Tackling Perinatal Mental Health

A Multidisciplinary Approach to Caring for our Perinatal Patients Mental Health

August 28, 2026

THE KAREN KLEIMAN TRAINING CENTER
The Art of Holding Perinatal Women in Distress

About Me

- My pronouns are she/her/ella.
- Mother of two teenagers (ages 18 and 15)
- I am a Certified Childbirth Educator, Birth Doula, and hold certification in Perinatal Mental Health.
- I work at Bronson Methodist Hospital in Kalamazoo coordinating their Perinatal Mental/Emotional health program.
- I teach and am the Director of the Collaborative Care Education Program for the Postpartum Stress Center.
- I teach, facilitate, and train other professionals for Postpartum Support International (PSI), as well as co-chair the Michigan Chapter of PSI.
- I am a survivor of fertility challenges, perinatal anxiety, depression, and OCD.
- I'm deeply grateful for the opportunity to share this critical information with you today.

About Karen Kleiman

Expert

- Perinatal Mental Health expert for over 35 years.
- Founded The Postpartum Stress Center to provide comprehensive clinical intervention for those suffering from Perinatal Mood and Anxiety Disorders.

Author

- Has authored and co-authored numerous bestselling books.
- Featured on local and national media for decades advocating and bringing awareness to Perinatal Mental Health.

Educator

- Founded The Karen Kleiman Training Center, dedicated to the advancement of clinical expertise and therapeutic strategies for the treatment of Perinatal Mood and Anxiety Disorders.

Learning Journey

1

Define Perinatal Mood and Anxiety Disorders and Understand Prevalence

2

Identify Risk Factors & Implications of Untreated PMADs

3

Explore Treatment Options

4

Understanding "Holding" and How to Intervene Within Your Role

5

Resources and Questions

What is a Perinatal Mood or Anxiety Disorder (PMAD)?

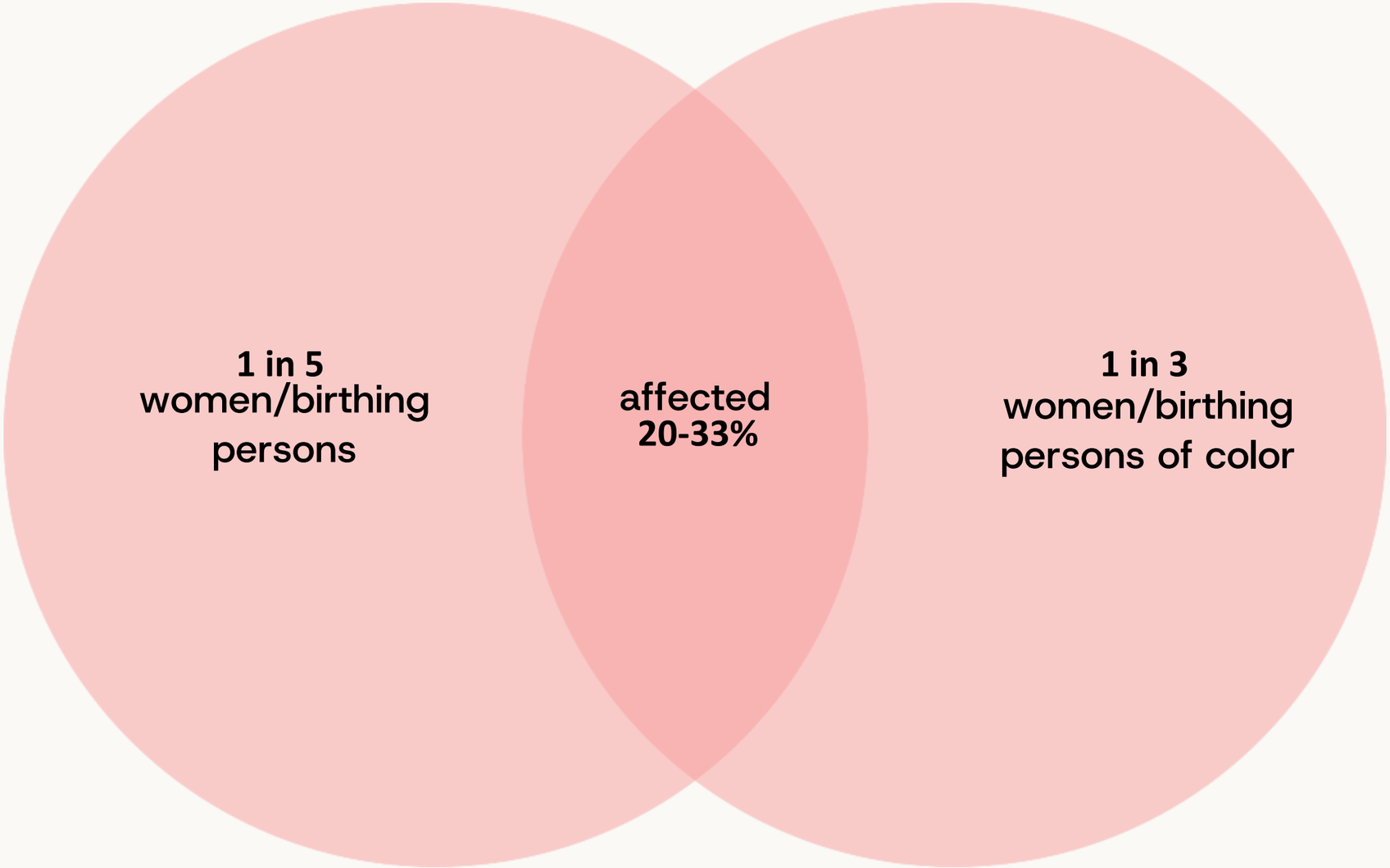
> "When mothers struggle emotionally, we don't ask, 'What's wrong with you?' We ask, 'What happened to you?'"
>
> *— Karen Kleiman, Good Moms Have Scary Thoughts*

Understanding PMADs

Perinatal Mood and Anxiety Disorders encompass any unfavorable or devastating mood changes occurring during pregnancy or the postpartum period. These are not temporary mood swings—they're serious conditions that require understanding, support, and treatment.

- Depression
- Anxiety
- Obsessive Compulsive Disorder
- Bipolar Disorders
- Post Traumatic Stress Disorder
- Bipolar Disorders
- Psychosis
- Substance Use Disorders

The Scope of the Challenge



PMADs During Pregnancy

Pregnancy Is Not Protective

There's a common misconception that pregnancy hormones shield women from mental health challenges.

Key Facts About Prenatal Mental Health:

- **Stress hormones cross the placenta** – Elevated maternal cortisol can affect fetal development
- **Pre-existing conditions often worsen** – Anxiety and OCD frequently intensify during pregnancy
- **PMHDs exceed other pregnancy complications** – Twice as common as gestational diabetes or hypertension
- **Increased physical risks** – Untreated PMHDs raise the risk of preterm delivery, C-section, low birth weight, small-for-gestational-age babies, NICU admissions, and preeclampsia

The Postpartum Experience

Varying Degrees of Severity

PMHDs exist on a spectrum, from mild symptoms that interfere with daily functioning to severe conditions requiring immediate intervention

ALL Must Be Treated

Even "mild" symptoms don't resolve on their own. Without treatment, PMHDs can persist indefinitely, affecting parenting, relationships, and overall quality of life

The "Baby Blues"

A Normal Part of Adjustment

About 85% of new mothers/birthing persons experience the "Baby Blues"

Common Symptoms:

- Tearfulness without clear reason
- Mood swings
- Sadness or emotional sensitivity
- Guilt or feelings of inadequacy
- Difficulty concentrating
- Worry about the baby or parenting abilities

Postpartum Stress Syndrome

- Adjustment disorder associated with persistent distress that does not resolve with reassurance or self help measures.

Perinatal Depression

More Than Just Sadness

Approximately 20% of new mothers/birthing persons experience perinatal depression.

Key Symptoms to Recognize:

- **Anger or irritability** – Often more prominent than sadness
- **Lack of interest in the baby** – Feeling disconnected or emotionally numb
- **Appetite and sleep disturbances** – Beyond typical new parent exhaustion
- **Persistent crying or overwhelming sadness**
- **Feelings of guilt, shame, or hopelessness** – "I'm a terrible mother"
- **Possible thoughts of harming the baby or oneself** – Always requiring immediate attention

Perinatal Anxiety

Affecting approximately 20% of new parents, perinatal anxiety can be debilitating.

Constant Worry

Excessive, uncontrollable worry about the baby's health, safety, or development that goes beyond typical parental concern

Catastrophic Thinking

Feeling that something terrible is about to happen, even without evidence

Physical Symptoms

Racing thoughts, rapid heartbeat, difficulty breathing, chest tightness, or panic attacks

Sleep & Appetite Disruption

Inability to sleep even when the baby sleeps, or changes in eating patterns unrelated to infant care

Restlessness

Inability to sit still, constant need to check on the baby, or feeling "on edge"

Irritability

Feelings of anger, irritability, or rage

Obsessive Compulsive Disorder

The prevalence ranges from 7.8% during pregnancy to 16.9% during postpartum.

Obsessions (Intrusive/Scary Thoughts):

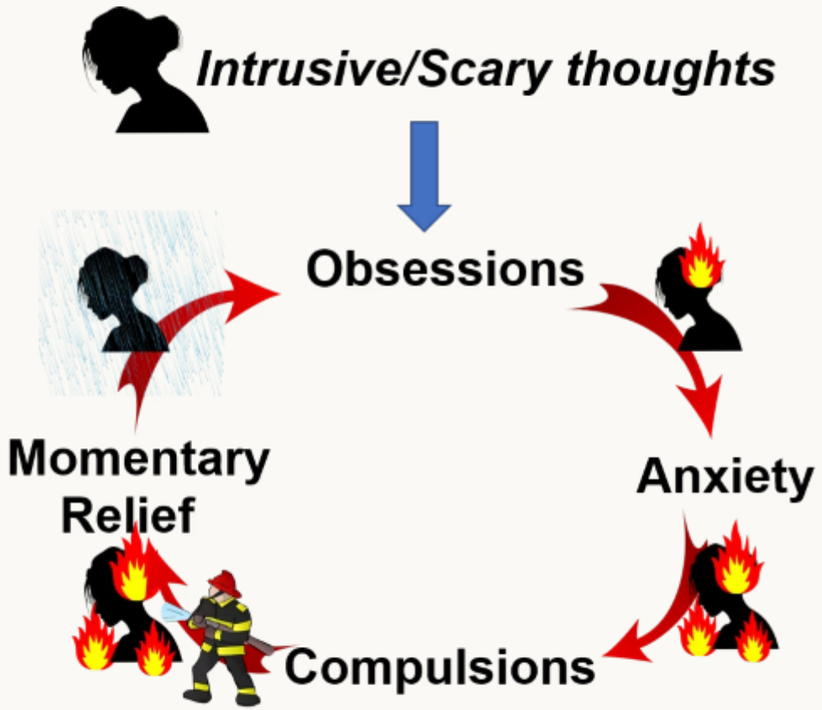
These are unwanted, disturbing thoughts or images.

Compulsions (Repetitive behavior to reduce fears and obsessions):

- Excessive cleaning or hand washing
- Repeated checking
- Counting rituals
- Arranging items in specific patterns

Other Symptoms:

- Fear of being alone with the baby
- Extreme protective measures
- Awareness of irrationality



Post-Traumatic Stress Disorder (PTSD)

5-20% of women may develop CB-PTSD, with higher rates in medically complicated births

- Intrusive Re-experiencing
- Avoidance
- Hyperarousal
- Emotional Numbing
- Anxiety and Panic

Bipolar Mood Disorders

- Periods of severely depressed mood and irritability
- Elevated mood, higher energy than normal.
- Rapid speech
- Little need for sleep/racing thoughts
- Trouble concentrating
- Overconfidence
- Impulsiveness
- Poor judgment
- Grandiose thoughts
- In the most severe cases, delusions and/or hallucinations

Postpartum Psychosis

A Psychiatric Emergency

Warning Signs:

Mania

Paranoia and suspiciousness

Confusion and disorientation

Hallucinations

Delusions

Difficulty communicating

Substance Use Disorders

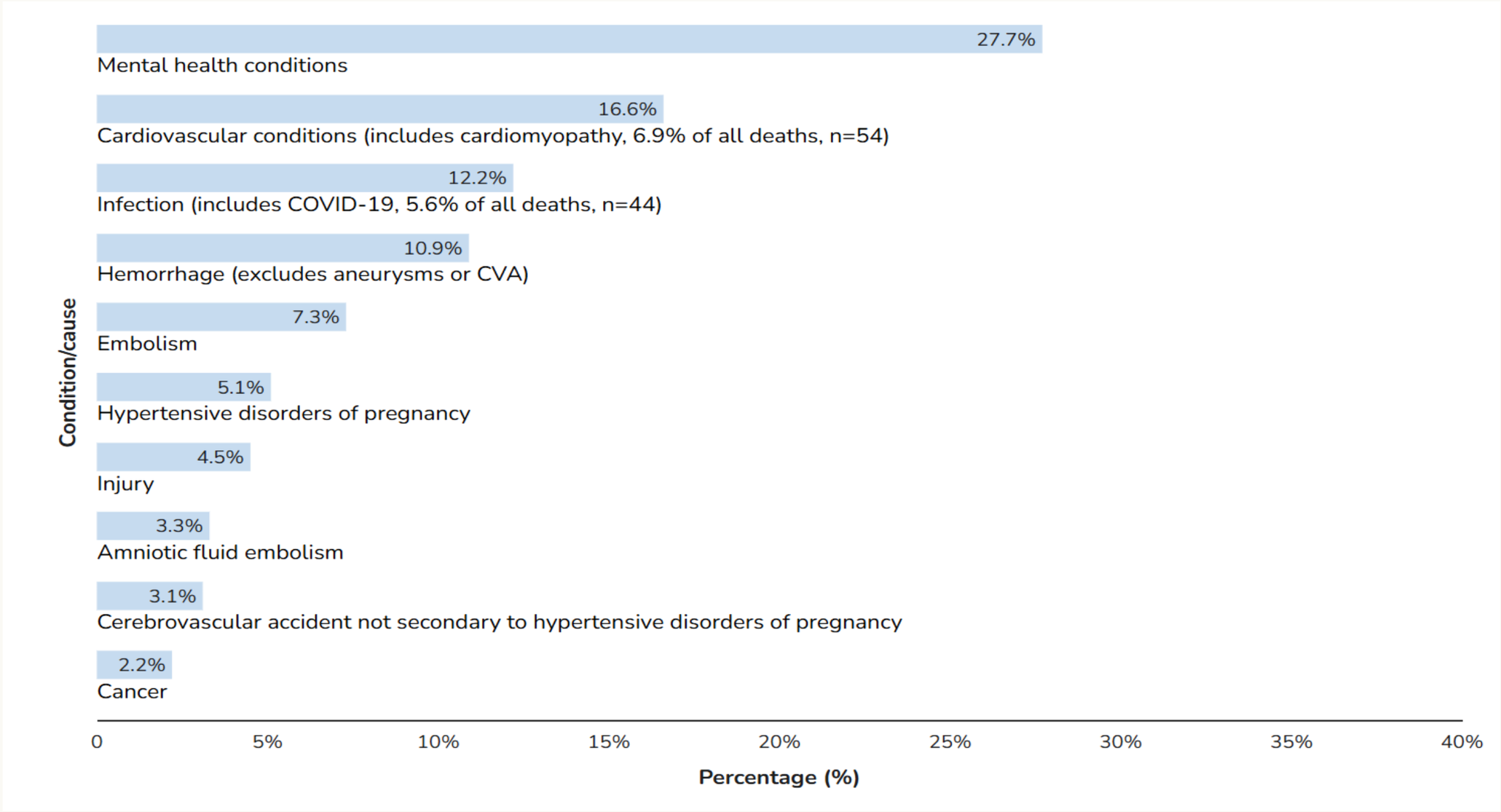
Substance Use Disorder (SUD) during the perinatal period can include the use of alcohol, tobacco, prescription medications (such as opioids), and illicit drugs.

Co-occurrence of mental health conditions and SUD is common among pregnant and postpartum women.

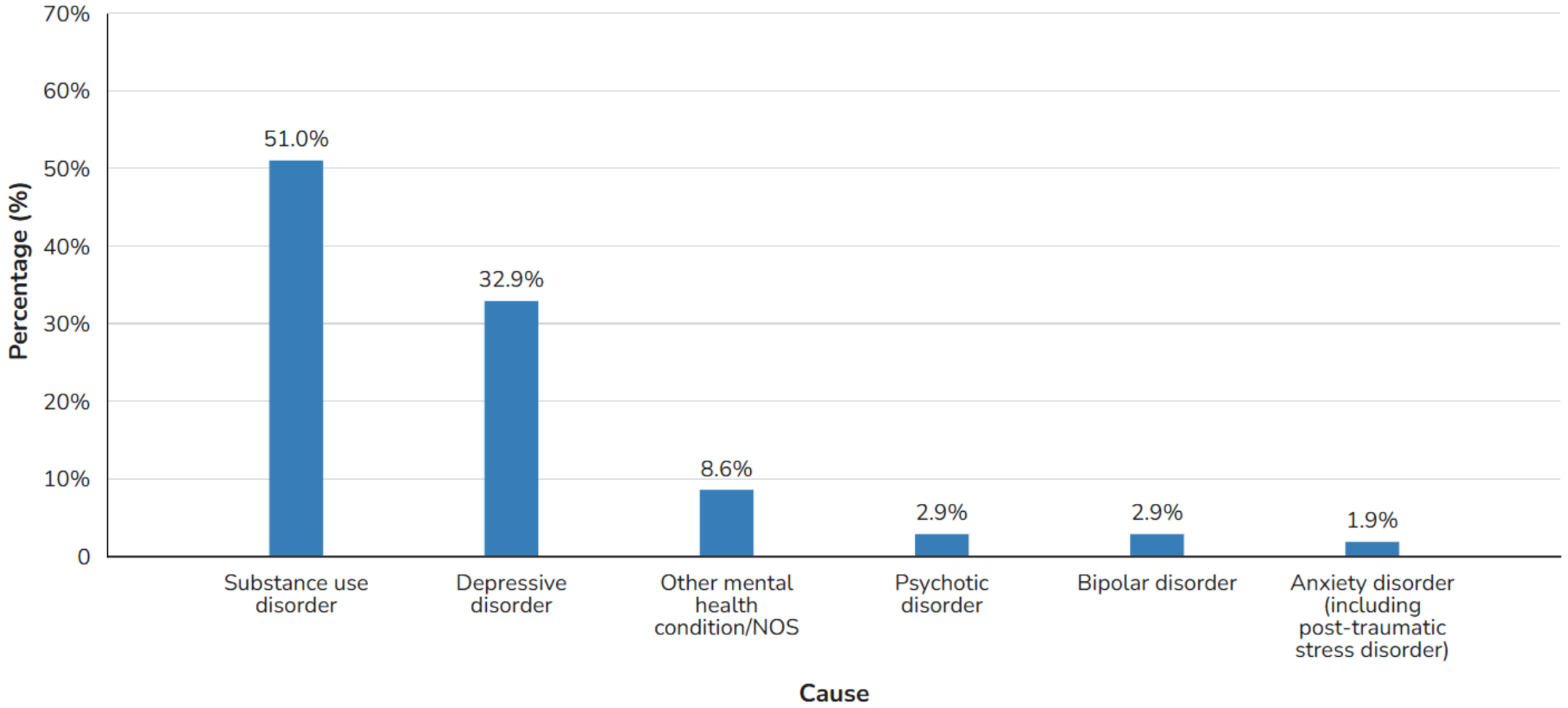
Approximately 5% of pregnant women use one or more addictive substances.

More than 30% of pregnant women in substance use treatment screened positive for moderate to severe depression, and over 40% reported symptoms of postpartum depression.

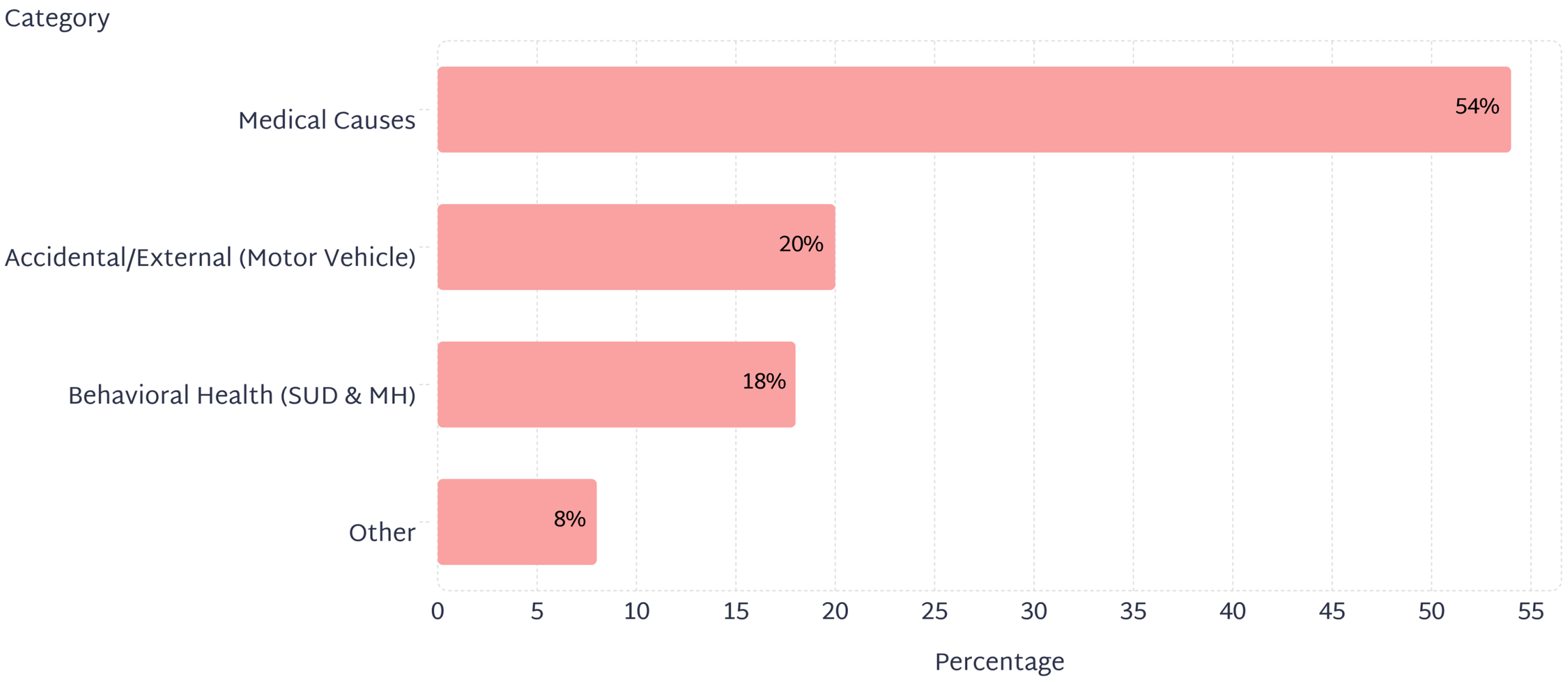
Leading Causes of Pregnancy-Related Death in the **United States**. Data from Maternal Mortality Review Committees (2022, published April 2026)



Specific MMRC-determined underlying causes of death in the **United States** among pregnancy-related mental health deaths, (Year 2022, published 2026)

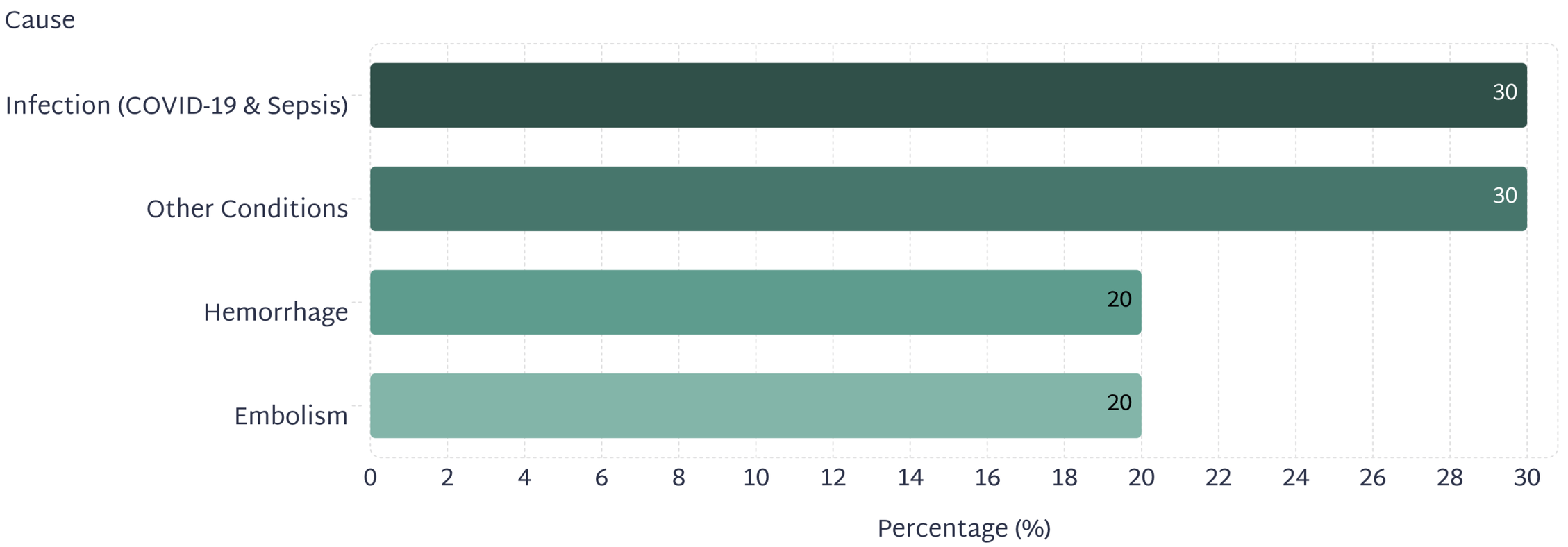


Nebraska: Leading Causes of Pregnancy-Related Death



Nebraska Pregnancy-Associated Deaths by Category/Cause (%)

Iowa: Leading Causes of Pregnancy-Related Death



Iowa Pregnancy-Associated Deaths by Category/Cause, 2019–2021 (MMRC)

Note: "Other Conditions" includes cancer, cardiovascular conditions, hypertensive disorders of pregnancy, and mental health conditions including substance use disorder. Infection was the leading cause, driven by COVID-19 deaths among unvaccinated women.

Who Will Suffer From PMADs?

PMADs Don't Discriminate

These conditions affect people across all demographics, cultures, and backgrounds

Risk Factors Help Us Be Proactive

Understanding vulnerabilities allows for earlier identification and support

50% Are Missed Without Screening

Clinical observation alone fails to identify half of those suffering

Examples of Risk Factors for PMHDs

- Previous history of depression, anxiety, or other mental health disorders
- Fertility challenges; history of pregnancy loss or miscarriage
- Unplanned or unwanted pregnancy
- Adverse neonatal outcomes (NICU admission, health complications)
- Stressful life events (job loss, move, relationship issues)
- Poor social support or isolation
- Low socioeconomic status
- Low self-esteem
- Traumatic delivery experience
- Difficult infant temperament
- Feeding challenges

Additional Barriers Facing BIPOC Communities

Understanding Systemic Inequities

Systemic Racism

Discrimination in healthcare settings, implicit bias, and unequal treatment

Adverse Childhood Experiences

Higher rates of trauma and its intergenerational effects

Healthcare Access Barriers

Lack of insurance, transportation, or nearby quality providers

Distrust in Medical Systems

Historical mistreatment creating valid concerns about seeking care

Lack of Representation

Few providers who share cultural background or lived experience

Economic Instability

Unemployment or underemployment limiting resources

PMHDs in the BIPOC Community

https://www.youtube.com/watch?v=ViDYIStqNeI

Dads/Partners and PMADs

- Estimates suggest 1 in 5 to 1 in 10 experience perinatal anxiety and 1 in 10 experience depression.
- Non birthing parents (cisgender males) also experience biologic changes.
- Typically presents differently
- Screening should occur for partners whenever possible

Implications of Untreated PMHDs

Photo: — Karen Kleiman, Good Moms Have Scary Thoughts

What Does a PMAD Feel Like?

In Their Own Words

> "It feels scary and hopeless."

> "I am crippled with fear."

> "No one understands."

> "I feel like my baby would be better off without me."

> "It feels like an emergency only you know is happening. Like everything is on fire."

> "I have no energy to care for myself or baby."

— Background photo from Karen Kleiman's "Moods in Motion"

We are working with HIGH Stakes

- Risk of suicide is HIGH
- Risk of physical depletion is HIGH
- Risk of hormonal disruption is HIGH
- Risk of misinterpretation of symptoms is HIGH
- Risk of undisclosed distress or severity of distress is HIGH
- Risk of impaired support relationships is HIGH

*Ability for patient to accurately assess the severity of distress is LOW

-AOH Kleiman Training

The Cost for Mothers/Birthing Persons

During Pregnancy:

- **Poor prenatal care**
- **Nutritional deficits**
- **Substance use**
- **Poor pregnancy outcomes**

After Birth:

- **Impaired parenting behaviors**
- **Longer symptom duration**
- **Increased risk with future pregnancies**
- **Relationship strain**
- **Risk of self-harm or suicide**

The Cost In Birth Outcomes

- Higher rates of preterm birth, especially among women with untreated anxiety
- Increased incidence of low birth weight infants
- Greater risk of pregnancy complications
- Neonatal Abstinence Syndrome (NAS)

The Cost On Infants and Children

Motor Development

Delays in reaching physical milestones

Cognitive Development

Impacts on learning and cognitive processing

Emotional Regulation

Difficulty managing emotions and behaviors

Poor Mother-Infant Attachment

Impacts on bonding.

The Cost In Dollars

$14B

Annual National Cost

Total cost of untreated PMHCs in the United States per year

$32K

Per Mother-Infant Pair

Average cost for each untreated mother and baby

**These figures encompass healthcare costs, lost productivity, and the long-term developmental interventions required for affected children. Investment in prevention and treatment would yield substantial returns.*

The Cost Of A Life

Suicide Risk

Increased risk of suicide, particularly during the late postpartum period when oversight decreases

Rare but Severe

In cases of untreated postpartum psychosis, extremely rare risk of infanticide

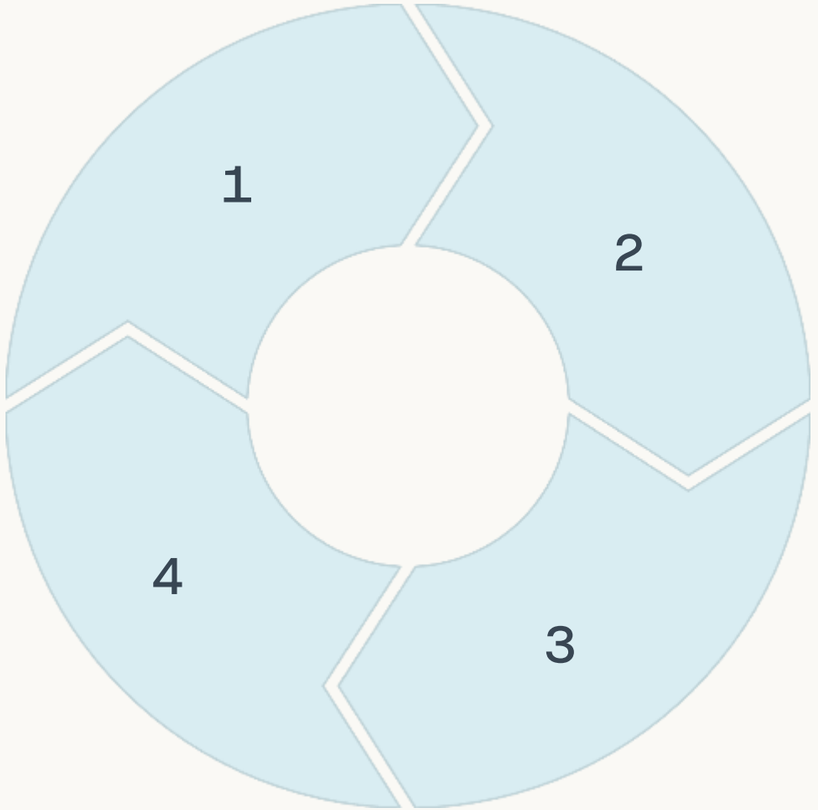
Chronic Illness

Long-term mental health impacts that can persist for years without intervention

The Intergenerational Impact

Mother's Untreated PMHC

Depression, anxiety, or substance use without adequate treatment



Impaired Early Bonding

Difficulty with responsive caregiving and attachment

Long-term Consequences

Behavioral issues, academic difficulties, own mental health risks

Child Developmental Effects

Motor, cognitive, and emotional regulation challenges

How Do We Treat PMADs?

> "Recovery isn't about being perfect. It's about being present. It's about showing up for yourself and your baby, even on the hardest days."
>
> *— Karen Kleiman, Good Moms Have Scary Thoughts*

The Basics: Sleep, Nutrition, Hygiene

Sleep Is Medicine

Nourishment Matters

Hygiene Basics

These foundational needs aren't luxuries—they're necessities.

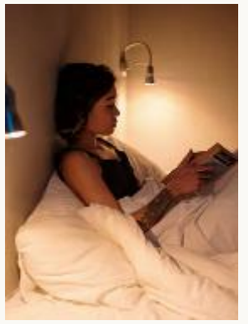
Treatment Foundations

- Basic Self-Care
- Social Support/Practical Help
- Professional Therapy
- Medication When Needed

Self-Care: What It Really Looks Like

Self-care is about survival and small moments of relief. It looks different for everyone:



- A 10-minute walk around the block
- Sitting in the car alone for a few minutes
- A phone call with a trusted friend
- Watching a favorite show
- Asking for help and accepting it
- Saying "no" to non-essential obligations
- Moving your body in ways that feel good

The Power of Social Support and Practical Help

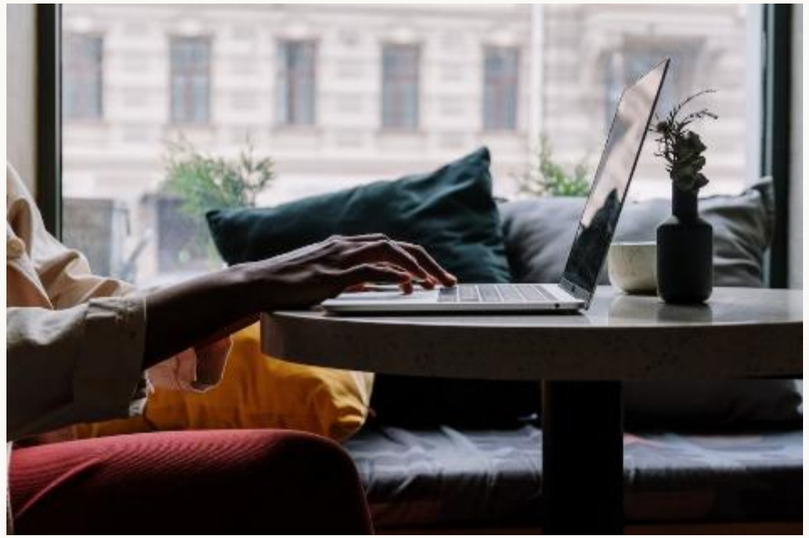
Emotional Support

- Listening without judgment
- Validating feelings and experiences
- Offering reassurance and hope
- Being present and available
- Checking in regularly

Practical Support

- Holding the baby so the parent can rest
- Preparing or delivering meals
- Doing laundry or light housework
- Running errands
- Attending appointments together

Professional Therapy



Specialized Perinatal Mental Health Counseling

Effective Therapeutic Approaches Include, (*but are not limited to*):

- **Cognitive Behavioral Therapy (CBT)** – Identifying and changing negative thought patterns
- **Interpersonal Therapy (IPT)** – Addressing relationship issues and role transitions
- **Support-focused therapy** – Providing validation, education, and coping strategies
- **Specialized treatment for OCD and PTSD** – Exposure therapy and trauma processing, EMDR

Medication as Part of Treatment

For many parents, medication is an essential component of recovery.

Key Points About Medication:

- **There is no single "right" medication** – Treatment is individualized based on symptoms, history, and personal factors
- **Many antidepressants and anti-anxiety medications are considered safe during pregnancy and breastfeeding** – The risks of untreated mental illness often outweigh the minimal risks of medication
- **Medication decisions require collaboration** – Work with a psychiatrist or prescriber experienced in reproductive psychiatry
- **It takes time** – Most medications require 4-6 weeks to reach full effectiveness

What You May Encounter

- Anti-Depressants
- Mood Stabilizers
- Antipsychotics/Neuroleptics
- Benzodiazepines
- Stimulants

What Can You Do?
Your Role

> "You don't need to be a therapist. You just need to be present, to listen, and to connect families to help. That alone can save lives."
>
> *— Karen Kleiman, Good Moms Have Scary Thoughts*

Wisdom in Perinatal Care

> *"Within the context of treating perinatal women in distress, wisdom is the balance between what you know and who you are." – Karen Kleiman*

What You Know

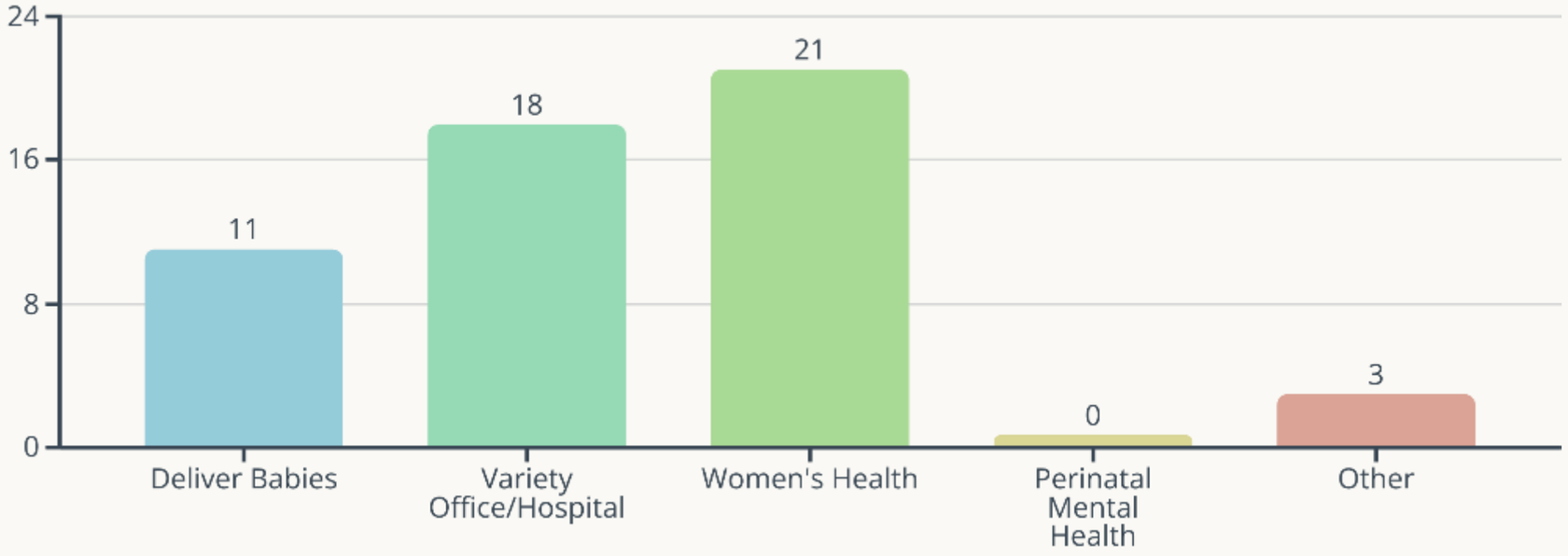
Your clinical expertise, medical knowledge, and professional experience in treating the perinatal population.

Who You Are

Your personal qualities, empathy, and authentic presence as a healthcare provider.

The Survey…

53 Prescribing Providers contributed to an informal survey about why they chose to go into Obstetrics



* ***0 Prescribing Providers went into Obstetrics because they were interested in Perinatal Mental Health.***

Healthcare Professional Preparedness

Understanding of PMH

You must know the basics of Perinatal Mental Health.

Prescribing Knowledge

Providers need to know how to prescribe for perinatal patients

Trauma Informed Care

You must know the foundation of TIC

What is Holding?

Definition

Within Kleiman's therapeutic work, it is defined as "a loss-informed, strength-based approach which provides prompts and specific skills to enable the therapist to contain high levels of distress and do so in a way which cultivates the early stages of connectedness."

Healthcare Professional Translation

A loss-informed, strength-based approach which provides prompts and specific skills to enable you, **the healthcare professional**, to contain high levels of distress and do so in a way which cultivates the early stages of connectedness to your patient, so you can establish trust and get them to the next right person for help.

Patient Translation

"I GOT YOU. It's okay to talk to me."

Benefits of Holding

Safety

Foster an environment of safety

Engagement

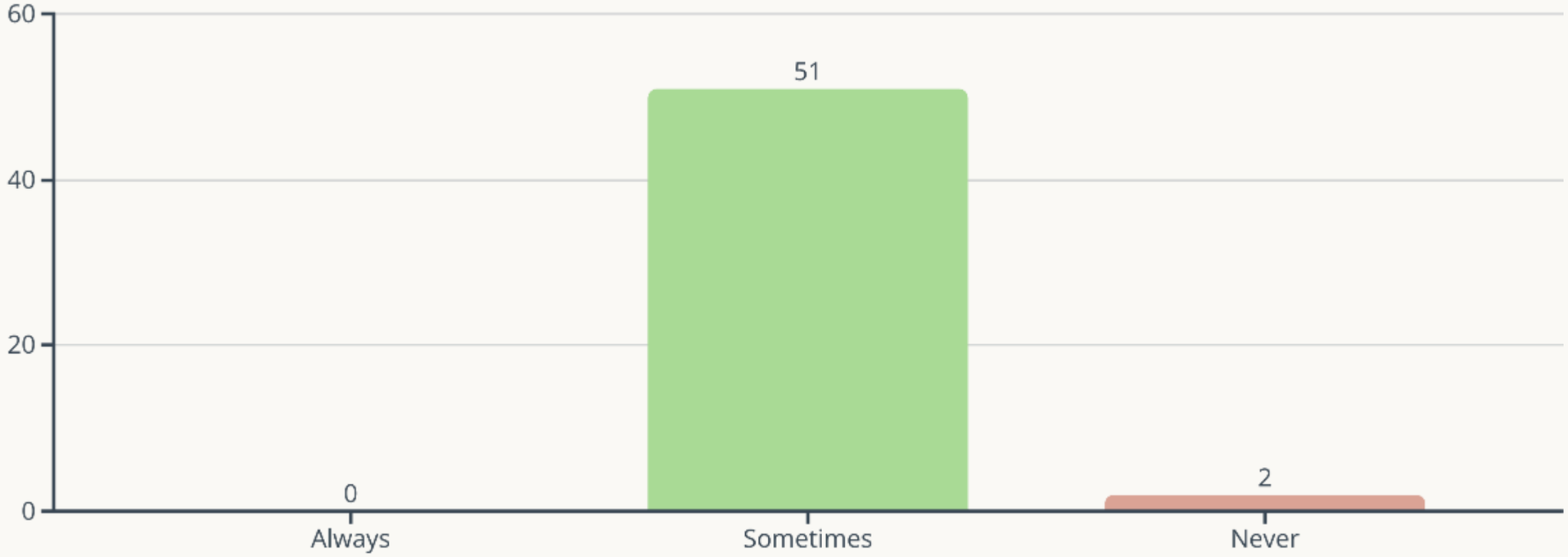
Encourage patient engagement

Self-Disclosure

Promote patient self-disclosure

Why is Learning to Hold Important?

Back to our 53 surveyed Prescribing Providers… When asked if they know how to speak, react, and build trust with a Perinatal patient that discloses they are struggling with their mental health…



- ***0*** stated they Always knew what to do
- ***51 stated "Sometimes, but I could DEFINITELY benefit from education, as this can make me nervous."***
- ***2 stated, "Never. I absolutely need education, because I feel in over my head every time this happens."***

Six Points to Holding for the Therapist

We will use this framework as our guide, but modify in a way that will not only work best for you as the provider, but for the patient in your care.

Grounding

Current State

Expert

Design

Presence

Safeguarding

HOLD Framework for the Healthcare Professional

1 **Hear**

Listen to your patient's ***current state***

2 **Observe**

Use ***expert*** skills to notice unspoken cues

3 **Lead**

Guide with confidence, ***grounding***, and ***presence***

4 **Design**

You will ***safeguard*** their well being by utilizing TIC to ***design*** a treatment plan together

Importance of Trust

Holding can only happen with established trust.

Warmth

Demonstrate genuine care and empathy

Competence

Show expertise and confidence in care

**** Both warmth and competence are crucial for gaining patient trust.***

Hear

*Learning your patient's ***Current State.***

"I just don't feel like myself."

"Is this what motherhood feels like?"

"I'm not sure I should have had this baby."

"I don't think my baby likes me."

Hear

Your actions right now…

Listen.

- remain present
- try not to anticipate and finish their sentences in your head.

Be Patient.

- This is not easy for them to disclose. They are worried you will judge them- or worse, decide they are unfit to mother.

Watch your body language.

- Are you standing or sitting? Remove the physical power differential.
- Where are your eyes? Primary focus should be on them.

Why she may be feeling bad:

- The incompatibility between motherhood and a sense of control
- The absence of independence and the baby's dependence
- She's having a hard time asking for/accepting help
- She may feel pressure to "bounce back" to look good – a mother that looks good is a good mother.
- She's grieving the idea of motherhood as she has always imagined it
- Her timeline for baby was "her idea" with partner
- Societal and Cultural Implications – the weight of responsibility

Photo: — Karen Kleiman, Good Moms Have Scary Thoughts

Her symptoms-

Experiences **symptoms** as **self**

Grief- Loss of identity, relationship with partner, idea of motherhood

Helplessness – this is my baby – who am I going to ask for help?

Anger – The "unfathomable pressure to redefine self"

- Societal and cultural expectations
- Partner in a parenting role
- Changing relationships with parents, in-laws

Loving her baby but **ambivalent** toward motherhood

Numbness – simultaneous elation and anger

Self-blame and Guilt – Timing of baby, underestimated role/tasks

Distress with magnitude of responsibility she now feels

Photo: — Karen Kleiman, Good Moms Have Scary Thoughts

Observe

*Using your ***Expert*** skills based on what they are NOT disclosing.

Non-verbal behaviors and mood.

- Speech, demeanor, interaction with others?

Appearance

- Hygiene, self-care?

Care of Infant

- Attentive to needs, interacting?

Observe

Your actions right now...

Notice.

Pay attention. There is a lot of information in unspoken dialogue.

Lead

*Guiding your patient with confidence, ***grounding,*** and ***presence***

Lead

Your actions right now…

Acknowledge

- Let them know they have been heard and their feelings are valid

Thank them

- Yes. Thank them for trusting you.

Assess Distress

- Screen if you haven't already.
- Determine level of suffering.

The importance of screening

What formal screenings are part of your intake process?

***EPDS is seen most frequently:**

Edinburgh Postnatal Depression Scale (Cox et al., 1987)

PHQ-9:

Patient Health Questionnaire

(Kroenke et al., 2001)

GAD-7

General Anxiety Disorder 7

Drs. Robert L. Spitzer et al., 1999

PASS:

Perinatal Anxiety Screening Scale

(Somerville et al., 2014)

PDSS:

Postpartum Depression Screening Scale (Beck & Gable, 2000)

Y-BOCS

Yale-Brown Obsessive Compulsive Scale (Goodman et al. 1989)

Assessing Distress

Frequency + Intensity + Duration = DISTRESS

Photo: — Karen Kleiman, Good Moms Have Scary Thoughts

Design

***Safeguarding** their well being by utilizing trauma informed care to ***design** a treatment plan together.

*** Remembering the foundations of TIC**

Safety

Create a physically and emotionally safe environment

Choice

Offer options and respect patient decisions

Collaboration

Work together on treatment plans

Empowerment

Support patient strengths and resilience

Design

Your actions right now…

Ask questions

- Are there thoughts of self harm or suicide?
- What does their support system look like?
- Have they ever felt like this before?

Discuss Medication

- Are they open to medication if they are not taking it already?
- Have they been on something previously that helped?

Refer and Reassure

- Make a Social Work referral. This can help them get the other resources in place- Counseling, support groups, and follow up.
- Remind them PMADs are treatable.
  - They are NOT their symptoms.
  - They will be well again

Starting Supportive Conversations And Asking Questions

"As part of our training, we learn how common anxiety and depression are for new parents. I wanted to check in—how are you doing emotionally since your baby was born?"

"Some parents have shared with me that they feel so alone during this time. I want you to know that support is available, and you're not alone."

"Perinatal mental health challenges are very common, and we want to make sure you're healthy and well. Is this something you'd feel comfortable talking about?"

"We ask all families about emotional wellbeing because it's such an important part of health. Universal screening helps reduce stigma."

Key Strategies:

- **Normalize the conversation** – Frame mental health as a routine part of wellbeing
- **Use open-ended questions** – Allow space for the parent to share
- **Convey genuine concern and care** – Let them know you're asking because you care

Asking Questions With Care

Lead With Kindness

"I care about you and want you to be well. How have you been feeling emotionally since your baby was born?"

Preface Questions With Support

"I'm here to support you because you deserve to feel well. Would you allow me to help by connecting you with someone who specializes in supporting new parents?"

Don't Unpack What You Can't Put Back

DO NOT ask probing questions about past traumas unless you're trained to handle the responses. This can cause immediate shutdown and erode trust. Stick to present-focused, supportive questions.

DO Ask Directly About Safety Concerns

If you're concerned about harm to self or others, ask directly: "Are you having thoughts of harming yourself or your baby?" Direct questions can be lifesaving and don't increase risk.

Remember: Your goal is to create a safe opening for the parent to share concerns and to facilitate connection for the next right step.

Align Your Network
Inside And Outside Of The System

**Warm handoffs are imperative.*

Example- New mother is screened on PP floor after delivery. EPDS and risk factors are high. SSRI is prescribed and a therapy referral is placed.

1

Report given to RN for plan of supportive action.

2

1-2 week med check in office with provider set up prior to discharge

3

-Therapist calls and sets up appointment

4

Warm handoff to Outpatient MSW for follow up

Photo: — Karen Kleiman, Good Moms Have Scary Thoughts

What's available for me to access?

Resources

Resources for Professionals

The Postpartum Stress Center

Postpartum Support International

The International Marcé Society for Perinatal Mental Health

The Center for Women's Mental Health at Massachusetts General Hospital

Maternal Mental Health Leadership Alliance (MMHLA)

Policy Center for Maternal Mental Health

MC3 at the University of Michigan Medicine

*People, books, podcasts, etc...

Learn the Resources Available – for Patients (and provide them)

The Postpartum Stress Center

Postpartum Support International

WIC, Maternal Infant Health Programs, Nurse-Family Partnerships, In Person Support Groups, Available Therapists, etc...

People, Books, Podcasts, etc..

Questions?

Contact Information:

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