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NEWS

One in five pregnant or postpartum women deal with anxiety disorders. Why are most not getting help?

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When Sarah Ornst Bloomquist gave birth to her first child, the thought that immediately came to mind scared her.

Put him back!

She knew her reaction was way off, but the apprehension wouldn't ease. And then anxiety kicked in, so debilitating and relentless she could hardly care for her newborn son.

When she opened up to doctors, they sidestepped the questions. One actually told her to drink more water. Even with loved ones, articulating the fraught intersection of new motherhood and paralyzing angst proved elusive.

"I didn't have the language to communicate what I was feeling — it's my first baby, I don't know what's going on," said Ornst Bloomquist, who lives in Cedarburg. "I had a history of depression and anxiety, but this was a different animal. When it comes to the perinatal period, mental health conditions look different, they feel different. And now there's a child involved."

Her background in nonprofit advocacy, her experience in managing depression and anxiety, her knowledge that this was a planned pregnancy — none of it helped.

Years after her own experience after birth, Ornst Bloomquist learned that more than one in five pregnant and postpartum mothers in the United States deal with depression and anxiety disorders on top of the exhausting task of new motherhood. The number rises to one in four in lower socioeconomic communities. Yet 75% of women who experience maternal mental health symptoms will not receive treatment, according to Maternal Mental Health Leadership Alliance.

Some women endure alone. Some fall into self-harm or destructive behaviors. Some see their marriages fray or struggle to develop the early bonding they had envisioned with their child. Few doctors or clinics know how to identify or treat mood and anxiety disorders during the perinatal period, which generally means the period before and after the birth of a child — although there is no agreement on the length of that period.

The disorders, also known as PMADs, can appear as depression or obsessive-compulsive disorder or psychosis. A parent might check on a baby every five minutes through the night or have manic mood swings, thinking too much and talking too fast. An untrained eye might chalk it up to stress or fatigue, but a professional with the right training would recognize this as potentially building into something more serious for both mother and child.

Ornst Bloomquist went on to co-found Moms Mental Health Initiative, a nonprofit intended to provide southeastern Wisconsin moms suffering from such disorders with peer support and a bridge to sound treatment.

The key is that new mothers shouldn't bear the burden of mental health challenges alone, said Sheng Lee Yang, a licensed clinical social worker and executive director of Us 2 Behavioral Health Care in Appleton. The organization is forming a new perinatal mental health training program for a wide range of care providers across Wisconsin — from medical professionals to case managers to substance abuse counselors.

The effort is, in part, the result of a $310,000 grant from the Wisconsin Department of Health Services in November to grow the number of health care workers with knowledge of perinatal care. The intent is to reach far beyond the Fox Valley.

"From a society perspective, we have this perception that it's supposed to be the happiest time of your life; you should be grateful," said Yang. "There's so much pressure, particularly for mothers, of how to be a mother and what that should look like. We have this false narrative of what motherhood should be."

Psychiatrists scarce for pregnant and postpartum women

Perinatal mental health is the leading cause of maternal mortality in the state, a fact that Dr. Christina Wichman has been trying to impress on health care providers for some time. Wichman is an OB-GYN and medical director of The Periscope Project at the Medical College of Wisconsin, a statewide program that provides resources to health care providers caring for pregnant and postpartum women struggling with mental health or substance use disorders.

"I always say that if a woman is struggling with any kind of mental health or substance use disorder during pregnancy, adding a newborn baby to that mix is not going to help anything," Wichman said. "Sleep deprivation, the hormone piece, role transition, trying to care for herself as well as her baby oftentimes is the straw that breaks the camel's back."

In her experience, Wichman said, few psychiatrists feel comfortable treating pregnant and lactating parents. The problem is exacerbated by growing shortages of psychologists and psychiatrists.

Not only does mental illness account for the biggest cause of death for pregnant and postpartum people, according to the U.S. Centers for Disease Control, but the riskiest time in the perinatal period occurs seven to 365 days after childbirth. About 53% of all pregnancy-related deaths happen during this timeframe, with mortality rates increasing, rather than tapering, up to a year after childbirth.

That CDC data was from 36 states, including Wisconsin, who shared comparable information.

The yearly cost of untreated perinatal mental health conditions in Wisconsin, according to Moms Mental Health Initiative, is more than $300 million, a calculation based on the current rate of birth, the number of mothers who experience PMADs but don't receive treatment, and the estimated cost of not treating those mother-infant pairs.

The second leading cause of death, at nearly 14% of all deaths, is hemorrhaging — about a 40% difference.

Additionally, Wisconsin Department of Health Services partnered with the University of Wisconsin–Madison Prevention Research Center to track pregnancy-associated overdose deaths in the state from 2016 to 2019. The report found that, in 92% of all overdose deaths, mental health conditions were a contributing factor — and normally occurred six to nine months following pregnancy.

That timeline is a problem for mothers who rely on Medicaid, Ornst Bloomquist said. Pregnant patients in Wisconsin can lose their eligibility for Medicaid three months postpartum, which is three months before the most dangerous period. That's also when new parents tend to return to work, which presents a whole new wave of transitions.

"This is really a crisis. Women are dying from this," Bloomquist said.

Health care providers encouraged to do mental health screens at every appointment

National guidance from the American College of Obstetricians and Gynecologists recommends screening at least once during the perinatal period for depression and anxiety. But to Wichman, health care providers should be screening pregnant and postpartum patients every time they have an appointment.

"A lot of data shows that the highest risk of suicide and drug overdoses actually happens in those later months postpartum," Wichman said.

One of the reasons that so many depressive symptoms go overlooked, Wichman said, is that those behaviors overlap with typical life changes in birthing mothers. Changes such as sleep, appetite, energy level, disconnection with others, and transitioning roles are virtually universal in pregnant and postpartum patients.

"A lot of times, women are being passed off as, 'That's OK, that's normal, you're supposed to be tired, you're not supposed to have much energy, you're supposed to have appetite changes,'" Wichman said. "We tend to think about these physical symptoms that can be associated with depression, but we're not asking about emotional symptoms, and those are more difficult to ask about, they're more difficult to talk about — which is why we really advocate for screening."

The American College of Obstetricians and Gynecologists recommends either the commonly used Edinburgh Postnatal Depression Scale, a 10-question form specific to new parents that weighs emotions over the past seven days, or more generalized depression and anxiety tests such as the Patient Health Questionairre-9 or the General Anxiety Disorder 7 Screen.

According to the Wisconsin Pregnancy Risk Assessment Monitoring System, 44% of women are not screened for depression in the year prior to pregnancy, 20% of women aren't screened during prenatal care visits and 12% of women aren't screened for depression following pregnancy.

Even when they are screened, Yang said, that's normally the extent of it.

"If they are screened, they're just screened. There's no follow up, or resources provided," Yang said.

Much of that is the result of mental health training not being part of the four years of OB-GYN residency training, Wichman said. And the few resources in the state that do exist have exceedingly limited availability.

In the meantime, however, "these women are falling through the cracks," Wichman said.

Pre-existing conditions complicate treatment options

After Kinsey Pierre, clinical director of Us 2 Behavioral Health, gave birth to her premature twins last year, she watched helplessly as doctors whisked them off to the neonatal intensive care unit (NICU). Pierre experienced a range of emotions that she couldn't make sense of — and there was no script for how to proceed.

Pierre had given birth to her first child in the first wave of pandemic lockdowns, and had her twins in 2022. Each time, she felt isolated and alone.

"Overnight, you're on somebody else's schedule and routine. Somebody else needs you to do everything for them. Your relationship with your significant other changes, because you're juggling multiple roles; then, you go back to

work and you're juggling even more roles," Pierre said. "You're sleep deprived and isolated — and that's all without any birth trauma or unhealthy infant or whatever the case might be. That's just a normal pattern."

All this is made more complicated by pre-existing mental health conditions, Yang said. And it gets even more complex if the patient takes certain mood-stabilizing medications, which is more common than most people realize. Some medications used to treat anxiety, bipolar disorder and schizophrenia, for example, carry a small, increased risk of birth defects, according to the CDC. But the alternative — going cold turkey with a medication that a patient with mental illness may have relied on for years — can be dangerous.

"The birthing person really has to work with their psychiatrists and their treatment team to find alternatives. Not every alternative is going to work, and a medication in itself takes a while to actually work its course," Yang said. "If it doesn't work, you have to wait for that med's half-life to wear off in order to start all over. It can really leave the birthing person in limbo."

Not too long ago, one of Yang's clients told her a story she would never forget. Her client had shared with her OB-GYN that she was experiencing depression symptoms, and asked what to do. The OB-GYN's response was: "You're asking the wrong person; I work on the opposite end."

The OB-GYN could have asked about external environmental stressors and even more simply, "How do you feel about this pregnancy?" Having an established list of perinatal mental health specialists in the area could create more opportunity for that kind of exchange to be productive, instead of defeating.

Us 2 Behavioral Center's perinatal mental health training would give providers a multi-step process to determine mental illness by presenting a list of possible explanations for a patient's symptoms and eliminating them one by one.

It's been more than a decade since Ornst Bloomquist struggled with postpartum anxiety. Her organization, Moms Mental Health Initiative, engages in what Ornst Bloomquist described as "resource brokering" — trying to find the right help when a woman is suffering from a particular mental health condition. There's also a peer-support group called Circles of Hope.

"We need to have everybody who's working in maternal child health coming from the same baseline of knowledge about perinatal mental health disorders," Ornst Bloomquist said. "It can't just be *some* who have these touch points with perinatal women knowing about it and not others."

Natalie Eilbert covers mental health issues for USA TODAY NETWORK-Wisconsin. She welcomes story tips and feedback. You can reach her at neilbert@gannett.com or view her Twitter profile at @natalie_eilbert. If you or someone you know is dealing with suicidal thoughts, call the National Suicide Prevention Lifeline at 988 or text "Hopeline" to the National Crisis Text Line at 741-741.