BLACK MOM Ish
FOUNDATION

A BLACK MOM ISH FOUNDATION GUIDE

Maternal Mental Health

When to get help: signs it's more than “baby blues,” and what support can look like.

ROOTED IN EVIDENCE. WRITTEN FOR US.

WHAT'S NORMAL • WHEN TO WORRY • EMERGENCY SIGNS • REAL SUPPORT

IF YOU NEED HELP RIGHT NOW

This page is here so you never have to dig for it. If any of this is you today, please use it.

If you are thinking about harming yourself or your baby

Call or text **988** (the Suicide & Crisis Lifeline), any time, day or night. If you are in immediate danger, call **911** or go to the nearest emergency room.

If you're seeing or hearing things that aren't there, or feel disconnected from reality

This can be postpartum psychosis, a medical emergency. Call **911** or get to an emergency room now. Don't wait for a scheduled appointment. See Section 3 for what this looks like.

If you need to talk to someone today, but it's not an emergency

Call or text **1-833-TLC-MAMA (1-833-852-6262)**, the National Maternal Mental Health Hotline. Free, confidential, 24/7, and built for exactly this. Full resource list in Section 10.

None of this means something is wrong with you. It means it's time to get some support, and that is a completely normal, reasonable thing to need.

A Note Before You Start

Somewhere between the hospital bracelet and the six week checkup, a lot of us got handed a pamphlet about the baby blues and not much else. Nobody sat us down and explained the difference between a hard week and something that actually needed treatment. Nobody told us what postpartum psychosis really looks like, or that the scary thought you had in the shower doesn't mean what you're afraid it means, or that the same screening questionnaire your doctor hands you was built and tested mostly on women who don't look like you.

This guide is our attempt to fill in that gap, in plain language, with the actual research behind it. It covers what's normal, what isn't, what counts as a true emergency, and what real support looks like once you ask for it. There's a section written specifically about why this often looks and feels different for Black mothers, because it does, and pretending otherwise doesn't serve you.

You don't have to read this cover to cover. Jump to whatever section you need using the table of contents. And if anything in here matches what you're feeling right now, the very next page has the numbers to call before you read another word.

In your corner,

The Black Mom Ish Foundation

What's Inside

Every heading below jumps straight to that page.

SECTION 1 What's Normal: The Baby Blues

In the first week or two after birth, your hormone levels drop faster than at almost any other point in life, your sleep is in pieces, and your body is healing from one of the most physically demanding things it will ever do. Against that backdrop, it's normal to cry more easily than usual, feel a wave of worry for no clear reason, or feel emotionally raw in a way that catches you off guard.

This is usually called the baby blues, and it affects a large majority of new mothers, not a struggling few. It's common enough to be considered a typical part of the fourth trimester rather than a warning sign on its own.

What it tends to look like

- Starts within the first two to three days after delivery.
- Comes and goes, weepy one moment, fine an hour later.
- Fades on its own within about two weeks, without treatment.
- You're tired and overwhelmed, but you're still able to care for yourself and your baby.

The marker worth remembering

If two weeks have passed and you still don't feel like yourself, or the feelings are getting heavier instead of lighter, that's no longer just the baby blues. Section 2 walks through what that can look like instead.

> WHAT'S COMMON **You are not the exception.**
>
> Most sources put the baby blues at affecting somewhere around half to as many as eight in ten new mothers. If you're crying in the shower this week, you are solidly in the majority, not falling behind everyone else.

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SECTION 2 When It's More Than Baby Blues

Depression and anxiety during pregnancy and after birth fall under a broader medical term: *perinatal mood and anxiety disorders*, or PMADs. “Perinatal” means during pregnancy and after, which matters, because roughly half of what gets diagnosed as postpartum depression actually starts during pregnancy itself, not after the baby arrives.

PMADs are the single most common complication of childbirth, more common than gestational diabetes or preeclampsia. Somewhere between one in seven and one in five women experience one. They are also highly treatable. Here's what the different forms tend to look like.

Postpartum depression

- A low mood or sense of emptiness that doesn't lift, most of the day, most days.
- Losing interest in things that used to bring you joy, including the baby.
- Fatigue that sleep doesn't touch.
- Feelings of worthlessness or guilt that feel out of proportion.
- Trouble bonding with your baby, or feeling like you're going through the motions.
- Real changes in appetite or sleep beyond normal newborn chaos.
- Trouble concentrating on simple tasks.

Postpartum anxiety

- Worry that doesn't let up, even when everything is objectively fine.
- Racing thoughts, especially at night.
- Physical symptoms: a racing heart, nausea, dizziness, a sense of dread you can't quite name.
- Trouble sitting still or relaxing, even when the baby is sleeping safely.

Postpartum OCD

- Unwanted, repetitive, disturbing thoughts, often about harm coming to the baby.
- Compulsive behaviors to manage the anxiety: excessive checking, cleaning, counting, or seeking reassurance.
- Avoiding normal caregiving tasks (bathing the baby, being alone with them) because the thoughts are so distressing.

This one deserves its own explanation, since it's widely misunderstood and often the most frightening for the person experiencing it. Section 4 is dedicated to it.

Postpartum PTSD

- Usually follows a traumatic birth: an emergency C-section, a NICU stay, a complication, or an experience where you felt unheard, unsafe, or dismissed.
- Flashbacks or intrusive memories of the birth.
- Avoiding reminders, sometimes including avoiding follow up appointments.
- Feeling on edge or emotionally numb.

> **WORTH KNOWING** **This isn't only a “first six weeks” thing.**
>
> PMADs can start any time from early pregnancy through the first full year after birth. If something feels off at month eight and everyone around you assumes it's too late for it to be postpartum depression, it isn't too late. Bring it up anyway.

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SECTION 3 The Emergency Signs

Everything else in this guide is about symptoms worth bringing to a provider. This section is different. These are signs that need care today, not at your next scheduled appointment.

Postpartum psychosis

This is rare, affecting roughly one to two out of every thousand births, but it is a true psychiatric emergency. Onset is sudden, usually within the first two weeks after birth, sometimes within the first 48 hours.

- Hearing or seeing things that aren't there.
- Believing things that aren't true: paranoia, delusions, a fixed idea that doesn't respond to evidence.
- Extreme confusion or disorganized thinking.
- Rapidly shifting moods, or not sleeping for days at a time.
- A sense of being disconnected from reality.

The biggest risk factors are a personal or family history of bipolar disorder or a previous episode of postpartum psychosis, so this is worth mentioning to your provider during pregnancy if it applies to you. **If you or someone you love is showing these signs, call 911 or go to the nearest emergency room immediately. Do not wait to see if it passes.** With prompt treatment, the long term outlook is genuinely good. Waiting is what makes it dangerous, not the condition itself.

Thoughts of suicide, or of harming your baby, that come with a plan, urge, or intent

There's an important difference between a thought that horrifies you the moment it shows up, and a thought that feels like something you might actually act on. The first is common and covered in the next section. The second is an emergency.

- Call or text 988, the Suicide & Crisis Lifeline, any time, day or night.
- If there is immediate danger, call 911 or go to the nearest emergency room.
- You do not need to be calm, coherent, or certain to call. That's what the line is for.

> **REAL TALK** **You will not be punished for telling the truth.**
>
> A lot of mothers stay quiet about the scariest thoughts because they're afraid of what happens next, that a hospital will take their baby, that they'll be labeled unfit. A real emergency response is built to keep you and your baby safe together whenever possible, and getting ahead of a crisis with honesty is what protects your family, not what threatens it.

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SECTION 4 The Thoughts No One Talks About

Picturing the baby slipping in the bath. A flash image of dropping them on the stairs. A thought like “what if I hurt her” that arrives out of nowhere and horrifies you the second it lands. If something like this has happened to you, you're not broken, and you're far from alone.

Research on this varies, but many studies put the number of new mothers who experience at least one unwanted, disturbing thought about their baby somewhere between seven and nine out of ten. These are called intrusive thoughts, and having them does not mean you are dangerous or that you secretly want to act on them.

How to tell the difference

The distress itself is the clue. A mother having an intrusive thought is horrified by it. She reacts by pulling her baby closer, double checking the stairs, avoiding the thing that triggered it. A person experiencing true psychosis, by contrast, tends not to be horrified by the thought, because on some level they believe it, rather than fear it. That's the core difference between an intrusive thought and a genuine warning sign: unwanted and distressing versus believed and acted on.

When it's worth bringing to a provider

- The thoughts are constant, not occasional.
- You're organizing your day around avoiding triggers: refusing to be alone with the baby, avoiding the kitchen, skipping bath time.
- The thoughts are taking over your ability to function or enjoy your baby at all.

This pattern is often postpartum OCD, and it responds well to treatment, usually a specific kind of talk therapy alongside, if needed, medication. Naming it out loud to a provider trained in this area tends to bring enormous relief, precisely because so few people talk about it.

> **KNOW THIS** **When to treat it as more urgent.**
>
> If a thought ever shifts from something that horrifies you into something that feels like a plan, an urge, or a thought you agree with, that's the line into Section 3 territory. When in doubt, treat it as worth an honest, same day conversation with a provider rather than something to sit with alone.

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SECTION 5 Why This Looks Different for Black Mothers

Everything in the sections before this one applies to you the same as anyone else. But the path to getting it recognized and treated often does not look the same, and pretending otherwise would leave out the part of this story that matters most.

The numbers worth knowing

- Across multiple studies, Black mothers are significantly less likely than white mothers to be screened for postpartum depression at all, in some studies close to a third less likely.
- When Black mothers are screened, research using large hospital datasets shows postpartum depression is still diagnosed less often than it is for white patients, a gap researchers attribute to under-detection rather than lower true rates.
- Black mothers report postpartum suicidal thoughts at meaningfully higher rates than white mothers, a disparity that holds up even after researchers control for income, insurance, and marital status.
- Nationally, mental health conditions, including suicide and substance related overdose, are the single leading underlying cause of pregnancy related death, responsible for roughly a quarter of them. More than eight in ten of these deaths are considered preventable.

That last point is the reason this guide exists. Getting screened and taken seriously isn't a nice extra step, it's tied directly to survival.

It isn't only about access

A 2024 study focused specifically on Black mothers found that racism related stress, on its own, measurably predicted postpartum depression and anxiety symptoms, separate from the usual risk factors like income or lack of support. Carrying that weight is its own risk factor, even when everything else in your life looks stable on paper.

There's also a tool problem. The screening questionnaire most providers use, the Edinburgh Postnatal Depression Scale, was developed and validated mainly on white populations. It may not fully capture how distress shows up for you. For some Black women that looks less like sadness and more like irritability, anger, or physical symptoms like tension and fatigue that a standard questionnaire doesn't ask about directly.

The “strong Black woman” script

A lot of us were raised to see endurance as strength and asking for help as a burden on someone else. That instinct made sense in a lot of contexts. It can also cost you real

support now, at a moment when your body and mind genuinely need backup, not more proof that you can carry everything alone.

There's also a real, earned wariness about the medical system itself. Black patients have a long, well documented history of having pain dismissed, symptoms attributed to the wrong cause, and concerns minimized. That history isn't paranoia. It's data, and it's reasonable that it shapes how safe it feels to open up in an appointment. None of that means staying quiet is the safer choice. It means finding a provider who doesn't require you to prove your pain before taking it seriously is worth the extra effort of looking, and Section 7 covers how to find one.

> **REAL TALK** **Your maternal mortality risk is part of this story too.**
>
> Black mothers face an overall maternal mortality rate that is roughly two to three times higher than white mothers, a gap that shows up across income and education levels, not just among mothers facing financial hardship. Mental health is one thread in that larger picture, and it's the thread this guide can help you pull on directly.

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SECTION 6 Getting Screened: What to Expect

Screening sounds clinical, but it's usually just a short questionnaire, and knowing what it's supposed to look like helps you tell a real conversation from a rushed one.

The tool itself

Most providers use the Edinburgh Postnatal Depression Scale, ten questions, about five minutes, self reported. One question specifically asks about thoughts of self harm. Answering that question honestly always warrants a follow up conversation, regardless of what your total score is. That follow up is a good thing. It means the system is working the way it's supposed to, not that something has gone wrong.

A positive screen is not a diagnosis. It's a signal that a longer conversation is warranted, nothing more, nothing less.

Where screening tends to happen

- At your postpartum OB or midwife visit.
- Often at your baby's pediatric well visits too. Many pediatricians now screen the mother at the baby's checkups, so you may get asked somewhere other than your own doctor's office.
- The American College of Obstetricians and Gynecologists now recommends contact with a provider within the first three weeks after birth, not the traditional six week wait, specifically because that's the window when many mood symptoms start showing up.

A good conversation versus a rushed one

- Good: the provider asks follow up questions, talks through what treatment could look like, and offers a next step, whether that's a referral, a follow up appointment, or resources to take home.
- Rushed: you get handed a pamphlet, told it's normal, and the visit moves on.

If your screening conversation felt rushed, you're allowed to ask for more. “I'd like to talk about this further” or “Can we schedule time to actually go through what I'm feeling” are complete, reasonable sentences. You're also allowed to ask for a different provider, a referral to someone who specializes in this, or to be screened again if the first attempt felt dismissive. Section 8 has more language for exactly this.

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SECTION 7 What Support Can Look Like

Treatment isn't one size fits all, and it usually works best as a combination rather than a single fix.

Therapy

Look specifically for a provider with perinatal mental health training. The credential to ask about is **PMH-C** (Perinatal Mental Health Certified), which means someone has specific training in this exact period of life, not general therapy experience. The Postpartum Support International provider directory (see Section 10) lets you filter for this.

- Talk therapy or CBT works well for anxiety and intrusive thoughts.
- EMDR is often used specifically for birth trauma and postpartum PTSD.
- Group therapy and peer support groups help with the isolation piece, which is often just as heavy as the symptoms themselves.

Medication

Antidepressants are frequently compatible with breastfeeding. This is a decision to make with a provider who actually knows perinatal psychiatry, not a door to close before you've even asked. If your current provider seems unsure or hesitant, that's a sign to get a second opinion from someone who specializes in this, not a sign that medication is off the table.

Peer and community support

- Postpartum Support International runs more than 50 free online support groups, organized by specific need, from general postpartum depression to birth trauma to loss.
- A postpartum doula is trained to do more than help with the baby. Many are specifically trained to notice when a mother needs more support and to help her get it.
- The Shades of Blue Project is a nationally serving nonprofit built specifically for Black and Brown mothers navigating postpartum depression, anxiety, and related challenges. They run peer support groups, provide direct resources, and were founded by a Black mother who went through undiagnosed postpartum depression herself. You shouldn't have to be the only Black woman in the room explaining your context from scratch, and spaces like this exist so you don't have to be.

WORTH KNOWING **Coverage may go further than you think.**

Nearly every state, including Illinois, now provides a full 12 months of Medicaid coverage after birth rather than the old 60 day window. If cost has been the thing holding you back from following up on a referral, it's worth checking your current coverage before assuming it isn't covered.

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SECTION 8 How to Ask for Help

Naming what you're feeling out loud is often the hardest part, harder than the appointment itself. A few starting points.

To your OB, midwife, or pediatrician

- “I think this might be more than the baby blues. Can we talk about what a postpartum depression or anxiety screening would look like for me?”
- “I'm having thoughts that are scaring me. I need to talk about that today, not at my next scheduled visit.”
- “That felt rushed. Can we go deeper, or can you refer me to someone who specializes in this?”

To a partner or family member

A lot of us carry pressure to be fine for everyone else, especially once a new baby has everyone's attention. Saying “I am not okay and I need help” out loud is not a failure. It's the single most protective thing you can do for your family right now.

- “I need you to actually hear this: I'm struggling more than I'm letting on.”
- “I need help getting to an appointment” or “I need you to take the baby for a few hours so I can call someone.”

If your first ask gets dismissed

Keep asking. Try a different provider if you have to. Bring someone with you to the appointment if it helps you say the hard part out loud. Being persistent here is not being difficult. It's advocating for care you are entitled to.

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SECTION 9 For Partners and Family

If someone handed you this guide, or you're reading it to understand what someone you love is going through, thank you. Here's what's actually useful.

- Watch for the signs in Sections 2 through 4, not just how she looks on the surface. A lot of mothers, especially Black mothers who've been taught to perform strength, look fine in front of family while struggling privately.
- Ask directly, more than once. “How are you really doing” lands differently the third time you ask than the first.
- Offer specific help, not just “let me know if you need anything.” Try “I'm taking the baby from 2 to 4 today so you can rest” instead.
- If you see the emergency signs in Section 3, act. Get her to care immediately, even if she resists or insists she's fine. This is one of the rare moments where overriding her wishes in the moment is the right call, because her safety and the baby's safety come first, and postpartum psychosis in particular can affect a person's own insight into how serious the situation is.

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SECTION 10 Free and Low Cost Resources

Every number and link here is free to use. Save this page, or better, save these numbers directly in your phone before you need them.

Resource	Contact	What It's For
National Maternal Mental Health Hotline	1-833-TLC-MAMA (1-833-852-6262)	Call or text, 24/7, free and confidential. Not a crisis line, but built specifically for pregnant and postpartum mental health support. English, Spanish, and interpreters in 60 languages.
988 Suicide & Crisis Lifeline	Call or text 988	For suicidal crisis or thoughts of harming yourself or your baby. Available anytime.
Postpartum Support International (PSI) HelpLine	1-800-944-4773	Call or text, English or Spanish. Not a crisis line. Connects you to resources, a provider directory, and free peer support groups.
Crisis Text Line	Text HOME to 741741	Free, 24/7 text based crisis support for any kind of crisis.
The Shades of Blue Project	shadesofblueproject.org	National nonprofit built specifically for Black and Brown maternal mental health. Support groups, resources, and community.
IL MOMS Line (Illinois)	1-866-364-6667	Free, 24/7, answered live by licensed mental health professionals trained in perinatal care and cultural humility. For Illinois patients and families.

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SUMMARY Quick Reference

A condensed version of everything above.

- ☐ Baby blues: common, starts within days, fades on its own within about two weeks.
- ☐ Still not feeling like yourself after two weeks: worth a real conversation with a provider.
- ☐ Constant worry, unwanted intrusive thoughts, or a traumatic birth replaying in your mind: name it out loud, these are treatable.
- ☐ Hallucinations, delusions, or a break from reality: call 911 now, this is postpartum psychosis.
- ☐ Thoughts of harming yourself or your baby with a plan or urge: call or text 988 now.
- ☐ A scary thought that horrifies you rather than one you agree with: likely an intrusive thought, common and not a sign of danger on its own.
- ☐ Screening felt rushed: you can ask for more, a referral, or a different provider.
- ☐ Cost is a concern: check your state's 12 month postpartum Medicaid coverage before assuming it isn't covered.
- ☐ Want community built for you specifically: look into the Shades of Blue Project and PSI's free support groups.

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CLOSING A Final Word From The Foundation

If you take one thing from this guide, let it be this: struggling after having a baby is not a character flaw, and it is not a test of how strong you are. It's a medical experience with a name, a known set of treatments, and a real path back to feeling like yourself.

You deserve a provider who takes you seriously the first time you bring something up, not the third. You deserve care that accounts for who you are, not care built around someone else's experience. And you deserve support that doesn't require you to fall apart completely before anyone notices.

We built this guide because too many of us were never told any of this. If it helped, or if there's another topic you wish existed as a resource, we want to hear about it.

The Black Mom Ish Foundation

Chicago, IL

You don't have to figure this out alone.

GET HELP NOW

988 · Suicide & Crisis Lifeline · call or text, any time
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