first cry or ask. Recognize that being at everyone else's beck and call depletes you and leaves you more vulnerable to self-doubt and self-judgment.

***Practice*:** When you feel the urge to react immediately, pause and take one deep breath. Ask yourself, *"Is this truly urgent, or can I respond calmly after finishing what I was doing?"* The practice of mindfulness is critical in increasing the ability to be in the present moment and respond, not react.

3. Build Regulating Relationships and Support Systems

Codependent mothers believe they have to do it all themselves to prove they are "good" mothers. They believe that asking for help means they are failing as a mother. But the truth is, we were never meant to do this alone. We find joy in motherhood when we're held, heard, and supported by people who remind us that our needs matter, too. Whether it's a friend who truly listens, a partner who actually shows up as a partner, or a coach who helps you stay grounded, sharing the weight is not a weakness; it's how we are meant to be as mothers.

***Practice*:** Reach out to someone you trust to get perspective and share how you're *really* feeling. Start building a circle of support that sees and honors you, not just the role you play. Work with a therapist to stop you from reinforcing the codependent patterns you have worked so hard to release yourself from.

Final Thoughts

Motherhood is one of the most profound and demanding transformations a woman can experience. It has the power to reawaken our deepest wounds—but also to offer us an opportunity to heal them. By recognizing codependent patterns as the result of unresolved developmental trauma, not personal failure, we free mothers from the impossible standards that keep them stuck.

Supporting maternal mental health means moving beyond symptom management and toward deeper emotional integration. It means helping women reconnect with their Authentic selves, not so they can be perfect mothers, but so they can be present ones. Because when a mother connects to herself, she can connect to her child, and the cycle of self-abandonment finally comes to an end.

Let's stop telling mothers to be everything to everyone. Let's help them become *themselves.*

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Resources (books)

Mother Hunger by Kelly McDaniel

Power Past the Imposter Syndrome by Anne Dranitsaris

The Body Keeps the Score by Bessel van der Kolk

Change the Story from page 27

check-up often ignores mental health symptoms and needs entirely.

While hormonal shifts and physical changes are well-known biological contributors to perinatal mental health conditions, psychological and social drivers play an equally powerful role in shaping a mother's mental well-being throughout the perinatal period. Despite enormous physical and emotional changes, many women feel pressure to meet unrealistic ideals and maintain constant joy. Some mothers perceive it as a failure that they don't instinctively know how to parent. These expectations, often fueled by social and cultural pressures, can lead to guilt, shame, and self-doubt when reality falls short.

For those with a history of mental health challenges or past traumas, the emotional demands of the perinatal period can reopen old wounds. This increases vulnerability to mental health problems, especially following birth experiences that feel traumatic or disempowering.

Confronting the Gaps in Care

Beyond individual experiences, broader social and structural factors profoundly impact maternal mental health. A lack of affordable health care, childcare, paid leave, or culturally competent healthcare leaves many mothers unsupported and overwhelmed.

For women who are part of minoritized communities, the stress of navigating discrimination and negative social determinants of health can add a compounding layer of harm that is too often overlooked in perinatal care. High maternal mortality rates in the United States are alarming, as over half of pregnancy-related deaths in the U.S. happen after delivery, with 25% occurring between one week and one year postpartum. Addressing these issues requires careful observation to ensure all mothers receive the care, support, and dignity they deserve during one of the most mentally and physically challenging times in their lives.

Cara McNulty, DPA

Estimates from a study in the National Library of Medicine suggest that between 6.5% and 20% of people who give birth will have depression symptoms. This figure also includes pregnant people who miscarry, terminate pregnancies, or have stillbirths.

The staggering reality is that up to 50% of these cases of depression remain undiagnosed due to patients' reluctance to disclose symptoms, according to the National Institute of Health. For some under-resourced parents, a lack of support or trust from institutions can lead to fear of their child being taken away.

Building a Maternal Mental Health Response System

My personal experience navigating the mental health care system in my time of need stays with me and shapes my work in the mental health system every day. It reminds me to center personal stories and drive lasting change. A critical part of this work is in crisis response and advocating changes that can bolster the continuum of care and increase integration and collaboration across mental health services.

No single service or intervention suffices on its own. We must redesign the mental healthcare ecosystem to identify where women are in their journey and meet them there, across providers, health systems, and communities. Women are often praised as "supermoms" for pushing through pain silently, despite the fact that suffering in silence carries severe consequences for untreated maternal mental health. These are not inevitable outcomes. They are preventable tragedies that demand an urgent, systemic response.

There *are* resources available, and it is core to our work as mental health advocates to ensure that all mothers have access to them throughout their motherhood journey. Stigma, lack of childcare, language differences, or distrust of the system too often block the way. We must proactively integrate mental health into prenatal care, with tailored screening and support pathways for anxiety, PTSD, OCD, depression, and psychosis. Integrating behavioral health into OB-GYN visits, lactation consultations, and pediatric checkups creates important touchpoints for early detection and intervention. These touchpoints can address real-world needs in a way that is accessible, affordable, personalized, and coordinated across disciplines.

We all have a role to play as partners, employers, healthcare professionals, policy leaders, and communities. Together, we must create a culture where talking about maternal mental health is no longer stigmatized but embraced as a normal and essential part of pregnancy. Mothers should feel safe, supported, and empowered to seek help.

If you're in need of help, you can reach the National Maternal Mental Health Hotline by calling or texting 1-833-TLC-MAMA (1-833-852-6262), where trained counselors can offer support and direct women to additional care.

Cara McNulty, DPA, is the Chief Executive Officer of Vibrant Emotional Health.

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support. Recommended resources include:

- Postpartum Support International
- Mayo Clinic's postpartum depression guidelines
- Consultations with mental health professionals specializing in perinatal care

2. Provide Consistent Emotional Support

Mothers experiencing postpartum depression often report feelings of guilt, inadequacy, and isolation. Effective partner strategies include:

- Active listening without judgment
- Validation of maternal experiences
- Encouraging dialogue while avoiding pressure

3. Facilitate Access to Treatment

- Identify qualified mental health professionals specializing in perinatal mood disorders
- Attend therapy sessions jointly where appropriate
- Discuss psychopharmacological interventions (e.g., SSRIs) with healthcare providers

4. Assist in Daily Care and Responsibilities

- Reduce cognitive and physical burdens by managing household tasks

Richard Anemone, MPS, LMHC

- Facilitate maternal rest through active involvement in childcare
- Encourage routine self-care practices

5. Monitor for Signs of Severe Depression

Clinically significant indicators include:

- Suicidal ideation or thoughts of harming the infant
- Severe withdrawal or emotional dysregulation
- Inability to perform basic daily tasks
- Timely intervention, including professional consultation and crisis management, is imperative in cases of acute psychiatric distress.

6. Foster Relational Stability and Connection

- Prioritize nonverbal emotional engagement (e.g., affectionate gestures)
- Respect maternal preferences regarding intimacy and connection
- Maintain open communication regarding relationship dynamics

7. Promote Adaptive Coping Strategies

- Encourage physical activity (e.g., walking or outdoor engagement)
- Facilitate healthy sleep and nutrition
- Provide access to structured relaxation techniques

8. Maintain Partner Well-being

- Engage in professional counseling when needed
- Practice self-care strategies to mitigate emotional exhaustion
- Seek peer support networks for caregivers of individuals with PPD

Conclusion

Postpartum depression necessitates a comprehensive support system that extends beyond individual clinical interventions. Partners play an integral role in promoting maternal recovery, and their involvement can significantly reduce symptom severity and enhance overall well-being.

A structured approach encompassing education, emotional support, practical assistance, and treatment facilitation is essential for fostering a positive mental health trajectory. Recognizing the interdependence of familial mental health will enable more holistic and effective interventions, ultimately benefiting both mothers and their partners.

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Holistic Providers from page 27

clinical settings.

Midwives—especially those trained in the Certified Professional Midwife (CPM) or Certified Nurse Midwife (CNM) models—offer trauma-informed, patient-centered care that integrates mental health screening, perinatal education, and continuous support. In rural and underserved communities, midwives often serve as a critical access point for prenatal counseling and emotional care (Vedam et al., 2018).

Other alternative providers—such as acupuncturists, massage therapists, herbalists, and reiki practitioners—offer non-pharmacological support for perinatal stress, insomnia, grief, and emotional dysregulation. Acupuncture, in particular, has been found to reduce anxiety and depressive symptoms during pregnancy (Manber et al., 2010), while somatic practices like Reiki and breathwork can promote nervous system regulation and trauma release. These interventions are often accessible outside clinical walls, making them essential tools in mental health promotion.

Additionally, lactation consultants, chiropractors, and even community healers often serve as confidants and informal mental health monitors during postpartum recovery. Their consistent contact with new parents creates natural opportunities to flag emotional distress early—often long before a clinical diagnosis is made.

For example, a mother struggling with anxiety might receive support from a licensed therapist while also accessing somatic therapies like acupuncture or breathwork through trusted providers in her neighborhood. The combination reduces psychological distress, increases care adherence, and honors the lived experiences of women who have historically been underserved by traditional systems.

Georgina Dukes-Harris, MHA

Moreover, data-driven platforms that support coordination between these care types allow for better outcome tracking, insurance reimbursement, and health system integration. These platforms help ensure that community-rooted providers—who have long served on the frontlines of maternal care—are not just included in the conversation, but resourced and reimbursed to deliver impact.

Preventing Generational Trauma at Scale

The integration of mental and maternal health is not just about reducing symptoms—it's about interrupting cycles of trauma and building stronger families. From reducing NICU admissions and preterm births to improving early childhood development and school readiness, the ripple effects of maternal mental health access extend well beyond the birthing room.

In Black, Indigenous, and immigrant communities, the protective role of cultural and spiritual care cannot be overstated. Whether through prayer circles, plant medicine, postnatal rituals, or culturally specific parenting practices, these traditions offer meaning-making, connection, and resilience. Mental health strategies that ignore these dimensions risk missing some of the most powerful sources of healing.

To truly advance equity and prevent the transmission of psychiatric disorders, our systems must embrace a whole-person model—one that combines science, tradition, data, and dignity. The future of maternal health is not just medical. It's community-centered, tech-enabled, and trauma-informed.

To learn more, contact Georgina Dukes-Harris, MHA, Founder and CEO of Swishvo, at georgina@swishvo.com or visit www.swishvo.com.

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Super Mom from page 31

A 2013 review by the Pew Research Center found that 65% of mothers make career-related sacrifices, like turning down promotions or quitting entirely. This shows that motherhood can often put a woman's goals on hold.

And it doesn't end there.

A new study published by Cornell Chronicle shows that while both parents spend meaningful time with their children, mothers experience more stress and fatigue due to the invisible load of house chores they carry.

Additionally, a Journal of Child and Family Studies publication states that mothers who believe in intensive parenting prefer putting children's needs above all. Ultimately, they report higher rates of stress and depression. A mother's love knows no limits, but it costs a lot.

Despite that, if you ask a mother if she spends maximum time with her children, the reply will be No. The invisible load she carries daily drains her energy so much that it gets her thinking she's not doing enough. This results in a feeling of inadequacy among moms!

So, when Lilly hesitates before saying yes to that meet-up, she's just being cautious. She's maintaining a balance between joy and responsibility.

This is motherhood. Full of love but also full of unseen sacrifices.

Temitope Fabayo, BA, MBA-HR

Redefining the Narrative!

The Super Mom monthly magazine belongs in the trash! Next time you find such a magazine, throw it away, for mothers are also humans. Motherhood doesn't grant them superpowers. Instead, it comes with myths that need to be shunned right away.

Ask for help if you want to. Hire a nanny. Talk to your loved ones and share the burden that you're carrying. Look around for the support groups for Super Moms.

Share the load! Similarly, if you're a working mom, ask for parental leave, affordable childcare, and mental health support.

That being said, to all the mothers like Lilly, you're not a lighthouse that has to stand storms alone. Next time someone whispers, "Be strong," respond, "I am strong because I'm not alone." After all, you're a human being, and humans need each other.

And those who praise mothers for being supermoms and for their resilience should stop acting like the audience watching a show. Instead, be the anchor and support the mothers. Extend your help to them. Let them take a break from being too hard on themselves.

Overdoing things in motherhood can make them resent anything that comes their way. They might yell and nag at every little thing, not because they want to, but because they don't know how to ask for help.

Beyond being mothers, they are also human. If you look closely, the dark circles, puffy eyes, and messy hair they carry just reveal how overwhelming motherhood can be.

So, be kind to the mothers around you instead of being judgmental. It could be your wife, sister, or anyone else. If they're too tired to prepare a meal, cook for them. Help them in any way you can.

This little act of support can give them strength and remind them that they're not alone. And that it's okay to ask for help without fear of judgment. By doing so, we don't just strengthen them; we strengthen us all!

Though motherhood can be tough, it is also very satisfying. The happiness kids give tends to balance out all the hardships. All appreciate your hard work. Keep going; you're doing a fantastic job. And never be shy to ask for help, for it's a strength!

Temitope Fabayo, BA, MBA, is President of DMC HomeCare.

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Residential Treatment from page 29

feelings of worthlessness. These feelings often underlie an individual's decision to continue to use substances rather than seek treatment. The removal of the child before the recommendation for residential placement creates desperation and feelings of failure. For those who do elect to seek treatment, the removal creates additional barriers to treatment engagement and family reunification.

Oftentimes, parenting women afflicted by substance use disorder conceal, under report, and minimize their substance use and need for treatment for fear of triggering child protective service investigations and, as a result, continue to parent in dangerous or high-risk situations. The stigma around substance using parents seeking care that results in underreporting then feeds the escalation of addiction and typically contributes to worsening circumstances for their child, and by the time child welfare agencies are involved, the only legal option as it relates to prioritizing child safety is the recommendation to remove the child from the parent's care.

Between 2007 and 2017, parental drug use-related child removals in the U.S. rose by 60%, largely driven by the opioid crisis (Sieger, 2020), with up to 79% of children in foster care having experienced some level of parental substance use. Children from such families face increased risks of maltreatment, foster care entry, placement instability, and permanent separation from their parents. Reunification is less likely, especially without access to high-quality, culturally responsive, family-centered treatment. Family-focused care has been shown to improve both parental engagement and reunification outcomes compared to individual-focused interventions. Skivenes and Tonheim (2019) emphasize that child removals are among the state's most invasive actions, usually court-decided, and call for systemic reform, including earlier intervention and better resourcing of child welfare agencies. Similarly, Buek and Mandell (2023) highlight the burden prenatal substance exposure places on the child welfare system and advocate for prevention-focused, community-based responses over punitive court-driven actions. In many states, including New York, opportunities exist to support pregnant people before birth. Peddireddy et al. (2022) note that inconsistent policies across states contribute to racial disparities and biased outcomes, calling for comprehensive support, such as family-centered SUD treatment, mental health services, and help with basic needs

Sarah March, LMHC, MSW, CASAC

Two consistent interventions are recommended to reduce child welfare involvement and family separation caused by SUD: shifting toward preventive care strategies and increasing funding for family-centered services and child welfare supports. Rather than reacting after maltreatment has occurred, prevention aims to address risks earlier and keep families intact. To be effective, this requires systemic reform that extends across local, state, and federal levels and addresses longstanding structural barriers and biases in child welfare. While the opioid crisis intensified child removals, these systemic issues have existed long before, and addressing them demands collaboration between healthcare, social services, criminal justice, and child welfare systems. Federally, the Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction and Recovery Act (CARA) require states to define child maltreatment and mandate notifications for substance-affected infants. In New York, the Family First Prevention Services Act allows for federal funds to support preventive, evidence-based services like SUD treatment and kinship foster placements. The Family Court Act provides legal procedures for intervention when a child's needs are unmet.

Currently, most child welfare interventions related to SUD begin with a report from a mandated reporter, followed by investigation, assessment, and, if substantiated, treatment recommendations. If a child is found to be at immediate risk or if caregivers fail to comply with services, removal occurs, followed by court-ordered steps toward reunification. These may include parenting classes, SUD treatment, testing, mental health care, housing referrals, and supervised visitation. However, outcomes remain poor: children removed due to parental SUD are less likely to reunify and more likely to re-enter care (Sieger, 2020). This suggests that court-based, individual treatment responses often fail to resolve underlying systemic issues. Research urges a shift to prevention—providing intensive, in-home support and family-based residential care when needed. Increasing early access to care, particularly for pregnant people, offering wraparound services in healthcare and shelter systems, and improving care coordination could dramatically improve outcomes.

To realize the goals of our existing legislation, we must invest in resources that support child safety and family unity. This includes expanding access to family-centered SUD and mental health treatment, housing support, financial assistance, and services that address poverty, employment, and education. Families impacted by SUD need holistic, proactive support, not punitive, reactive systems that separate rather than strengthen. Instead of relying on the legal system to enforce compliance or viewing residential treatment as a last resort, it should be reframed as a preventive, stabilizing intervention. Family-centered residential treatment has the potential to break intergenerational cycles of trauma and substance use, particularly when used early and equitably. The real barrier is not a lack of need, but a lack of access and investment. Today, 14 adult and 25 child beds sit empty in our mother-child program. Ignoring this unmet need undermines both public policy and the well-being of the families we are supposed to protect.

If you are interested in learning more about the Young Mothers Program, please contact Sarah March, Program Director at sarah.march@samaritanvillage.org or (212) 222-5285 x8363. You can learn more about Samaritan Daytop Village at www.samaritanvillage.org.

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Teen Mothers from page 40

can be successful young women and mothers if given support, dignity, and respect.

- Acknowledge that support from teachers and school administrators can keep them in school and facilitate their education, which is associated with better planning, better work trajectories, better health, etc. Be aware that under U.S. federal law, expectant and parenting students are protected from discrimination in school.

- Keep in mind that for these young women, parents, clergy, social support workers, and other adults may be intimidating figures who can provide or withhold approval and resources—and that adult disapproval hurts.

- Policymakers need to acknowledge that stress in early childhood not only blights the quality of life for children and their parents but also causes huge downstream costs in health, education, social supports, and in the legal system. A dollar spent for young children and their families saves many multiples over time.

What Healthcare Workers Can Do

- They can ask themselves about their own often unconscious beliefs. How might they manifest in their interactions? How might they oppress teen mothers? And how might they disadvantage their babies and children?

- They can ask themselves, their colleagues, and their office staff about resources they can make available to teen mothers and their babies. How do these compare to resources offered to older mothers or to less marginalized teens who are not pregnant? How might they evaluate the language they use with peers and young families?

- They can ask themselves what it would be like to be a teen parent and what might they need to be successful.

- They can question policies that disadvantage teen mothers and their babies and support policies that help them.

- They can ask patients and clients about their experiences working with healthcare professionals and use that feedback to guide future interactions and challenge professional beliefs.

When the goal is to improve health, everyone can stop adding to the stigmatizing of teen mothers while playing an important role that focuses on the strength of young parents, supports their goals of doing the best they can to raise their children, helps them get the resources they need, gives them hope and optimism, and views them as having the capacity to be good parents and successful adults.

Group for the Advancement of Psychiatry (GAP) is a think tank of top psychiatric minds whose thoughtful analysis and recommendations serve to influence and advance modern psychiatric theory and practice.

This article has been reprinted with permission. You may view the original article, published on January 18, 2023, at psychologytoday.com/us/blog/psychiatrys-think-tank/202212/teen-mothers-when-stigma-trumps-compassion-and-research.

Childhood Separation from page 28

responses often fail to address children's emotional needs, focusing instead on punitive measures (Human Rights Watch, 2022, 2023).

Individual-Level Impacts: Attachment and Grief

Attachment Disruption

Bowlby's (1969) attachment theory demonstrates that early separations impair emotional development. Studies on children separated from their parents exhibited:

- Higher rates of insecure attachment (Firestone, 2018).
- Lifelong anxiety and depression (Rusby & Tasker, 2009).
- Similarly, children of incarcerated parents often develop:
- Fear of abandonment (Rojas-Flores et al., 2017).
- Difficulty forming trusting relationships (Simmons, 2000).

For children of parents with mental illness, separations are often sudden and unexplained, compounding trauma. According to Metz & Jungbauer, 2021:

"*More than half of the children were burdened with profound feelings of guilt. Especially in early childhood, they often believed that they were to blame for their parents' psychological problems, such as feeling as if they had done something wrong" (p. 68).*

Disenfranchised Grief

Doka (2002) defines disenfranchised grief as unacknowledged loss occurring when:

1. The relationship is not recognized (e.g., society assumes children are "better off" without a parent with mental illness or a parent incarcerated).
2. The loss is invalidated (e.g., separation is framed as necessary rather than traumatic).
3. The child's capacity to grieve is ignored (e.g., adults assume children "will forget").

Both groups internalize societal messages that their grief is unworthy of acknowledgment, leading to suppressed emotions (Murphy et al., 2017) and delayed mental health struggles (Zoll, 2019).

Systemic-Level Impacts: Bias and Structural Harm

Child Welfare and Racial Disparities

The U.S. child welfare system disproportionately targets low-income Black and Indigenous families (Human Rights Watch, 2022). Key systemic biases include:

- 75% of child welfare cases involve "neglect" tied to poverty (ACLU, 2019).
- Parents with mental illness are automatically flagged as high-risk (Gambrill & Shlonsky, 2001).
- Children of parents who are incarcerated are 5 times more likely to enter foster care (Roberts, 2022).

Consequences of Removal		
Outcome	***Children of Parents with Mental Illness***	***Children of Parents Incarcerated***
Delinquency	2–3× higher rates (Ryan & Testa, 2005)	2–3× higher rates (Doyle, 2008)
Educational Attainment	Lower academic performance (Lowenstein, 2018)	Higher dropout rates (Simmons, 2000)
Adult Incarceration	Increased risk (Doyle, 2008)	70% higher likelihood (Rojas-Flores et al., 2017)

Long-Term Consequences of Removal

Research shows that children removed from their homes are more likely to face (see the above table "Consequences of Removal").

These outcomes suggest that systemic interventions often cause more harm than the original family circumstances.

Recommendations for Policy and Practice

1. Family Preservation Policies

- Provide mental health support to prevent unnecessary removals (Slade et al., 2022).
- Expanding community-based mental health support to help parents manage crises without losing custody.
- Expand and reform visitation programs for parents incarcerated to maintain parent-child bond (Zayas, 2015).

2. Trauma-Informed Interventions

- Train child welfare workers to recognize disenfranchised grief (Doka, 2002).
- Provide trauma-informed care and support for separated children (Murphy et al., 2017).
- Systemic Reforms
- Track separation outcomes in mental health and carceral systems.
- Invest in alternatives to removal, such as kinship care and wraparound services, to support families and children.
- Challenge biases linking mental illness and incarceration to unfit parenting (Reupert et al., 2021).

Most importantly, we must listen to those most affected – adults who endured childhood separation, who can speak to what would have helped them heal. Their insights, long ignored, hold the key to creating systems that truly protect children.

Conclusion

The trauma of childhood separation lingers long after the event itself. Whether caused by mental health systems or incarceration, these separations leave children with wounds that society too often refuses to see. By acknowledging these parallels—and the systemic failures that enable them—we can begin to build approaches that prioritize healing over punishment and connection over isolation.

Acknowledgments

In Memoriam: This manuscript is based on a literature review developed initially by Cheri Bragg Acker. This submission is dedicated to the Memory of Cheri Bragg Acker (12/31/1967-12/17/2024), daughter of a mom with mental illness and advocate and leader in the rights of families and children separated from parents with mental illness and parents incarcerated.

Cheri A. Bragg Acker, BA, MSW, was the Creator of Family Lived Experience Initiatives at the Yale Program for Recovery and Community Health, Yale School of Medicine, Department of Psychiatry.

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View the full list of references here.

Daughters and Sons from page 28

experience anger at being denied, by virtue of "wellness", the same importance to mental health professionals and policy makers that the ill relative receives. But I also know that this is not the whole picture.

At the 2004 NAMI National Conference, I, along with Joe Donovan, organized two panel discussions were presented titled "Daughters and Sons of Parent's with Psychiatric Illness" and "Separating Fact from Myth: Child Welfare and Parental Mental Illness," Among the presenters, Heather Burack, a recent graduate of the Hunter School of Social Work Masters Program, pointed out that, as a daughter of a parent with schizophrenia, she has found that titles among the few clinical studies of "daughters and sons" which exist paint a grim picture of our experience. She mentioned titles of articles including "Anguished Voices", "Troubled Journey," and "Hidden Victims." These titles did not reflect her experience (or mine) of pride in our parents and in ourselves. She shared five redemptive aspects that she has identified through introspection and two research projects that focused on adult daughters and sons. Those positive characteristics are: creative orientation, tolerance of difference, willingness to challenge the status quo, emotional expressiveness, and a sense of humor.

As dialogue between our informal group of "daughters and sons" has increased (in New York and across the United States), we identified primary issues for further discussion. The top five issues we identified to increase support for both parents with psychiatric conditions and their children (of all ages) are:

1) Expanded Research: People of all ages who have a parent (or parents) with psychiatric conditions need access to information that identifies and normalizes our common experiences. Currently, there is a gap in information, although there is growing knowledge about common experiences in our community. Therefore, one of the needs of our community is research that goes beyond a focus on the statistical likelihood of our becoming ill. Other aspects of our experience and our demographics (especially related to economic status, the number of us who are in divorced families, the number of us who become foster children, or who are reared by extended family) need further investigation.

2) Support Groups and Literature: Support groups by and for people who have a parent with a psychiatric condition and access to relevant (age-appropriate) family peer support can help us feel less isolated and help us process developmental grief. Access to basic literature can be extremely helpful and easy to provide for people

Maggie Jarry, M.Div.

who are just beginning to come out of the shadows. Children and youth need developmentally appropriate psychoeducational materials so that they experience support, to mitigate internalizing stigma related to their parents' experiences. As well, people I have met as peers over decades often also mention their need for help in considering how to help aging and elderly parents with psychiatric disabilities.

3) Special Support for Young Adults: Adolescent and young people who have a parent or parents with psychiatric conditions, depending on our situation – may need special attention with life skills, especially to minimize vulnerability when prior resilience factors (economic hardship, disrupted periods of education) have been weak or altogether absent. Adolescents may need help to survive the high stress of attempting to build a life and act "normal" or build friendships without feeling fearful of stigma through disclosure of their parents' psychiatric condition. People I have met as peers over several decades mention that they would have benefited from help with financial planning for themselves, as well as help building healthy personal and professional relationships. One other person mentioned that a referral list for psychiatrists who specialize in the experience of people who have a parent (or parents) with psychiatric experiences would be helpful.

4) Children Need the Most Attention: Extended family, parents, and professionals should be trained and encouraged to talk to young people about their parents and their experience, including their perception/identification with their parents. It is important to note that children often attempt to suppress their needs because they are worried about the adults around them. They may appear "fine" but may be struggling with serious fears that need to be discussed. For children who have become little adults in the home, simply asking them to play may not be enough. Indeed, play may be difficult. In such cases, we need to provide support so that children can "transition back" into childhood by acknowledging the important role they have played in taking care of the family during an emergency. In countries such as Australia, there are documents that help children prepare in case of a family emergency, so they know how to communicate with friends and family if needed. Increasingly, the use of psychiatric directives helps families plan in advance for the care of children and youth when a parent needs respite. This type of planning is supportive of parents and their children.

5) Advocacy for Parents with Psychiatric Conditions: Parents with psychiatric conditions need advocacy and support to keep custody of their children. Stigma has unjustly and disproportionately prejudiced the "system" against parents with psychiatric experiences. Parents with psychiatric disabilities can be very good parents, but external supports are needed (including advocacy, parenting support, and better parenting-ability assessment tools for social workers). Increasingly, research shows that parenting is an important factor in recovery for people with psychiatric conditions. The right to be a parent should be supported, and parenting can be a huge, motivating factor for wellness for people who have psychiatric conditions

The experience of people (of all ages) who have a parent (or parents) with psychiatric conditions is as diverse as the experience of people with various psychiatric diagnoses. While we have overarching characteristics as a group, it is not easy to form a movement for people who have a parent with a psychiatric condition. Unresolved grief can make it difficult for some people to become advocates for people with psychiatric conditions, sometimes reacting to wider advocacy movements when their experiences as people with a parent experiencing a psychiatric condition are not acknowledged (reinforcing their experiences of "invisibility" with families as children). While others are passionate advocates, they may not disclose their experiences due to pervasive stigma against parents with mental health conditions and pathologizing of people who are their children (of all ages).

Parenting is a human right. The wellness of parents and their children (of all ages) must be supported in their relationship, together. The strengths of people who are raised by people who have psychiatric experiences should be recognized. Stigma against people who have a parent (or parents) with a psychiatric condition must be consistently addressed through balanced studies, such as those highlighted above. People who have a parent with a psychiatric condition often grow into amazing adults. Parents need to know this to reduce their own stress and worry. Young people need to know this so that they can feel hopeful and recognize that they are not alone.

In fact, many of us have stories to share that may shatter stigma. As people, we also must receive support to help us overcome the stigma that is attached to us as a group, an extension of the stigma that our parents face. People who have parents with psychiatric conditions have important roles to play in diverse mental health movements as they focus on human rights and recovery. As we embrace recovery, I hope that many of us will also live with less fear of becoming ill. People (of all ages) who have parents with psychiatric conditions need to be supported in carving out our own identity and voice within larger mental health movements, as much as we must be supported in developing our voice and identity as individuals separate from our parents. I hope you all will join me in seeking out ways to lend support to people (of all ages) who have parents with psychiatric conditions while also supporting parents with psychiatric conditions in the days, months and years ahead.

This article has been adapted from a previously published 2004 NAMI-NY Newsletter. This article reflects the views of people who participated in the Daughters and Sons Initiative and is submitted in memory of Cheri Bragg Acker.

Maggie Jarry, M.Div., is the Co-Founder of the Daughters and Sons Initiative. For more information, visit dandsinitiative.org.

Footnotes

1. See the Parenting Well website for more information and access to both research and tools to support parents with diagnoses psychiatric disability and their Daughters and sons.

2. As of 2003, we began coining the term "Daughters and sons" instead of "adult children" or "offspring." We did so to express that we feel the term "adult children" has pathologizing layers of meaning, on the one hand relegating us to the word "children" independent of our age or lifetime experiences and because the term is often associated with negative experiences and codependence. We rejected the term "offspring" because it felt clinically dehumanizing. At the same time, we wanted to express balanced information inclusive of positive aspects of our experiences, while recognizing the essential human relationship that exists between a parent and their daughter or son. "Daughters and Sons" also translated well into different languages as our efforts grew beyond the United States and primarily English-speaking countries.

TMS from page 34

While antidepressants are a common option, they're not the right fit for everyone. Many mothers worry about:

- How meds might affect their baby while breastfeeding
- Not feeling like themselves
- Unpleasant side effects or emotional numbness

TMS addresses these concerns head-on. It supports healing without disrupting your ability to parent, bond, or function day-to-day.

At Serenity Mental Health Centers, we offer:

- Flexible scheduling to fit your lifestyle
- Warm, welcoming environments
- Thorough evaluations to tailor treatment to each mother's unique needs
- Help with insurance navigation

Destroying the
Postpartum Depression Stigma

Society puts enormous pressure on mothers to be perfect, and that makes asking for help feel scary.

But struggling with PPD doesn't make you weak. It doesn't make you a bad mom. It just means you need support, and that's okay.

You deserve to feel whole. You deserve to enjoy motherhood. You deserve to heal.

If you're struggling, you're not alone. And you don't have to stay stuck. TMS is an alternative that could finally work for you like it has for so many others.

Interested in learning more about TMS? Visit serenitymentalhealthcenters.com or call 844-310-1665 to schedule a consultation and explore if TMS is right for you.

Mah Mekolle is Regional Nurse Practitioner Lead at Serenity Mental Health Centers.

Silent Crisis from page 29

or fear of losing themselves in the process can all shape the decision around whether to have children. These are not hypothetical fears. They are grounded in the lived experiences of millions of women. And when those experiences are ignored, the impact is felt across generations.

Evidence shows that treating maternal depression leads to measurably improved outcomes for children, including better growth and development patterns and reduced rates of illness. When mothers receive appropriate mental health interventions, the benefits extend beyond symptom relief to create tangible improvements in child health and development outcomes.

Building Solutions that Work

Addressing this crisis means building systems that go beyond simply responding to mental health emergencies, but preventing them in the first place. Healthcare organizations must fundamentally rethink how they approach maternal care by embedding mental health screening into routine visits from early pregnancy through the full postpartum year. This requires training OB/GYNs, pediatricians, and family physicians, among other licensed professionals, to identify early signs of distress and establish protocols for connecting mothers to specialized care, ensuring accessible therapy without stigma or long wait times.

The current approach treats newborns with tremendous care while often overlooking the emotional well-being of the parent during well-baby appointments. When healthcare systems integrate maternal mental health assessments into these visits and leverage telehealth platforms to eliminate barriers like transportation and childcare, mothers gain access to perinatal mental health specialists who can provide early intervention that makes recovery more likely and reduces long-term complications.

However, clinical solutions alone are insufficient without addressing the systemic pressures that leave mothers without support. Policy changes like expanding paid family leave and making childcare affordable, combined with healthcare systems that create seamless referral pathways between obstetric, pediatric, and behavioral health services, ensure no mother falls through the cracks.

Supporting maternal mental health requires reshaping how we care for mothers at every stage — before, during, and after birth. If we want to change the story, we must start by listening to mothers and building healthcare systems that are empathic, supportive, and accessible.

Dr. Tom Milam serves as Chief Medical Officer at Iris Telehealth and President of Iris Medical Group – guiding their team of clinicians in telemedicine and industry best practices. He received his undergraduate degree from WVU in Anthropology, where he graduated summa cum laude and Phi Beta Kappa. He went on to earn his Master of Divinity Degree from Yale, where he was a Yale's Associate Scholar, followed by receiving his Doctorate of Medicine (MD) from the University of Virginia. His residency training in psychiatry took place at Duke and UVA. Dr. Milam has practiced in North Carolina and New Zealand and is an Associate Professor of Psychiatry and Behavioral Medicine at the Virginia Tech Carilion School of Medicine and Research Institute, where he has been on faculty for the last 15 years.

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Fertility Struggle from page 30

feel blindsided—if conception was once possible, why does it feel impossible now?

Unlike primary infertility, where women grapple with the fear of never knowing motherhood, secondary infertility comes with an added layer. Some hesitate to voice their sorrow, fearful that others will dismiss their pain, saying, "At least you have a child." They question themselves, wondering if they are allowed to grieve. But the pain is no less valid; longing for another baby does not diminish the love for a firstborn.

Recurrent Miscarriages Create Emotional Upheaval

For those facing recurrent miscarriages, grief can feel cyclical. Losing a pregnancy time and time again creates an emotional upheaval that is hard to articulate, pregnancy is no longer purely a symbol of hope but an experience tainted by fear. What begins to emerge is a feeling of "Oh my God, this may never happen for me." A positive test brings not just excitement but the creeping anxiety of past losses. Each miscarriage deepens the emotional wounds, making optimism harder to grasp. And yet, hope continues because it has to!

Fertility Clinics Recognize the Emotional Toll and Play a Crucial Role

Fertility clinics have begun to recognize the emotional toll of treatment. IVI RMA North America, a leader in assisted reproductive technologies with over 22 IVF laboratories throughout the U.S. and Canada, plays a crucial role in supporting patients through their emotional struggles by offering spaces where mental health care is as integral as physical treatment. IVI RMA North America integrates mental health counseling into patient care, offering therapy sessions to process grief, frustration, and hope.

Simple changes, like creating a more welcoming and compassionate environment, offering relaxation techniques, or connecting patients to peer support groups, can make a difference in reducing feelings of isolation. For women navigating this path, healing comes in many forms. In moments of self-compassion, in connections with others who understand, in finding ways to carry hope without being consumed by it. And for loved ones, sometimes the most meaningful support is quiet, simply being present, listening, and validating the emotions that arise.

At its heart, fertility care is not just a medical endeavor, it is an emotional transformation, an experience that shifts the way women see their bodies, their futures, their dreams. It is not a measure of worth nor a test of strength. It is simply a journey, one that demands incredible patience, resilience, and, most of all, unwavering hope.

Dealing with Societal Stigma

Despite advancements in reproductive health, societal stigma around infertility and miscarriage remains strong. Many women keep their struggles private, fearing judgment or unsolicited advice. While some find strength in sharing their stories publicly, others grieve privately to avoid criticism. The stigma surrounding infertility often forces women to carry their pain in silence, preventing open conversations and reinforcing feelings of shame.

Breaking this stigma starts with education and awareness. It requires fostering a culture where infertility is seen not as a personal failure but as a medical reality, one that deserves compassion, not judgment.

Friends and Family Play an Important Support Role

For friends and family of someone undergoing fertility treatment, the desire to be supportive is natural, but knowing what to say can be difficult. Often, the best way to help is simply to listen. Offering advice or solutions isn't always what's needed; rather, validating feelings and providing a safe space for vulnerability can be profoundly comforting.

Small gestures, like checking in, offering companionship, or simply holding space, can make all the difference.

As fertility treatment continues to evolve, so too must the way society and the medical field address the emotional toll of the journey. Fertility care has been viewed primarily through the lens of science—the delicate balance of hormones, the success rates of treatments, and the carefully calculated steps designed to bring about conception. But beneath the statistics and protocols are real people, real emotions, and real struggles that demand attention just as urgently as the medical aspects of care.

Women navigating infertility are not just patients in need of clinical solutions—they are individuals carrying the weight of uncertainty, the sting of loss, and the ever-present hope that tomorrow might bring better news. Their mental health is not a secondary concern; it is an integral part of the process, shaping how they endure the treatments, how they recover from setbacks, and how they remain engaged in treatment regardless of the outcome.

Emotional Wellness Must Be Integrated into the Journey

A future where emotional wellness is fully integrated into fertility care is not just ideal, it's essential. Clinics must prioritize mental health support, ensuring every patient has access to specialized counseling. Removing the stigma around infertility will empower women to share their struggles openly, fostering understanding and reducing isolation. Financial accessibility also plays a crucial role, as no one should have to choose between their emotional well-being and the hope of having a child. Insurance coverage, expanded financial aid options, and legislative changes must be part of the conversation if true holistic fertility care is to become a reality.

Mental health professionals are not just advisors in the fertility process, they are lifelines. They play a vital role in guiding patients through their experiences, offering coping strategies, and helping them manage the emotional highs and lows of treatment. And most importantly, they help reframe the narrative, reminding patients that their worth is not tied to their ability to conceive. Knowing when to refer patients to reproductive specialists is also critical. Many women hesitate to seek medical intervention, blaming themselves, hoping that time will bring change. Mental health counselors can gently guide patients toward the right resources, ensuring that they receive the best care both physically and emotionally—without feeling pressured or rushed in their decisions.

Ultimately, fertility care must embrace not only the science of reproduction but the profound emotional realities it entails. Compassion, understanding, and support must stand alongside medical advancements, ensuring that every patient feels seen, not just as someone striving for pregnancy but as a whole person, carrying dreams, pain, and hope in equal measure. The future of fertility care is not just about improving medical outcomes. It is about humanizing the experience, removing the shame, and ensuring no one has to walk this journey alone.

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connecting mothers to the care they deserve.

The Stigma That Silences Support-Seeking

The pressure to manage motherhood, often without adequate support, can leave many women feeling like they're falling short. When struggles arise, self-doubt can quickly set in. Over time, that doubt can grow into shame, silencing the instinct to ask for support. Research with mothers in recovery shows how quickly labels like "unfit," "weak," or "not good enough" become internalized. Many describe stigma as a constant presence, feeling judged more harshly than fathers and held to an impossible standard of what a "good mother" should be. Without supportive, women-centered spaces or providers who know how to unpack those judgments, it's no surprise that some moms pull away from the very services meant to support them.

That withdrawal can show up in the exam room. Most postnatal visits focus on the baby, and a mother's emotional well-being might get just a quick check-in. If mood shifts are brushed off as normal hormonal changes, some women hesitate to speak up—especially if what they're feeling has lasted beyond the early days. And that can mean missing the window for timely, meaningful support.

Reopening the Window Through Telehealth

When that window for support is missed, it can take time—and intention—to reopen it. That's where telehealth can make a real difference. In-person visits are often brief, centered on the baby's health, and difficult to access for new mothers juggling recovery, feeding schedules, and transportation barriers. Telehealth offers a way to re-center the mother, providing consistent emotional health check-ins from the comfort of home.

Asking something as simple as, *"Many new caregivers go through a mix of emotions—what has that looked like for you lately?"* can open the door to honest conversation. When care models create space for those check-ins—and follow through with meaningful, ongoing support—more mothers stay connected to care and receive the help they need and deserve.

Andrea Womack

The Role of Digital Tools and Resources in Increasing Access to Care

In the hours between feedings, often at 2 a.m., when doubt and exhaustion can feel loudest, many mothers may also feel the need to open the window to support and care options. Some moms may need help figuring out what kind of care will truly fit their needs, preferences, and circumstances. That's where thoughtfully designed care navigation tools come in. Tools that rely on clinician-created surveys that assess what a mom is experiencing, what kind of care they're comfortable with, and practical details like location and cost can better connect someone to the right care at the right time. That support might be evidence-based resources, mental health apps, or qualified providers who match their unique needs, helping mothers feel confident that they're not just reaching out, but reaching out to the right support.

Digital platforms also meet mothers where they are, offering flexible check-ins that fit around nap schedules or after work, short therapeutic or mindfulness exercises that can be completed while the bottle warms or work breaks, and direct pathways to licensed clinicians without the long waitlists that often stall momentum. By lowering time and barriers, these tools shift the narrative that care is out of reach or reserved only for moments of crisis.

Just as importantly, early digital touchpoints can prevent small worries from growing into isolation. When a well-being screen highlights rising anxiety or mood concerns, it can prompt timely follow-up, whether that's educational content to build understanding, moderated peer connection, or a direct referral to a mental health professional. Over time, this approach normalizes mental health check-ins, much like pediatric growth charts normalize tracking a baby's development.

Why Cultural Competency Matters in Maternal Mental Health Support

Access to care is essential, but it is not enough. For maternal mental health services to be effective, they must be culturally responsive. That means care that reflects and respects each mother's lived experience.

Telehealth makes culturally attuned matches more possible than ever. A mother in a rural town can scroll through a multi-state directory, filter for Spanish-speaking therapists or providers familiar with Pacific Islander traditions, and book a video session that fits between feedings or work meetings. Interstate licensure compacts let many clinicians practice across state lines, while platform-based matching tools use intake questions—preferred language, cultural background, schedule—to pair mothers with the right providers in seconds. Real-time interpreters, closed captioning, and translated after-visit summaries can also help bridge communication gaps.

But cultural competency isn't just about matching or materials, it's about mindset. It means approaching care with humility: listening first, honoring different ways of understanding distress, and recognizing how race, language, culture, and history shape what healing and motherhood look like. When mothers feel seen and respected, they are more likely to engage in care and stay in care.

Where Mothers Can Turn for Help and Community

Connection is central to maternal health and well-being. In one randomized controlled trial, weekly peer phone calls starting in late pregnancy and extending through the first eight weeks postpartum significantly reduced depressive symptoms compared to routine care. Today, digital platforms make similar support more accessible than ever. A mother can join a virtual circle after bedtime, post a voice note during a stroller walk, or exchange encouragement with others who are awake for the same early morning feeding.

National mental health navigation tools now offer anonymous mood checks and personalized recommendations within minutes, from educational videos about loneliness to moderated chats for new parents. By delivering expert guidance through smartphones and laptops, these services help mothers find support whenever and wherever they need it most.

Creating a Culture of Ongoing Support

When maternal mental health is treated as a shared responsibility—woven into family life, clinical care, community networks, and digital tools—mothers gain more space to breathe, reflect, and heal. A simple, sincere "How is your emotional health?" or "What support would help you most?" asked during feedings, postnatal visits, or group chats can go a long way toward normalizing care-seeking and reducing stigma. And when support is timely, culturally attuned, and emotionally safe, more mothers can access the care they deserve.

Promoting maternal mental well-being isn't just a task for specialists; it's a mindset shift for all of us. It means noticing, reaching out, and making space for mothers to be cared for, too. When we build systems and care cultures that center the mother alongside the baby, we don't just support individuals, we strengthen families and communities.

Andrea Womack is Chief Content Officer at Psych Hub.

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where they are. New parents often struggle to attend in-person appointments due to childcare challenges, physical recovery, and overwhelming schedules. An asynchronous video assessment platform allows mothers to engage with care on their own time, from the comfort of home, using their personal devices.

This approach has been shown to yield:

- Earlier identification of mothers needing support
- Increased engagement in treatment when needed
- Significant improvements in maternal emotional well-being
- Better medication adherence for those requiring pharmacological intervention
- Reduced emergency interventions and hospitalizations

Looking Forward: A Multi-Faceted Approach

While technology offers promising solutions, addressing maternal depression requires a comprehensive approach. Technology should complement, not replace, human connection, enhancing the relationship between mothers and healthcare providers by providing more touchpoints and deeper insights.

To ensure that no mother suffers in silence, mental healthcare providers should commit to leveraging every tool available, including innovative AI technologies. By combining compassionate care with advanced technology, we can create a future where maternal depression is identified early, treated effectively, and ultimately, prevented wherever possible.

Every mother deserves support during one of life's most challenging transitions. Through innovation and commitment, we can make that support more accessible than ever before.

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