PERINATAL MENTAL HEALTH ALLIANCE OF ARIZONA

PSI Postpartum Support International Arizona Chapter

Maternal Mental Health in Rural Spaces

Understanding and Supporting Perinatal Mood & Anxiety Disorders (PMADs)

Presented by Kelly Donohue, PhD, ABPP, PMH-C

About Your Presenter

Kelly Cooper (she/her) is a licensed Psychologist and is Perinatal Mental Health Certified. She specializes in Developmental Disabilities and Serious Mental Illnesses. She is a strong advocate for mental health equity, and has completed her clinical work primarily in rural parts of Arizona where there is a limited network of mental health professionals. Kelly is originally from Massachusetts and relocated to Arizona to complete her doctoral degree at Northern Arizona University. As a mother of two under two, she is passionate about providing support to parents and their families during the postpartum period.

Scope of Perinatal Mood Disorders

1 in 5

PARENTS IMPACTED

The #1 Complication of Childbirth

Perinatal Mood and Anxiety Disorders (PMADs) encompass depression, anxiety, OCD, and PTSD during pregnancy or the first year postpartum.

The Ripple Effect: Left untreated, PMADs can profoundly impact infant secure attachment, developmental milestones, and whole-family stability.

Early Intervention and Detection: Immediate support acts as a preventative buffer, halting long-term adverse effects on the birthing person, child, and family system.

Substance use and Mental Health combined are the number one driving factor of maternal mortality

Recognizing Signs & Symptoms

Mood Shifts

Severe sadness, emotional flatness, or intense maternal rage that goes far beyond expected sleep exhaustion.

Intrusive Thoughts

Distressing, repetitive, scary thoughts of accidental or intentional harm that drive severe anxiety and hyper-vigilance.

Cultural Factors

Symptoms are often expressed non-verbally or described as physical pain ("nerves", aches) due to stigma or fear of judgment.

Adjustment vs. Clinical Concern

Observation Point	Typical Postpartum Adjustment	Clinical PMAD Concerns
Duration	Resolves naturally within 10 to 14 days	Persists continuously beyond 2 weeks
Daily Function	Fatigued, but able to care for self & child	Inability to sleep or complete basic tasks
Emotional Profile	Fleeting tearfulness & transient worries	Hopelessness, terror, intrusive imagery
Action Step	Offer practical help and gentle reassurance	Initiate clinical connection & screening

Common PMADs

Depression:

- anger or irritability
- Lack of interest in baby
- Appetite and sleep disturbances
- Crying and sadness
- Feelings of guilt, shame, and/or hopelessness
- Loss of interest in doing things
- Thoughts of harming self or baby
- Approximately 15% of birthing people have significant depression postpartum

Common PMADs

Anxiety:

- Constant worry or feeling something bad is going to happen
- Racing thoughts
- Disturbance of sleep and appetite
- Inability to sit still
- Physical symptoms including dizziness, hot flashes, and nausea

Postpartum Panic Disorder

- Anxiety with panic attacks

Obsessive Compulsive disorder

- obsessive or intrusive repetitive thoughts and/or mental images that are upsetting
- Competitive Behaviors done to “reduce” stress
- Fear and hypervigilance around infant safety, checking behaviors

Common PMADs

Bipolar Disorder:

- 50% of birthing people with bipolar disorder are first diagnosed in the postpartum period
  - Individuals with a previous diagnosis are at a high risk of relapse
- Family history is a risk factor
- Periods of severe depression and irritability (this is when they are most likely to ask for help).
- Periods of improved mood and increased productivity, needing little sleep.
- Delusions, rapid speech, trouble concentrating, overconfidence

Psychosis

- 1-2 out of every 1,000 deliveries
- Onset is usually sudden often within 2 weeks postpartum
- Delusions, Hallucinations, Strange belief systems
- Psychosis is ALWAYS an emergency

Common PMADs

Post Traumatic Stress Disorder:

- 9% of new parents (birthing person and partners)
- Real or perceived trauma during delivery, peripartum, or postpartum
- Previous trauma is a risk factor for development of pp PTSD
- Intrusive reexperiencing the real or perceived threat, nightmares
- Avoidance of stimuli associated with the event
- Persistent arousal
- Panic attacks
- Sense of detachment

Risk & Protective Factors

Vulnerabilities

Biological triggers combined with life stress heighten risk:

- Past history of mood disorders
- Financial strain & severe isolation
- Drastic physical shifts postpartum

$$\Delta\text{Hormones} + \text{Isolation} \rightarrow \text{PMAD Risk}$$

Protective Buffers

Factors that significantly lower clinical severity:

- **Social Support:** Strong, non-judgmental human connection
- **Care Access:** Proactive medical and peer pathways
- **Coping Capacity:** Adaptive emotional regulation

PMADs in Rural Contexts

A Unique Landscape of Care

The Challenges: Rural parents face severe workforce shortages, long travel times, and a "fishbowl effect" that severely limits medical anonymity.

The Strengths: Tight-knit local systems foster deeply trusted organic networks. Community leaders are often highly effective advocates.

Context-Sensitive Care: Support must meet parents where they live, utilizing existing social structures to identify concerns early.

Practical Support Strategies

- **Strengths-Based Validation:** Remind parents that this is a temporary, treatable complication. Frame self-care not as a luxury, but as essential medical recovery.
- **Collaborative Safety Planning:** Help families map warning signs, list immediate local supports, and save the national maternal health line: **1-833-TLC-MAMA**.
- **Warm Referrals:** Do not just hand over clinical phone numbers. Offer to sit alongside the parent or facilitate a direct, warm handoff to regional specialists.

Postpartum Support International has many free resources including online support groups, peer supports, and a provider directory

Leveraging Community Assets

1. Natural Allies

Neighbors and relatives recognize subtle personal shifts.

2. Trusted Figures

Pastors, librarians, community leaders provide stigma-free validation.

3. Public Nurses

WIC & visiting home nurses integrate routine screening.

4. Clinical Hubs

Specialists & telemedicine deliver diagnostic care.

A multi-tiered community network bypasses rural clinical shortages to build a safe, proactive envelope of care.

Takeaway Message

"A parent's mental health is the foundation of a family's future. When we support the parent, we protect the child."

MATERNAL & FAMILY WELL-BEING NETWORK

Case Study: Rural Support

Applying PMAD Differentiation, Risk Screening, and Local Adaptation for Sarah

Case Study Introduction

Sarah's Presentation

The Profile: Sarah is a 28–year-old mother of a 6–week-old newborn, living in a rural farming township with a population of 1,200, situated 45 miles from the nearest hospital.

The Struggle: She presents with extreme sleep hypervigilance, sudden bursts of maternal rage, and recurring, distressing thoughts about unintentional harm happening to her baby.

Workplace/Life Stress: Sarah feels completely cut off from her previous social circles and fears being labeled as an "unfit parent" by her tight-knit community. Her employer was not supportive in planning for her maternity leave and has reached out to her with work related questions since being out of the hospital (but has not checked on her)

Clinical Differentiation

1. Typical Postpartum

Often colloquially referenced as the "Baby Blues," affecting approximately 60–80% of new parents.

- **Onset:** Emerges 2–3 days postpartum.
- **Duration:** Resolves naturally within 10–14 days.
- **Function:** Mild, passing weepiness; basic coping remains intact.

2. Sarah's Case (PMAD)

Sarah exhibits clinically significant symptoms that warrant clinical pathways and specialized support.

- **Duration:** Active and worsening at 6 weeks postpartum.
- **Severity:** Severe sleep avoidance, intrusive scary thoughts.
- **Function:** Significant distress and functional impairment.

Rural Risk & Protective Factors

Geographic Obstacles

Sarah resides 45 miles from OB/GYN care and 140 miles from specialized psychiatric providers. No local public transit options exist.

Stigma & Fishbowl

Sarah worries that parking her car at the lone community clinic exposes her private struggle to nosy neighbors and church acquaintances.

Local Protective Buffers

Her home is visited monthly by a trusted county WIC nurse. Her local community library features a private study room with broadband internet.

Analyzing Intervention Impact

2.4x

ISOLATION VULNERABILITY

Mitigating Rural Risks Mathematically

In rural communities, the severity of a perinatal mood crisis is compounded exponentially by distance and stigma, but can be significantly lowered by informal and formal community buffers.

When modeling Sarah's support network, clinical staff visualize her risk profile using a simplified balancing equation:

$$\text{Risk Severity} = \frac{\text{Vulnerability} + \text{Geographic Isolation}}{\text{Virtual Connections} + \text{Local Trusted Allies}}$$

Adapted Rural Support Flow

1. Trusted Contact

WIC nurse screens Sarah at home using EPDS, normalizing and validating her postpartum struggles.

2. Stigma-Free Hub

Library sets up a private room for secure telehealth visits, bypassing transport barriers.

3. Virtual Peer Care

Sarah joins an asynchronous virtual support circle for rural parents, easing local isolation.

4. Community Aid

Local faith-based and family circles organize informal meals, allowing Sarah to rest.

Leveraging Sarah's unique rural landscape to build an accessible, secure, and stigma-free care pipeline.

Case Discussion & Debrief

How can we replicate Sarah's adapted network in your local rural service area?

Questions & Discussion

Thank you for advocating for mothers and families.

Resource Slides

AZ'S REPORT CARD

Award	Providers & Programs
⊗	PMH-C Provider to Patient Ratio
✓	Maternal Mental Health Prescriber to Patient Ratio
⊗	Inpatient Perinatal Mental Health Treatment Program
⊗	Outpatient Intensive or Partial Hospitalization Programs
✓	Maternal Mental Health Task Force or Commission
✓	CBOs Providing Direct MMH Services

FREE Resources for Providers

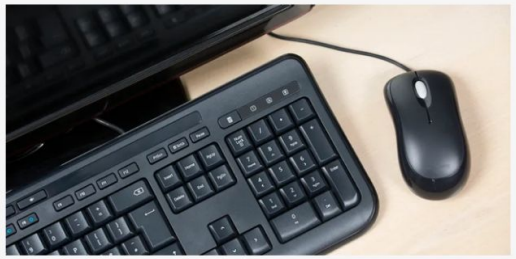
Virtual Certification Training

Tucson, AZ

Frontline Provider Training

Let us bring training to you

On-Demand Webinars



FREE Educational Webinars

FREE MMH 101

Maternal Mental Health 101

PSI Perinatal Psychiatric Consult Line

Medical professionals: Get a free consult about mental health care related to childbearing and pre-conception planning.

LEARN MORE

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PSI Arizona

FREE Resources for Help Seekers

National Maternal Mental Health Hotline

Not Feeling Like Yourself?

Let's Talk About It.

National Maternal Mental Health Hotline

HRSA Health Resources & Services Administration

For Emotional Support & Resources
CALL OR TEXT 1-833-TLC-MAMA
(1-833-852-6262)

ALWAYS FREE — 24/7 — CONFIDENTIAL — 60+ LANGUAGES

Support Groups

60+ online (free)

Find Your Peer Mentor

Paired for 4 month (free)

Connect with a Local Specialist

Connect with a Specialized Coordinator

Chat with an Expert

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COLLEGE OF MEDICINE TUCSON

Arizona Perinatal Psychiatry Access Line

1-888-290-1336

APAL.arizona.edu | team@apal.arizona.edu

Scan QR code to subscribe to our newsletter

FREE Consults | Monday - Friday, 12:30 - 4:30 p.m.

FREE Provider Training

FREE Toolkits & Resources for Providers, Moms and Families

Trainings, Toolkits, Website

98% were deemed preventable

2016-2018 Deaths in Arizona of Women 15-49 Years Old with a Pregnancy in the Previous 365 Days

Source: "Maternal Mortality Related to Mental Health and Substance Use in Arizona" presentation. Maternal Mental Health Task Force Meeting, April 20, 2022