

Creating Culturally Competent Perinatal Spaces for African American and Latina Women to Address Mental Health Challenges Resulting from Birth Trauma

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Abstract: The need for more research and implementation of risk prevention interventions in perinatal mental health is immediate. More research is needed to fill the gaps and shift medical care for African American and Latina women. As one of the most developed countries in the world, the United States must develop a protocol to directly address the disparities that women of color face within the current medical system. This protocol starts with policy changes reinforcing a woman's inalienable right to autonomy over her body, implementing a community-based health model, developing more patient-designed interventions, instituting freedom of cultural practices, and eliminating structurally racist systems.

Keywords: mood disorders, pregnancy-related mortality, morbidity, patient-designed interventions, cultural competence

Women of African descent in America have been stripped of autonomy over their bodies for centuries. As an African American woman in America, my experiences with the medical system have been traumatic, disheartening, frightening, and angering. As a practicing mental health clinician, I have helped clients navigate experiences akin to mine. The experiences vary in severity, as some were nearly fatal. In this article, I endeavor to impress upon the reader that African American women are not disposable in medical spaces or in general. African American women deserve high-quality medical care, the ability to make their own decisions regarding their bodies, and the ability to give birth without unnecessary trauma resulting from racial bias and insufficient care. Access to culturally supportive care is the first step to early detection and possible prevention of perinatal mood disorders, perinatal anxiety disorders, and pregnancy-related deaths among African American women.

Achieving health equity requires shifting the structures that support the ecosystem of racism that Black, Brown, and Indigenous birthing people must navigate before, during, and after childbearing. These structures extend beyond the healthcare system in which clinicians operate day-to-day. However, they cannot be excluded from research endeavors to create the actionable evidence needed to achieve perinatal health equity. (Headen et al., 2022)

Since the unethical kidnapping and transport of African people to the United States, African American women's bodies have been considered a commodity in the marketplace and the development of Western medicine. Owens (2017) detailed how dating back to the enslavement period, women of color have suffered ill treatment and deliberate disregard of fundamental human rights by white physicians in the American health system. For example, enslaved African women were the subject of unconsented medical experimentation, were denied anesthesia, and were frequently over-drugged with morphine so white male doctors could perform surgical procedures on their reproductive systems (Owens, 2017).

Hundreds of years later, we still see the same disregard in medical spaces for the opinions, needs, and desires of women of color (specifically those African American and Latina)—for example, Howell (2018) explains how significant racial disparities in perinatal morbidity and mortality are prevalent in the United States. Disheartening data shows that pregnancy-related death is three to four times more likely in African American women than in white women (Howell, 2018).

My personal experience with the current medical system during my perinatal period left me traumatized and in need of mental health support that was not offered or readily available. At 41 weeks pregnant, I was coerced into an induction because I was “overdue.” My midwife stated that the supervising obstetrician “would not allow” my pregnancy to extend another week. For 62 hours, I experienced almost every labor induction intervention. Without consent, an induction medication was intravenously introduced while I slept, despite my verbal and written objection. The medication caused my and my baby’s heart rates to skyrocket, creating more stress and fear. Around hour 58, I agreed to receive an epidural, which was done incorrectly twice by a medical student from whom I did not consent to receive treatment. The failed injections caused my nervous system to malfunction, resulting in minimized feeling on one side of my body and heightened feeling on the other.

Finally, my provider stated that my baby was at risk of dying, and I needed an emergency cesarean section. I was told an alternative anesthetic was required due to the epidural failure. The provider explained that this method offered “two hours to get the baby out and get me back together.” Hence, it was possible that I would be “very uncomfortable with some pain” until the after-procedure medication took effect. We survived, but I could not hold my baby without assistance because my body was shaking heavily from the excessive medication. Three days later, I took home my perfect new baby and moderate post-traumatic stress disorder (PTSD). I found myself completely unstable. I lived in a mental space where PTSD intersected with joy and fulfillment. I had no tools to help balance the extreme spectrum of emotions I experienced. I entered a second pregnancy, still heavily impacted by PTSD. It was four years and three therapists later before I understood what had happened and how I was affected.

As a clinical social worker, I specialize in perinatal mental health for women of color, primarily African American women. My own experiences during my perinatal period led me to this work. During a morning shower meditation on the day of my master’s degree graduation, I had an epiphany. I was frustrated, tired, and felt like I ran into so many roadblocks. I did not feel I was prepared for the postpartum period with either of my children, as they were both difficult yet different births. I remember feeling that no one prepared me for the depression, anxiety, or PTSD I took home with my babies. As a new clinician and mother, I realized that my best service to the community would be in the perinatal space, where I had learned to swim in the midst of drowning. Thus, I attended certification classes, conferences, workshops, and anything perinatal I encountered. My purpose was clear; this work was for them and me.

My clients seek assistance for various challenges concerning pregnancy and parenthood. Due to my personal and professional experience, I can assist clients with mostly all issues they present. This is the strength and the challenge of my duality in my work. On occasion, there may be

client situations that may be a trigger for me. In a few situations, I have decided to refer to another practitioner. The main point of balance is working without ego and always centering the best interest of my clients while maintaining healthy self-care for myself. As a professional, I have check-ins with myself to evaluate my capacity. All therapists should have a therapist as an outlet for balance and release. This strategy has served me, my family, and my clients well.

A common theme for women who give birth in hospitals is not feeling heard by providers. For one client, “Kee,” her experience was almost fatal. Kee is an African American woman in her 30s. She had private medical insurance and selected a widespread, predominantly white obstetrics practice. Kee also selected an African American woman doula to support her during her pregnancy. Throughout her prenatal appointments, Kee’s blood pressure was frequently elevated. Kee’s doula expressed concern, but her medical team repeatedly said there was not much need for concern. Finally, one afternoon Kee left work due to a migraine and feeling ill and called her doula to update her. The doula suggested she report to the hospital emergency department immediately. Kee listened and was admitted to the hospital that day.

Kee had preeclampsia and was several weeks early. The weeks of elevated blood pressure had matured, and Kee was induced to ensure the safety of both her and her baby. During labor, a Caucasian nurse refused to listen when she stated she was ready to push. The nurse ignored calls to come to the room. Kee’s doula had to find an obstetrician in the hallway to come assist. The doctor found that Kee had crowned, and her baby was coming out.

Because Kee had preeclampsia, a precautionary set-up was required to receive the newborn in case of complications; unfortunately, the doctor failed to look at the staff notes on the board and started the delivery process. At the doula’s insistence, the physician stopped to review the notes and sent an emergency call to the Neonatal Intensive Care Unit (NICU) team. After a successful delivery, the doula discovered that the placenta was missing a few pieces. The physician located a small piece and insisted there was nothing else to recover.

A week later, Kee went to the emergency room due to feeling ill, having a high fever, and a foul vaginal odor. Retained placental fragments cause sepsis, which is a high contributor to maternal mortality. It is important to note that Kee’s doula urged her to go to the hospital after a primary care nurse instructed her on postpartum hygiene and rest. Kee struggled with mental health challenges resulting from the traumatic birth, having a baby in the NICU, and a near-fatal medical experience that was likely preventable. She repeatedly said, “If they had just listened to my doula or me, my story would be different, and I probably wouldn’t even be in your office.” Kee’s case is not uncommon.

African American and Latina women have publicly discussed mistreatment from medical providers. Surviving family members also publicly advocate for their transitioned loved ones, demanding change in the quality of care that African American women receive in medical spaces. Charles Johnson, a key leader of black maternal health justice and founder of 4Kira4Moms, openly discusses how his wife Kira was a victim of medical neglect and maternal mortality due to birth inequity from a medical system that ignored the family’s pleas for help post-cesarean. Cox et al. (2016) provided data that detailed women of color—specifically Black,

Hispanic, Indigenous, and Asian women—were two times more likely than white women to report that their providers ignored requests for help, ignored raised concerns, or failed to provide necessary assistance within an appropriate timeframe. The fight for birth equity in the United States is led primarily by those impacted by the lack of birth equity; thus, those whose families will be forever changed by largely preventable deaths.

Research proves that perinatal mental health challenges impact more than the child-carrying person. Griffen et al. (2021) acknowledged how treatable yet untreated perinatal mental health disorders lead to damaging, long-term, multigenerational effects for birthing women. The need for more research and implementation of risk prevention interventions in perinatal mental health is immediate. More research is needed to fill the gaps and shift medical care for African American and Latina women. Howell (2018) revealed that the risk of pregnancy-related death for birthing black women in the United States is comparable to pregnancy-related risks for women in developing countries. As one of the most developed countries in the world, the United States must develop a protocol to directly address the disparities that women of color face within the current medical system.

This protocol starts with policy changes reinforcing a woman's inalienable right to autonomy over her body, implementing a community-based health model, developing more patient-designed interventions, instituting freedom of cultural practices, and eliminating structurally racist systems. In a cross-sectional analysis, McKee (2020) evidenced racial disparities in mental health diagnoses among women of color and Medicaid-insured women. The analysis indicated that black women were disproportionately diagnosed with serious mental illness compared to all women of other races. Howell (2018) cites structural racism, implicit bias of providers, and political policies as contributors to maternal health complications, comorbidities, and mortality. The National Birth Equity Collaborative (NBEC, 2022) directed that reviewed data indicates that inequity in the medical discipline results from interpersonal and structural racism. Federal policies that grant full-spectrum perinatal care to all birthing people are one step towards eliminating maternal health disparities.

In a pilot study, Morain et al. (2022) determined that system-level barriers contribute to the perinatal mental health crisis, as patients must navigate restrictive healthcare systems limiting providers, advanced-level services, and high-quality support resource tools. A community-based model would include partners dedicated to the health and wellness of birthing people, despite social determinants such as income that have served as barriers to treatment. Finally, having culturally sensitive providers is necessary. The birthing person should feel heard and understood. Medical protocol requiring cultural humility training—that includes practice simulations with culturally competent providers—should be required for all medical practitioners working with marginalized populations.

A recent study by Matthews et al. (2021) introduced five significant pathways to equitable maternal mental healthcare: specified training for practitioners; the expansion of Black women in the mental health workforce; Black women-led, community-grounded organization; valuing, honoring, and investing in traditional cultural healing practices; and promoting integrated care

and shared decision-making between providers and patients. Each pathway addresses an intricate, individual aspect of care designed to be addressed jointly.

The literature presented highlights a recurring theme: perinatal mood and anxiety disorders, along with maternal mortality, are preventable among women of color. To save the lives of birthing women of color, more clinical research is needed. Creating space at the helm for those most affected by this social issue is vital to remedying the black maternal mental health crisis.

Birth equity contributes an understanding of how structural and social determinants affect birthing outcomes and the well-being of pregnant and postpartum people, particularly Black people, who are most burdened by adverse outcomes because of racism, sexism, classism, and other systems of oppression. (Matthews et al., 2021)

Both reproductive justice and birth equity require centering and valuing the expertise of the people who are most marginalized within systems. Introducing more patient-designed interventions, instituting freedom of cultural practices, and eliminating structurally racist systems are imperative. As one of the most developed countries in the world, the United States must create a new protocol to save black and brown birthing women.

References

- Cox, E. Q., Sowa, N. A., Meltzer-Brody, S. E., & Gaynes, B. N. (2016). The perinatal depression treatment cascade: Baby steps toward improving outcomes. *The Journal of Clinical Psychiatry*, 77(9), 1189–1200. <https://doi.org/10.4088/JCP.15r10174>
- Griffen, A., McIntyre, L., Belsito, J. Z., Burkhard, J., Davis, W., Kimmel, M., & Meltzer-Brody, S. (2021). Perinatal mental health care in the United States: An overview of policies and programs. *Health Affairs*, 40(10), 1543–1548. <https://doi.org/10.1377/hlthaff.2021.00796>
- Headen, I. E., Elovitz, M. A., Battarbee, A. N., Lo, J. O., & Debbink, M. P. (2022). Racism and perinatal health inequities research: where we have been and where we should go. *American Journal of Obstetrics and Gynecology*, 227(4), 560–570. <https://doi.org/10.1016/j.ajog.2022.05.033>
- Howell, E. A. (2018). Reducing disparities in severe maternal morbidity and mortality. *Clinical Obstetrics and Gynecology*, 61(2), 387–399. <https://doi.org/10.1097/GRF.0000000000000349>
- Matthews, K., Morgan, I., Davis, K., Estriplet, T., Perez, S., & Crear-Perry, J. A. (2021). Pathways to equitable and antiracist maternal mental health care: Insights from Black women stakeholders. *Health Affairs (Project Hope)*, 40(10), 1597–1604. <https://doi.org/10.1377/hlthaff.2021.00808>
- McKee, K., Admon, L. K., Winkelman, T. N., Muzik, M., Hall, S., Dalton, V. K., & Zivin, K. (2020). Perinatal mood and anxiety disorders, serious mental illness, and delivery-related health

outcomes, United States, 2006–2015. *BMC Women's Health*, 20(1), Article 150.

<https://doi.org/10.1186/s12905-020-00996-6>

National Birth Equity Collaborative. (2022). *Want to make birth more equitable? Adopt a framework for respectful maternity care*. Ovia Health by LabCorp.

<https://www.oviahealth.com/blog/nbec-respectful-maternity-care/>

Morain, S. R., Fowler, L. R., & Boyd, J. W. (2022). A pregnant pause: System-level barriers to perinatal mental health care. *Health Promotion Practice*, 24(5), 804–807.

<https://doi.org/10.1177/15248399221101373>

Owens, D. C. (2017). *Medical bondage: Race, gender, and the origins of American gynecology*.

University of Georgia Press. <https://openresearchlibrary.org/viewer/5271c428-741f-482e-9174-4c2d86854697>

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