Issue Brief: Black Maternal Mental Health

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Top Lines:

Chronic stress from racism, rather than race, is a risk factor for maternal mental health disorders. Chronic stress and higher levels of lifetime exposure to trauma increase adverse health and mental health outcomes for Black women, culminating in even higher levels of stress.

Discrimination, racism, and inequities in the maternity care system greatly increase the risk for maternal mental health disorders for Black women. Policy recommendations include increasing Black and BIPOC providers, utilizing non-clinical professionals such as peer support specialists and community health workers, and supporting community-based organizations.

Introduction:

Maternal mental health disorders are the most common complication of childbirth. Up to 20% of women experience maternal mental health disorders such as maternal depression and anxiety during the perinatal or postpartum period.[1] The estimated economic cost of untreated maternal mental health disorders over five years is $14.2 billion.[2] The societal impact of maternal mental health disorders is pervasive, with far-reaching consequences on early childhood development, pediatric mental health, and general family well-being.[3,4] While mothers of any race can face maternal mental health disorders during pregnancy and the postpartum period, women of color are especially vulnerable. Black women have increased risk factors for maternal mental health disorders due to higher levels of trauma exposure throughout their lifetime; Research indicates that trauma exposure rates (defined as exposure to at least one traumatic event) during the perinatal period is 87% for Black women.[5] These are much higher rates of trauma exposure when compared to the rates of trauma in perinatal women, which range from 29-74%.[6–8]

Higher rates of trauma exposure, combined with being 3-4 times more likely to experience dangerous complications during birth, significantly increase the risk of maternal mental health disorders, including birth trauma and post-traumatic stress disorder, for Black women.[9] Other trauma-related risk factors for maternal mental health disorders in Black women include

exposure to negative drivers of health (DOH), chronic stress, and gendered racism across the lifespan.[10–12]

Risk Factors

Drivers of Health (DOH)

According to the US Department of Health and Human Services (HHS), social determinants of health (SDOH), now referred to as Drivers of Health (DOH), are defined as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[10,13] Black Americans have a higher DOH burden, which was further exacerbated by the COVID-10 pandemic, resulting in increased health and social disparities.[14] Additionally, Black women experience unique disparities at the intersection of gender and race that are often not shared by Black men and White women. These disparities include high levels of sexism, discrimination, gender-related violence, and racism--all risk factors for maternal mental health disorders.[15,16]

Racism and Weathering

Chronic stress from racism, rather than race, is a risk factor for maternal mental health disorders.[11] Chronic stress increases adverse health and mental health outcomes for Black women, culminating in even higher levels of stress. This cycle of persistent intergenerational stress is known as "weathering," defined as "a chain of biological processes that undermine Black women's physical and mental health."[17] For example, Black women have increased stress exposure due to a higher prevalence of cardiometabolic (CM) conditions, such as hypertension, diabetes, and obesity, which are linked to elevated risk for depressive symptoms.[18] At the same time, maternal depression has been linked to poor maternal and birth outcomes for Black women, resulting in a higher risk of preterm births, low birth weight, gestational diabetes, and preeclampsia.[19] This chain of biological processes that contribute to adverse mental and physical outcomes for Black women delineates the process and impact of weathering.

Discrimination, racism, and inequities in the maternity care system also greatly increase the risk for maternal mental health disorders in Black women. Research shows that Black women who felt upset due to the experience of racism in the year before delivery experienced significantly higher odds of depression during pregnancy.[12] Black women, along with other women of color, reported higher rates of mistreatment, defined as "loss of autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help," during hospital births.[20] Women of color as well as women with lower socioeconomic status (SES), also reported lower quality of care during hospital births.[20] It is theorized that these culminating systemic, societal, and environmental factors play a huge role in Black women having higher rates of maternal mental health disorders and maternal mortality rates than White women.[21]

Black women also experience one of the highest rates of intimate partner violence (IPV) in the US. IPV is a risk factor for depression, PTSD, anxiety, and suicide and is associated with increased SDOH burden. The threat or presence of IPV is yet another stress and trauma-inducing factor for Black women. Women during the perinatal period are especially vulnerable to

IPV. Additionally, IPV is especially prevalent in minority and underserved populations, making it a notable risk factor for maternal mental health disorders in Black women.[16]

Due to a complex mix of SDOH, racism, weathering, and increased stress due to these various factors, Black women are disproportionately at risk for poor health and mental health outcomes, which includes poor maternal mental health outcomes.[15] Therefore, risk factors for maternal mental health disorders in Black women should be examined through the lens of equity and holistic wellness to better address gaps that can support the mental and physical wellness of Black women.[15]

Prevalence

Depression and Anxiety

There is a growing recognition that rates of postpartum depression and anxiety are higher among Black women, with some estimates more than double compared to their White counterparts.[22] The risk for postpartum depression increases in Black women living in smaller cities or rural communities, with research showing rates of postpartum depression at 80 percent higher for Black women when compared to their white counterparts.[23]

Dysthymia and Somatic Symptoms

It should be noted that depression in Black women may often not present in psychological symptoms but manifest in somatic symptoms. While Blacks have a lower prevalence of major depressive disorder (MDD), some research shows that Blacks, especially Black women, have a higher prevalence of dysthymia.[24] Some clinicians have labeled this increased prevalence of dysthymia in Blacks as “Cultural Dysthymia,” attributing it to historical inequities and discrimination.[25] Other researchers classify these somatic symptoms as part of a wider symptom presentation of depression that is unique to Black women.[18] It is important for clinicians and healthcare workers to recognize the range of presentation of dysthymia and general depression in Black women so that clinical identification of these disorders is not overlooked.[18]

Post-traumatic Stress Disorder (PTSD)

The correlation between race/ethnicity and PTSD within pregnant women and new mothers has not been largely studied, but one comparative analysis of cross-sectional data from a cohort study suggests that the current prevalence of PTSD is four times higher in Black women.[26] This was largely because Black women have higher rates of trauma exposure throughout their lifetime, leading to higher rates of PTSD during pregnancy.[27] The study noted peak traumatic exposure occurring between 16-20 years of age, which is close to the age at which many Black women experience pregnancy, creating the threat of PTSD onset.[26] The analysis also found that

socioeconomic status did not play a significant role in determining PTSD risk in Black women, making trauma the greatest predictor for PTSD in Black women.[26] Additionally, there is generally a lack of trust between Black women and healthcare providers, which increases the risk for birth trauma, which then raises the subsequent risk for PTSD and other MMH disorders.[9]

Suicide

Suicide is a leading cause of maternal death during the postpartum period and is often associated with PPD and drug overdose.[28] Studies approximate that 14-30% of reported maternal deaths are accounted for by suicide and accidental drug overdose.[29] Studies also show that Black women have higher rates of suicidal ideation, which are thoughts of suicide. In the immediate postpartum period, Black women are 2 times more likely to report suicidal ideation than white women.[30]

Barriers to Treatment and Care

Approximately 15% of women diagnosed with postpartum depression receive treatment.[31] While undertreatment of postpartum depression is prevalent in the general population, Black women are even less likely to initiate treatment for postpartum depression.[32] One study found that Black women were half as likely than White women to initiate treatment and had a longer time gap between delivery and treatment initiation.[32] Women who receive delayed treatment, undertreatment, or no treatment of maternal mental health disorders are more likely to have severe symptoms and negative postpartum outcomes.

Black and other minority women face difficulties regarding access to care on four different levels - individual, organizational, sociocultural, and structural.[33] Individual barriers include stigma or not being informed of resources, organizational barriers include lack of resources and service fragmentation, sociocultural level issues include cultural and language barriers, and structural barriers include unclear policies.[33] Nearly 60 percent of Black mothers do not receive any support or treatment for prenatal or postnatal mental health care due to these factors.[34]

Sociocultural barriers play a significant role in whether or not individuals seek out care; for example, some cultures do not acknowledge mental health as a whole, creating barriers to care due to limited access to information or stigma and fear.[35] These studies suggest that cultural competency training in maternal healthcare settings is a critical consideration in addressing how to treat women from all races and ethnicities.

Despite the higher rate of MMH disorders among Black women, the mental health workforce is not reflective of the moms in need of care. A 2020 American Psychological Association (APA) Center for Workforce Studies (CWS) report found that 84% of the psychology workforce

identified as White, while only 4% identified as Black.[36] These disparities highlight the importance of diversifying the mental health workforce and considering community-based behavioral health services.

The use of community-based behavioral health services is important to addressing maternal mental health issues in Black women in a culturally congruent and sensitive manner. One example is the use of the federal Healthy Start Initiative, a national maternal child health program, to implement comprehensive, culturally appropriate community-based health and behavioral health case management for Black women.[37] This program integrated risk factors that are unique to Black women, such as chronic stress and racism, into its strategic plan for addressing perinatal depression for Black women, making care more sensitive to the specific needs of Black women.[37]

Additionally, various studies have demonstrated the effectiveness of implementing healthcare interventions in a predominately Black church setting. As spirituality and ancestral traditions are important to Black culture, incorporating maternal mental health support and interventions in a trusted spiritual setting for Black women is critical to better addressing the needs of Black moms.[38–41]

Screening for Black Women

Despite having an elevated risk for depression due to increased stress due to the high prevalence of cardiometabolic conditions, research shows that depressive symptoms in Black women may not be detected via standard depression screening tools.[18] As screening tools were historically created and informed by White research participants, there has been increased discussion as to whether maternal depression screening tools such as the Patient Health Questionnaire 9 (PHQ-9) and Edinburgh Postnatal Depression Scale (EPDS) are valid or sensitive to the cultural nuances of non-White women, specifically Black women,[42] Until more validated screening tools are developed to specifically address the maternal mental health screening needs of Black women and other persons of color, it has been recommended that a lower screening score cut-off be used for Black women.[43]

It is important to consider how acculturation, cultural stigmas, or immigration status may skew self-reported rates of maternal mental health disorders, creating further need for screening protocols within healthcare settings.[44] The Policy Center for Maternal Mental Health addressed this concern in the 2022 issue brief *Universal Screening for Maternal Mental Health Disorders:*[45]

> Dr. Alfiee Breland-Noble conducts research on health disparities in mental health screening, diagnosis, and treatment. She found that the screening tools referenced above are often less relevant for mothers of color. These screening tools were developed and

tested with mostly white research participants and did not take cultural differences into account. In an interview with National Public Radio (NPR), Dr. Breland-Noble said Black people are less likely to use the term "depression," rather they may say that they "do not feel like themselves." She also notes that ethnically and racially diverse people suffering from mental illness often experience symptoms as physical symptoms, such as stomach aches and migraines.[42] Research has found that these screening tools are not catching as many mothers as they should, particularly when looking at moms of color or those who are low-income.[46]

Also noted in the Policy Center for Maternal Mental Health's Universal Screening for Maternal Mental Health Disorders[45] brief are several tools that are culturally appropriate and validated for the detection of maternal mental health challenges in the Black population. The Healthy Pregnancy Stress Scale (HPSS) offers a pregnancy-specific stress scale validated in a population of low-income African-American women but designed for use in diverse populations. This is important for understanding the relationship between structural inequities, pregnancy stress, and pregnancy health. This internally validated tool has the potential to function as a quick assessment of the pregnancy environment.[47] Additional tools include the Perceived Pre-Natal Maternal Stress Scale (PPNMSS),[48] Tilburg Pregnancy Distress Scale (TPDS),[49] and Brief Pregnancy Experience Scale (PES.)[50]

Screening, even if successful in the identification of disorders, must be followed up to initiate treatment. While follow-up is a crucial part of treating maternal mental health disorders, it is especially paramount to focus on follow-ups for Black women to maximize their chances for a successful recovery.

Community Recommendations

According to *Pathways To Equitable And Antiracist Maternal Mental Health Care: Insights From Black Women Stakeholders*, a study based on insights from Black women community members in the maternal mental health community, highlighted 5 key pathways to address racism and inequities for Black women in maternal health.[40] These pathways are:

- Educating and training maternity care and mental health practitioners, such as Ob-Gyns, therapists, and doulas.
- Investing in the Black women's maternal health and mental health workforce, including Ob-Gyns, midwives, doulas, licensed mental health providers, certified peer specialists, and certified community health workers.
- Investing in Black women-led, community-based organizations providing group support, education, and other community-based resources.
- Valuing, honoring, and investing in traditional healing/ancestral practices.
- Promoting shared decision-making by patients in their treatment and care.
- Integrating maternal mental healthcare practitioners within maternal healthcare.[40]

Policy Recommendations

1. **Increase the number of Black and BIPOC mental health and community health professionals.**

    a. Lawmakers should consider financial support to develop and recruit students into education programs for professions such as licensed counselors, certified peer support specialists, and certified community health workers through public community colleges and state universities.

    b. States should also leverage funding through the federal Workforce Innovation and Opportunity Act (WIOA) to identify and enroll behavioral health training as qualified programs and target specific initiatives and programs focused on engagement and recruitment in diverse racial, ethnic, rural, and other underserved communities.[51]

2. **Increase the number of Black and BIPOC obstetric professionals.**
   Lawmakers and federal and state agencies should provide/promote existing training and scholarship funding to increase the number of Black and BIPOC midwives, Ob/Gyns, and family practice providers. Similar to the federal Health Resource and Services Administration's (HRSA) Rural Maternity and Obstetrics Management Strategies Program, but for Black and BIPOC obstetric providers.

3. **Support embedding CHWs/PSSs in clinical settings with protocols, incentives, and clear billing coding.**
   Certified community health workers (CHWs) and certified peer support specialists (CPSSs) have the potential to reduce distrust of traditional clinical and mental health settings/professionals by supporting culturally competent care. These providers could support maternal mental health screening, provide brief intervention, work with the patient/OB/mental health professional in developing treatment plans, support referral and care coordination to community services, and follow up with the patient. Payors, including the Centers for Medicaid and Medicare Services (CMS), state Medicaid agencies, and private insurers, should incentivize such care by publishing guidelines for supervision and billing codes (including care coordination, integration, and other codes) for obstetricians and licensed mental health professionals.

4. **Test for proficiency in recognizing and addressing personal bias, cultural competence, and maternal mental health.**
   Before issuing licensure/certification/renewal, organizations and state licensing/certifying boards for midwives, doulas, and OB/Gyns should test for proficiency in addressing personal bias, cultural competence, and maternal mental health. These competencies should align with the Policy Center for Maternal Mental Health's provider core competencies for maternal mental health.

5. **Mandate insurers/health plans report provider demographics and conduct network adequacy assessments based on the population served.**
   Demographics such as race, ethnicity, etc., should be collected through the provider network credentials process by insurers/health plans and included in provider directories so patients can easily assess whether a provider meets a patient's race/ethnicity

preferences. Insurers/plans should also conduct network adequacy assessments to ensure providers' demographics align with patient demographics.

6. **Support research and adoption of community-based organizations (CBO) Interventions.**
   Invest in research studying interventions led by CBOs and incentivize the adoption of promising/evidence-based practices through grants, community learning networks, and insurance billing guidance and support.

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