

DOI: 10.1377/hlthaff.2021.00805
HEALTH AFFAIRS 40,
NO. 10 (2021): 1592–1596
©2021 Project HOPE—
The People-to-People Health
Foundation, Inc.

By Vu-An Foster, Jessica M. Harrison, Caitlin R. Williams, Ifeyinwa V. Asiodu, Sequoia Ayala, Jasmine Getrouw-Moore, Nastassia K. Davis, Wendy Davis, Inas K. Mahdi, Aza Nedhari, P. Mimi Niles, Sayida Pephrah, Jamila B. Perritt, Monica R. McLemore, and Fleda Mask Jackson

COMMENTARY

Reimagining Perinatal Mental Health: An Expansive Vision For Structural Change

Vu-An Foster is the executive director of Life After 2 Losses, in Montclair, New Jersey.

Jessica M. Harrison is a doctoral candidate in the Department of Social and Behavioral Sciences, University of California San Francisco (UCSF), in San Francisco, California.

Caitlin R. Williams is a doctoral candidate in the Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, in Chapel Hill, North Carolina.

Ifeyinwa V. Asiodu is an assistant professor in the Department of Family Health Care Nursing, UCSF.

Sequoia Ayala is the director of operations for Move to End Violence, in Atlanta, Georgia.

Jasmine Getrouw-Moore is a PhD candidate at the University of North Carolina at Greensboro, in Greensboro, North Carolina. She was the executive director of the Office for Diversity, Equity & Inclusion, Guilford County Schools, in Greensboro, North Carolina, at the time this work was performed.

Nastassia K. Davis is the executive director of the Perinatal Health Equity Foundation, in Montclair, New Jersey.

ABSTRACT Diagnoses of depression, anxiety, or other mental illness capture just one aspect of the psychosocial elements of the perinatal period. Perinatal loss; trauma; unstable, unsafe, or inhumane work environments; structural racism and gendered oppression in health care and society; and the lack of a social safety net threaten the overall well-being of birthing people, their families, and communities. Developing relevant policies for perinatal mental health thus requires attending to the intersecting effects of racism, poverty, lack of child care, inadequate postpartum support, and other structural violence on health. To fully understand and address this issue, we use a human rights framework to articulate how and why policy makers must take progressive action toward this goal. This commentary, written by an interdisciplinary and intergenerational team, employs personal and professional expertise to disrupt underlying assumptions about psychosocial aspects of the perinatal experience and reimagines a new way forward to facilitate well-being in the perinatal period.

On its face, *perinatal mental health* can seem to be a broad term. Yet in practice, it is often shorthand for a specific subset of pregnancy-associated mood and anxiety disorders such as perinatal depression, perinatal obsessive-compulsive disorder, and postpartum psychosis. These diagnoses each capture an aspect of perinatal mental health, but they lack context and overlook the full complexities of pregnant and birthing people's lived experiences. This narrow scope maintains a distinction between the physiologic and psychosocial aspects of pregnancy, effectively consigning social and emotional perinatal experiences to a highly stigmatized and underresourced arena of health and health care. However, no pregnancy exists in a vacuum—pregnant and birthing people experience and make sense of the perinatal period as

it coexists with other parts of their lives. Importantly, physical, emotional, and social processes are co-constitutive. For example, stressful life events degrade physical well-being, and poor health (or health care) experiences can induce posttraumatic stress disorder or other types of anxiety.

The interrelated nature of mental, physical, and social health is globally recognized. As defined in the Constitution of the World Health Organization, health is a complete state of biopsychosocial well-being.¹ Adequately addressing perinatal mental health, then, requires engaging with the totality of the perinatal experience in ways for which the biomedical orientation of the US health care system is ill equipped. Reorienting care toward a more holistic approach can be effective only if the initial assumptions underpinning how perinatal mental health is concep-

tualized are critically assessed and reconfigured. The purpose of this commentary is to reimagine perinatal mental health, considering a new paradigm that reorients perinatal health practice and policy toward the holistic well-being of all birthing people and their families.

To facilitate this reimagination, an intergenerational team of advocates; clinicians; creatives; educators; researchers; students; and people with lived experiences of pregnancy, birth, miscarriage, abortion, infertility, and childlessness by choice collected personal data and professional expertise during multiple focus groups and interviews. The objectives were twofold: to begin to map, understand, and disrupt underlying assumptions about the psychosocial aspects of the perinatal experience and to imagine a new way forward to foster comprehensive perinatal well-being inclusive of mental health. We began with the central argument that diagnoses of depression, anxiety, or other mental illness capture only one aspect of the psychosocial elements of the perinatal period. These diagnoses often ignore the full range of lived experiences, which may include perinatal loss; unaddressed trauma; unstable, unsafe, or inhumane work environments; structural racism and gender-based oppression in health care and across society; and unequal impacts of climate change, police violence, and the general lack of a social safety net, which threatens the well-being of birthing people and their families.

From this starting point, we highlight the inadequacies of the current system's approach to perinatal mental health. We find that US policies, programs, and practices that locate perinatal mental health as a physiological phenomenon disconnected from the broader social milieu ignore the fundamentally integrated nature of health and well-being. Drawing from human rights framing under international law,² we describe the types of policy changes needed to address the gaps we identified, thinking expansively about how policy could be leveraged to support pregnant and birthing people, their families, and their communities.

Our Method: Centering Black, Indigenous, And People Of Color

We convened our group using personal and professional networks and the electronic discussion list of the Black Mamas Matter Alliance, with the goal of recruiting a wide range of perspectives. We endeavored to center the voices, experiences, and expertise of Black, Indigenous, and people of color (BIPOC). For example, our thinking was informed by the historical and ongoing state-sanctioned family separation in Indigenous com-

munities and the collaborative advocacy efforts toward family preservation in Black, immigrant, and Indigenous communities. None of the authors are enrolled members of any Indigenous nation. However, some have studied, trained, and practiced within Indigenous communities and frameworks and have Indigenous ancestry.

We used a qualitative approach to determine the definition of *perinatal mental health* and to describe our understanding of the concept.³ Interview and focus-group guides included questions specific to the current structure of perinatal mental health care; recommendations for changes to perinatal mental health care; experiences with perinatal mental health diagnostics and treatment; intersections and distinctions in perinatal health care for BIPOC, people with disabilities, women, and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) people; and barriers to thriving for pregnant people and their families. All authors participated in the discussions, analyses, or manuscript writing according to the guidelines put forth by the International Committee of Medical Journal Editors. All transcripts were read and reviewed using thematic analysis.^{3,4} The following commentary represents the synthesis of the discussion and highlights a few key themes that are actionable and could be resolved through policy.

Mapping Perinatal Mental Health: People, Systems, And Structures

The way mental health is understood in the US flattens the lived experiences of BIPOC communities, negates cultural truths, and shapes treatment options that are frequently incongruent with pregnant women's and birthing people's needs and are, at times, punitive. Fear of being assessed as "crazy" or otherwise incompetent by medical professionals remains a source of stress for many BIPOC people. There is notable cultural incongruence in how assessment and treatment options are designed within the health care system. Mental health stigma—both that held within communities and that imposed on individuals by the biomedical model of care—can be particularly difficult to navigate and is experienced as oppressive. In our attempt to define and map new domains of perinatal mental health, we determined that there are multiple perspectives necessary to understand the phenomenon. We developed fifteen themes that fall under three major categories: people, systems, and structures. The themes included community-based healing, disenfranchised experiences and grief, and unhelpful or harmful health care structures (see online appendix figure 1 for the full list of

Wendy Davis is the executive director of Postpartum Support International, in Portland, Oregon.

Inas K. Mahdi is a doctoral student in the Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland.

Aza Nedhari is the executive director of Mamatoto Village, in Baltimore, Maryland.

P. Mimi Niles is an assistant professor and faculty fellow at the Rory Meyers College of Nursing, New York University, in New York, New York.

Sayida Peprah is the executive director of Diversity Uplifts, Inc., in Rancho Cucamonga, California.

Jamila B. Perritt is the president and CEO of Physicians for Reproductive Health, in Washington, D.C.

Monica R. McLemore (monica.mclemore@ucsf.edu) is an associate professor in the Department of Family Health Care Nursing, UCSF.

Fleda Mask Jackson is the president and CEO of MAJAICA, LLC, in Atlanta, Georgia.

themes).⁵

We conceptualize *people* as interchangeable with the word *community*. One limitation of mainstream understandings of perinatal mental health is that healing and well-being are not just individually oriented but also community based. Community-based knowledge and healing lie in contrast to the current individualistic nature of perinatal mental health services, theories, and treatment modalities, which arise from the mental-physical health binary produced by biomedical models. Among our author group, we have had multiple perinatal health experiences that required extensive leveraging of personal and professional networks to address urgent health needs, particularly those involving miscarriage and stillbirth. Consistent with data that carefully document mistreatment during labor and childbirth,⁶ we have personally experienced discriminatory and inappropriate treatment by health care providers, including hospital-based social work care and outpatient therapy. Approaches to resolving these issues include educating others to establish a shared knowledge base about the range of perinatal mental health experiences for self-advocacy and mutual support. In addition, we advocate for group care models and access to midwifery;⁷ these impactful interventions could be leveraged to expand definitions of and approaches to well-being in the perinatal period.

We define *systems* here as processes related to health care service provision. Barriers specific to systems are cumbersome entry points to health services (such as inconvenient hours of operation and lack of racially or ethnically concordant providers), a lack of health care provider support in the postpartum period; and insurance inaccessibility or limitations. Harm caused within health care systems complicates their utility and safety as places of care. This underscores how systems that were not designed for birthing BIPOC and their families may actually be a factor contributing to anxiety, trauma, or other suffering. Critically, we do not see systems as the foundation for facilitating optimal perinatal health.

Systems have far-reaching effects that are magnified based on the structures in which they are embedded. We contend that these structures encompass the larger sociolegal ecosystem in which perinatal mental health is situated. In BIPOC communities it is impossible to conceptualize perinatal mental health without accounting for structural factors such as mental health stigma, racism, criminalization of substance use in pregnancy and the postpartum period, and the disproportionate impact of surveillance (such as that resulting in child “welfare” interventions in Black, Indigenous, Latinx, Asian, and Pacific Is-

lander communities). For example, the use of Child Protective Services as a child “welfare” intervention and the ways in which health care systems collude with Child Protective Services and other forms of policing have been rigorously documented as a structure that is punitively used to target and criminalize Black, Indigenous, and Asian/Pacific Islander mothers.^{8–10} Acknowledging the recent harms of child separation experienced by immigrants¹¹ and Indigenous people⁹ is one step in disrupting the cycles of harm and the generational trauma that is such a huge part of the history of health care in the US.

Although systems may be somewhat fluid operationally, we argue that they remain embedded within static structures, particularly for BIPOC. For BIPOC communities, pregnancy, birth, and postpartum are deeply spiritual, mental, and emotional journeys. Yet US biomedical systems were created to serve individuals (divorced from their families and communities) within a specific pathological- and medicine-dominant model of care. In other words, systems and structures are constituted and reified by the mental-physical health binary. They neglect the integrated biopsychosocial reality of health and well-being. As a consequence, the spiritual, mental, and emotional aspects of pregnancy, childbirth, and postpartum adjustment are essentially erased from the dominant paradigm of care.

Policy Recommendations

These themes illuminate significant and substantial policy gaps. Although some might not be immediately self-evident when viewed through the prism of US biomedical-centrism, human rights (as codified under international law) can provide useful framing.¹² Under human rights law, adhering countries have the obligation to respect (that is, not violate) individuals’ and communities’ human rights, protect individuals and communities from human rights violations perpetrated by nongovernment actors, and take progressive action to fulfill human rights when the conditions and resources needed to enjoy them are not freely available. In the context of perinatal mental health, this means that governments must both refrain from enacting systems and structures that violate rights and take action to prevent others from doing the same. For example, governments must not separate families, and they must also prevent private agencies from separating families.

Perhaps most relevant, however, is the obligation to fulfill human rights. To meet this obligation, policy efforts are needed to address the gaps we identified in both systems and structures. In addition to policy changes to existing systems,

focused and concerted effort is needed to address deep-rooted inequity in health care systems and structures that negatively affect perinatal mental health and to reconfigure them in ways that support perinatal thriving. Using this framing, we briefly review some examples of how policy can be leveraged to address the issues specific to people, systems, and structures.

PEOPLE Under the Universal Declaration of Human Rights, all people are equal in rights and dignity.¹² Discriminatory treatment is by definition a rights violation, so rooting out discrimination is a key policy imperative. Interpersonal discrimination might be addressed through implicit bias and antiracism training but must also include diversification of the perinatal health workforce.¹³ Critically, discrimination also operates at an institutional and systemic level and requires complementary efforts to address discriminatory systems and structures. For instance, the differential treatment of parents who are not traditionally married partners of opposite gender can “other” families with different configurations. In addition, policy changes are needed to provide more reliable reimbursement of a wider range of care models that seek to treat the whole person, involving care by community-based midwives,¹⁴ doulas,¹⁵ in-home lactation consultants,¹⁶ and community-based organizations that nurture birthing people and their families in culturally relevant ways.¹⁷

SYSTEMS Human rights law mandates that health care services be available, accessible, acceptable, and of sufficient quality for all people.¹² Barriers such as cost, lack of insurance coverage,¹⁸ and poor geographic distribution of services¹⁹ that disproportionately bar pregnant and birthing BIPOC from accessing needed care constitute human rights violations. Policy makers can respond by universally expanding insurance coverage, such as through Medicaid expansion, so that pregnant and birthing people are able to obtain the care they need without waiting to qualify, extending the length of pregnancy-related Medicaid coverage beyond sixty days postpartum, and creating and adequately resourcing programs dedicated to supporting the perinatal mental health of pregnant and BIPOC birthing people.¹⁸ An example of such a program is the Shades of Blue Project that provides comprehensive online and in-person services in BIPOC communities developed with and by BIPOC providers.²⁰

STRUCTURES Human rights-based approaches to advancing health underscore the importance of also considering social and structural determinants of health.²¹ Chronic stressors such as worry about how to keep food on the table and

a roof over one’s head, how to keep oneself and loved ones safe from interpersonal violence, and how to ensure that water used to drink and bathe children is safe are clearly detrimental to mental health. Under human rights imperatives, governments have an obligation to address these concerns. Policies that provide universal paid leave—regardless of the outcome of a pregnancy²²—as well as universal child care;²³ acknowledge and address interpersonal, community, police, and other forms of violence;^{24,25} and ensure environmental protections such as functioning water and sanitation infrastructure²⁶ are key to supporting a wider view of perinatal mental health.

Many of the structures that pose obstacles to perinatal mental well-being are based in policy. Policy institutionalizes racist thought both directly through discriminatory instruments such as housing covenants and indirectly through discriminatory implementation of seemingly race-neutral policies such as Temporary Assistance for Needy Families. Thus, policy must be leveraged in dismantling these harmful structures and replacing them with structures that support thriving.

Conclusion

Reimagining perinatal mental health first requires the mapping and defining of domains of the phenomenon. Doing so disrupts underlying assumptions about the psychosocial aspects of the perinatal experience, challenges the maintenance of the mental-physical health binary, and makes it possible to imagine a new way forward to provide comprehensive perinatal health care and advocate for conditions across society that allow all birthing people and their families to thrive. Well-intended advocacy for perinatal mental health has led to the professionalization of a specialized mental health field that may be a pathway to well-being for some people. However, perinatal mental health, as a concept and a field, has been built within existing systems of care that uphold oppressive US structures. We argue for a paradigm shift that dismantles the mental-physical health binary in the biomedical model and centers policy addressing structural inequalities. Instituting universal paid leave and child care, as well as other policy efforts that redress inequitable distribution of social determinants of health, are promising approaches. If implemented in concert, the policies suggested here could dramatically restructure perinatal mental health in the US toward individual and community thriving. ■

The authors of this article acknowledge the work of perinatal mental health practitioners and the people they serve, who push them toward well-being and improved outcomes.

NOTES

- 1 World Health Organization. Constitution of the World Health Organization [Internet]. Geneva: WHO; 2006 Oct [cited 2021 Aug 20]. Available from: https://www.who.int/governance/eb/who_constitution_en.pdf
- 2 United Nations General Assembly. Universal declaration of human rights [Internet]. New York (NY): UN; 1948 Dec 10 [cited 2021 Aug 20]. Available from: <https://www.un.org/en/about-us/universal-declaration-of-human-rights>
- 3 Creswell JW. A concise introduction to mixed methods research. Los Angeles (CA): SAGE Publications; 2015.
- 4 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101.
- 5 To access the appendix, click on the Details tab of the article online.
- 6 Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health*. 2019;16(1):77.
- 7 National Academies of Sciences, Engineering, and Medicine. Birth settings in America: outcomes, quality, access, and choice. Washington (DC): National Academies Press; 2020 Feb 6.
- 8 Roberts D. Shattered bonds: the color of child welfare. New York (NY): Basic Books; 2002.
- 9 Crofoot TL, Harris MS. An Indian Child Welfare perspective on disproportionality in child welfare. *Child Youth Serv Rev*. 2012;34(9):1667–74.
- 10 Fong R, Petronella G. Underrepresented populations in the child welfare system: Asian American and Native Hawaiian/Pacific Islander populations. In: Dettlaff AJ, editor. Racial disproportionality and disparities in the child welfare system. New York (NY): Springer International Publishing; 2021. p. 125–38.
- 11 Gemmill A, Catalano R, Casey JA, Karasek D, Alcalá HE, Elser H, et al. Association of preterm births among US Latina women with the 2016 presidential election. *JAMA Netw Open*. 2019;2(7):e197084.
- 12 Gostin LO, Meier BM, editors. Foundations of global health and human rights. New York (NY): Oxford University Press; 2020.
- 13 Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci U S A*. 2020;117(35):21194–200.
- 14 Zephyrin L, Seervai S, Lewis C, Katon JG. Community-based models to improve maternal health outcomes and promote health equity [Internet]. New York (NY): Commonwealth Fund; 2021 Mar 4 [cited 2021 Aug 20]. Available from: <https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity>
- 15 McLemore MR, Warner Hand Z. Making the case for innovative re-entry employment programs: previously incarcerated women as birth doulas—a case study. *Int J Prison Health*. 2017;13(3-4):219–27.
- 16 Asiodu IV, Bugg K, Palmquist AEL. Achieving breastfeeding equity and justice in Black communities: past, present, and future. *Breastfeed Med*. 2021;16(6):447–51.
- 17 Black Women Scholars and the Research Working Group of the Black Mamas Matter Alliance. Black maternal health research re-envisioned: best practices for the conduct of research with, for, and by Black mamas. *Harv Law Policy Rev*. 2020; 2(14):393–415.
- 18 Taylor J. Promoting better maternal health outcomes by closing the Medicaid postpartum coverage gap [Internet]. New York (NY): Century Foundation; 2020 Nov 16 [cited 2021 Aug 20]. Available from: <https://tcf.org/content/report/promoting-better-maternal-health-outcomes-closing-medicaid-postpartum-coverage-gap/>
- 19 Hung P, Casey MM, Kozhimannil KB, Karaca-Mandic P, Moscovice IS. Rural-urban differences in access to hospital obstetric and neonatal care: how far is the closest one? *J Perinatol*. 2018;38(6):645–52.
- 20 Shades of Blue Project [home page on the Internet]. Houston (TX): Shades of Blue Project; [cited 2021 Aug 20]. Available from: <https://www.shadesofblueproject.org>
- 21 Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017; 389(10077):1453–63.
- 22 Taylor JK, Asiodu IV, Mehra R, Alspaugh A, Bond T, Franck LS, et al. We must extend postpartum Medicaid coverage. *Scientific American* [serial on the Internet]. 2021 Mar 11 [cited 2021 Aug 20]. Available from: <https://www.scientificamerican.com/article/we-must-extend-postpartum-medicaid-coverage/>
- 23 Color of Change, National Employment Law Project, Time's Up Foundation, ILR Worker Institute. Foundations for a just and inclusive recovery: economic security, health and safety, and agency and voice in the COVID-19 era [Internet]. New York (NY): NELP; 2021 [cited 2021 Aug 20]. Available from: <https://www.nelp.org/wp-content/uploads/Foundations-for-Just-Inclusive-Recovery-Report.pdf>
- 24 American Public Health Association. Addressing law enforcement violence as a public health issue [Internet]. Washington (DC): APHA; 2018 Nov 13 [cited 2021 Aug 20]. Available from: <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>
- 25 Jackson FM, James SA, Owens TC, Bryan AF. Anticipated negative police-youth encounters and depressive symptoms among pregnant African American women: a brief report. *J Urban Health*. 2017;94(2): 259–65.
- 26 Bekkar B, Pacheco S, Basu R, DeNicola N. Association of air pollution and heat exposure with preterm birth, low birth weight, and stillbirth in the US: a systematic review. *JAMA Netw Open*. 2020;3(6): e208243.