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“Black Wom(b)anhood”: An Explorative Analysis of Black Women's Narratives of Healthcare Encounters During and After Pregnancy

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“Black Wom(b)anhood”:

An Explorative Analysis of Black Women's Narratives of Healthcare Encounters During and After Pregnancy

by

Janae Baker, M.S., B.A.

A Thesis

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In honor of the beloved memory of *Rachel Delores Sweet*.

My mind still talks to you, my heart still longs for you, but my soul knows you are at peace.

Your love and support for me was priceless and I will cherish it for the rest of my life.

You have been planted, not buried; so I will continue to grow.

Acknowledgements

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To each and every one of you, I extend my sincerest thanks for your support, encouragement, and belief in me. This journey would not have been possible without you.

This qualitative study explores the intricate dynamics of patient-provider relationships within the context of prenatal care among Black women and how these experiences may affect their perinatal mental health. The study was conducted using a methodology consisting of structured interviews with 12 participants, snowball sampling facilitated recruitment. Thematic analysis revealed six prominent themes encapsulating the multifaceted interactions between Black women and their healthcare providers during the perinatal period. The findings illuminate nuanced aspects of the patient-provider relationship, shedding light on issues such as: (a) Anticipation of Low Quality Care, (b) Lack of Communication, (c) Listening, (d) Stereotype Threat, (e) Colorism, (f) Education Status, (g) Birth Anxiety, (h) Postpartum Care, (i) Advocacy, (j) and In-Depth Screening. These codes underscore the complexity of navigating healthcare systems as Black women seeking prenatal care. Furthermore, this study underscores the importance of future research focusing on three critical areas: delivery experiences, patient advocacy, and patient education. Further exploration of Black women's experiences during childbirth can provide insights into potential disparities and inequities within obstetric and mental health care. Additionally, prioritizing patient advocacy initiatives can empower Black women to assert their healthcare rights and preferences, fostering more equitable and respectful care environments. Moreover, enhancing patient education efforts can promote informed decision-making and improve health outcomes among Black women during the perinatal period. By addressing these research priorities, healthcare systems can work towards cultivating more supportive, culturally sensitive, and patient-centered care practices for Black women navigating pregnancy and perinatal mental health.

Curriculum Vitae

Education

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Clinical Experience:

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- Conduct individual and group therapy sessions for clients with diverse mental health concerns.
- Document pertinent information from client sessions to inform treatment planning.
- Collaborate with a multidisciplinary team to develop comprehensive treatment plans.
- Conduct referral and assessment meetings to best address client needs.

Summer 2020
Instructor | Elaine Clark Center | Chamblee, GA |
- Provide instruction and support for adolescents and young adults with varying special needs. (i.e. Autism, ADHD, Down Syndrome)
- Organize and supervise therapeutic recreational activities and instruction to the ability level of the student.
- Create meaningful connections with students to establish trust and rapport.
- Ensure instruction and activities met center standards of creating an inclusive child development process.

Teaching Experience

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Black in Mental Health: There's a Career in That – Oct. 2023, Panelist

Research Experience

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Laboratory Technician
University of Florida
Supervisor: Natalie Ebner, Ph.D.
Professor of Psychology

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"You actually can't have an informed opinion on this if you are choosing to be gender-neutral and racially indifferent. Because that is impossible. Her existence as a black woman shapes both how she is seen by others, and how she sees the world. And, in this case, how she is seen by you."

-Taylor Rooks

Perceived Quality of Patient-Provider Relationships on the Prevalence of Perinatal Mood and Anxiety Disorders in Black Women

The unique intersection of experiencing life as a Black woman creates experiences that compound racism, misogynoir, colorism, and prejudice. Black women in America have faced systematic mistreatment since their forcible removal from Africa. During slavery, Black women were stripped of their autonomy and used to replenish the labor forces of plantations. This is where the reproductive control of Black women began. After slavery ended in the United States, Black women still weren't afforded fundamental rights. Black women were again overlooked as White women rallied to be treated as equals, vote, and work. This historical experience has made it inherently more difficult for the experiences of Black women to be acknowledged as essential and applied in research settings. The experiences of Black women are a critical component in the fight for reproductive justice, they know what needs to change.

Everyone may look forward to parenthood, but what aspects of parenthood look different for Black women? How is their mental health uniquely affected? Becoming a parent marks a transition where individuals move from being responsible for themselves to sustaining life for another person. This milestone can be accompanied by feelings of stress, doubt, and worry (Belsky & Pensky, 1988). It is not abnormal for new parents to experience these feelings, but there are occasions when the symptoms do not subside. Declining mental health may also make adjusting to the maternal role more difficult. Investigating the relationship between the perception of quality of care and the prevalence of perinatal mood and anxiety disorders (PMADs) among Black women is imperative to developing intervention measures. A study of southern urban Black women found that 56% of their sample displayed symptoms of perinatal mood and anxiety disorder (Hernandez et al., 2022). Early research has often studied the

occurrence of perinatal mood and anxiety disorders in Black women compared to other racial groups (Hall, 1996; Kane et al., 1971). This approach makes it inherently more difficult to understand the unique circumstances that affect the incidence of these disorders among Black women.

Existing research suggests Black women may experience unique sources of stress during pregnancy, including a lack of material resources such as food, clothing, housing, transportation, health care, and money. (Mann et al., 1999). The leading cause of maternal morbidity and mortality is suicide (Lindahl et al., 2005; Trost et al., 2021). In a Washington state study, women hospitalized for a psychiatric diagnosis within the last five years were 27 times more likely to attempt postpartum suicide (Comtois et al., 2008). Depression, hopelessness, and anxiety have also been established as a risk factor for suicide (Masango et al., 2008). Studies have also demonstrated that mood and anxiety disorders during the perinatal period can diminish the maternal behavioral responses in mothers (Byrnes, 2018). Researchers would be irresponsible not to study ways interventions can be developed.

Current literature and research studies are fragmented and ignore how Black womanhood affects outcomes for Black mothers. There is a plethora of research designed to examine how racism affects Black people, how misogyny affects women, or how motherhood affects perinatal mental health. This has resulted in the presentation of these issues separately and interventions that target one facet of Black motherhood. To effectively tackle the challenges surrounding Black motherhood, discussions and research must address racism, misogyny, and motherhood simultaneously. Considering this, we aim to explore the relationship between the perception of quality of care and the occurrence of perinatal mood and anxiety disorders among Black women.

Race-related stress, resulting from experiences of discrimination, prejudice, and systemic inequalities, can have lasting effects on an individual's psychological and physical well-being. Understanding how these stressors manifest and impact individuals as they transition into and experience adulthood provides crucial insights into the persistent influence of societal dynamics on mental health. Additionally, perinatal mood and anxiety disorders, which affect individuals during and after pregnancy, exemplify the importance of considering life stages and transitions of adulthood. The stressors associated with race and ethnicity can intersect with the challenges of parenthood, potentially exacerbating mental health issues. Exploring these phenomena within the context of adulthood allows researchers and practitioners to develop more comprehensive strategies for promoting mental health and well-being across diverse populations.

Overview of Perinatal Mood and Anxiety Disorders (PMADs)

Perinatal mood and anxiety disorders is an umbrella term that refers to disorders of depression, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, and psychosis in the timeframe immediately preceding and immediately following birth. However, some researchers will categorize these disorders as PMADs (depression and anxiety) and SMI (OCD, PTSD, and psychosis). Although many women experience the “baby blues,” women who experience long-lasting or more intense symptoms may meet the diagnostic criteria for a disorder. The postpartum onset of major depressive disorder (MDD) was not recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until the 1990s (Segre & Davis, 2013). Other mood and anxiety disorders are still not recognized in the DSM with a pre-or postpartum onset. A formal diagnosis of MDD requires symptoms to present for at least two weeks and cause significant distress. Studies have shown that perinatal mood and anxiety disorders affect as many as 1 in 5 mothers (Kendig et al., 2017). Diagnosis and treatment of

mood and anxiety disorders outside of MDD during the perinatal period becomes inherently more difficult because mothers must meet the traditional diagnosis criteria, which often require a more extended timeframe for the presence of symptoms.

Lack of preventative measures also contributes to the occurrence of PMADs. Although The American College of Obstetricians and Gynecologists has published a recommendation of at least one screening for depression and anxiety in the perinatal period and close monitoring for those at risk, there is no standard (ACOG, 2016). Up to 50% of those who experience PMAD are never identified (Gjerdingen & Yawn, 2007). Since mothers are not being screened consistently, providers cannot identify at-risk patients and provide proper intervention measures. For those identified as at risk or experiencing PMADs, there is no straightforward process for management and referrals. Previous research has established that women are unlikely to self-refer or seek help for perinatal depression (Murray et al., 2003).

Previous research has established that women are 2-3x more likely than men to develop depression, and the most significant risk for this development is during reproductive years (Accortt & Wong, 2017). Other studies have demonstrated that Black women have been found to experience depression in association with stressful life events (Warren, 1997). Since previous research has established the transition to parenthood as a stressful life event, it can be inferred that Black women are at an even greater risk for developing depression in the perinatal period. Every year from 1999 to 2019, Black women were more likely to die during childbirth or from related complications than any other racial group (Fleszar et al., 2023). An awareness of these statistics can also become a source of stress or worry for pregnant Black women. Outside of the immediate effects of experiencing a PMAD, women who experience one are at risk for recurrence later in life (Cooper & Murray, 1995).

Prevalence and Disparities in PMADs among Different Racial and Ethnic Groups

In a sample of 7.9 million deliveries, the Black women were found to have had a PMAD 10.6% of the time. The study also determined that the prevalence of PMAD and severe mental illness has increased among birthing women in the United States in the last decade (McKee et al., 2020). Historical research has also found that Black women experience higher rates of anxiety in the prenatal period than White women (Hernandez et al., 2022). This indicates that without intervention, this will continue to be a problem and can potentially affect larger proportions of women as time goes on.

A study that evaluated perinatal mental health in Atlanta-based Black women specifically found that only 32% reported a mental health challenge before pregnancy, whereas 71% reported a mental health challenge after birth (Hernandez et al., 2022). The challenges experienced included low mood, depression, anxiety, and psychosis. Although research explains previous mental health history as a risk factor, even with no differences in group depression history, minority women were twice as likely to report probable postpartum depression and almost thrice as likely to report clinically significant traumatic stress responses to childbirth (Iyengar et al., 2021).

The disparities in perinatal health and healthcare are evident and exemplified in study after study. Taking an approach that considers more than numbers, diagnoses, and deaths is necessary. Black women need to be an integral part of gaining their reproductive justice. Perception develops reality, there is no way to have an accurate understanding of someone's experiences without listening to their perception of said experiences. Hearing their voices, understanding their experiences, and utilizing their expertise are the only ways to move forward and *do* something.

Racism in Healthcare

Definition and Manifestations of Racism in Healthcare Settings

Racism is "prejudice, discrimination, or antagonism by an individual, community, or institution against a person or people based on their membership in a particular racial or ethnic group, typically one that is a minority or marginalized" (Oxford Dictionary, n.d.). Experiences of racism can occur on an individual level, within institutions, and systemically. Within healthcare settings, this racism has a distinct complexity that can manifest as bias from care providers, policies, or accessibility. A national study found that 32% of Black Americans reported an experience of racial mistreatment in the healthcare context (Attanasio & Hardeman, 2019).

Researchers have done an exemplary job identifying current manifestations of racism in healthcare settings, however racism has impacted healthcare for Black women historically as well. The lack of availability of birth control when desired, eugenics movement, forced sterilization, and imposing birth control as a condition of probation exemplify the storied history of racism that targets Black women in healthcare (Roberts, 2014). This historical context also informs researchers' understanding of power dynamics imposed on women during healthcare visits.

Participants in previous qualitative studies discussed individual experiences of blatant racism while receiving prenatal care, such as slurs or asking if they do crack. Participants had also resigned themselves to the fact that they would receive care last and were not treated as a priority (Alhusen et al., 2016). Other studies have shown that the awareness of racism others have experienced had an impact on when women initiated receiving prenatal care (Alhusen et al., 2016). These experiences have the potential to become sources of anxiety for patients. The generalization of this anxiety may affect the help-seeking behavior of women during the

postpartum period. Furthermore, poor patient-provider relationships have been shown to decrease patient participation in decision-making and increase perceived discrimination in healthcare encounters (Attanasio & Hardeman, 2019).

The occurrence of racial mistreatment and disparities could be a consequence of implicit racial biases and explicit racial stereotypes held by non-Black clinicians. At the surface or when operating consciously, non-Black clinicians may deny these stereotypes or behave in contrast. These conscious behaviors cannot undo the centuries of socialization that have culminated in present experiences of racism. The same behavior displayed by Black and White patients has been interpreted differently (Attanasio & Hardeman, 2019). Behaviors demonstrating self-advocacy can be interpreted as being engaged in care and having done research when enacted by a White woman versus interpreted as hostility or ignorance when enacted by a Black woman. Black women have even reported that their attempts to advocate for themselves are being suppressed by clinicians (Oparah et al., 2018).

Manifestations of racism in healthcare have led to disproportionate conditions for Black women that researchers and social justice advocates alike have tried to address. The current study's exploration of Black perinatal mental health is a body of work that aims to support the movement for reproductive justice. Reproductive justice has been defined as "the complete physical, mental, spiritual, political, social, and economic wellbeing of women and girls, based on the full achievement and protection of women's human rights" (Ross, 2007). To protect women's rights and achieve complete mental healthcare, the primary roadblocks to these goals need to be identified and understood. Although reproductive rights have gained traction as an established field, reproductive justice has not been well integrated into programming (Onwuachi-Saunders, 2019).

Consequences of Racism in Healthcare on Patient Outcomes

The racial disparities in prenatal care are two-fold. There is mistrust from members of minority communities regarding healthcare practitioners, and there are differences in the perception of quality of care. According to a 2013 study, healthcare system distrust is associated with a greater burden of experiences of racial discrimination in Blacks vs. Whites (Armstrong et al.) Experiences of racism and discrimination in healthcare settings can erode trust in healthcare providers and institutions among patients from marginalized groups. This distrust may lead patients to avoid seeking care altogether or to delay seeking care until their condition has worsened, negatively impacting their health outcomes.

Racial mistreatment during prenatal care can be an isolated incident or the culmination of multiple occurrences, especially considering that mothers must see providers regularly while pregnant. A previous research study reported that 19%–21% of women in the sample who identify as an ethnic minority reported poor treatment due to race, language, or culture, and in total, 24% perceived discrimination during birth hospitalization (Attanasio and Kozhimannil, 2015). There is no reason for ¼ of women giving birth to experience racism during delivery. The data from a California survey demonstrated a strong positive significant correlation between perinatal anxiety and racial mistreatment (DeClercq et al., 2014). These results indicate the potential for lasting impact from racism during pregnancy.

Part of the reason racism continues to impact health outcomes is that it transforms over time and is pervasive. Racism is embedded in healthcare practices and policies. Without intentional intervention, the systems and times will continue to shift. A critical component of racism that affects health is segregation. Although formal segregation is illegal, it still exists in many forms, such as redlining, zoning, and gerrymandering. These practices increase the

concentration of poverty in specific areas, decrease accessibility to quality care, and make voting to change these practices more difficult. When poverty concentration is high, businesses and the government may also be less likely to invest in the area (Williams et al., 2019). These factors culminate in a situation where poor physical and social conditions interact to increase elevated levels of chronic and acute stressors. Lack of investment will also decrease the likelihood of health-enhancing resources readily available to these populations. Segregation will also affect the availability and affordability of care. Segregated communities will face geographic barriers to care, and seeking care outside of their direct community can be expensive.

Self-reported racism and discrimination are subjective but provide valuable insight into how these interactions affect health outcomes. Self-reported racism was associated with 54% of the health-related outcomes, with the most consistent correlation being self-reported racism and adverse mental health outcomes (Paradies, 2006). When people have reported experiences of discrimination, it has been associated with the trigger of adverse emotional reactions, altered physiological responses, and changes in health behaviors (Major et al., 2018). Other analyses have found an even stronger correlation between experiences of discrimination with mental health versus physical (Paradies et al., 2015). Exposure to racism has also been correlated with mental health symptoms of distress, increased allostatic load, inflammation, dysregulation in cortisol, and more significant oxidative stress (Williams et al., 2019). Mothers who emotionally responded to experiences of racism during racism also experienced lower birth weights for their infants (Carty et al., 2011). This previous research indicates that self-reported experiences of racism or discrimination from healthcare providers may be a particularly salient factor leading to adverse mental health outcomes for Black mothers.

The socialization Black women experience will influence how they approach and experience prenatal care. A previous study showed that pregnant African American women experienced intense stress, including experiences where they were treated badly (Green, 1990). As social beings, we often consider the experiences of others when we are making decisions for ourselves. Research has indicated that delayed initiation of prenatal care was associated with consideration of racism that had affected friends and family (Gadson et al., 2017). This study also discussed how these women denied individual experiences of racism indicating that they may avoid encounters where they feel they may experience racism, including prenatal care and treatment. Knowledge of historical medical mistreatment (i.e. Henrietta Lacks, Tuskegee Experiment) also needs to be considered as a potential risk factor. These research findings indicate that knowledge of others' negative experiences may also be salient in the decision making process regarding healthcare for Black women.

Epidemiological Studies on PMADs and Racial Disparities

Epidemiology studies the distributions and patterns of diseases and how they can be controlled. In the context of this study, we are examining patterns among the racial group of black women for bias during prenatal treatment and experiences of PMADs. The types of healthcare providers women can see during pregnancy are varied. OBGYNs, family medicine doctors, doulas, midwives, nurse practitioners, and physician assistants are qualified to provide prenatal care. However, the training for each profession is different and may contribute to differences in the perception of quality of care. The World Health Organization has previously identified midwives as the most appropriate primary health care providers for the care of "normal" births (Technical Working Group, World Health Organization, 1997). Furthermore, existing literature has identified that Black women are seeing the slowest increase in utilization

of midwifery care among all ethnic groups (Parker, 1994 & Vedam et. al, 2018). An epidemiological approach would need to consider how the differences may affect occurrence of perinatal mood and anxiety disorders.

Patient-Provider Relationships

Patient-provider relationships are an essential part of care. The cultivation of these relationships varies by practice, provider, and patient. However, the perception of quality of care is an abstract concept. Research has been conducted to determine what traits Black women desire in their providers during prenatal care. It was found that the women in the research group desired to see the same provider throughout their visits, have their provider know and remember them, have quality communication, and receive compassion and respect (Lori et al., 2011). Another tool used to study patient-provider relationships is the Trust in Physician Scale. A 2013 study found that Black women's trust in their providers was related to a history of perceived racism and strength of ethnic identity (Peters et al. 2014). Understanding desirable traits in providers allows us to conduct relevant research.

When patients feel cared about in healthcare relationships stress hormones are secreted less and patients can return to a level of homeostasis. Caring doctor-patient relationships have been shown to lead to a more accurate diagnosis, relieve suffering, and increase adherence to treatment recommendations (Adler, 2002). If patients feel cared about, they may be less likely to interpret certain behaviors as biased. During pregnancy, mothers see their healthcare providers every few weeks and this frequency continues for the first few weeks postpartum. With these visits being so frequent, if mothers are experiencing stress due to their patient-provider relationship, they may experience sustained stress later, versus positive experiences possibly leading to decreased stress.

Cultural Factors and Help-Seeking Behaviors in Minority Populations

Focusing on the perception of quality of care acknowledges that pregnancy and prenatal care are subjective experiences. That said, these subjective experiences are important to study. A survey administered to postpartum women found that 22% of respondents changed the provider they were seeing or the hospital they were visiting to receive better care and 16% saw U.S. healthcare as fair or poor (DeClercq et al., 2014). Inadequate prenatal care has also been correlated with constant feelings of stress during pregnancy (Sable and Wilkinson, 1999). Screening, dissemination of educational materials, and providing resources are all components of care. However, some providers have stated that circumstances such as staff shortages, feelings of burnout, and inadequate training as barriers to being able to provide the best care possible (McCauley et al., 2019). What mothers regard as important relating to quality of care will differ among age, race, and socioeconomic background. In one study, African American women reported that it was important to them that their healthcare providers know and remember them (Lori et al., 2012). Building a rapport with providers may lead to improved continuity of care and a relationship where women are more trusting and open. This is supported by studies that have demonstrated a correlation between patient-provider communication and discrimination (Dahlem et al., 2015). When mothers feel seen, respected, and listened to; they are less likely to report negative experiences of discrimination.

Specifically, regarding help-seeking for mental health there are cultural barriers that impact someone's likelihood to seek help. In a study regarding Japanese immigrant women some of the obstacles found were misunderstanding from the therapist, feeling alienated within their culture, economic barriers, mistrust, stigma, and therapist cultural biases (Saint Arnault and Woo, 2017). Authors also coined the term Suffering Interpretation to describe cultural beliefs

about the cause of suffering, how it can be controlled, what they expect the course of suffering to look like, and if it can be cured. If women interpret emotional postpartum distress as something that cannot be cured or controlled, they may be less likely to seek help. Cultural norms around mental health will also affect whether women perceive the need for help or if they acknowledge their mental health is a problem to begin with.

The social identities people hold also affect their self-image. Many Black women are socialized to embrace the "Strong Black Woman" schema. Sandra Igwe published a novel about her journey into motherhood. The existence of this schema did not just affect how she was perceived at work or in health establishments, it affect how she saw herself. And it exhausted her (Igwe, 2022). Culturally, Black women are often perceived as pillars of strength, walls of fortitude, streams of affection, and unwavering monuments of resilience. Although these descriptors appear positive, one consequence of these labels is that they may lead Black women to feel insecure about acknowledging the need for and seeking help. The burden of this expectation, however, can create a space of pressure, worry, and self-doubt that is left unmonitored and untreated.

Black women have identified the physical and emotional presence of family, availability of access to others who have given birth, physical presence of and caring attitudes from providers, and coaching as important components of feeling safe and cared for while giving birth (Etowa, 2012). In addition to these factors, Black women associated negative birth experiences with providers being more concerned with their timeline or agenda versus positive experiences when their birth plans were respected and providers worked with their perinatal support professionals (Collins et al., 2021). These findings indicate that culturally competent care for Black women should include support for their desires and a collaborative patient-provider

relationship. Essentially, patients desire to be treated as experts in their care. They often understand what they want and desire to be an integral part of decision-making.

Social Determinants of Health and PMADs

Normative social determinants of health (SDH) and traditional risk factors do not fully explain the differences in maternal health outcomes experienced by Black women (Riggan et al., 2021). There is currently a gap in the literature regarding SDH and perinatal mood and anxiety disorders. Oftentimes, social determinants of health are examined concerning physical health. Further research is needed to discern which social determinants of health greatly impact perinatal mood and anxiety disorders. Previous research has established that social support is a SDH that greatly impacts stress reduction (Adler, 2002). In this study, social support will also be examined as a potential protective factor for women who have experienced bias from their healthcare providers.

Theoretical Framework

Black Feminist Consciousness and Its Application to PMADs

Black feminist consciousness is a perspective that arose from the understanding that Black women are discriminated against because of their race *and* gender. The struggle of Black women is unique and cannot be understood when isolating race and gender. Research must acknowledge participants' multiple social identities to address and interpret the study results adequately. Gender and racial discrimination need to be considered as risk factors for PMADs in this study. Furthermore, Black feminist consciousness endorses Black women as change agents and producers of intellectual material (Simien & Clawson, 2004). This leads to the study design of interviewing Black women; they are the voices to be heard.

Black feminist consciousness also emphasizes how Black womanhood needs to be defended because of the historical attack on the character of Black women (Simien & Clawson, 2004). Stereotype threat refers to how individuals from marginalized or stigmatized groups may experience anxiety about confirming negative stereotypes about their cultural group (Steele et. al, 2002). The "angry Black woman" stereotype is prevalent among Black women and is part of the historical attack on their character. This can lead to increased anxiety during prenatal care visits and hesitancy to address sub-par care they may receive. The increased anxiety during prenatal care visits can impact PMADs as prenatal anxiety has been established as a risk factor (Beck, 2001). Additionally, individuals may avoid medical care altogether if their mistrust or anxiety is heightened.

Labels are used to categorize items and organize information for ease of processing, but what happens when these labels become stereotypes that restrict the identity and experiences of others? What happens when these stereotypes lead to implicit and explicit bias? Incidents of implicit or explicit discrimination can negatively impact mental health. In particular, the experiences of Black women have consistently been ignored, disregarded, and undervalued throughout United States history. Stereotype threat can also impact what patients disclose to their providers; if they try to avoid confirming stereotypes, they may withhold information, downplay symptoms, or avoid specific preventative care measures (Hausmann et. al, 2011). If patients perceive that their provider holds implicit biases, this can intersect with stereotype threat as they attempt to be more "careful." An earlier investigation into self-advocacy during medial encounters found that Black women were less likely to mention health information to their physician (Wiltshire et. al, 2006). It is possible that Black women have developed the fear that their normative behavior, such as self-advocacy or exerting agency, can be interpreted as a lack

of cooperation or compliance (Vetterly et. al, 2024). An avoidance of these normative behaviors could be interpreted as a protective factor so that they do not further experience racism.

Critical Race Theory and Racism in Healthcare

Critical Race Theory (CRT) is an orientation that was initially developed in legal studies to help explain the impact of systemic racism on marginalized communities (Hartlep, 2009). An essential consideration of this theoretical framework is that historical racism can contribute to present outcomes. Framing this for healthcare, CRT would address racial disparities in access to care, quality of care, biases experienced within the healthcare system, and health outcomes. Furthermore, since factors like quality of care and experiences of bias have subjective components, it is crucial to apply theories developed with marginalized communities in mind. This would indicate that providers need culturally competent and sensitive care to avoid bias.

CRT also encourages a perspective that considers additional factors that contribute to intersectionality. Traditional promotion of healthy behaviors such as exercise, decreasing drug use, or a balanced diet are not enough to combat the impact of systemic racism within the healthcare system (McClendon et. al, 2021). There is already an inherent power dynamic between patient and provider since patients are expected to heed the directions and advice of their providers. This power dynamic is exacerbated by additional factors such as systemic racism and personal bias (Adebayo et. al, 2021). Applying CRT to this research study will ensure that considerations are made of systemic practices and policies that affect outcomes for individual provider behaviors and patient mental health.

CRT also acknowledges psychological models of sustained stress have included racial discrimination and perceived prejudice as contributing factors (Harrell et al., 2011 & Flentje et al., 2019). These models demonstrate that sustained stress (with unique stressors related to racial

experiences) has adverse psychological outcomes, including sustained periods of distress. The sustained status of this stress is also affected by the anticipation of experiencing this stress. The continued burden is allostatic load (McEwen & Stellar, 1993). In a study examining allostatic load, Black women had the highest documented scores of allostatic stress out of all demographics (Riggan et al., 2021). The allostatic load model explains that the consistent stress from experiencing racism can contribute to metabolic conditions that exacerbate pregnancy-related risks. In addition to exacerbating pregnancy-related risks, allostatic load contributes to weathering. Weathering is where the body essentially degrades over time from constant stress. Considering the constant nature of this stress for some women, it is reasonable to explore how this may affect their mental well-being after birth since risk factors for perinatal depression include depression during pregnancy, anxiety during pregnancy, and previous history of depression.

Implicit bias is essential because some healthcare professionals do not intentionally engage in biased behaviors. Since these beliefs and attitudes are unconscious, unraveling them and intentionally addressing them takes more work. Their beliefs direct their decision-making, behaviors, expressions, perceptions, and interactions, whether they intend them to or not. In the healthcare setting, this can affect the provider's diagnosis, treatment plan, and how they interact with patients. This can culminate in lower quality of care and negative patient experiences for minority groups.

Bronfenbrenner's Ecological Systems Model

Bronfenbrenner's Ecological Systems Model proposes that human development and experiences are impacted by their interactions with their environment (Bronfenbrenner, 2000). The model has five phases: microsystem, mesosystem, exosystem, macrosystem, and

chronosystem. Each of these phases or systems interacts with each other to influence the development and experiences of individuals. The model provides much flexibility for interpretation by conceptualizing the systems that impact a specific issue or point of concern. Although individual risk factors and experiences can influence perinatal mental health, the other systems' cumulative effects also impact prevalence.

The microsystem could include factors such as racial/ethnic identity, coping mechanisms, and healthcare providers. The mesosystem is focused on how the microsystems interact with each other; in this study, that would be how a woman's racial/ethnic identity affects their interaction with healthcare providers. The exosystem can include the hospital or organizations, access to mental health care, and extended family members and their experiences of bias. The macrosystem would include structural racism, public policy, societal attitudes, and even colorism. The chronosystem would include historical racism, intergenerational trauma, and recent movements to address racial disparities in perinatal care (Phelan & Kirwan, 2020). Further, the model can be applied to the study's findings by identifying the resilience and protective factors available to these women.

Current Study

The purpose of this study was to examine the perception of Black women's experiences with their healthcare providers during pregnancy and how it may affect the occurrence of perinatal mood and anxiety disorders to develop common themes for future research. Bronfenbrenner's Ecological Systems Model, Black Feminist Consciousness, and Critical Race Theory each offer unique lenses through which to understand and analyze social phenomena like patient-provider relationships in prenatal healthcare. By integrating these theoretical frameworks into the methods of the current study, researchers can gain a more nuanced understanding of the

complex factors at play and identify opportunities for improving care delivery and addressing health disparities.

Black feminist consciousness centers the experiences and perspectives of Black women, recognizing the unique challenges they face due to intersecting systems of oppression based on race, gender, and often socioeconomic status. The study utilized an interview modality to prioritize the voices and experiences of Black pregnant women. Individual interviews allowed participants to express how race, gender, and other intersecting identities shaped their interactions and healthcare experiences. Bronfenbrenner's model emphasizes the importance of considering multiple layers of influence on individuals within their environment. This model informed the development of interview questions to ascertain how factors at each level, such as individual beliefs and behaviors, interpersonal relationships, community norms, as communication, trust, decision-making, and societal structures, impact the quality of care pregnant individuals receive from healthcare providers. Critical race theory emphasizes the ways in which racism is ingrained in societal structures and institutions, shaping power dynamics and perpetuating inequalities. CRT also informed the current study and interview question development by prompting the exploration of how racial biases and stereotypes influence providers' attitudes and treatment decisions, as well as how Black pregnant women navigate and resist these dynamics to advocate for their own health and the health of their children.

Perinatal mood and anxiety disorders range in severity but ultimately have adverse outcomes for mother and child, sometimes even leading to diminished interaction with the child (Misri & Kendrick, 2007). Many studies have determined other risk factors, such as previous history of mental health disorders, but have not explored avenues such as perceptions of their interactions with providers and racial discrimination. Studies that have explored patient-provider

relationships and desired characteristics have not explored how that may affect anxiety or depression. Exploring the relationship between perceptions of one's experience and the occurrence of anxiety and depression will allow healthcare providers to implement desired characteristics appropriate to the client to improve perinatal treatment for Black women.

The following research questions were used to develop interview questions and guide analysis:

1. How do black mothers describe and make meaning of their experiences with their providers?
2. In their prenatal care visits, do participants perceive any of their interactions with healthcare providers as influenced by racial discrimination?
3. Are the prenatal/delivery experiences of others salient to the decision making process for Black mothers?
4. What patterns can be identified regarding provider characteristics that contribute to increased or decreased comfort levels among participants during prenatal care visits?
5. When or where do Black mothers feel supported and cared for during their prenatal visits?

Methodology

Sampling and Participants

Demographic Considerations

Recruitment for study participants began with contacting local hospitals, birth advocacy organizations, and maternal mental health services in Richmond, VA. However, it was found that accessing mothers using this recruitment method proved challenging. Therefore, recruitment continued with the snowball method. Friends, family, colleagues, and participants were contacted to encourage those in their network who meet the criteria to participate.

The initial criteria for participants to be included in the study were as follows: (1) identify as Black a woman, (2) given birth since 2020, (3) gave birth to a single baby, and (4) between the ages of 25 and 35 at the time of birth. The age of the participants was determined using the information that women over 35 are at increased risk for preeclampsia and gestational high blood pressure, making their pregnancy high risk (Medline Plus, 2014). There is an increased risk for complications, including preeclampsia, premature labor, and preterm birth for women carrying more than one fetus. (Hamilton et al. 2015). Participants were required to have given birth at least once since January 2020. This timeframe was selected due to the COVID-19 pandemic and subsequent changes to the protocol in hospitals and OB-GYN offices. After some consideration, the criteria were expanded to include any women who (1) identified as Black and (2) gave birth to a single baby. The criteria were expanded after considering that Black women will continue to give birth post-Covid and across a variety of ages, therefore their experiences should be heard as well.

They were asked to speak generally about their experiences with the healthcare system, providers, and subsequent personal experiences regarding symptoms of PMADs. Participants are not required to have had a diagnosis of PMAD, as this would have eliminated participants who are unable to access the resources needed for a formal diagnosis.

Recruitment Methods

Participants were recruited through community-based organizations and reproductive healthcare agencies as well as using the snowball technique. A flier was provided indicating the point of contact at each recruitment site and to individuals who know others who meet the criteria. The flier included basic information about the study and where potential participants can contact researchers. Community-based organizations are being used in addition to reproductive

healthcare agencies as recruitment sites because researchers understand some participants may have anxiety related to reproductive healthcare sites. Community-based organizations can be an opportunity to reach potential participants who might refrain from participating otherwise. The snowball approach began with an initial set of participants or individuals aware of the study who are directly contacted. Those who were directly contacted were encouraged to refer others from their network who meet the criteria.

Demographic Characteristics

The total number of mothers who completed an interview was twelve. The mothers' average was 32.08 years old (SD=4.62), ranging from 25-41 years old. All study participants were asked to self-identify their race, and identified as “Black or African American” and not of Hispanic origin. Household income varied from $35,000 - $49,99/year to $200,00+/year. Education status included participants who “completed high school” to “doctoral degree.” All participants were assigned female at birth and identified as women. Nine participants are employed full-time, one participant is employed full-time and works full-time raising children/caregiving, and one participant works full-time raising children/caregiving. Eleven participants are eligible for paid maternity leave from their employers. Each participant was randomly assigned a pseudonym to protect confidentiality when their quotes are presented in the document.

Pseudonym	Age	Education	Annual Household Income Range	Marital Status	OBGYN	Doula	Mid-Wife	Family Medicine	Other
Susan	31	Master's degree	$150,000-$199,999	Married	X				
Diane	28	Master's degree	$35,000-$49,999	Partnered	X				

Delores	30	High school	$50,000-$74,999	Married		X	X		
Grace	35	Doctoral degree	$75,000-$99,999	Single	X				
Delilah	41	Master's degree	$200,000 or more	Married	X			X	MFM*
Raven	32	Bachelor's degree	$100,000-$149,999	Married	X				
Julie	30	Bachelor's degree	$35,000-$49,999	Single	X				
Valeria	25	Master's degree	$75,000-$99,999	Single	X				
Brittney	29	Bachelor's degree	$200,000 or more	Married		X	X		
Elizah	39	Bachelor's degree	$100,000-$149,999	Married	X				
Alexis	35	Doctoral degree	$100,000-$149,999	Married	X				
Aliyah	30	Bachelor's degree	$200,000 or more	Married	X				

*Maternal Fetal Medicine Doctor

Research Design

Qualitative research has the unique opportunity to hear the voices of Black women. Surveys and quantitative data have provided valuable information and opened the door for insight into these experiences. However, it does not project the voices of these women so we can genuinely understand their experiences, perceptions, and understandings of their world. It is not enough to have awareness of an issue and do nothing about it. Previous studies have proven that there are disparities in healthcare experiences that are associated with mental health outcomes. To move research toward tangible outcomes that inform future interventions, an understanding of what causes these disparities needs to be gathered.

A cornerstone of Black feminist consciousness is social justice. Beyond acknowledging these issues, individuals are responsible for contributing to the liberation of marginalized people. Thus, this research study aims to listen to the stories of the marginalized to explore a pathway toward change. Exploratory research aims to understand what problem needs to be solved. Exploratory research also allows for flexibility in understanding the problem's origins and where interventions would be appropriate. Utilizing interviews allows those conducting qualitative research to investigate the psychological and socio-cultural processes of the participants (Agar & MacDonald, 1995). Studies regarding perinatal mood or anxiety disorders and patient-provider relationships can provide valuable data when the mothers who experience those relationships are more directly involved. Interviews will allow for the determination of recurring themes in this relationship. From these themes, directions for further research can be ascertained.

Interview Procedure

Participants were interviewed via Zoom utilizing a semi-structured interview design. The questions revolved around issues of race in healthcare settings, particularly as it relates to Black women and the time before and after giving birth. The questions were developed after review of previous literature, examination of methodology for other qualitative studies, and incorporating the theoretical framework informing the present study. Before the interview began, participants were advised of the study's purpose and provided informed consent regarding their participation. Following this, the primary researcher/or trained colleagues facilitated the discussion regarding their experiences with healthcare systems and providers and subsequent personal experiences regarding symptoms of PMADs. For this study, healthcare providers included primary care physicians, OBGYNs, doulas, midwives, and nurses. The discussions were videotaped and transcribed via Sonix, the primary researcher verified the transcription following electronic

transcription. Access to the videotape was restricted to the primary researcher, trained colleagues, and her advisor. After the interview, participants were debriefed and allowed to ask the researcher questions. Participants were also asked if they wanted to include any information that was not asked about during the semi-structured interview. Each participant was compensated $25 with an Amazon gift-card for their participation.

Measures

After participants agreed to be interviewed, they were emailed an electronic demographic survey to be completed on RedCap. Participants were asked to report their age, gender identity, sexual orientation, racial identity, education level, current occupation, household income, marital status, and paid maternity leave eligibility. In addition to verifying personal demographic information, participants were asked to report the types of healthcare providers they used for prenatal care and if they have chronic health conditions.

Instruments

Researchers are an integral part of qualitative research as their collection and interpretation of the data are utilized for publications and future research. Psychological distance is a term used to describe the proximity of a researcher. Within this study, the social identities of the researcher are of interest (Medin et al., 2010). The primary researcher (hereafter referred to as “P.R.”) of this project is a 23 year-old graduate student in the Counseling Psychology program at Virginia Commonwealth University, a Minority Serving Institution. She obtained her bachelor’s degree in Psychology from North Carolina Agricultural and Technical State University, which is classified as a Historically Black University (HBCU). Attending an HBCU emphasized the importance of centralizing the experiences of Black people, rather than observing them as “others". Her background in counseling contributes to her desire for

therapeutic interventions to be developed from research. She is from a suburban area in Georgia and grew up in a middle-class family. Both of her parents have obtained Bachelor degrees, and education has been valued and sought after within her immediate family. The P.R. identifies as a Black American, and finds the distinguishment between Black American and African American to be a critical part of her identity. As a Black American, she has not had the opportunity to identify and learn about her African heritage due to the forcible removal of her ancestors from their native land. Furthermore, identifying as Black American honors her experience as a Southern American. Being raised in the South instilled values of the importance of family, the necessity of respectability when presenting the self to others, and hospitality. P.R. identifies as a Baptist Christian, and her religious beliefs are salient in her experiences with the world.

As a Black woman, the P.R. shares those social identities with participants. These shared social identities have led her to the belief that the cumulative effects of racism and misogynoir have the potential to negatively affect the mental health of Black women during the perinatal period. In addition to shared social identities, the P.R. has been diagnosed with Major Depressive Disorder and Generalized Anxiety Disorder. This has cultivated a special interest in Black women's mental health, and creates a sense of empathy for participants who have had similar experiences with their mental health. In addition to exploring Black women's mental health, the P.R. is a counseling psychology student and has committed herself to treatment for Black women. She integrated aspects of her clinical training, such as rapport building and providing positive regard, to aid in conducting the interviews and creating comfort for participants. This allows for a connection with participants beyond surface level. They are often recounting very difficult experiences at a vulnerable time in their lives, it is of utmost concern to prioritize their safety.

While the researcher has also had experiences with healthcare providers impacted by her race and gender, she has never been pregnant or given birth, so those interactions have not occurred in maternal or perinatal health. To aid with this knowledge gap, the primary researcher has done an extensive literature review to gain more knowledge on the subject and the most appropriate questions to include in the interviews. The primary researcher is also susceptible to biases stemming from her experiences with healthcare providers. The researcher is particularly interested in a qualitative study to provide a space for the voices of Black women to be heard rather than overlooked or cast aside.

The P.R. was assisted by a fellow lab member, Micah White, with the execution of the present study. Mr. White conducted interviews, participated in verbal discussions around interview structure as a thought partner, and commented on possibilities for future research. Mr. White is a 23-year-old graduate student in the Counseling Psychology doctoral program at Virginia Commonwealth University. His research interests regard the well-being and liberation of Black people. Considering his background and training in the School, Home and Internet Contexts of Emotional Development (S.H.I.E.L.D.) research lab during his undergraduate studies, his expertise and support were solicited for the present research. The S.H.I.E.L.D. lab focuses on emotional connection and how we express, regulate, and process the emotions of others and ourselves. It is important to note that Mr. White is a Black man, and that identity adds nuance to the interviews he conducted.

Reliability and Validity

Qualitative research is not exempt from measures of reliability and validity. The following methods to emphasize trustworthiness are derived from prior research regarding credibility for qualitative research (Noble & Smith, 2015). Cronbach's alpha face/construct

validity. Accounting for personal biases that may have influenced bias led to the development of a positionality statement for the researchers involved in interview protocol and data analysis. The P.R. engaging with her lab member as a thought partner allowed them both to identify and reduce personal biases that may have influenced findings or interpretations of data. Biases in sampling include the snowball recruitment method. Participants were used to reach other participants, therefore they may share many identities and life circumstances (i.e. S.E.S. or education level). To ensure the quality of data, records were kept meticulously. Each interview was recorded, transcribed with software, and verified by the P.R. Transcripts from interviews were kept and utilized to present participants' recount of their experiences in the results section. In the Results and Discussion, accounts from each participant will be reviewed. This will allow for a variety of experiences to be captured, without focusing solely on experiences relevant to the research questions presented above.

Participants' will be quoted verbatim using pseudonyms to support research findings and data interpretation. The results section will walk through the development of themes and categories to provide clarity on the thought process for data analysis and interpretation. Respondent validation is a critical component of qualitative research. During interviews, researchers checked back in with participants to verify their understanding of the participants' stories. Upon completion of the semi-structured interview, participants were asked if there was anything else salient about their pregnancy or delivery that they wanted to share. The theoretical framework of the present study functioned as a method of data triangulation. Utilizing three theories to inform interview procedures and questions helped to avoid bias by providing multiple perspectives for data collection and interpretation. Each theoretical framework contributed to question development and data analysis for a variety of perspectives.

Results

Qualitative Data Analysis Plan

The Sonix transcriptions software was used to transcribe the audio from participant interviews. Sonix provides encrypted data storage and routinely completes security and data safety checks. Six months after the study's completion, the audio files will be removed from Sonix, and the transcription files will be securely stored in FileLocker. Thematic coding is a qualitative analysis of common themes relevant to a research question. After analyzing the commonalities and differences between the experiences described in the interviews, codes were identified. These codes were separated into themes based on their similarities and application to future research. Body language, tone, and affect will also be noted during the interviews to aid analysis. Nvivo qualitative data analysis software was used to identify and organize codes from the transcription of the interviews. Sonix software also has thematic coding tools, which will be used in conjunction with Nvivo for a preliminary analysis.

Reflexive thematic analysis informed the primary analysis of transcripts. Reflexive thematic analysis emphasizes the researcher's deep interaction with and influence on the data (Braun & Clarke, 2006) In this study, the P.R. of this project interacted with the data deeply. Reflexivity requires the researcher to consider their role and how it influences the data collection and analysis. This is why the positionality statement was provided in the "Instruments" section. Latent (or interpretive) data analysis was performed on the transcripts. Rather than focusing on the explicit statements from participants, their interviews were studied to help reveal themes that were present in their various experiences. What was shared? What was different?

Reflexive thematic analysis has four distinct phases: data familiarization, initial code generation, developing initial themes, and theme review. For data familiarization, the P.R.

listened to recordings of each interview while transcribing and re-read each transcript twice. During the interviews, notes were taken on what each participant was describing and used to verify that the researchers were understanding the participants. During initial code generation, patterns from Nvivo and research observations were identified and words or phrases that appeared frequently were taken note of. However, some codes were developed due to the richness of the descriptions from participants. With reflexive analysis, an emphasis is placed on utilizing themes to tell a story of shared meaning. The development of initial themes aligned with word clouds and similarities/differences from participants recounting their experiences. What made the codes distinct? What brought them together? Theme review solidified the choice of each theme so that it was representative of how each code interacted with one another.

Findings from Qualitative Data

Reflexive thematic analysis led to the development of the following codes: (a) Anticipation of Low Quality Care, (b) Lack of Communication, (c) Listening, (d) Stereotype Threat, (e) Colorism, (f) Education Status, (g) Birth Anxiety, (h) Postpartum Care, (i) Advocacy, (j) and In-Depth Screening. Patterns among the codes were identified, and three themes emerged that were related to the prenatal experiences Black women had with their healthcare providers and subsequent mental health experiences: Barriers and Challenges in Patient-Provider Communication, Sociocultural Factors and Perceived Discrimination, and Maternal Well-being and Healthcare Access. These themes provide a roadmap for how the codes are relevant to the participants' birth experiences, and how the codes relate to each other. Relevant examples were drawn from the interview to illuminate how healthcare providers may have impacted the mental health of Black mothers. Body language and tone observations during the interview are included as supporting data.

Barriers and Challenges in Patient-Provider Communication

This theme encapsulates the various obstacles and difficulties faced by Black mothers when trying to effectively communicate with their healthcare providers or understand treatment processes. Effective communication in healthcare settings is reliant on both parties' willingness to develop and maintain a working relationship. The study began with a focus on prenatal care providers, however throughout the interviews a pattern emerged with the participants and the providers they had trouble communicating with or connecting to. For many participants, their delivery was not an uneventful process that came and went. They described vulnerability and a desire to understand what was going on. Sadly, many providers missed the mark. This was underscored by hesitancy some participants held when engaging with healthcare providers.

Anticipation of Low Quality Care

This code highlights the pervasive fear or expectation among Black women of being mistreated or discriminated against by their healthcare providers. The experience of racial trauma within the healthcare system is not localized to the person experiencing it, and it is not uncommon for women to share their experiences with friends, family, or community members. Participants often discussed how they had conversations with other Black women about trauma they had experienced within the healthcare system. Participants recounted a sense of worry about initiating care and what their own experience would be like. They relied on family and friends to find care providers. Participants also discussed driving over 30 minutes, hiring birth workers virtually, and soliciting providers they had a personal relationship with to ensure they received adequate care and were not mistreated by their providers. "Susan" related her selection process to her career as an analyst. She used reviews, research, and ranked in an effort to find the best care for herself and her child.

This anticipation may stem from historical and systemic racism within healthcare systems, leading to a lack of trust and confidence in healthcare professionals. Disparities in maternal care, high rates of maternal mortality, and inadequate attention to Black women's health concerns contribute to this trauma. Further, even when women had positive experiences with healthcare providers, they specifically emphasized that this experience is not one that every Black woman has access to. Diane's account of her thought process regarding this:

> " I feel like overall I had a pretty good experience. I know some people do have really bad experiences. But I think during my pregnancy and even afterwards, while I was in the hospital giving birth, like I was treated, treated very well. So I'm very thankful for that because like I said, I know there's a lot of people who don't get to experience that."

Lack of Communication

The absence of effective communication from healthcare providers during birth and delivery can have profound consequences. Participants reported increased stress or worrying and an erosion of their trust in providers. "Grace" mentioned "But she still went behind my back and scheduled a C-section anyway, so I had to, like, do things to put myself in labor." This resulted in a rupture in the patient-provider relationship. Clear and open communication is essential for fostering a sense of security and empowerment in patients, especially during the vulnerable and high-stakes moments of childbirth. Many participants also underwent a C-Section, which is a major surgery. "Julie" remembers being worried that something bad would happen, exacerbated by the fact that she was on drugs and was not informed by providers of what was going on. When healthcare providers fail to adequately convey information, address concerns, or involve patients in decision-making processes, it can leave participants feeling isolated, anxious, and disempowered. Patients also reported being separated from their support system during this time.

This breakdown in communication can lead to heightened stress levels for patients and their families, as they grapple with uncertainty and a lack of understanding about their own care. “Delilah” remembers:

> “We're like, nobody's coming in here. Nobody's rushing in here. And. My husband is usually a very mild mannered person. Like if you get him mad, then it's really issue because I'm usually the one who gonna get mad first. But he went off because he just felt like nobody cared. Nobody came in there to see about our son and what was going on.”

Moreover, the erosion of trust stemming from inadequate communication can undermine the foundation of the patient-provider relationship, hindering effective collaboration and compromising the quality of care delivered.

Listening

Communication goes beyond providers hearing what their patients have to say. Active listening plays an essential role in healthcare outcomes. Providers must prioritize active listening to mothers throughout prenatal visits, birth, and delivery to ensure comprehensive, patient-centered care. Listening attentively to mothers allows healthcare providers to understand their unique concerns, preferences, and experiences, fostering a sense of trust and collaboration. During prenatal visits, actively listening to mothers enables providers to address any questions or anxieties, empowering mothers to make informed decisions about their care. Similarly, in the labor and delivery room, attentive listening allows providers to respond promptly to mothers' evolving needs and preferences, facilitating a more supportive and comfortable birthing experience. By valuing and incorporating mothers' voices into the decision-making process, healthcare providers can enhance maternal satisfaction, reduce stress levels, and ultimately promote positive birth outcomes.

Moreover, listening to mothers fosters a sense of partnership and mutual respect between providers and patients, reinforcing the importance of patient-centered care throughout the perinatal journey. “Raven” recalled “So with my black physician, she just always advocated for me. She never rushed me through an appointment, which my white physician did. She listened to every single thing that and word that I had.” This sense of partnership was cited by multiple participants as being a characteristic they valued in the relationships they had with various healthcare providers. Participants enjoyed collaboration and were especially receptive to feedback or changes when they felt listened to beforehand.

Sociocultural Factors and Perceived Discrimination

The ironic thing about sociocultural factors is that they are not tangible. Sociocultural factors have developed over time and continue to morph. However, these abstract concepts critically define an individual’s intersectionality. In turn, our intersectional identities affect our world view, interactions, and interpretations of those around us. These factors include stereotypes, S.E.S., education level, and in turn affect someone’s “respectability”. Are they deemed worthy of respect in our society? The study focused on participants’ perceptions of their experiences. When recounting perceived discrimination, many participants described a social cultural factor they feel like influenced the behavior of their care providers.

Stereotype Threat

Racial awareness is vital for black mothers to navigate a world where race significantly influences experiences, opportunities, and challenges and is inherently connected to racial identity. Cultivating this awareness involves understanding systemic racism, preparing for potential biases in various settings, and fostering a sense of identity and resilience for both themselves and their children. Ideally, racial awareness would empower black mothers to

advocate for themselves during prenatal care visits. “Grace’s” baby was drug tested post-birth, despite “Grace” being sober and having no history of drug abuse. After verifying that this was not standard practice, “Grace” reported feeling disrespected and that they only did this because she’s Black,

There are pervasive stereotypes about Black women and families that cultivate mistreatment. Stereotyping undermines the complexity of individual experiences and emotions, pigeonholing Black women into a narrow and distorted archetype. Some people also use the stereotype to undermine or dismiss the frustrations of Black women. Within prenatal health, this is especially concerning as it can lead to negative physical health outcomes or missed opportunities for treatment. Participants reported dismissiveness and annoyance from healthcare providers if they expressed frustration with the care plan. To overcome this, participants filed formal complaints of their mistreatment. According to participants, formal complaints of mistreatment were addressed appropriately and in a timely fashion. Notably, the participants reported being primarily concerned that other mothers did not receive the same mistreatment from staff.

Colorism

Colorism affects Black women within and outside of the Black community. Lighter skin tones are often privileged, leading to disparities in opportunities and societal perceptions. Addressing colorism involves challenging beauty standards, promoting inclusivity, and recognizing the diversity within the Black community. However, these methods of addressing colorism are often more about social inclusivity. Colorism within the healthcare context is complex as it affects the way people interact with each other, not just how people feel about themselves. “Aliyah” reported that she felt like their status as a light-skinned Black woman

contributed to more aggressive treatment from healthcare providers. She described that were darker-skinned were mean to her and remembers her darker-skinned husband being treated much better, and nursing staff interacting with him more. This recount was included because although the participant experienced the inverse of what is traditionally associated with colorism, her description of this experience was rich and a prominent story during review and coding. Furthermore, colorism was not a concept explicitly explored during interviews, but that may have been important. In an effort to avoid overlooking this phenomenon, the participant's perspective of colorism is included as a code.

Education Status

Stereotyping Black women as uneducated is limiting, and often inaccurate. Countering this stereotype requires highlighting the achievements, intellect, and contributions of Black women across various fields. Participants included women who had been employed in healthcare for more than a decade and/or obtained a doctoral-level degree. Despite attaining these things, many Black women are still dismissed or patronized. Participants explained feeling unheard when expressing preferences for their care. "Alexis" said:

> "So I just like had to really advocate to myself, especially to a point like telling them, hey, you know, I have a PhD too. I, I'm in a lung immunology lab. Like, I know what I'm talking about here, y'all."

However, the insinuated lack of intelligence Black women face is not limited to formal education. Providers may assume women are inexperienced in other areas or not qualified to make decisions for themselves and dismiss their opinions. Many participants had done extensive research to decide on their birth plan and were still told what would be "better" or ignored

altogether. Other participants had taken education courses through the hospital and cited it as the only reason they were aware of certain protocol or choices.

Maternal Well-being and Healthcare Access

Maternal well being is complex, and before and after birth is a space of vulnerability. Many mothers reported lackluster care during and after childbirth that culminated in a bad experience. They were unwell, monitored their blood pressure themselves, and even had emergency room visits mere days after giving birth. Healthcare providers have more than an opportunity to create equitable access, it is their responsibility.

Birth Anxiety

As discussed previously, the transition to parenthood can be a point of stress. Further, an increased allostatic load is often present among Black women due to their intersecting identities of race and gender. Pregnancy itself can be anxiety inducing, and Black women face specific challenges during pregnancy because of their intersecting identities. Another stressor identified by participants was the physical act of giving birth. Those who were first time mothers cited uncertainty about how the process would be. Diane said:

> " I think more so towards the end. Just like the uncertainty of knowing, like where I was going to be when I went into labor, like how how was all going to plan out? Was I going to be alone? Was I going to be at work? Was I going to be driving just like the anxiety of that part?"

Those who had given birth before had anxiety from their previous experiences. Participants in the study described constantly feeling "on guard" and worrying about how their interactions with healthcare providers would be. Participants also described being nervous to

speak up. The participants who described these experiences also reported more frequent symptoms of anxiety immediately after birth.

Postpartum Care

Participants described being dismissed after giving the birth and that the baby was treated as the only patient. To have such high levels of concern for the infants while ignoring their mothers is a point of concern. “Aliyah” spoke about how quickly she was discharged.

> “And I get it like. Something has happened with my body, and I've brought a life into this world. And we want to make sure baby is okay. But I just feel like if you have to knock on my door every hour or two hours, then maybe I should be here longer than 2 or 3 days. Like, maybe you should spread it out to where I'm there for 5 to 7 days, and then I can get those 4 to 5 hour increments of sleep, and then baby can rest because baby has gone through a major surgery also.”

Providing adequate postpartum care after giving birth is essential for supporting the physical, emotional, and psychological well-being of mothers and promoting optimal maternal *and* infant health outcomes. This period represents a critical transition for mothers as they navigate recovery from childbirth, adjust sleep schedules, establish breastfeeding routines, and adapt to the demands of caring for a newborn. “Elizah” recalled being asked to take note of the input and output levels she had for her own chart! She also experienced two shift changes before receiving any assistance with the peri-bottle or going to the restroom. This led to her feeling like no one was concerned for her since the baby had come. She went through something major and now faced a lack of support while being responsible to care for herself and her child.

Adequate postpartum care involves regular monitoring of maternal health, including assessments for complications such as postpartum hemorrhage, infections, and mood disorders.

The culture developed in certain hospitals and healthcare centers should be examined since organizational culture can support or hinder efforts to address racism. Additionally, healthcare providers should offer guidance and support on breastfeeding, newborn care, and maternal self-care practices. Emphasizing open communication and accessible resources can help mothers feel empowered and confident in their caregiving abilities during this vulnerable time. By prioritizing comprehensive postpartum care, healthcare providers can contribute to the holistic well-being of mothers and infants, fostering a smoother transition to parenthood and promoting long-term health and wellness for both. Multiple participants said they had hired or were interested in postpartum doulas and birth centers for long term care after delivery.

Advocacy

Building and maintaining a strong support system is crucial for Black women. Facing the challenges associated with race-related healthcare trauma, colorism, stereotypes, and other forms of discrimination can be emotionally taxing. When feeling unheard or ignored, a support system can step in to advocate. "Susan" used a prenatal advocate that she could text throughout her pregnancy. "Brittney" fondly remembers how her birth worker stepped in after seeing a change to her birth plan that they hadn't previously discussed. "So she did a great job. And just like checking to make sure I was okay with the changes that I made to my birth plan, like in the moment. But I really appreciated that."

Although some participants were comfortable advocating for themselves, a support system provides encouragement and validation during a stressful time. Participants in the study described how their partners and birth-workers (i.e. doulas and midwives) made them more comfortable advocating for themselves or advocated on their behalf. This became essential when interacting with doctors or residents who were ignoring their wishes. "Delores" discussed how

she felt trampled on by others. “I believe it was more so just people not respecting my boundaries.” In contrast, “Raven” recounted that the advocacy was a defining point of her birth experience and something she admired about her providers. “It was really as if the team with my son cared about me like I was one of their own, not just another number in the hospital.”

In-Depth Screening

A chief complaint among participants was the lack of in-depth mental health screening. Participants reported briefly being asked how they were feeling during prenatal visits and at their 6 week check-up. “Alexis” could hardly recall any screening at all.

> “I felt like it was very generic because they just [asked] postpartum. They just asked me like the how are you feeling? Do you feel like a disconnect between you and your baby? Do you feel like you want to hurt yourself or your baby? Like those type of questions?” Postpartum care for mental health is critical as well.

“Delilah” was diagnosed with postpartum anxiety, postpartum depression, and PTSD related to her birth experiences. She was referred to a clinician after contacting a crisis center. Other participants did not receive a formal diagnosis but reported feelings of depression and anxiety. Furthermore, some participants chose not to disclose these experiences to healthcare providers because they felt nothing would be done.

In-depth mental health screening during and after pregnancy is crucial for identifying and addressing potential mental health concerns that may arise during the perinatal period. Close monitoring of mothers' mental health status is essential for early detection and intervention. By implementing thorough mental health screening protocols, healthcare providers can identify at-risk mothers and connect them with appropriate resources and support services. Multiple participants expressed the sentiment that the time from birth to 6 weeks postpartum was crucial

for their mental health and that they were not being monitored at all. Two participants attended a crisis appointment before their 6-week check-up. Increased monitoring of mothers postpartum allows for ongoing assessment of mental health symptoms and ensures timely intervention if symptoms worsen or new concerns emerge.

Discussion

Significance of the Study

Reproductive justice is more than creating awareness, it is movement building (Ross, 2007). It is not enough to identify causes of concerns or desired provider characteristics. This body of research should be utilized to inform *preventative measures.* Interventions have been developed, but Black women deserve help before adverse outcomes have occurred. Black prenatal and delivery care must evolve to protect the physical and mental health of Black women.

It is exceedingly crucial that psychologists research minority or marginalized groups that do not "other" them or imply that they deviate from the norm in some way. Researchers decided not to use control or comparison groups since Black women are the population of interest. Research should be tailored to populations of interest so that when interventions are developed and theories are created, they do not have to be adapted to minority or marginalized groups. Previous studies have indicated that increased utilization of healthcare and preventative screening occurred when patients felt the care they received was aligned with their gender and race (Riggan et al., 2021). This study will allow researchers to examine where the misalignment in care may be coming from and aid in developing interventions for Black women. Every patient deserves safety, respect, and quality care during the prenatal period, hospitalization for birth, and

follow-up visits. “Elizah” stated “And it's just like, I don't need you to be down. I need you to do your job.”

Studies have already shown that a significant source of stress for women of color is interacting with the healthcare system and medical personnel. Adverse experiences were reported in all types of healthcare, but reproductive and women’s health-specific were particularly distressing (Riggan et al., 2021). Increased distress during pregnancy related to healthcare experiences may lead to adverse outcomes for PMADs. This indicates a gap in research surrounding the disorders as they are not well established. Occurrence of PMADs impacts more than the immediate family of the mothers. Researchers have estimated that the societal cost of untreated PMADs is upwards of $14 billion for the five years after birth (Luca et al., 2019). A 2014 study (Decleq et al.) found that 34% of respondents felt stressed six months or more postpartum. Further, the study hypotheses were supported, and themes emerged that can inform future research on addressing this complex issue.

This study began with a focus on the care Black women received at their prenatal visits. These visits were emphasized because of their recurrent nature. However, the importance of the delivery and postpartum care experience was highlighted by multiple participants. Participants recounted a level of comfort that had been established with the care provider they selected for prenatal visits. However, those they encountered during delivery and postpartum care were unfamiliar to them. This means they had less time to establish trust and rapport, which could further exacerbate experiences of racism. Participants recounted increased levels of distress and a lack of communication during delivery and postpartum care. Participants were shuffled to the OR for unplanned C-Sections with no communication, separated from their partners, and had to visit the nurses’ station themselves when monitors and alarms rang. For many participants, these

experiences were years ago. Yet they described them with pain on their faces and in harrowing detail, with some participants crying. They have carried the burden of these experiences with them.

The lack of adequate and appropriate care could be related to company culture and practices within hospitals. Participants reported utilizing teaching hospitals and being seen by attendants or other medical professionals who were still in training. This can create a disconnect for practitioners who are unsure of the best steps to provide quality care. Participants also had to navigate the added stress of deciding whether to allow trainees to participate in their birth. One participant recalled at least 20 people in her room after she chose the suction method for her VBAC. In addition to training status, participants reported hospitals were understaffed which made it more difficult for nurses to do their job.

A 2015 study found that women who chose midwifery care were less likely to hold back questions or feel discouraged from discussing their concerns and reported better communication with providers (Kozhimannil et al., 2015). The current study supported these findings. Women who engaged with a midwife or doula described feeling more informed, confident in the care provided, and that they had a medical advocate. These participants were also more satisfied with how complications were handled during birth and delivery. This increased satisfaction may be related to having someone present to advocate for their needs or the additional monitoring birth workers provide. Notably, these participants also consistently recommended a doula or midwife when asked about improvements that could be made to Black prenatal care. Midwifery and doula care was described by participants as individualized and they expressed that they never felt rushed. This suggests that women have a desire to be treated as more than a patient, they want to be treated as a person.

Scope and Limitations

There were multiple notable limitations of the study, including the sample. The women participating in the study live primarily on the East Coast. Cultural experiences and norms differ geographically in the United States, and future research should include a broader geographic sample. The sample only included straight, cisgender women, so the experiences do not include those who are not part of the gender binary. The audio for two of the interviews was corrupted and could not be transcribed. Although notes were taken for each interview conducted, the audio corruption decreased the availability of direct quotes from the participants.

It should be noted that the sample size (12) is considered small, however generalizability for qualitative research is difficult to achieve even with larger sample sizes. The experiences described are unique and nuanced, so increasing sample size will inform researchers but not necessarily generate generalizable findings. However, saturation was achieved which was the goal for the present study. Some participants had difficulty recalling the particulars of their experiences with prenatal care providers or during their delivery. The data is reliant on participants' ability to accurately represent what occurred, which can be compromised when data collection is years after the experience.

Implications of the Study Findings

Theoretical and Practical Contributions

A large part of qualitative research is determining how findings can be applied to improve the communities of interest so that researchers do not take without contributions. Quite a few organizations study disparities in perinatal care and outcomes. The Virginia Neonatal and Perinatal Collaborative works toward improving perinatal and infant care by performing quality improvement initiatives. They emphasize a "data-driven collaborative process." Birth in Color is

a Virginia-based non-profit organization that aims to raise awareness about maternal health and reproductive justice. The organization provides racial bias training for healthcare providers and aids community members in accessing birth workers pre-and post-birth. They also provide easily accessible pre- and postnatal mental health screening forms. Working with such organizations would allow the data to be presented in settings where it can be applied and utilized for training, policy creation, and educational materials. This application allows for the practical utilization of the materials to provide tangible benefits to the community. Similar benefits and programs can be replicated in other geographic areas.

Clinical Contributions

Black women often face race-related healthcare trauma stemming from historical injustices, biases, and systemic racism within the healthcare system. Disparities in maternal care, high rates of maternal mortality, and inadequate attention to Black women's health concerns contribute to this trauma. The findings of the present study can serve as a valuable foundation for developing targeted therapeutic interventions aimed at improving healthcare experiences and outcomes for this demographic. The identification of key issues presented in the themes and codes can aid clinicians in the design and implementation of interventions that address these specific concerns. The interviews also highlighted struggles participants encountered with mental health, and a subsequent lack of resources. The individual interviews provide support of the narrative approach to support Black women in processing their emotions and lived experiences. Additionally, this space to narrate could focus on empowering Black women to advocate for themselves within healthcare settings, providing them with tools and strategies to navigate challenging interactions and assert their preferences and needs effectively. Multiple participants discussed utilizing mental health resources, this is an opportunity to provide emotional care they

may not receive elsewhere. Through tailored therapeutic interventions informed by the study's findings, healthcare systems can work towards dismantling barriers, fostering trust, and promoting more equitable and inclusive care experiences for Black women during pregnancy, childbirth, and beyond.

Suggestions for Future Research

Future research could be enhanced by including a larger sample size. This increases the scope of experiences researchers can draw from. A larger sample size would also allow for more in-group diversity. In-group diversity can help uncover patterns that may not be as apparent when the group's demographics are more homogenous. Future research would benefit from implementing scales with proven validity and reliability for focus group participants. If mothers are screened with scales such as the Edinburgh Postnatal Depression Scale or the Generalized Anxiety Disorder Scale-7 and then reassessed after delivery, consistent data will be available. Eligibility requirements should also be modeled to capture the same pre/perinatal periods. For example, mothers must have completed screening in the first trimester and completed the follow-up within six weeks after birth.

Despite all participants being asked the same questions, the time of the interviews varied significantly. Some of this can be attributed to differences in experiences, but it should be considered by future researchers to re-examine the questions. Future questions may examine how participants selected their care providers, if participants experienced colorism, what after-care/post-natal care was provided, what method of delivery was used, and how they accessed the mental health resources they used. Several participants reported the racial demographics of their healthcare staff, and it could be helpful for researchers to identify the racial demographics of the neighborhoods in which participants live. This would allow researchers to further investigate

how community-level factors, such as neighborhood segregation, access to resources, and regional historical injustices, influence healthcare experiences and outcomes.

References

Accortt, E. E., & Wong, M. S. (2017). It Is Time for Routine Screening for Perinatal Mood and Anxiety Disorders in Obstetrics and Gynecology Settings. *Obstetrical & Gynecological Survey*, *72*(9), 553–568. https://doi.org/10.1097/ogx.0000000000000477

Hall, L. (1996). African-American women and postpartal depressive symptoms. *Unpublished manuscript*.

ACOG Statement on Depression Screening. (2016, January 26). Www.acog.org; ACOG. https://www.acog.org/news/news-releases/2016/01/acog-statement-on-depression-screening

Adebayo, C. T., Parcell, E. S., Mkandawire-Valhmu, L., & Olukotun, O. (2022). African American women's maternal healthcare experiences: A critical race theory perspective. *Health Communication*, *37*(9), 1135-1146.

Adler, H. M. (2002). The sociophysiology of caring in the doctor-patient relationship. *Journal of General Internal Medicine*, *17*(11), 883–890. https://doi.org/10.1046/j.1525-1497.2002.10640.x

Agar, M., & MacDonald, J. (1995). Focus Groups and Ethnography. *Human Organization*, *54*(1), 78–86. https://doi.org/10.17730/humo.54.1.x102372362631282

Alhusen, J. L., Bower, K. M., Epstein, E., & Sharps, P. (2016). Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. *Journal of Midwifery & Women's Health*, *61*(6), 707–720. https://doi.org/10.1111/jmwh.12490

Ananya Suresh Iyengar, Tsachi Ein-Dor, Emily Xujia Zhang, Chan, S. J., Kaimal, A. J., & Dekel, S. (2021). Racial and ethnic disparities in maternal mental health during COVID-

19. *MedRxiv (Cold Spring Harbor Laboratory)*. https://doi.org/10.1101/2021.11.30.21265428

Armstrong, K., Putt, M., Halbert, C. H., Grande, D., Schwartz, J. S., Liao, K., Marcus, N., Demeter, M. B., & Shea, J. A. (2013). Prior Experiences of Racial Discrimination and Racial Differences in Health Care System Distrust. *Medical Care*, *51*(2), 144–150. https://doi.org/10.1097/mlr.0b013e31827310a1

Attanasio, L. B., & Hardeman, R. R. (2019). Declined care and discrimination during the childbirth hospitalization. *Social Science & Medicine*, *232*, 270–277. https://doi.org/10.1016/j.socscimed.2019.05.008

Attanasio, L., & Kozhimannil, K. B. (2017). Health Care Engagement and Follow-up After Perceived Discrimination in Maternity Care. *Medical Care*, *55*(9), 830–833. https://doi.org/10.1097/mlr.0000000000000773

Beck, C. T. (2001). Predictors of Postpartum Depression: An Update. *Nursing Research*, *50*(5), 275. https://journals.lww.com/nursingresearchonline/Fulltext/2001/09000/A_Meta_Analysis_of_the_Relationship_Between.00004.aspx?casa_token=ndLabI6PuMYAAAAA:j8ziLS_ZGoEArWvx0t7yO5XIqFfxz-MYbaM1zFtiTYwcHYrZ19fxrimCKklrA0c00fe-_RMDcrWX9w3DO9ft2XQ

Belsky, J., & Pensky, E. (1988). Marital Change Across the Transition to Parenthood. *Marriage & Family Review*, *12*(3-4), 133–156. https://doi.org/10.1300/j002v12n03_08

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Bronfenbrenner, U. (2000). *Ecological systems theory*. American Psychological Association.

Byrnes, L. (2018). Perinatal Mood and Anxiety Disorders. *The Journal for Nurse Practitioners*, *14*(7), 507–513. https://doi.org/10.1016/j.nurpra.2018.03.010

Carty, D. C., Kruger, D. J., Turner, T. M., Campbell, B., DeLoney, E. H., & Lewis, E. Y. (2011). Racism, Health Status, and Birth Outcomes: Results of a Participatory Community-Based Intervention and Health Survey. *Journal of Urban Health*, *88*(1), 84–97. https://doi.org/10.1007/s11524-010-9530-9

Collins, C. C., Rice, H., Bai, R., Brown, P. L., Bronson, C., & Farmer, C. (2021). "I felt like it would've been perfect, if they hadn't been rushing": Black women's childbirth experiences with medical providers when accompanied by perinatal support professionals. *Journal of Advanced Nursing*, *77*(10), 4131–4141. https://doi.org/10.1111/jan.14941

Cooper, P. J., & Murray, L. (1995). Course and Recurrence of Postnatal Depression. *British Journal of Psychiatry*, *166*(2), 191–195. https://doi.org/10.1192/bjp.166.2.191

Dahlem, C. H. Y., Villarruel, A. M., & Ronis, D. L. (2014). African American Women and Prenatal Care. *Western Journal of Nursing Research*, *37*(2), 217–235. https://doi.org/10.1177/0193945914533747

Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., & Herrlich, A. (2014). Major Survey Findings of Listening to MothersSM III: New Mothers Speak Out. *The Journal of Perinatal Education*, *23*(1), 17–24. https://doi.org/10.1891/1058-1243.23.1.17

Etowa, J. (2012). Black Women's Perceptions of Supportive Care During Childbirth. *International Journal of Childbirth Education* |, *27*(1).

Fleszar, L. G., Bryant, A. S., Johnson, C. O., Blacker, B. F., Aravkin, A., Baumann, M., Dwyer-Lindgren, L., Kelly, Y. O., Maass, K., Zheng, P., & Roth, G. A. (2023). Trends in State-

Level Maternal Mortality by Racial and Ethnic Group in the United States. *JAMA*, *330*(1), 52–61. https://doi.org/10.1001/jama.2023.9043

Gadson, A., Akpovi, E., & Mehta, P. K. (2017). Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Seminars in Perinatology*, *41*(5), 308–317. https://doi.org/10.1053/j.semperi.2017.04.008

Gjerdingen, D. K., & Yawn, B. P. (2007). Postpartum Depression Screening: Importance, Methods, Barriers, and Recommendations for Practice. *The Journal of the American Board of Family Medicine*, *20*(3), 280–288. https://doi.org/10.3122/jabfm.2007.03.060171

Green, N. (1990). Stressful events related to childbearing in African-American women *1A pilot study. *Journal of Nurse-Midwifery*, *35*(4), 231–236. https://doi.org/10.1016/0091-2182(90)90116-m

Hamilton, B. E., Joyce, M., Michelle, Curtin, S. C., & J, M. T. (2014). Births : final data for 2014. *Cdc.gov*, *64*. https://stacks.cdc.gov/view/cdc/36961

Hartlep, N. D. (2009). Critical Race Theory An Examination of its Past, Present, and Future Implications. *Online Submission*.

Hausmann, L. R., Hannon, M. J., Kresevic, D. M., Hanusa, B. H., Kwoh, C. K., & Ibrahim, S. A. (2011). Impact of perceived discrimination in healthcare on patient-provider communication. *Medical care*, *49*(7), 626-633.

Hernandez, N. D., Francis, S., Allen, M., Bellamy, E., Sims, O. T., Oh, H., Guillaume, D., Parker, A., & Chandler, R. (2022). Prevalence and predictors of symptoms of Perinatal Mood and anxiety Disorders among a sample of Urban Black Women in the South.

Maternal and Child Health Journal, *26*(4), 770–777. https://doi.org/10.1007/s10995-022-03425-2

Hernandez, N., Francis, S., Evans, B., Parker, A., Dorsey, J., Glass, D., & Chandler, R. (2022). Addressing Maternal Mental Health among Black Perinatal Women in Atlanta, Georgia: a CBPR approach. *Journal of the Georgia Public Health Association*, *8*(3). https://doi.org/10.20429/jgpha.2022.080314

Julia Chinyere Oparah, Arega, H., Dantia Hudson, Jones, L., Talita Oseguera, & Black Women Birthing Justice. (2018). *Battling over birth : Black women and the maternal health care crisis*. Praeclarus Press.

Kane Fj, Pa, L., Lokey, L., Chafetz, N., Auman, R., Pocuis, L., & Ma, L. (1971). Post-partum depression in Southern black women. *PubMed*, *32*(7), 486–489.

Kendig, S., Keats, J. P., Hoffman, M. C., Kay, L. B., Miller, E. S., Moore Simas, T. A., Frieder, A., Hackley, B., Indman, P., Raines, C., Semenuk, K., Wisner, K. L., & Lemieux, L. A. (2017). Consensus Bundle on Maternal Mental Health: Perinatal Depression and Anxiety. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *46*(2), 272–281. https://doi.org/10.1016/j.jogn.2017.01.001

Kozhimannil, K. B., Attanasio, L. B., Yang, Y. T., Avery, M. D., & Declercq, E. (2015). Midwifery care and patient–provider communication in maternity decisions in the United States. *Maternal and child health journal*, *19*, 1608-1615.

Lindahl, V., Pearson, J. L., & Colpe, L. (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archives of Women's Mental Health*, *8*(2), 77–87. https://doi.org/10.1007/s00737-005-0080-1

Lori, J. R., Yi, C. H., & Martyn, K. K. (2010). Provider Characteristics Desired by African American Women in Prenatal Care. *Journal of Transcultural Nursing*, *22*(1), 71–76. https://doi.org/10.1177/1043659610387149

Luca, D. L., Garlow, N., Staatz, C., Margiotta, C., & Zivin, K. (2019). Societal costs of untreated perinatal mood and anxiety disorders in the United States. *Mathematica Policy Research*, *1*.

Major, B., Dovidio, J. F., & Link, B. G. (2018). *The Oxford handbook of stigma, discrimination, and health*. Oxford University Press.

Mann, R. J., Abercrombie, P. D., Dejoseph, J., Norbeck, J. S., & Smith, R. T. (1999). The Personal Experience of Pregnancy for African-American Women. *Journal of Transcultural Nursing*, *10*(4), 297–305. https://doi.org/10.1177/104365969901000408

Masango, S., Rataemane, S., & Motojesi, A. (2008). Suicide and suicide risk factors: A literature review. *South African Family Practice*, *50*(6), 25–29. https://doi.org/10.1080/20786204.2008.10873774

McCauley, M., Brown, A., Ofosu, B., & van den Broek, N. (2019). "I just wish it becomes part of routine care": healthcare providers' knowledge, attitudes and perceptions of screening for maternal mental health during and after pregnancy: a qualitative study. *BMC Psychiatry*, *19*(1). https://doi.org/10.1186/s12888-019-2261-x

McClendon, J., Chang, K., Boudreaux, M. J., Oltmanns, T. F., & Bogdan, R. (2021). Black-White racial health disparities in inflammation and physical health: Cumulative stress, social isolation, and health behaviors. *Psychoneuroendocrinology*, *131*, 105251.

McKee, K., Admon, L. K., Winkelman, T. N. A., 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). https://doi.org/10.1186/s12905-020-00996-6

Medin, D., Bennis, W., & Chandler, M. (2010). Culture and the Home-Field Disadvantage. *Perspectives on Psychological Science*, *5*(6), 708–713. https://doi.org/10.1177/1745691610388772

Misri, S., & Kendrick, K. (2007). Treatment of Perinatal Mood and Anxiety Disorders: A Review. *The Canadian Journal of Psychiatry*, *52*(8), 489–498. https://doi.org/10.1177/070674370705200803

Murray, L., Woolgar, M., Murray, J., & Cooper, P. (2003). Self-exclusion from health care in women at high risk for postpartum depression. *Journal of Public Health*, *25*(2), 131–137. https://doi.org/10.1093/pubmed/fdg028

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-based nursing*, *18*(2), 34-35.

Onwuachi-Saunders, C., Dang, Q. P., & Murray, J. (2019). Reproductive rights, reproductive justice: Redefining challenges to create optimal health for all women. *Journal of Healthcare, Science and the Humanities*, *9*(1), 19.

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology*, *35*(4), 888–901. https://doi.org/10.1093/ije/dyl056

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLOS ONE*, *10*(9), 1–48. https://doi.org/10.1371/journal.pone.0138511

Parker, J. D. (1994). Ethnic differences in midwife-attended US births. *American Journal of Public Health*, *84*(7), 1139-1141.

Peters, R. M., Benkert, R., Templin, T. N., & Cassidy-Bushrow, A. E. (2014). Measuring African American Women's Trust in Provider During Pregnancy. *Research in Nursing & Health*, *37*(2), 144–154. https://doi.org/10.1002/nur.21581

Phelan, A., & Kirwan, M. (2020). Contextualising missed care in two healthcare inquiries using a socio-ecological systems approach. *Journal of Clinical Nursing*, *29*(17-18), 3527-3540.

Preeclampsia: MedlinePlus Medical Encyclopedia. (n.d.). Medlineplus.gov. Retrieved May 8, 2023, from https://medlineplus.gov/ency/article/000898.htm

racism noun - Definition, pictures, pronunciation and usage notes | Oxford Advanced Learner's Dictionary at OxfordLearnersDictionaries.com. (n.d.). Www.oxfordlearnersdictionaries.com. Retrieved October 9, 2023, from https://www.oxfordlearnersdictionaries.com/us/definition/english/racism

Riggan, K. A., Gilbert, A., & Allyse, M. A. (2020). Acknowledging and Addressing Allostatic Load in Pregnancy Care. *Journal of Racial and Ethnic Health Disparities*, *8*. https://doi.org/10.1007/s40615-020-00757-z

Roberts, D. (2014). *Killing the black body: Race, reproduction, and the meaning of liberty*. Vintage.

Ross, L. (2007). Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change. *Reproductive Technologies*, 4-6

Sable, M. R., & Wilkinson, D. S. (1999). The Role of Perceived Stress on Prenatal Care Utilization: Implications for Social Work Practice. *Health & Social Work*, *24*(2), 138–146. https://doi.org/10.1093/hsw/24.2.138

Segre, L. S., & Davis, W. N. (2013, June). *Postpartum depression and perinatal mood disorders in ...* Postpartum Support International. https://www.postpartum.net/wp-content/uploads/2014/11/DSM-5-Summary-PSI.pdf

Simien, E. M., & Clawson, R. A. (2004). The Intersection of Race and Gender: An Examination of Black Feminist Consciousness, Race Consciousness, and Policy Attitudes*. *Social Science Quarterly*, *85*(3), 793–810. https://doi.org/10.1111/j.0038-4941.2004.00245.x

Steele, C. M., Spencer, S. J., & Aronson, J. (2002). Contending with group image: The psychology of stereotype and social identity threat. In *Advances in experimental social psychology* (Vol. 34, pp. 379-440). Academic Press.

Technical Working Group, World Health Organization. (1997). Care in normal birth: a practical guide. *Birth*, *24*(2), 121-123.

Trost, S. L., Beauregard, J. L., Smoots, A. N., Ko, J. Y., Haight, S. C., Moore Simas, T. A., Byatt, N., Madni, S. A., & Goodman, D. (2021). Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008–17. *Health Affairs*, *40*(10), 1551–1559. https://doi.org/10.1377/hlthaff.2021.00615

Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., ... & Powell Kennedy, H. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. *PloS one*, *13*(2), e0192523.

Vetterly, S., Kaselitz, E. B., Doswell, W., & Braxter, B. (2024). A Qualitative Exploration of Self-Advocacy Experiences of Black Women in the Perinatal Period: Who Is Listening?. *Journal of Midwifery & Women's Health*.

Warren, B. J. (1997). Depression, stressful life events, social support, and self-esteem in middle class African American women. *Archives of Psychiatric Nursing*, *11*(3), 107–117. https://doi.org/10.1016/s0883-9417(97)80033-7

Wiltshire, J., Cronin, K., Sarto, G. E., & Brown, R. (2006). Self-advocacy during the medical encounter: use of health information and racial/ethnic differences. *Medical care*, *44*(2), 100-109.

Appendices

Research Instruments

A. Interview Questions

1. How did you feel after giving birth?
2. Were you comfortable interacting with your healthcare providers?
3. How would you describe your mood when interacting with healthcare providers?
4. Did you notice anything in particular about the affect of your healthcare providers?
5. Were you provided with any mental health screening during your pregnancy or within two months postpartum? If so, please describe them.
6. Did your maternal care providers respect your wishes regarding your birth plan?
7. Did you experience any anxiety or depression during pregnancy?
8. What were some of the contributing factors to any feelings of anxiety or depression you may have experienced up to two months postpartum?
9. What qualities did healthcare providers have that encouraged a positive experience, and which qualities encouraged a negative experience?
10. Did you experience any racism or discrimination from providers during prenatal healthcare visits?
11. What sort of prenatal healthcare providers did you utilize?
12. How did you select what prenatal healthcare providers you wanted to use?
13. Did you utilize any mental health resources during your pregnancy or within the two months following giving birth?
14. How well do you feel any complications were handled during your pregnancy?

15. What reactions did you receive to instances where you advocated for yourself or disagreed with provider recommendations?
16. How involved were you with decision-making regarding your pregnancy and birth?
17. Is there anything else you would like me to know about your pregnancy, birth, or postpartum experience with healthcare providers?

B. Basic Demography Form

1. First name
2. Last name
3. Phone number
4. E-mail
5. Date of birth
6. Age (years)
7. Ethnicity
    a. Hispanic or Latino
    b. Not Hispanic or Latino
    c. Unknown/Not Reported
8. Please select the group(s) that represent(s) your Hispanic/Latino or Spanish origin or ancestry.
    a. Mexican
    b. Puerto Rican
    c. Cuban
    d. Dominican Republic
    e. Costa Rican

f. Guatemalan

g. Honduran

h. Nicaraguan

i. Panamanian

j. Salvadoran

k. Other Central American

l. Argentinean

m. Bolivian

n. Chilean

o. Colombian

p. Ecuadorian

q. Paraguayan

r. Peruvian

s. Uruguayan

t. Venezuelan

u. Other South American

v. Filipino

w. Spaniard

x. Spanish

Spanish American

y. Hispano/Hispana, Hispano/Hispana

z. Hispanic/Latino, Hispanic/Latino

aa. Other Hispanic/Latino (specify)

bb. Chicano

cc. Refused

dd. Don't know

9. Highest level of education completed

    a. No schooling

    b. 8th grade/less

    c. 9-11 grades

    d. High school

    e. Technical or trade school

    f. Some college

    g. Associate degree (e.g., AA, AS)

    h. Bachelor's degree (e.g., BA, AB, BS)

    i. Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)

    j. Doctoral degree (e.g., PhD, EdD)

    k. Professional degree (e.g., MD, DDS, DVM, LLB, JD)

10. Race

    a. American Indian/Alaska Native

    b. Asian

    c. Native Hawaiian or Other Pacific Islander

    d. Black or African American

    e. White

11. What terms best express how you describe your gender identity?

    a. Woman

b. Man

c. Non-binary

d. Transgender man/Female-to-male (FTM)

e. Transgender woman/Male-to-female (MTF)

f. Gender non-binary/Genderqueer/Gender nonconforming

g. Agender

h. Bigender

i. None of these describe me

j. Prefer not to answer

12. Sexual orientation

a. Lesbian

b. Gay

c. Straight

d. Bisexual

13. What is your assigned sex at birth?

a. Female

b. Male

14. Employment Status

a. Full Time Working now or paid sick leave/parental leave/family leave/administrative leave

b. Part-Time Work or Hourly less than full time

c. Only temporarily laid off, or unpaid sick leave/parental leave/family leave/administrative leave

d. Looking for work, unemployed

e. Retired

f. Disabled, permanently or temporarily

g. Raising children full-time, full-time caregiver, or keeping house

h. Student

i. Other/specify:, Other/specify:

15. Annual Household Income Range

a. Less than $10,000

b. $10,000-$24,999

c. $25,000-$34,999

d. $35,000-$49,999

e. $50,000-$74,999

f. $75,000-$99,999

g. $100,000-$149,999

h. $150,000-$199,999

i. $200,000 or more

j. Prefer not to say.

16. What is your role at work?

17. Does your job offer paid maternity leave?

a. Yes

b. No

18. Marital status

a. Married

b. Living as married or living with a romantic partner

c. Married or partnered, but not living together Divorced

d. Widowed

e. Separated

f. Single, never been married-not living with romantic partner

g. Prefer not to answer

19. Height (inches)

20. Weight (pounds)

21. Where did you give birth?

22. Which of the following healthcare providers did you use during your pregnancy?

a. OBGYN

b. Doula

c. Midwife

d. Nurse Practitioner Family Medicine Doctor

e. Other

23. Please list any other healthcare providers you saw for prenatal care?

24. Do you have any chronic health conditions? If so, please list them here.

25. Please indicate if you are willing to be contacted for future research on the same subject.

a. Yes

b. No