APA Resource Document

Resource Document on Health Disparities in Perinatal Mental Health

Approved by the Joint Reference Committee, June 2025

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." – *APA Operations Manual*

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Introduction

APA's Health Disparities in Perinatal Mental Health Resource Document — developed by the APA's Health Disparities in Perinatal Mental Health Work Group — is an evolving resource for members who want to learn more about health disparities in women's perinatal mental health.

Health disparities exist in perinatal maternal mental health. Black and Hispanic women have higher rates of postpartum depression and are at increased risk of developing perinatal anxiety disorders. Women of color also experience higher rates of maternal suicide and substance use disorders (SUD) during the perinatal period. Lower socioeconomic situation, lack of insurance, geographic location, age, having a dominant language other than English, being single, and experiencing abuse by an intimate partner also increase the risk of perinatal mental health issues for women.

Understanding health disparities; training in culturally responsive practices; enhancing screening and support services, including for intimate partner violence (IPV), trauma, and social determinants of health (SDOH); and providing psychoeducation to decrease stigma are important at the provider level. Additionally, at the systems level, reducing barriers to care, improving access to culturally responsive care, and advocating for policies that reduce social and political determinants of health are all ways to continue to address health disparities for women and their mental health during the perinatal period.

Access

While there are many evidence-based practices for perinatal mood and anxiety disorders, screening rates vary widely, and ≤25% of those who screen positive for depression receive any treatment. Gaps in care loom largest for individuals who are Black/African American, Hispanic/Latina/o/e/x, American

Indian or Alaska Native, or Native Hawaiian or other Pacific Islander (i.e., populations that have been marginalized).

While effective treatments are available, care often falls short of patients' needs and of recommended standards. Barriers persist across the mental health care pathway (screening, assessment, and treatment until symptom remission), including stigma, fear regarding treatment, and a dearth of community-based mental health supports. Providers and patients report that barriers are amplified by 1) gaps in provider training; 2) lack of established treatment protocols; 3) lack of access to mental health care resources, referrals, and consultation; 4) lack of integrated responses to IPV and other lifetime trauma; 5) adverse SDOH; and 6) microaggressions, implicit racial biases, and discrimination. Gaps and inequities persist across the perinatal mental health care pathway. Thus, the U.S. lags behind other high-income countries.

SDOH and disparities in screening or treatment rates drive inequities in perinatal mental health care. SDOH are the social circumstances in which people are born, work, live, and age, and the wider set of forces shaping daily life. SDOH influence 80% of health outcomes as well as patient engagement with the health care system. Addressing patients' adverse SDOH is critical to improving health equity and is essential for high-quality health care.

Professional organizations and policymakers recommend screening for adverse SDOH at health care visits. Integrating social services into mental health care is critical for improving health equity and patient experience. While health care and community providers want to address inequities in access to care, they may not have the necessary training, skills, resources, or tools to do so. This lack of health care assets, combined with racial discrimination in health care and in community settings, contributes to both 1) higher rates of depression and anxiety symptoms and 2) lower screening and treatment rates among marginalized populations.

Postpartum Depression and Anxiety

Women of color are disproportionately less likely to receive accurate diagnoses and treatment for perinatal mood and anxiety disorders than white women. Limited access to health care contributes to this lack of treatment. Additionally, cultural stigmas and taboos surrounding mental health in specific communities contribute to underreporting and underdiagnosis of perinatal mood and anxiety disorders. This disparity is also exacerbated by bias in the health care system. It is vital that we continue to develop culturally sensitive screening tools and treatment plans and train a health care workforce that is culturally aware, compassionate, and knowledgeable about the ways that SDOH, IPV, and trauma across the lifespan affect diagnosis and treatment.

Postpartum Psychosis

Racial disparities in postpartum psychosis reflect inequities in the diagnosis, treatment, and outcomes for women of color. Postpartum psychosis is a rare but severe condition that can occur after childbirth, requiring prompt intervention due to its potential for life-threatening consequences.

Black and Hispanic women often face delayed diagnoses or are misdiagnosed with other conditions such as depression or schizophrenia, rather than postpartum psychosis. There are a number of contributing factors. Stereotypes and biases in mental health care contribute to these disparities. Symptoms in women of color may be dismissed or underestimated, leading to a failure to timely recognize the

severity of their condition. Socioeconomic disparities play a significant role. Women of color tend to have less access to high-quality perinatal mental health care due to systemic factors such as lack of insurance, geographic barriers, and limited access to culturally competent providers. Cultural beliefs around motherhood and mental health may also create barriers to openly discussing mental health concerns. Mental health disorders, including postpartum psychosis, may be stigmatized in some racial and ethnic communities. This stigma can discourage women from seeking help or sharing their symptoms, worsening the risk of untreated psychosis. Additionally, health care providers may harbor implicit biases which can lead them to underestimate the severity of symptoms and the necessity of prompt intervention, which may result in less aggressive or comprehensive interventions compared to white women. Delays in diagnosis and treatment can lead to severe consequences, including suicide, infanticide, or long-term psychiatric illness.

Research on postpartum psychosis has focused on predominantly white populations, limiting the understanding of how this condition manifests and impacts women of different racial and ethnic backgrounds. This lack of data contributes to the challenges in creating effective, targeted interventions.

Mortality Rates

Maternal mortality refers to deaths due to complications from pregnancy or up to a year following childbirth. Suicide, drug overdose, and homicide are currently the leading causes of pregnancy-related deaths in the United States. There are a number of factors that drive disparities in maternal mortality, including limited access to quality care, IPV, income insecurity, limited access to education, limited access to interpreters, and structural and implicit biases driven by racism and other forms of oppression.

Black women are disproportionately affected, with maternal mortality rates approximately three times higher than those of white women. This disparity persists regardless of income or education level, highlighting systemic issues in health care access and quality. Indigenous women also experience maternal mortality rates that are nearly twice as high as those of white women. While the maternal mortality rate for Latina women is lower than that for Black and indigenous women, it is still higher than that for white women. Asian and Pacific Islander women tend to have lower maternal mortality rates compared to other racial minorities — rates that are closer to those of white women. However, disparities can exist within subgroups and based on geographic locations. White women have the lowest maternal mortality rates among racial groups, but these rates have been rising over time.

Poverty, lack of access to education, IPV, and inadequate insurance coverage disproportionately affect minorities, impacting maternal health and mental health outcomes. Implicit biases in health care and historical mistrust contribute to these disparities. Minoritized communities often face barriers to accessing quality prenatal and maternal health care. Improving health care access, addressing adverse SDOH, and increasing awareness and training among health care providers to deliver culturally responsive care are all ways to reduce these disparities.

Substance Use Disorders

Having a lower socioeconomic situation contributes to financial stressors, unstable housing situations, and food insecurities which can increase the use of substances as a coping mechanism. Pregnant persons of color (POC) are at increased risk of SUD during pregnancy, which can lead to complications during pregnancy and birth. Lower levels of social support can also contribute to substance use during

pregnancy. Limited access to prenatal care and SUD treatment can further impact risk of morbidity and mortality.

Systemic racism intersects with other forms of discrimination and results in increased chronic stress, which can make pregnant POC more vulnerable to substance misuse. This effect can be exacerbated when it intersects with adverse SDOH such as poverty and IPV that can each independently increase the risk of substance use disorders.

There is limited availability for specialized SUD programs designed for pregnant persons. Additionally, lack of access to SUD treatment disproportionately affects those with limited financial resources. Intra- and extra-community stigma related to substance use against minority perinatal patients can create barriers to care. Systemic racism also makes it more likely that pregnant people of color would face harsher penalties for substance use compared with white women. This may be a barrier for pregnant persons of color to seek help. Other barriers include limited access to culturally and linguistically appropriate care and affordable access to care.

Trauma and Intimate Partner Violence (IPV)

It is important to understand the links between IPV, maternal mental health, and SUDs when assessing for these conditions. Experiencing IPV has a significant impact on maternal mental health and substance use and is a major contributor to maternal mortality, suicide, overdose, and homicide. People who experience IPV often face additional barriers to care caused by abusive partners who actively undermine their mental health, coerce them to use substances, prevent them from accessing treatment, control their medications, sabotage their recovery efforts, and then leverage stigma-related policies against them, particularly in relation to child custody loss, as part of a broader pattern of abuse and control (Phillips et al., 2024; Warshaw et al., 2014). These policies disproportionately impact women from marginalized communities and serve as a major deterrent to seeking care.

Relevant APA Documents

Intimate Partner Violence: Guide for Psychiatrists Treating IPV Survivors

Perinatal Mental Health Toolkit

Position Statement on Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorders

Position Statement on Medicaid Coverage for Maternal Postpartum Care

Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum

VIGNETTE #1

Visit 1

Isabella, a 24-year-old Spanish-speaking woman with a past history of one previous miscarriage, who is currently nine weeks pregnant, presents to your psychiatric office after being referred from her PCP for scoring 16 on the GAD-7 at her last PCP visit two weeks ago. While in the waiting room today, she completed the GAD-7 again and scored 18. You speak with her using the aid of a virtual Spanish interpreter. After you introduce yourself and your role, Isabella tells you that she just recently found out about her pregnancy. She says that she has been constantly worried about her baby, her own health, and her future, and that she feels restless, cannot sleep at night, and is tired throughout the day. She mentions that she has been getting into more arguments with her partner as well. She is fidgeting in her seat and tapping her foot. She does not make eye contact with you. She asks if there is a way to help control her worry.

You acknowledge that it is very normal to feel nervous during pregnancy and inquire about any depressive symptoms she may be experiencing, including low mood, decreased interest in activities she usually enjoys, and feelings of hopelessness. She reports that she is not experiencing any symptoms of depression and again states that she has felt increasingly on edge over the past two months. She has no thoughts of hurting herself, her partner, or her baby, and reports no substance use. You are concerned about her mention of the increasing number of arguments with her partner, accompanied by her lack of eye contact, and inquire further about what the arguments are about, how her partner feels about her pregnancy, and how he's been responding to her current distress. She says that her partner has been "as supportive as he can be" while working two jobs. You provide education on various methods that can reduce anxiety, including medication, therapy, and coping skills/techniques. She says that she is not interested in any psychiatric medication at this time, and she requests time to think about whether she wants to start therapy. You take five minutes to share breathing exercises, relaxation techniques, and other tips, including exercise, meditation, and journaling, that she can try. You provide her with written handouts of these techniques in Spanish that she can take home with her. She agrees to see you again in two weeks so you can track her progress. Based on your assessment, you believe that her symptoms are consistent with adjustment disorder with anxiety. You recognize that cultural stigmas surrounding mental health in specific communities can lead to underreporting and underdiagnosis of mood and anxiety disorders among women of color.

Visit 2

Before your next appointment with Isabella, you conduct a brief review of her chart to see whether there have been any major medical events since her last appointment. You see a note from an emergency department visit that occurred five days prior to today in which she complained of severe nausea and vomiting. She received IV fluids and antiemetic therapy and was discharged home the same day. You look over the labs and see that she had a mildly elevated blood alcohol concentration. You make a note to yourself to ask her about this during her next visit with you.

When Isabella arrives at her psychiatric follow-up appointment, she appears more visibly anxious than last time. She says that she tried to use some of the strategies that you shared with her previously, but she is only able to do them for a few minutes before her heart starts to pound and her mind starts to race. You ask her about her recent emergency department visit and again inquire whether she has been

using any substances recently. She reports that she did not tell you at her last appointment that she has been having several glasses of wine throughout the week. She says, “Alcohol has helped me feel calmer in the past. I know that it’s not good for you when you’re pregnant, but I don’t know what else I can do.” She has not vomited since her emergency department visit, is not tremulous or diaphoretic, and denies any perceptual disturbances. You inform her of the negative impacts of alcohol exposure during pregnancy on fetal development. She voices understanding but starts crying, saying “I’m a bad mom; I’m a bad mom — I’m so stressed out and I need help.” You provide empathetic support and tell her that you are there to help her. You recognize that lower socioeconomic status and lack of support can contribute to higher rates of substance use. You also inform her that anxiety and alcohol use can both lead to the other and that although alcohol may temporarily suppress anxiety while drinking, there can be a rebound effect that significantly increases anxiety afterwards.

She says that she is now interested in starting an anti-anxiety medication as well as psychotherapy. You recognize that many women who screen positive for mood and anxiety issues during pregnancy do not receive adequate treatment and that barriers to culturally and linguistically appropriate care exist. You are eager to share treatment options with her. You provide her with the indications/risks/benefits/side effects of sertraline, and she is agreeable to starting 25 mg daily and following up with you in another two weeks. You give her a list of Spanish-speaking therapists who she can contact to schedule a session. You also provide her with a list of support groups, such as “Mommy and me” groups, that are occurring within her community. She tells you that she will stop drinking, which you encourage, but you also provide her with alcohol use resources, including AA materials, in Spanish.

Visit 3

At Isabella’s next appointment with you, you notice that she has a moderate-sized bruise on her right cheek and several smaller bruises on her right arm. She smiles when you greet her but then looks down at the floor. She says that she had some diarrhea the first week she took the sertraline but that it went away. Although she does not report any additional side effects, she says that she has not noticed any significant reduction in her anxiety.

You reiterate that it may take several additional weeks for the anxiolytic effect of the medication to work. She says that she has not drunk any alcohol since her last appointment with you because “I was scared to.” She says that this past week, she was trying to get rid of the alcohol in her home as a way to prevent herself from drinking but that her partner intervened and got upset that she attempted to throw out the beer and wine. You ask her if she felt threatened or if anything physical took place. She shakes her head and says no. You ask her if she feels safe at home, and she replies, “Yes, I do.” You provide normalizing information acknowledging that there often is increased tension within intimate relationships that may occur during pregnancy. You also inquire if she has any concerns about how her partner will respond to her stopping drinking and to her taking meds and starting treatment. You understand that IPV against pregnant women is a major public health issue that can lead to adverse outcomes for both the mother and fetus, and that mental health and substance use coercion are common forms of abuse. You also recognize that women may be reluctant to share details about their relationships with health care providers. You remind her that you are there to help her and that if there is any time when she does not feel comfortable at home or fears for the safety of her baby or herself, she can contact your office, go to the emergency department, or call 911. She nods in understanding. You ask her about her social support system; she says that she has an aunt who lives around 35 minutes

away. She says that she could get extra help from her aunt if she needed it. You let her know about the kinds of help domestic violence programs can offer and ask whether she'd like any resources or information about domestic violence shelters. She politely declines. You discuss increasing her sertraline to a more therapeutic dose of 50 mg daily, and she is in agreement. She says that she was able to schedule a therapy appointment with a Spanish-speaking therapist that will take place next week.

Her next appointment with you will be in two weeks.

Visit 4

At Isabella's next appointment with you, she says that she has been feeling a bit better. She has been calling her aunt once a week to talk about her pregnancy, and she has found her aunt's words of support and knowledge of pregnancy to be comforting. She also says that she had a good first session with her therapist and that it is nice to have someone else to talk to about her life stressors. She reports no side effects with the increase in sertraline. She still reports feeling anxious at times but has been better able to manage it with meditation and breathing techniques. When asked about how things are going with her partner, she replies, "The same," and does not elaborate further. She says that she likes her OB-GYN and feels more prepared to handle her pregnancy. You and Isabella decide to keep her medication at its current dosage for now, and you encourage her to continue relying on her social support system, seeing her therapist, and using her coping skills. She thanks you for your help. You know that prenatal anxiety is a strong predictor of postpartum mood symptoms, so you recognize that after her delivery, she will need closer follow-up with you, but for now, given her overall improvement, you will see her again in one month.

- Perinatal = Prenatal (conception to birth) + Postpartum (birth to six weeks post-delivery, though this phase can extend to one year).
- Prenatal anxiety is a strong predictor of postpartum depression and anxiety. Women of color are disproportionately less likely to receive accurate diagnosis and treatment for perinatal anxiety disorders than white women, a disparity exacerbated by racial discrimination and bias in the health care system. Additionally, cultural stigmas and taboos surrounding mental health in specific communities contribute to underreporting and underdiagnosis of perinatal anxiety disorders among women of color.
- While there are many evidence-based practices for perinatal mood and anxiety disorders, screening rates vary widely, and ≤25% of those who screen positive for depression receive any treatment. Gaps in care loom largest for individuals who are Black/African American, Hispanic/Latina/o/e/x, American Indian or Alaska Native, or Native Hawaiian or other Pacific Islander (populations that have been marginalized).
- Adverse social determinants of health (SDOH) and disparities in screening or treatment rates drive inequities in perinatal mental health care.
- While the maternal mortality rate for Latina women is lower than that for Black and Native American women, it is still higher than that for white women. Socioeconomic factors, immigration situation, and access to culturally competent care play significant roles.
- Racial disparities, lower socioeconomic status, and lower social support contribute to higher rates of SUD which can lead to complications during pregnancy and birth.

- There is limited availability for specialized SUD programs designed for pregnant persons. Additionally, lack of access to SUD treatment disproportionately affects those with limited financial resources. Intra- and extra-community stigma related to substance use against minority perinatal patients can create barriers to care. Systemic racism also makes it more likely that a pregnant person of color would face harsher penalties for substance use compared with white women. This may be a barrier for pregnant persons of color to seek help. Other barriers include limited access to culturally and linguistically appropriate care and affordable access to care.

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VIGNETTE #2

Visit 1 — First trimester

Janelle is a 28-year-old female with a past psychiatric diagnosis of schizoaffective disorder, bipolar type, who presents to your office after her sister recommended that she see a psychiatrist. She scored a 3 on the Edinburgh Postnatal Depression Scale that she completed before her appointment. She just found out that she is pregnant with her second child, and her sister wants to make sure that she's healthy during this pregnancy. She has been prescribed psychiatric medication in the past but she discontinued her medications because she doesn't want to "hurt the baby" with problems that are "all in her head." She says that she heard from her family that medications can cause birth defects.

You gather additional information about her past psychiatric history. She explains that she was diagnosed with schizoaffective disorder when she was 19. Review of symptoms during that time is significant for irritability. She also explains, "The doctors said I was paranoid." You consider the roles of bias in psychotic spectrum diagnoses and cultural paranoia. You explore her past psychiatric history

further and realize that she has a history of sexual trauma and that her symptoms of irritability, wariness toward males in a hospital setting (interpreted as paranoia), avoidance, flashbacks, and poor sleep most closely fit with PTSD as a result of her sexual trauma. Per a review of her symptoms, you find she has not had any symptoms consistent with a manic episode or true psychosis.

You consider the disparities in maternal mortality and you recommend that she follow up with her OB visits in addition to seeing you for appointments.

You explore her symptoms after her first pregnancy, and she states that she had increased irritability, anhedonia, difficulty connecting with her baby, and suicidal thoughts after the birth of her first child. She also had unwanted thoughts about harming her baby and they scared her. She reports that her strong Christian faith prevented her from acting on these homicidal thoughts. She goes to church weekly and feels community at her church but is worried about being judged for her thoughts. She reports that she is worried that disclosing her unwanted homicidal thoughts toward her child would result in her child being taken away by DSS. You acknowledge her fears that there is still a stigma toward mental illness and ask further questions about her understanding of why she's experiencing these symptoms and how others within her community interpret similar symptoms. You use elements of the cultural formulation interview. She explains that she worries that it's her fault that she wasn't able to connect the way she wanted to with her baby. She states that her pastor is very compassionate and welcoming. She has never talked to her pastor about her symptoms but she remembers her pastor leading a prayer for a community member who was in the hospital for their mental health.

You ask whether she would consider including her pastor in her care plan moving forward and she agrees to do so. She ultimately declines medication for her history of PTSD and postpartum depressive symptoms at this time. You review the symptoms of depression with her and discuss warning signs that should prompt her to return for an appointment and symptoms that are considered emergencies. You also review the risks of untreated depression compared with the risks of taking medication to treat depression during pregnancy. You are respectful of this decision and explain that you are here if she changes her mind in the future.

Visit 2 — Follow-up visit: Postpartum

The patient has had worsening depressive symptoms, including anhedonia, irritability, and suicidal thoughts. She scored a 13 on the Edinburgh Postnatal Depression Scale. She states that the symptoms began during her pregnancy and have not gotten better. In fact, the symptoms became so bad that she wasn't able to continue working. She is very withdrawn and flat on exam.

You consider that her symptoms impacting her work may have affected her ability to access safe and stable housing, food, and other necessities. You do a brief screening to better understand these issues. She explains that she was able to get additional support from her church community for now but is worried about the future. Your clinic has a social worker because of how closely intertwined mental health is with social determinants of health. You connect her with the clinic social worker, who can help explain the resources available in your area. If your clinic doesn't have a social worker, your clinic leadership compiled a list of local resources where the patient can get help.

You discuss treatment options with her, which include medication and therapy. She explains that she's willing to do therapy as long as the provider is respectful of her beliefs and integrates those beliefs into the treatment plan. You refer her to someone who practices culturally informed therapy.

- Maternal mortality refers to deaths due to complications from pregnancy or up to a year following childbirth. Black women are disproportionately affected, with maternal mortality rates approximately three times higher than those of white women. This disparity persists regardless of income or education level, highlighting systemic issues in health care access and quality.
- SDOH are the social circumstances in which people are born, work, live, and age, and the wider set of forces shaping daily life. SDOH influence 80% of health outcomes as well as patient engagement with the health care system. Addressing patients' adverse SDOH is critical to improving health equity and is essential for high-quality health care. Professional organizations and policymakers recommend screening for adverse SDOH at health care visits. Integrating social services into mental health care is critical for improving health equity and patient experience.
- While effective treatments are available, perinatal mental health care often falls short of patients' needs and of recommended standards. Barriers persist across the mental health care pathway (screening, assessment, and treatment until symptom remission), including stigma, fear regarding treatment, and a dearth of community-based mental health supports. Providers and patients report that barriers are amplified by 1) gaps in provider training; 2) lack of established treatment workflows; 3) lack of access to mental health care resources, referrals, and consultation; and 4) microaggressions, implicit racial biases, and discrimination. Gaps and inequities persist across the perinatal mental health care pathway. Thus, the U.S. lags behind other high-income countries.
- Professional organizations and policymakers recommend screening for adverse SDOH at health care visits. Integrating social services into mental health care is critical for improving health equity and patient experience.
- Black women are disproportionately affected, with maternal mortality rates approximately three times higher than those of white women. This disparity persists regardless of income or education level, highlighting systemic issues in health care access and quality.
- Implicit biases in health care, discriminatory practices, and historical mistrust contribute to these disparities. Chronic conditions like hypertension, diabetes, and obesity, which are more prevalent in some racial groups, increase maternal mortality risk. Poverty, lack of access to education, and inadequate insurance coverage disproportionately affect minoritized communities, impacting maternal health outcomes.
- Efforts to reduce these disparities include improving health care access, addressing social determinants of health, and increasing awareness and training among health care providers to deliver culturally responsive care.
- Black and Hispanic women often face delayed diagnoses or are misdiagnosed with other conditions such as depression or schizophrenia rather than postpartum psychosis. Mental health symptoms in women of color may be dismissed or underestimated, leading to a failure to timely recognize the severity of their condition.

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