Title

Medical Surveillance in Perinatal Care: Negotiating Constraints, Constructing Risk, and the Elusive Goal of Mental Health Integration

Author

Harrison, Jessica M

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Surveillance Medicine in Perinatal Care: Negotiating Constraints, Constructing Risk, and the Elusive Goal of Mental Health Integration

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Jessica M. Harrison

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Approved:

DocuSigned by:
Janet Shim
A58526EDCCB041A...
Chair

DocuSigned by:
Jennifer Reich
Jennifer Reich
[illegible]01...

DocuSigned by:
Ariana Thompson-Lastad
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Committee Members

“The only way to change the order, she thought, was not to do something differently, but to do a different thing.” —Toni Morrison, *Paradise*

"We are standing on a foundation. It should come as an incredible relief. Our only job is to build on what we've been given, and, even then, even our gifts we can trace back to the creativity, generosity, and foresight of others. Thank God we are a group project." -Kate C. Bowler

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Surveillance Medicine in Perinatal Care: Negotiating Constraints, Constructing Risk, and the Elusive Goal of Mental Health Integration

Jessica M. Harrison

ABSTRACT

Mental health conditions are a leading cause of pregnancy-related death in the United States (U.S.) and they are referred to as the most common complication of childbirth. Pregnancy is a social experience that unfolds differently across cultures and populations, and the perinatal period is emotionally and physically complex and relationally transformative. Yet, the predominant obstetric model of perinatal healthcare in the U.S. does not reflect the multidimensionality of pregnancy and postpartum health, leaving considerable gaps in care. As perinatal health outcomes in the U.S. worsen (e.g., birth and medical trauma; high depression/anxiety, suicide, and drug overdose rates), scholars and advocates have highlighted the intersectional impact of racism and misogyny on pregnancy-related death and injury, including harmful mental health outcomes, most significantly impacting Black and Indigenous women. Creating solutions to improve perinatal health outcomes and equity for all birthing people in the U.S. is urgent and must be responsive to mental health needs and the social, structural, emotional, spiritual, and cultural aspects of perinatal health and healthcare.

This dissertation takes a sociological approach to understanding the dynamics of mental health integration in perinatal healthcare in three key ways, including (1) tracing the implementation of standardized mental health screening and co-location of mental health professionals in obstetric settings, (2) exploring perinatal healthcare clinicians' efforts to attend to their pregnant patients' multifaceted needs, and (3) investigating pregnant and postpartum people's experiences of their perinatal mental healthcare. Using constructivist grounded theory, I conducted 75 hours of ethnographic observation with one behavioral health team embedded in an obstetric setting and 82 in-depth interviews with pregnant and postpartum people and interprofessional perinatal healthcare clinicians between June 2019 and December 2021.

This study reveals the possibilities and consequences of standardized mental health screening and behavioral health team integration in perinatal healthcare, primarily in obstetric settings. I describe how a combination of structural constraints impede obstetric clinicians' ability to address patients' mental health. I illustrate two strategies mental health clinicians use in obstetric settings to navigate high patient volume and the challenges imposed by medical authority and interprofessional hierarchy. These strategies include knowledge brokering to normalize mental health issues in pregnancy and improve their colleagues' competencies and leaning on standardized care logics in the medical model to enforce professional boundaries around their scope of practice. I next show how midwives and obstetricians strive to implement perinatal healthcare that encompasses the mental well-being of pregnant and postpartum people. I describe how this resembles a whole person health framework that is structurally facilitated or impeded in different practice settings. Finally, I demonstrate the consequences of the social construction of risk in obstetric care, arguing that the institution of obstetrics routinely takes up some aspects of health as a cause for concern while diminishing the clinical significance of others. I show how obstetrics' current form of surveillance medicine directly harms pregnant and postpartum people's mental health. Despite it being a well-intended intervention for perinatal health, I found that integrating mental healthcare in biomedically-structured perinatal care leads to challenging interprofessional negotiations and creates a new field of risk for surveillance medicine to address.

In full, this project expands on sociological literatures to analyze perinatal healthcare in the U.S. with a focus on integration of mental health into obstetric settings. I elucidate the consequences of integration, which include enforcement of the mind-body binary, the biomedicalization of pregnancy and childbirth, and the persistent marginalization of midwives and mental health clinicians in the organization of healthcare. This research contributes to our understanding of the misalignment between universal needs and lived experience and the culturally and structurally biomedicalized approach to pregnancy, childbirth, and postpartum in the U.S. It points to the need for policy change and comprehensive care that is better sensitized to mental health as a predominant health-related concern in the perinatal period.

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CHAPTER 1: Introduction

Mental health conditions are a leading cause of pregnancy-related death in the United States (U.S.) and they are referred to as the most common complication of childbirth. Postpartum depression in particular has worked its way into mainstream vernacular in recent years as advocacy efforts have increased public awareness of suffering and emotional stress that commonly occur in pregnancy or follow the birth of a baby. Occasional news stories highlight statistics about mental health in pregnancy and postpartum, reporting that one in five birthing people will develop perinatal depression and are more likely to complete suicide in the year following childbirth than any other time of life (Belluck 2016).

Pregnancy is a social experience that unfolds differently across cultures and populations, and the perinatal period is emotionally, physically, and relationally transformative. People in the perinatal period do not merely experience the physiological process of pregnancy and childbirth, as posited by biomedicine, but are also profoundly impacted by environmental context, social structures, interpersonal relationships, emotions, and psychological factors—all of which constitute mental health (SAMHSA 2023). Early parenthood may include an increase in social stressors such as economic strain (Gjesfjeld et al. 2010; Kimport 2017; Laraia et al. 2006), job insecurity (Grossman and Thomas 2009; Shiu and Wildman 2009), increased risk of violence (Abbott and Williamson 1999; Gomez-Beloz et al. 2009), plus a myriad of emotional experiences and identity transitions inherent to emerging parenthood (Connerty, Roberts, and Sved Williams 2016; Deutsch et al. 1988). Research about perinatal mental health has identified these as risk factors, finding that stressful life events, marital tension, low social support, and socioeconomic strain all have significant effect on mental health (Amankwaa 2003; Robertson et al. 2004).

Yet, the predominant obstetric model of perinatal healthcare in the U.S. does not reflect the multidimensionality of pregnancy and postpartum health, leaving considerable gaps in care. Despite the prevalence of perinatal mental health issues, research shows a majority of people do not receive screening or treatment (Austin and Priest 2005; Rompala et al. 2016). This gap—between the prevalence of mental health concerns during the perinatal period and the lack of services—only compounds already existing issues in perinatal healthcare. Despite intervention-oriented perinatal healthcare costing $111 billion annually, pregnancy-related mortality increased by 136% between 1990 and 2013 (Carroll 2017; Chambers et al. 2019; Ross et al. 2019; Scott, Britton, and McLemore 2019) with 77% higher mortality rates in high poverty states than in wealthier states (Carroll 2017; Chambers et al. 2019; Creanga and Callaghan 2017; Kasthurirathne et al. 2018; MacDorman et al. 2016). Significantly, the mortality rate among Black people in the U.S. is profoundly high and rates of obstetric intervention continue to rise with disparate effects, both of which can be explained in part by obstetric racism (Davis 2019; Masters et al. 2023). Other perinatal health outcomes are also poor and stratified, negatively impacted by a homogenous healthcare workforce, institutionalized racism, and other social and structural determinants of health (Crear-Perry et al. 2021). This paints a picture of perinatal healthcare in the U.S. as a high cost/poor outcomes system plagued by pervasive structural problems, putting into question the efficacy of the prevailing approach to pregnancy, childbirth, and postpartum.

Concerns about the structure of perinatal healthcare, the effects of multiple axes of oppression on perinatal health experiences, and elevated social and emotional stressors through pregnancy and early parenthood (felt even more acutely during the COVID-19 crisis) raise questions about how best to manage the care of perinatal people with multifaceted needs in an under-resourced, low-support society. Most prominently, perinatal health advocates (e.g., Wisner 2014) increasingly emphasize the importance of integrating mental healthcare in obstetrics to effectively address myriad social and emotional issues that bear on perinatal health outcomes. This dissertation takes a sociological approach to understanding the dynamics of mental health integration in perinatal healthcare in three key ways, including (1) tracing the implementation of standardized mental health screening and co-location of mental health professionals in obstetric settings, (2) exploring perinatal care clinicians' efforts to attend to their pregnant patients' multifaceted needs, and (3) investigating pregnant and postpartum people's experiences of their perinatal mental healthcare. Despite it being a well-intended intervention for perinatal health, I found that integrating mental healthcare in biomedically-structured perinatal care leads to challenging interprofessional negotiations and creates a new field of risk for surveillance medicine to address.

The Problematic Turn to Biomedical Behavioral Health

One response to the dissertation's empirical situation that I describe above is advocacy for more mental health screening and treatment during the perinatal period, leading to a sea change in the landscape of perinatal healthcare. Most notably, a legislative trend requiring mental health screening in routine perinatal care emerged alongside prominent health organizations' statements recommending perinatal mental health screening in obstetrics. In 2006, New Jersey became the first state to require screening for postpartum depression (Kozhimannil 2014). In 2016, the *New York Times* (Belluck 2016:2) reported that "in the wake of new evidence that maternal mental illness is more common than previously thought," the United States Department of Health and Human Services issued its first official recommendation to screen for depression during and after pregnancy. Most recently, California passed legislation, effective July 2019, requiring perinatal clinicians to screen for depression at least once perinatally (2020Mom 2020). And the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) both have issued position statements about perinatal depression screening in perinatal care (Rompala et al. 2016).

Routine perinatal care in the United States primarily occurs in obstetric settings and it involves healthcare visits once per month up to week 28 of pregnancy, then increasing to twice per month for weeks 28 through 36, and weekly in the final weeks of pregnancy. Typical postpartum care involves one or two visits around two or six weeks postpartum (USDHHS Office of Women's Health 2023). This visit schedule provides ample opportunity for perinatal patients to have contact with various health professionals who can engage screening procedures or otherwise discuss various health concerns. Since most people interface solely and numerous times with obstetric clinicians in the perinatal period and do not receive specialized mental healthcare, the argument that perinatal healthcare is a crucial front-line intervention to reduce severity and complications associated with perinatal mental health issues makes a great deal of sense on its face. However, it is not a straightforward task to simply require or otherwise expand screening and treatment procedures.

Critics of these emerging protocols point out two main concerns about standardized health screening in biomedical contexts. First, screening is not effective without significant resource expansion for care. The chronic deprioritization of mental healthcare and a lack of mental health training for clinicians have resulted in a dearth of mental health resources in the U.S. This lack of resources, plus variable quality in the care provided, is linked to mental health inequities (Cook et al. 2013, Kozhimannil 2014). Although some perinatal mental health legislation includes expansion of insurance coverage for care, access is a multifaceted problem and the literature points to a complicated confluence of issues at play. Limits imposed by insurance plans, the lack of community mental health centers, and the low density of specialty mental health clinicians are main factors in existing gaps in care—and addressing these systemic problems is a key precursor to enhancing people's perinatal healthcare experiences, particularly given the salience of mental health in the perinatal experience (Cook et al. 2013).

Second, standardized screening for mental health issues, such as depression and anxiety, or social stressors, like intimate partner violence, can cause harm that outweighs potential benefits (Thombs 2014) and worsen existing inequities in healthcare. Although some research highlights that psychosocial screening in primary care settings is acceptable to many patients (Kingston et al. 2015), there are important nuances, such as patient safety, to consider when screening for particularly difficult issues like intimate partner violence (Phelan 2007). Overarchingly, there is risk of producing or worsening health inequities when any new intervention is introduced. At times, interventions may reach already-advantaged people first, exacerbating the neglect of people who are subject to interpersonal and institutionalized discrimination in healthcare or whose socioeconomic resources do not afford them access to healthcare (Phelan and Link 2005; Phelan, Link, and Tehranifar 2010).

Further, a substantial body of research has accounted for the persistent and widespread nature of mental health-related stigma, including stigma arising from substance abuse and social issues like poverty, that has bearing on patients' experiences with mental health screening and their overall engagement with prenatal care (Corrigan, Watson, and Barr 2006; Gawley, Einarson, and Bowen 2011; Haugen et al. 2017). This is particularly pertinent to the process of behavioral[1] health integration and standardized mental health screening in perinatal healthcare because mental health issues in motherhood are uniquely stigmatized across-the-board. Social norms impose standards for women to perform parenthood flawlessly (Reich 2008) and to embody the commonly touted joys of pregnancy and new parenthood. For other reasons, screening procedures may generate fear and patients may strive to keep mental health issues hidden, especially given significant racial, linguistic, gender, and class discordance between patients and clinicians. There is a known relationship between medical authority, health screening, and child welfare involvement that disproportionately impacts poor, Black, and Indigenous families (Roberts 2022). Institutionalized racism, clinician biases, and state mandated reporting requirements in healthcare settings thus further complicate processes of screening and intervention and result in disparate treatment among patient populations (English 2017; Greenwood, Carnahan, and Huang 2018; Shen et al. 2018). Thus, we can expect that even in cases where resource expansion exists, stigma and the threat of surveillance and state intervention act as barriers to many people meaningfully engaging with biomedically integrated mental healthcare in the perinatal period.

As a sociologist of health and medicine, I am sensitized to what I contend is a third main problem in the quest to address pregnant people's mental health. That is, the interventions proposed to improve perinatal mental health have mainly focused on incorporating mental health into the existing biomedical, physician-led framework of U.S. healthcare. Although mental health and substance abuse are readily cited as issues clinicians in biomedical settings see in their

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[1] The term *behavioral health* refers to the connection between behaviors and the health and well-being of the body, mind, and spirit (samhsa.gov). In the context of integrated healthcare, behavioral health has often meant health behaviors related to wellness, specifically regarding the management of chronic illness (Reiter, Dobmeyer, and Hunter 2018), but it is often used interchangeably with the term *mental health*. I use the term *behavioral health* in select instances when explicitly referring to its team-based integration in healthcare settings, but in this dissertation I primarily employ the term *mental health,* a more encompassing term for people's emotional, psychological, and social well-being.

work, the organization of healthcare in the U.S. is not a collaborative interdisciplinary effort that reflects respect or concern for patients' mental health. The U.S. healthcare system is designed around and otherwise led by physicians who are historically undertrained in mental health and working within the biomedical model of care that maintains a binary distinction between mental and physical health (Collins et al. 2010; Pincus 2003; Pincus et al. 2005; Reiter, Dobmeyer, and Hunter 2018; Reiter et al. 2018).

Further, questions of professional expertise, jurisdiction, and interprofessional relations that inevitably arise through processes of behavioral health integration may be particularly conspicuous in perinatal healthcare. Since professionalized medicine took over the domain of perinatal care from traditional home-based midwifery and developed the specialization of obstetrics (Barker 1998; Bridges 2011; Brubaker and Dillaway 2009; Ehrenreich and English 2010; Owens 2017), perinatal healthcare has been a fraught arena occupied by multiple professions with stratified authority, differential control over the scope of work, and market dominance by biomedically-oriented obstetricians. Now in the U.S., over 98% of births take place in hospitals, and although certified nurse-midwives can legally practice in every U.S. state, they attend only 9.1% of births, and more than half of certified nurse-midwives identify physician practices or hospitals as their employer (American College of Nurse-Midwives 2020).

Persistently high rates of obstetric interventions point to the medicalization (Conrad and Schneider 2010; Ehrenreich and English 2010) of the perinatal period and an enduring cultural authority of medicine in pregnancy and childbirth. U.S. rates of cesarean sections are consistently among the highest in the world at over 30% of deliveries (Boucher et al. 2009; MacDorman and Declercq 2019; Montoya-Williams et al. 2017), even while research underscores a need for reduced obstetric interventions (Morris 2016; Morris, T. & Robinson, J.

2017; Tilstra and Masters 2020; Witt et al. 2015). Moreover, although a growing body of research points to lower rates of interventions, improved health outcomes, and reduced health inequities associated with the use of other health professionals such as community midwives, doulas, and lactation consultants, these are not mainstreamed nor reliably covered by insurance (Alliman and Phillippi 2016; Boucher et al. 2009; Kozhimannil et al. 2016; Mottl-Santiago et al. 2020; Wint et al. 2019). Anecdotally, there are known interpersonal and interprofessional tensions between obstetricians and doulas, and there is a ceaseless debate between defenders of medicalized childbirth and advocates for out-of-hospital birth. This landscape illuminates how pregnancy and childbirth are functionally biomedical projects in the U.S. with long-standing cultural resistance and systemic barriers to collaborative interdisciplinary efforts and de-medicalization.

Bringing mental health into the realm of perinatal care by way of standardized screening and interventions has, on the one hand, the possibility of elevating mental health as an important aspect of the perinatal period, and engagement with patients' mental health may improve clinicians' competencies. Stigma could dissipate, and the mental health needs of pregnant people may be more readily addressed. On the other hand, known problems with standardized mental health screening, health inequities potentially worsened by more medical oversight, the marginalized status of mental health, and biomedical dominance, all suggest major challenges in the process of expanding biomedical obstetrics to encompass mental health. That is, how do the many cultural and structural barriers to providing high-quality mental healthcare in the U.S. impact whether increased screening can be a pathway to higher degrees of support or if it might diminish perinatal health experiences? This dissertation seeks to answer this question by tracing the interactional and structural dimensions of extending perinatal care to address the mental health of its patients.

Theoretical Framings

This dissertation draws on several theoretical frameworks to analyze the interprofessional organization of healthcare and processes of mental health integration in perinatal care. Broadly, I draw on social constructionism and feminist scholarship, and I specifically use theoretical work that considers the influence of biomedical dominance in the field of perinatal healthcare, including medicalization, biomedicalization, constructions of risk, and clinical uncertainty. Chapters 2 and 4 also elaborate on theories that are relevant to those chapters' specific findings.

Medicalization and Gendered Health Processes

Several concepts in the medicalization literature and its application in feminist scholarship provide a framework for this project. With their theory of medicalization, Conrad and Schneider (1992; 2010) use sociological concepts of deviance and social constructionism to argue that deviant behavior is increasingly medicalized. They note a rise in the jurisdiction of medicine as a mechanism of social control through the medical gaze (Conrad 1992, 2005; Foucault 1975; Riessman 1983), providing examples of psychiatric diagnoses and interventions in previously unmedicated contexts to illustrate the changing landscape of illness and medical intervention addressed by medical treatment. The theoretical core of medicalization is that it begins with "the defining and labeling of deviant behavior as a medical problem, usually an illness," which leads to a mandate for "the medical profession to provide some type of treatment for it" (Conrad 1992:209). While the authors accept the biological underpinnings of health events and diseases, they complicate this by emphasizing the social meaning that is attached to the experience of illness and disease. They argue the meaning-making that arises out of social interactions and cultural contexts is the required process for something to *become* constructed as an illness or disease. To this point, the authors contend that something cannot be considered an illness in the absence of its cultural acceptance.

Conrad and Schneider (1992:33) challenge the widely accepted view that the development of medical treatments for deviant behavior is simply linear progress that is inevitably associated with a modern society, and instead suggest that progress is yet another social construct, meaningful only in relation to "some other point in time and to a specific audience." Moreover, new definitions of illnesses and development of treatments are laden with costs and benefits that differently impact various populations throughout a society. Therefore, though the authors recognize medicine as a common and pragmatic way of addressing problems in U.S. society, they problematize its uncontested, uniform acceptance.

Medicalization has been leveraged to understand and critique how pregnancy and childbirth have become highly controlled aspects of life. Primarily managed by obstetricians in clinics and hospitals and subject to technological interventions (Brubaker and Dillaway 2009; Davis-Floyd 1994; Liese et al. 2021; Rothman 2016), the medicalization of pregnancy and childbirth in the U.S. has contributed to a false yet persistent binary between medical and natural approaches, further enforcing adherence to the medical model of pregnancy management (Brubaker and Dillaway 2009). Medicalization can also account for the development of perinatal mental health as a subspecialty field of psychiatry. Taylor (1999) traced this phenomenon beginning with the development of a postpartum self-help movement in the 1980s. When a group of women initially gathered to raise awareness about the pervasiveness of postpartum emotional suffering, their social movement emphasized gender-based oppression and the resulting low support for women and children in American society as a primary cause of postpartum distress. Over time, however, this movement's focus evolved away from resistance to gender-based oppression and advocacy for social change, and instead, leveraged medical authority and sought medically legitimized means of explaining perinatal suffering and stress. It drew on mental illness diagnostics, framing perinatal mental health as an intervenable issue that falls in the territory of medical management. This process of medicalization explains contemporary engagement with the growing field of perinatal mental health, including health policy for mental health screening in obstetrics and increased use of psychiatric medication in pregnancy.

Considering the potentially inequitable impacts of the medical gaze as Conrad and Schneider argue, a body of feminist research has established how and where women's personhood and autonomy are uniquely targeted politically, socially, and medically in the U.S., particularly during pregnancy and while parenting (Arditti and Few 2008; Bentley 2005; Chandler et al. 2014; Connerty et al. 2016; Couvrette, Brochu, and Plourde 2016). Research shows, for example, how the institutionalization of medical authority operates as a form of social control, making women vulnerable to criminalization for substance use in pregnancy, and that state oversight of reproductive health matters, including abortion, infant health outcomes, and parenting behaviors, has far reaching impacts on women's safety, autonomy, and family relationships (Altshuler et al. 2017; Flavin 2008; Knight 2015; Reich 2005, 2008; Roberts 2022). Flavin (2008:182) asserts "the impact of the state's policing of reproduction affects every woman, including women who will never see the inside of a patrol car, courtroom, or cell. But the failure to ensure reproductive justice lands hardest on the most vulnerable members of society." Flavin and others highlight an important intersection of perinatal health care, parenting, and state policy, underscoring the inequitable consequences of medicalization in the reproductive lives of women.

Feminist applications of medicalization guide this dissertation's critical investigation of mental health integration in perinatal healthcare. This literature provides a framework for analyzing how the institutionalization of perinatal mental health screening and treatment has come to be and what consequences have ensued. I contribute to this literature by arguing that mental health integration in perinatal healthcare is a new biomedical process that seeks to validate perinatal mental health issues, but which also results in the medicalization of a complex phenomenon. Using the framework of medicalization, I argue there is a cost, both within and outside of healthcare, to expanding the jurisdiction of medicine to manage social and emotional problems associated with the perinatal period. Specifically, the medicalization of perinatal mental health leads to the decentering of social influences and systemic oppression and obscures the need for larger scale interventions, such as paid family leave and subsidized childcare, instead emphasizing individual-level explanations and treatment.

Biomedicalization in Pregnancy: The Institutionalization of Risk Appraisal and Surveillance

This dissertation is also informed by biomedicalization theory (Clarke et al. 2003, 2010) and its account of the complex transformations in biomedicine in the wake of technoscientific developments in the twenty-first century. Five key processes are central to the theory: 1) a new political economy of medicine, health, illness, living, and dying; 2) a new focus on health optimization and enhancement by technoscientific means, and elaboration of risk and surveillance; 3) the technoscientization of biomedicine, fueled by an increasing reliance on sciences and technologies; 4) transformations of the production, distribution, and consumption of biomedical knowledges; and 5) transformations of bodies and identities. These co-constituting processes lead to "old and new social arrangements that implement biomedical, computer, and information sciences and technologies to intervene in health, illness, healing, the organization of medical care" (Clarke 2010:2) with wide-reaching consequences. Particularly germane for this dissertation is the scope of biomedicalization which includes clinical expansions of healthcare both within and beyond the walls of the clinic, specifically via the elaboration of risk and surveillance. Institutionalized health categorizations of low, medium, or high risk formalize an assumption that everyone is subject to becoming ill, and the biomedicalization of often commonplace life experiences leads to new social arrangements in health, illness, and healthcare, changing how we think about and live life itself (Clarke et al. 2003, 2010).

Pregnancy management in the U.S. is a clear example of biomedicalization's concept of the problematization of the normal (Clarke et al. 2010), wherein even uncomplicated pregnancies are routinely subject to screening and self-monitoring as a means of mitigating risk. Barker (1998:1068) traces this conceptualization of risk-averse surveillance medicine in modern prenatal care and the co-occurring emergence of medical authority over pregnancy and childbirth to the early twentieth century, when a new biomedical rhetoric was systematically introduced via an educational campaign to "save women and children." In 1913, the U.S. Children's Bureau began offering educational and home-based public health services and started widely distributing its new handbook, *Prenatal Care,* that contained pregnancy-related guidelines and stressed the importance of medical supervision during pregnancy. Over the course of the next three decades, this handbook was distributed to over twenty-two million pregnant people, establishing this effort as the forefront of the sociocultural construction of pregnancy as medically problematic in the U.S. Importantly, Barker (1998:1074) asserts that obstetrics' persistent cultural authority is not because it offers health advantages, but rather is "the result of a reconceptualization of pregnancy as biomedical and ultimately an acceptance of that conceptualization by women." This claim points to a key point made by biomedicalization theory, that new biomedical discourses and technologies have a far-reaching impact that shapes how life is lived, in this case by pregnant people.

Scholars have further addressed the consequences of the continued biomedicalization of pregnancy in the U.S., specifically the surveilling of the bodies and behaviors of people who are or may become pregnant. In her book *The Zero Trimester*, Waggoner (2017) illuminates how the concept of prenatal care has expanded even further to include the period of time prior to conception (i.e., abstaining from alcohol use if one *could become* pregnant). Controversially conflating women's health with perinatal health, a new risk discourse about pre-conception health was developed as a public health strategy intended to reduce perinatal health inequities by encouraging people's proactive engagement in healthcare, much like the early twentieth-century intervention by the U.S. Children's Bureau discussed above. Waggoner's work illustrates that even a non-pregnant person is expected to attend to the field of risk in anticipation of a *potential* pregnancy, illustrating the ever-expanding field of biomedicine and patterned surveillance surrounding pregnancy. This is a stark example of what Clarke et al. (2003:172) argue is an effect of biomedicalization: that "it is impossible not to be 'at risk.'"

This dissertation primarily engages with three strands of biomedicalization to provide a framework for analysis: a focus on health optimization; the reliance on technologies in the self-monitoring of health and the provision of healthcare; and the transformation of bodies and identities. As mental health is taken up in perinatal healthcare, I engage with biomedicalization theory to consider how the expansion of the perinatal field further entrenches medical and self-surveillance to include not just the bodies but also the minds and emotions of pregnant people. I consider how this process of biomedicalization has led to perinatal mental health issues becoming a new field of risk to manage through pregnancy. Biomedicalization also sheds light on the co-constitution of technological monitoring throughout pregnancy because of and for health optimization. These processes of biomedicalization further transform the way pregnant people identify with their pregnancies and engage with healthcare, both of which have an impact on their mental well-being through the course of pregnancy and beyond.

Medical Authority, Clinical Uncertainty, and the Organization of Healthcare

One main consequence of the ever-expanding jurisdiction of biomedicine and medical authority is the stratification of various health professionals in the organization of healthcare (Freidson 1972, 1988; Saks 2015; Waring 2014) and subsequent challenges in the transfer of knowledge among these professionals (Currie and White 2012; Tasselli 2015). Hierarchy in the organization of healthcare is well-documented, with studies showing negative effects for patient outcomes (Currie et al. 2019; Green et al. 2017), relationships between health professionals and the public (O'Shea, Boaz, and Chambers 2019), and job satisfaction of lower-ranking health professionals (Quine 1999). When behavioral health teams are co-located in hierarchical biomedical settings, it creates a new system for healthcare professionals to navigate, one in which the mental health clinicians may be outsiders despite their expertise, and mental health, as a phenomenon and clinical profession, is persistently marginalized. My dissertation treats these known issues as empirical questions that motivate my exploration of attempts to institutionalize mental health services in the organization of perinatal healthcare.

Further complicating the uptake of mental healthcare in biomedicine is the social stigma it often carries (Conrad and Bergey 2014; Conrad and Potter 2000; Goffman 1963; Warren 1987) and diagnostic categories with broad symptom lists and a lack of telltale biomarkers to guide treatments (García-Gutiérrez et al. 2020). This makes mental health particularly enigmatic, especially in obstetrics which relies on measurable markers of health to guide interventions in its model of care. Thus, it is not easily addressed by the standardized care logics of U.S. healthcare and biomedicine and generates clinical uncertainty among clinicians (Lynch 2003; Timmermans and Berg 1997). Further, Rafalovich (2005) argues that because clinicians are broadly influenced by social and cultural contexts, their clinical subjectivity is swayed by the ever-changing zeitgeist of contemporary health issues. This is particularly salient in the case of mental health which is uniquely shaped by sociocultural fluctuations and changing diagnostic categories. For example, media is a primary source of information about mental health, typically portrayed in stigmatizing ways and strongly influencing the popular culture of mental health issues (Aguiniga, Madden, and Zellmann 2016). Revisions in the Diagnostic and Statistical Manual of Mental Disorders (DSM) show there is temporal and sociocultural influence on what becomes pathologized and depathologized over time; such was the case of homosexuality, a once diagnosable condition eventually removed from the DSM in 1973 (Drescher 2015). The seemingly fickle nature of mental health, then, makes clinicians' engagement with patients' mental health an especially tricky and subjective enterprise.

Timmermans and Angell (2001) argue that learning to manage uncertainty is a routine part of professional learning and crucial to their success as clinicians. However, clinicians' management of ambiguity can be incompatible with the implementation of standardized diagnostic and treatment protocols which can have a limiting effect on clinicians' assessment processes and clinical judgment. Among the most effective techniques shown to manage clinical uncertainty are shared decision making, physical examination, and establishing trust in patients, all of which are constrained by standardization (Ghosh 2004). This raises additional questions about managing ambiguity across and within the health professions where clinicians' tolerance of ambiguity, particularly in the case of mental health, may vary considerably and interprofessional clinical judgment may be in conflict.

I leverage these ideas and bridge literatures about professional hierarchy and clinical uncertainty to illuminate why and how mental health integration in obstetrics is challenging for interprofessional healthcare teams who must navigate clinical uncertainty, incompatible clinical judgments, and professional stratification in the quest to incorporate mental health in the perinatal healthcare arena. In particular, I explore the interprofessional process of knowledge brokering in behavioral health integration as one way mental health clinicians attempt to gain control over their expertise and improve their obstetric colleagues' tolerance of ambiguity in mental health.

Research Methods

This dissertation used constructivist grounded theory (Charmaz 2014) to guide data collection and analysis. Grounded theory is a systematic, yet flexible, inductive qualitative research process meant to generate or discover a theoretical explanation for a particular process. Grounded theory "invokes iterative strategies of going back and forth between data and analysis" to motivate the continuation of research, while also influencing the direction of subsequent research phases (Charmaz 2014:2). Though initial research aims and questions guide the project, the iterative nature of grounded theory supports openness to evolving themes as the data emerge.

For the complex and developing phenomenon of integrating mental health into perinatal healthcare, grounded theory is an appropriate theory-methods package that lends itself toward uncovering directions for further research beyond this study. Grounded theory enabled me to conduct sensitive and productive research attuned to understanding healthcare organization, processes of biomedicalization, and clinicians' and patients' lived experiences across multiple dimensions of mental health in perinatal healthcare.

Data Collection

This study used ethnographic observation and semi-structured, in-depth interviews to explore an emerging model of integrated perinatal healthcare. I used observations to study how mental health clinicians embedded in obstetric settings conducted their work and conceptualized their role, and in-depth interviews to illuminate the rich context of interprofessional clinicians' experiences providing and pregnant and postpartum people's experiences receiving perinatal healthcare. This study was approved by the University of California, San Francisco Institutional Review Board.

From June 2019 to December 2021, I conducted observations of one behavioral health program integrated in a large obstetrics and gynecology health organization, Umbrella Health.[2] I gained entrée with this organization by networking in my community of perinatal mental health clinicians. Months before beginning my research, I met with multiple leaders in the organization to discuss the intent of my study, the logistics for me as a researcher in their setting, and the implications of my presence given the various sensitivities, such as patient privacy, in healthcare settings. After some engagement with clinic managers, the chief medical officer, and the human

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[2] Pseudonyms for institutions and individual participants are used throughout.

resources department, Umbrella Health's behavioral health program director became my primary point of contact.

I chose to conduct ethnographic observations at Umbrella Health because: 1) it is a primary provider of perinatal healthcare in the West coast metropolitan area where my research is conducted, with 15 clinics and seven hospital affiliations; 2) it serves a broad population across three counties, caring for people with private insurance and Medicaid; and 3) it has an integrated behavioral health program with 10 mental health clinicians. I conducted observations to capture how the co-location of a behavioral health team in obstetrics is experienced by mental health clinicians, particularly aspects of interpersonal interactions between certified nurse-midwives (CNM), obstetricians (OB), and mental health clinicians, their varied responses to patients' mental health needs, and barriers or facilitators of integrating care.

The original design of this study included clinic observations multiple times weekly at two distinct Umbrella Health clinics. I aimed to observe nurses station activity, warm hand-offs to behavioral health clinicians, and brief interprofessional team "huddles" that occurred throughout the week. The COVID-19 pandemic significantly impacted my data collection plans: my observations were limited to the behavioral health team's biweekly and monthly meetings, most of which occurred on a teleconferencing platform, although some events were observed in-person. I observed group consultation meetings where the mental health clinicians discussed patient cases, administrative team meetings where they developed the behavioral health program, and behavioral health team retreats. When opportunities arose during the course of observations, I also had informal conversations with members of the behavioral health team, most often the behavioral health director and mental health clinicians with the longest tenure at the organization. These observations with Umbrella Health's behavioral health team amounted to approximately 75 hours across 45 occasions. Near-verbatim field notes were taken during each observation and further developed after the observation ended.

This study also includes 82 in-depth interviews. I conducted a total of 43 interviews with a sample of 25 patients with private insurance, no insurance, and Medicaid receiving perinatal healthcare in settings with and without behavioral health integration programs. The racial and ethnic representation in my sample is similar to the demographic make-up of the population in the metropolitan area in which this research was conducted. I attempted to purposively over-sample for greater racial and ethnic representation, but those efforts were hindered by the COVID-19 pandemic which limited my access to obstetric settings and thus a wider patient population. For the same reason, Medicaid recipients are under-represented in this sample (see Table 1.1).

Eight pregnant people participated in three longitudinal interviews: the first interview took place in the first 20 weeks of pregnancy, the second interview was conducted between weeks 32-40 of the pregnancy, and the final interview occurred between 6-10 weeks postpartum, after their postpartum follow-up appointment with their healthcare clinician. Two additional participants were enrolled later in their pregnancies and completed two interviews in this longitudinal series, one prenatally and one postpartum. Finally, I completed single interviews with an additional 15 people who had given birth in the past year, thus gaining wider perspectives about healthcare experiences through pregnancy and the postpartum period. Interviews with pregnant and postpartum people covered background about family and reproductive health experiences; psychosocial experiences; navigating perinatal healthcare; and the impact of COVID-19. I recruited pregnant and postpartum participants by advertising my study via contacts in my professional network of perinatal clinicians; inviting clinicians working in the

Table 1.1: Demographics of Pregnant and Postpartum Participants (N=25)

Characteristic	N (%)
Age	
18-24	4 (16%)
25-30	6 (24%)
31-35	8 (32%)
36-40	6 (24%)
40-45	1 (4%)
Racial or Ethnic Identity	
Asian	1 (4%)
Black or African American	2 (8%)
Hispanic or Latino	5 (20%)
White	18 (72%)
Gender Identity	
Cis woman	25 (100%)
Annual Household Income	
$20,000-$60,000	8 (32%)
$60,001-$100,000	8 (32%)
Over $100,000	9 (36%)
Highest Level of Education	
Less than high school degree	2 (8%)
High school degree	2 (8%)
Some college	2 (8%)
Associate’s degree	3 (12%)
Bachelor’s degree	6 (24%)
Master’s degree	8 (32%)
Graduate degree	2 (8%)
Insurance Coverage	
Uninsured	2 (8%)
Medicaid	5 (20%)
Commercial insurance	17 (68%)

clinic settings where I was conducting observations to share information about my study with their patients; and snowball sampling.

I also draw on 39 in-depth interviews with mental health clinicians (n=20) who were psychologists, clinical social workers, professional counselors, and psychiatric nurse practitioners[3], hospital-based CNMs (n=10), community midwives (n=5), and OBs (n=4) who worked in a total of seven distinct healthcare organizations, both with behavioral health teams and without. The overall sample of clinicians reflects national demographics of midwives and obstetricians, a large majority of whom are white women (American College of Obstetricians and Gynecologists 2017; American College of Nurse-Midwives 2019). National demographics of mental health clinicians reflect a somewhat more diverse workforce (U.S. Bureau of Labor Statistics 2019). Accordingly, this sample's slight racial and ethnic diversity is mostly accounted for by mental health clinician participants' racial and ethnic identities (see Table 1.2).

Clinician interviews focused on their experiences addressing mental health in their professional roles; perceived challenges and gains while integrating mental health in perinatal healthcare; the organization and dynamics of interprofessional work; and the impact of the COVID-19 pandemic on their work. I recruited clinicians by advertising my study via contacts in my professional network of perinatal clinicians; inviting clinicians working in the clinic settings where I was conducting observations; snowball sampling; and emailing all the perinatal clinicians found on the public websites of three large perinatal healthcare organizations in my community.

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[3] There are differences, such as training and philosophical approach to mental healthcare, across each mental health profession represented in this sample. However, as members of behavioral health teams in obstetric settings the nature of their work was less distinctive by profession and primarily reflected the collective programmatic approach of the behavioral health teams.

All interviews in this study were conducted through the teleconferencing platform, Zoom, and verbal consent was recorded at the beginning of each interview.

Participant recruitment for interviews was compromised by the COVID-19 pandemic. Not only did restrictions in healthcare settings limit my proximity to obstetric clinicians and patients, but the pandemic-related upheaval in healthcare systems and the added stressors on healthcare clinicians limited their capacity for research participation.

Table 1.2: Demographics of Clinicians (N=39)

Characteristic	**N (%)**
Clinician Type	
Certified nurse-midwife	10 (26%)
Community midwife	5 (13%)
Mental health professional	20 (51%)
Obstetrician	4 (10%)
Age	
25-30	1 (2.5%)
31-40	14 (36%)
41-50	17 (43.5%)
51-60	5 (13%)
>60	2 (5%)
Racial or Ethnic Identity	
Asian	1 (2.5%)
Black or African American	1 (2.5%)
Hispanic or Latino	5 (13%)
White	32 (82%)
Gender Identity	
Cis woman	39 (100%)
Years Providing Healthcare	
< 5	6 (15%)
6-10	16 (41%)
>10	17 (44%)

Data Analysis

I inductively developed codes in a multi-step process. First, I did a close reading of data from interviews with mental health clinicians, community midwives, CNMs, and OBs, coding sections of text, primarily using words that reflect action (e.g., “feeling valued”; “facing high workload”). Initial coding was mostly open-ended, while also informed by findings in the social science and health literatures on behavioral health integration, interprofessional work, and pregnancy and postpartum experiences (e.g., “emotion work”; “clinical confidence”). Next, I engaged a process of focused coding, making decisions about which initial codes have the most analytic salience for categorizing data about the interprofessional work of integrating behavioral health in obstetrics. This produced a codebook of approximately 65 codes. Using the qualitative data analysis software ATLAS.ti, I coded field notes from ethnographic observations using this codebook. I repeated the above process with the data from interviews with pregnant and postpartum participants, which produced a separate, second codebook of approximately 35 codes. Again using ATLAS.ti, I systematically coded and analyzed all participant interview transcripts using this second codebook.

I engaged in extensive memoing to clarify the relationships between the biomedical obstetric model of perinatal healthcare, clinical uncertainty, the organization of health professions, and the patient experience in perinatal healthcare. I also routinely memoed throughout data collection and during preliminary readings of field notes and interview transcripts to identify possible directions for further data collection and analysis. To develop the findings reported in the empirical chapters ahead, I drew on data coded with the following: “interdisciplinary relationships;” “integrating behavioral health;” “providing mental healthcare;” “COVID disruptions;” “time constraints;” “scope of practice;” “depression screening;” “mental health experience;” “health complications;” “pregnancy desires;” “obstetric intervention;” “self-advocacy.”

A Note on Positionality

I am a mental health clinician trained in anti-oppressive and biomedical approaches to mental healthcare, and I have expertise in perinatal mental health. My clinical work amounts to nearly twenty years of diverse experiences in biomedical settings, community mental health, independent practice, and social work education. This experiential knowledge has informed my strong opinions and concerns about the state of obstetrics and mental healthcare in the U.S.

Some, notably positivists, might argue this inevitably leads to imbalance in my approach to this research. They would not be incorrect in pointing out my solidarity with the mental health clinicians I interviewed and observed. I take my experiences, judgment, and commitment to the field of mental health to be a strength of my study rather than a hinderance. Because of my experience working in biomedical settings, I navigated my way into the obstetric organization with relative ease; my clinical background facilitated comfortable rapport and familiar conversation with the mental health clinicians I observed. As feminist theorists have long contended, it is always the case that researchers ask questions, design methods, and approach analysis from our unique points of view, and I am no exception. The particulars of my multidisciplinary identity played a large role in how and why I developed this study, and it will enable me to share relevant findings to clinicians and other stakeholders engaged in perinatal healthcare.

Overview of the Dissertation

This dissertation traces efforts to integrate mental health into perinatal healthcare. I pay particular attention to the interpersonal and organizational dynamics of interprofessional healthcare clinicians and structural constraints that facilitate and impede clinicians' efforts and patients' experiences, with a central focus on perinatal mental health.

In Chapter 2, I argue that a combination of structural constraints such as limited time in the clinical encounter, low access to community-based resources, high patient volume, and a lack of mental health competence impedes obstetric clinicians' ability to address patients' mental health. Drawing on observations and interviews with mental and perinatal healthcare providers, I show how these structural constraints coincide with increased demands that obstetric clinicians screen their patients' mental health—a demand that introduces a new risk discourse for obstetric clinicians to navigate. One response to this problem is bringing mental health clinicians into the obstetric setting to provide care, which I find serves to alleviate obstetric clinicians of some clinical responsibility, and it may improve access to mental healthcare for some people. I show that, in the obstetric setting, mental health clinicians face a two-pronged role: to provide patient care and to educate their obstetric colleagues about the mental health of their patients to improve obstetric clinicians' mental health competence. In this chapter, I illustrate strategies deployed by mental health clinicians in obstetric settings to manage this dual role, navigate high and often misplaced demand for their services, and face the challenges imposed by medical authority and an interprofessional hierarchy in the obstetric setting. This chapter illuminates the interprofessional negotiations that are required to accomplish joint work in perinatal healthcare, and I argue that one ultimate effect of behavioral health integration in obstetrics is a more siloed—that is to say, a *less* integrated—model of perinatal healthcare. These findings suggest the need for improvements in the organization of obstetrics to enhance interdisciplinary collaboration, and for a more expansive vision that reimagines all-encompassing approaches to perinatal healthcare in the United States.

In Chapter 3, I consider whether the whole person health (WPH) framework is a pathway to illuminate how perinatal clinicians' approaches to providing care already contain the ingredients necessary to support their patients' mental health. Based on interviews with pregnant and postpartum people and perinatal healthcare clinicians, I find that patients' mental health is sometimes addressed in alignment with a WPH framework, but also remains marginalized and structurally inaccessible because of emphases on formal treatment, diagnosis, and pathology in mental health and perinatal healthcare. This chapter shows that patients desire rapport with their perinatal clinicians, seek empowerment throughout their perinatal experiences, and prefer a model of perinatal healthcare that offers continuity and accessibility to clinicians. I show how clinicians successfully meet patients' preferences and, at times, incorporate the multidimensionality of their patients in the clinical context by providing home-based care, deploying interviewing and listening skills, and being attentive to the interconnectedness of patients' social experiences and health. At the same time, I find that clinicians face forces within biomedicine and the United States' healthcare system that constrain their ability to implement whole person healthcare. To address the gap between what patients and clinicians desire in perinatal healthcare and what is currently possible, I argue that policy change must address the myriad structural and systemic barriers that prevent the implementation of whole person healthcare. I contend WPH provides a potential pathway for shifting perinatal healthcare away from the mind/body distinction maintained by biomedicine and toward a model that promotes interrelation, and in which mental health is inherently incorporated. This could have the effect of emphasizing that perinatal mental health is a central component of pregnancy, childbirth, and postpartum experiences rather than a pathologized risk arena that is only responsive to standardized screening and specialty care. This chapter makes visible how clinicians' WPH-aligned approaches to care already are interventions for pregnant and postpartum people's mental health.

In Chapter 4, I address the common occurrence of perinatal anxiety and take a sociological look at its normalization in perinatal healthcare, paying specific attention to obstetric surveillance as one of the primary social influences on pregnant people. Through analysis of in-depth interviews with pregnant and postpartum participants, I show multiple dimensions of obstetric-induced stress and anxiety, such as the emotional fallout from routine ultrasounds, provisional diagnoses that place pregnant people in distressing states of limbo, and heightened vigilance about the risk category of “advanced maternal age.” I argue that obstetrics has institutionalized routine standards of care based on the highest risk categories, constructing the pregnant person as always already at risk which results in fear, anxiety, and patients’ self-surveillance vis-à-vis obstetric care. I find that, even when participants were disappointed by their obstetric care or had pregnancy desires misaligned with obstetric recommendations, they weighed their personal needs against the potential cost of being perceived by clinicians as difficult. This generated another layer of stress and anxiety for participants, and I show that they uniformly acquiesced or deferred to the enduring power of obstetrics, trapped by the obstetric paradigm of risk. As the gatekeeper of perinatal healthcare, I contend that the institution of obstetrics has an obligation not only to identify and address mental health issues, but to consider the impact of standardized surveillance medicine on the mental well-being of pregnant people. I argue that substantial gains toward improved mental health for pregnant and postpartum people are not possible within the current parameters of contemporary obstetric care, largely because of its direct negative impact on people’s mental well-being. Instead, we must dismantle the fear-driven surveillance model of perinatal healthcare we have come to accept as necessary and inevitable, and wholly reconsider our approach to caring for people through pregnancy, childbirth, and postpartum.

I conclude the dissertation by reviewing this study’s findings, considering next steps for future research, and highlighting policy and practice implications for continued development in the arena of perinatal mental health.

CHAPTER 2: “Take this patient off my hands”: Perinatal Mental Healthcare and Interprofessional Negotiations in Obstetrics

Introduction

Awareness about perinatal mental health issues is increasing. Known as “the most common complication of childbirth,” it is estimated approximately 25% of pregnant and postpartum people have depression or anxiety during pregnancy or postpartum (Araji et al. 2020; Rompala et al. 2016). Rates increased during the COVID-19 pandemic (Chen, Selix, and Nosek 2021), and some current estimates suggest up to 40% of pregnant people experience depression and/or anxiety (Araji et al. 2020). In response to policymakers’ and professional stakeholder organizations’ advocacy, the U.S. Department of Health and Human Services, the American College of Nurse-Midwives, and the American College of Obstetricians and Gynecologists issued official recommendations and protocols for standardized perinatal mental health screening in perinatal healthcare, and thirteen states have enacted one or more state-level perinatal mental health policies (Rowan, Duckett, and Wang 2015). Because perinatal healthcare is an entry-point to routine healthcare for many people, sometimes for the first time in their lives, it is seen as a fruitful site for mental health screening. Obstetric settings and clinicians play a crucial role in responding to policy changes and implementing these new standards of care. Some obstetric settings are incorporating mental health (MH) clinicians to specifically address the mental health needs of patients, leading to shifts in the organization of perinatal healthcare.

Though increased national attention to mental health during pregnancy and postpartum is recognized as a positive evolution for people’s well-being, how does this new demand on health systems impact the professionals tasked with providing care? In this chapter, I consider the interprofessional complexities of the biomedical expansion of perinatal healthcare to incorporate mental health. I examine how the co-location of behavioral health teams in obstetrics is experienced by clinicians, particularly aspects of interpersonal interactions between certified nurse-midwives (CNM), obstetricians (OB), and MH clinicians, their varied responses to patients' mental health needs, and barriers or facilitators of integrating care. The data on which this chapter is based include approximately 75 hours of observation of one integrated behavioral health program in a large obstetric and gynecology healthcare organization, and 34 in-depth interviews with MH clinicians (n=20), CNMs (n=10), and OBs (n=4) who worked in a total of seven distinct healthcare organizations, both with and without behavioral health teams.

First, I begin this chapter with the finding that standardization of mental health screening in obstetric care generated clinical uncertainty among obstetric clinicians. I describe how a combination of structural constraints—specifically limited time in the clinical encounter, inaccessible community-based resources, overwhelming patient volume, and a lack of mental health competence—impeded OB clinicians' ability to comfortably address patients' mental health. Second, I show how MH clinicians are organizationally and interpersonally marginalized in obstetric settings, leading to quandaries about how they provide patient care. Finally, I illustrate two strategies that MH clinicians use in obstetric settings to navigate high patient volume and the challenges imposed by medical authority and an interprofessional hierarchy in the obstetric setting. MH clinicians' first strategy was assuming an educator role for their obstetric colleagues, encouraging their development of a more expansive understanding of mental health intervention that would serve to enforce a shared load for mental healthcare. In this case, MH clinicians engaged in knowledge brokering (Currie and White 2012) and demonstrated subtle resistance to the biomedicalization of mental health in obstetrics. They highlighted the expected and normal (versus pathological) nature of psychological and social stressors in pregnancy and postpartum and promoted the benefits of relational attunement in clinical encounters to improve patient experiences. In their second strategy, they leaned on the medical model to enforce professional boundaries around their scope of practice, developing a referral protocol that limited obstetric clinicians' use of their services. This chapter highlights key challenges in behavioral health integration in obstetric settings, illuminating complex interprofessional negotiations to accomplish joint work in perinatal healthcare. These findings suggest the need for improvements in the organization of obstetrics to enhance interdisciplinary collaboration in the quest to meet people's myriad needs in the perinatal period.

Pandora's Box and a Lack of Clinical Confidence

As the frontline of perinatal healthcare, nurse-midwives and obstetricians are being asked to incorporate some mental healthcare into their clinical practice. At a minimum, they are tasked with responding to the standardization of mental health screening in obstetric settings. All seven healthcare organizations represented in this study had formalized at least one element of perinatal mental health screening, usually administering the Edinburg Postnatal Depression Scale (EPDS) at least one time during routine prenatal and/or postpartum care.

Efforts to implement and comply with this newly standardized practice generated considerable discomfort among the OB clinicians in this study, many of whom felt ill-equipped to deal with mental health issues. They encountered a tension between an emerging philosophy of care to include the psychosocial realm of life and multiple forces impeding their efforts toward mental health-inclusive care. Multiple clinicians said they were afraid to "open Pandora's box," using this idiom to describe their worry that if they asked about mental health issues, patients would disclose something that could be beyond their comfort to address, or that they would run out of time, or both. Jackie, a nurse-midwife, explained that simply asking about a patient's mental health can set in motion a difficult and lengthy clinical encounter, saying "that question right there is, like, a whole visit." OB Rachel said, "I don't have the bandwidth to get into that as much as I feel like it needs to be. It's one of those Pandora's Box things. When you bring it up, you have to be able to follow through and I can't do that adequately." Nurse-midwife Hailey said, "I honestly feel helpless. I'm seeing someone in front of me who's saying, 'I need support,' and I have 15 minutes and I can't be that person right now." OB clinicians were concerned that, given the scant 15 minutes they are typically allotted for each patient visit, they would need to interrupt a distressed patient and leave abruptly without closure or a satisfactory care plan. As OB Rachel described, time limitations in the clinical encounter are an impediment to providing mental health-encompassing care:

> In my job it is so hard to get at that quickly. People are coming in with an issue that needs to be cared for immediately. We do such a bad job of being able to get at where they're coming from. And so sometimes our interactions just start bad because we don't have that background. I struggle with that a lot. So, for people coming in with a background of mental health issues, boy, we can get off on the wrong foot really quickly and repairing relationships can be really, really hard.

Rachel concluded by saying this challenge is coupled with being "clearly underprepared" by training, leaving her without strategies to practically meet the mental health needs of her patients.

Clinicians reacted to some mental health issues with a strong sense that these pushed the limits of their clinical roles, concerned that they lacked good strategies for providing sufficient care. Some nurse-midwives and obstetricians cited common anti-depressants such as SSRIs as the only reliable "tool" they had to offer their patients and expressed worry about the challenges of treatment options beyond that. Nurse-midwife Angela explained,

> If it seems like a fairly straightforward issue—some anxiety, some depression—and the person is really feeling like they're needing to start medication or if they're needing more help than just talking to someone, and we've talked about the pros and cons of starting

> meds, I’m happy to start them on a medication. I don’t always feel comfortable managing it, or if a medication isn’t working for them I’m not comfortable figuring out which one is better for them. I feel like it’s just not my area of expertise, and I want to get them to someone [who is an expert] to get them on the best thing as quickly as possible.

Multiple clinicians said they would try “two rounds of anti-depressants” with their patients, but if both trials failed, they recommended a psychiatric consultation—a scarce resource that is not always accessible to perinatal patients and one that is complicated to navigate based on insurance status.

When available, some clinicians reported positive experiences consulting with a psychiatric colleague about patients’ medication needs, and others successfully referred patients for psychiatric care. Samantha, an OB, explained that she often refers patients with private insurance for outpatient psychiatry care, but if a patient has Medicaid, she relies on her health system’s on-call psychiatrist for consultation. She said, “I utilize that fairly regularly when I have a complicated question around medication that isn’t in my wheelhouse of knowledge.” But even in clinics that employed a psychiatrist or psychiatric mental health nurse practitioner (PMHNP), the demand for their services exceeded their capacity, mirroring a known nation-wide shortage of general outpatient psychiatry services (Weiner 2022). Moreover, many providers were reluctant to prescribe psychiatric medications to pregnant people, in part because of perceptions about the risk associated with having limited data about such medications in pregnancy (Battle and Salisbury 2010; Biedermann and Fleischhacker 2009; Chaudron 2007, 2016; Gold 1999; Hackley 2010; Jermain 1992), but also for other reasons. For example, nurse-midwife Kristine had reservations about pharmaceutical intervention saying, “I do not want to be just like, ‘okay well, I’ll give you some Zoloft’…that is not enough for me. I do not feel comfortable with that.” For her and some others, prescribing psychiatric medications felt risky because of the uncertainty of patient follow up or because their schedules did not allow for close monitoring of patients.

Not being able to have frequent or consistent contact with patients was a rationale deployed by nurse-midwife Hailey, who explained that "for safety reasons" screening for mental health or prescribing medications "is not necessarily always the best choice for us." She continued to describe something universally noted by study participants: their belief that they are undertrained to adequately address their patients' mental health. She said, "If we're not being trained on it, then it's really fearful to jump into that whole new world." The looming threat of serious negative health outcomes coupled with diagnostic ambiguity in mental health and lack of resources should mental health assessments reveal medical need meant that obstetric clinicians faced dual yet conflicting fears: on the one hand, *failing to identify* significant mental health issues, and on the other, *identifying* a mental health issue they would not be able to adequately address.

Behavioral Health in Biomedicine: Professional Marginalization and Compromised Care

Obstetric clinicians thus faced a paradox: though being called to strive for more holistic care that encompasses patients' emotional and psychosocial experiences, they are structurally constrained and lack confidence to incorporate this into their practice. Integrating behavioral health teams in OB settings was seen as a logical solution to this quandary, and it universally brought OB clinicians relief from their sense of helplessness. Reflecting OB clinicians' need for support, their referrals to co-located behavioral health teams were numerous and undiscerning, and created new challenges that had to be managed.

A high ratio between MH and OB clinicians, referral ambiguity, and the practice of "warm hand-offs" generated an infeasible amount of work for behavioral health teams. In this study where behavioral health teams were co-located in obstetric healthcare institutions, there was one MH clinician for every fifteen to twenty OB clinicians. This disparity between OB and MH clinicians resulted in a workload that one MH clinician described as “crushing.” The overwhelming amount of work for behavioral health teams was exacerbated by referral ambiguity and OB clinicians’ perceived high need for mental healthcare among for their patients. In the absence of clear referral standards, many OB clinicians employed a liberal referral strategy for patients, readily involving their mental health colleagues in patient care. Early in my fieldwork and prior to the COVID-19 crisis, I learned the behavioral health team at Umbrella Health received approximately 30 referrals from OB clinicians per day and, at that time, they maintained a waitlist of nearly 80 people. MH clinicians were routinely pulled into exam rooms by their OB colleagues for warm hand-offs, a practice that was sometimes used for brief crisis intervention with an OB patient. Mainly, warm hand-offs served to increase the likelihood OB patients would follow through with a mental health referral, and the practice brought comfort to OB clinicians seeking resolution to a patient’s problem. Karla, a clinical social worker, pointed out that having the behavioral health team readily available “is a satisfier for providers. They [OB clinicians] know they can’t just say [to their patients], ‘Well, here’s a referral list. You should try that out.’ I mean, that fails almost a hundred percent of the time.” But for Ruth, a clinical social worker, warm hand-offs and frequent informal “hallway consults” with her OB colleagues were disruptive. She said, “You can’t keep up with your workload if you’re getting sucked into all these consults about sad stories during the day.” Co-locating mental healthcare is thus compensating for the failures of a system in deficit, and clinicians are trying to navigate fluctuating roles at the frontline of this effort.

Pressure to respond to every referral and warm hand-off was evident among MH clinicians at all three institutions with co-located behavioral health teams—some told me they felt they had to “be in a yes place” all the time. Notably, this is also reflective of the hierarchical and fast-paced nature of the biomedical setting. Since OB clinicians originate every behavioral health referral, discretionary power over identifying who needs mental healthcare lies with them and places the onus on MH clinicians to respond to each referral. This unidirectionality, especially in a setting where biomedical knowledge is dominant, positions MH clinicians as in service to their OB colleagues. Though MH clinicians felt valued by some of their colleagues for filling healthcare gaps, they also articulated feeling “less than” in the social order of the obstetric clinic.

Mental health clinicians are outsiders in hierarchical biomedical institutions (Buche et al. 2017; Clavering and McLaughlin 2007; Mackintosh and Sandall 2010) and their services are poorly compensated by insurance companies, limiting their power (Braun and Cox 2005; O’Donnell, Williams, and Kilbourne 2013). This landscape is further complicated by the MH clinician ethos to be helpful. When combined with a professional orientation to be supportive, marginalizing conditions led to a tension between the behavioral health teams’ need to respond to their OB colleagues’ demands while attempting to remain aligned with familiar models of mental healthcare and their professions’ philosophies and ethics. As clinical social worker Hannah remarked, “Because we're at the bottom of the rank, the team's always set up to feel like they have to say yes in order to prove their value and contribution to the team.” While on the one hand MH clinicians were recognized for the unique expertise they brought to the OB setting, their positions also felt precarious and at odds with the system in which they worked, further compounding and constraining their capacity to cope with the flood of referrals that came their way.

Many MH clinicians struggled with ethics of care, worrying that efforts to meet demand came at the cost of diminished quality. Clinical social worker Jennifer described her experience navigating her role vis-à-vis her OB colleagues and the high workload in the obstetric setting, all while trying to provide appropriate care for her patient population:

> Trying to perpetually self-advocate is fatiguing and frustrating. So, there is that low-level drain that's always there. And then just the volume, the volume is crushing. I think that's the most adequate word. When you're in work that you love so very much and have the utmost respect and care for the patients that we see but knowing that you're not able to provide the care that you want and should be providing…for a while our model was able to sustain five to six patients a day, they'd have a full counseling hour. We could see them every two weeks. And they were actually able to make progress. But the volume can't sustain that anymore. We've had to do much more of a short-term intervention model, which is hard because some of those diagnoses don't really respond all that well to short term.

Mental health clinicians reported that patients frequently waited four to six weeks between appointments, when their standard of care is to see most patients on a weekly or biweekly basis. As clinical social worker Mariana explained, “People are really, really distressed in that moment and then having to wait a little while, and especially if they're in the third trimester and we're really wanting to set them up, you know, it’s not ideal.” Hannah, a clinical social worker, also noted this concern about patient needs and ethical mental healthcare, adding that there is a negative impact on MH clinicians’ sustainability in such high-volume systems. She said,

> I think that it’s a tension and contradiction that people are always holding. There is an agreement on the team that we can’t do good, safe, ethical practice spacing people out so long. If you have a first appointment with someone who’s in crisis or just had a big event in their life, whether it’s a pregnancy loss or they just gave birth to a baby, scheduling them out four to five weeks in many cases isn’t appropriate. And if you already have eight to nine patients a day, it’s also not good practice to be burnt out and fried when meeting with people. So, I think people found their way through that contradiction in different ways, like some people would work wildly overtime to fit more patients in.

Because the perinatal period is fleeting and early intervention improves health outcomes (Austin and Priest 2005, 2005), the need for timely mental healthcare is especially acute. Thus, MH clinicians saw lengthy wait times and limited sessions to be incongruent with ethical, responsible, and safe mental healthcare practice.

Mental health clinicians also described their work as not formulaic or linear, making it particularly challenging to manage in a high-volume biomedical setting that relies on standardized care protocols. Jennifer said,

> We do provide counseling over the reproductive lifespan. So, say we see a patient who initially has been struggling with infertility. We're providing them support, they get pregnant, then they experience a miscarriage. So, then the work transitions to grief work that's further compounded because of the infertility. So, we might discharge a patient after, you know, three to four grief sessions after a miscarriage, but then six months later when they start fertility treatments again, they want to come back. So, it’s not cut and dry. I mean, we're talking over the course of several years, so our caseload doesn't really ever actually decrease.

She highlighted what many clinicians emphasized—that mental healthcare, especially across the reproductive lifespan, requires a high degree of flexibility and the availability of clinicians to initiate care with new patients while also continuing the care of already established patients with changing needs. As they tried to define their scope of practice in the OB setting and faced an overwhelming demand for their services, MH clinicians grappled with their positionality and priorities. As I explore below, they encountered a challenging dilemma: how can they fit into obstetrics and maintain standards of care congruent with their understanding of the mental healthcare needs of their patient population?

Behavioral Health Referral Boundaries and Making Mental Health “Normal”

To establish the limits of their work and define a scope of practice, the behavioral health team turned their attention to their obstetric colleagues. They argued that, because emotional and mental health issues are an expected part of the perinatal experience, OB clinicians have a responsibility to address their patients’ mental health in some capacity. This issue arose during a bi-weekly behavioral health team meeting when psychologist Lynne was presenting a patient's case. As my fieldnotes from observing that meeting recount:

> Lynne describes her experience with a new patient, an 18-year-old pregnant with her first child, who has been reporting intrusive thoughts during her sessions. Lynne explains that this client describes sudden and frequent thoughts such as, "what will happen if I trip on this branch?" while she's on a walk, and then perseverates on what could happen to her, or her pregnancy, should she fall. The group of eight mental health clinicians spend about ten to fifteen minutes sharing insights and strategies to support this client and others who have intrusive thoughts, which the clinicians agree are congruent with, and can be indicative of, obsessive compulsive-type anxiety in pregnancy or postpartum. But, they emphasize, intrusive thoughts are common! Most people will experience intrusive thoughts at some point in their lives, her colleague Karla says, so they're not necessarily revealing of a mental illness. They continue discussing why this is especially true in the postpartum period when the coalescing of sleep deprivation, physical and emotional vulnerability, and the stressors of caring for a newborn are uniquely ripe conditions for intrusive thoughts. Sure, they can be distressing, the clinicians agree, but they explain that talking proactively about intrusive thoughts and educating perinatal people about them usually makes the thoughts more tolerable and, for many people, they lessen over time. It's here that the clinicians' conversation shifts away from clinical work with their clients and toward a frequent topic of conversation about a task that seems to be their other primary professional objective: educating their obstetric colleagues. With an edge of frustration in her voice, Lynne wonders aloud how they can encourage or better support the midwives and obstetricians in their clinics to normalize psychosocial issues. She says, "I wish they could make space for intrusive thoughts in their work, it's such a normal part of pregnancy and postpartum." *(Excerpt from fieldnotes, June 2021)*

This framing—the normalcy of a psychological experience in pregnancy and postpartum—was commonplace in my interviews and observations with MH clinicians working in OB settings, and it is an illustration of their knowledge brokering as members of interprofessional teams. Currie and White (2012) define knowledge as a resource used "by social actors to solve problems" and brokering as "the translation of knowledge in the course of day-to-day professional practice." Tied to their normalizing of various psychosocial issues, MH clinicians spent a considerable amount of time and effort leveraging their expert knowledge to teach their OB colleagues how to respond to their patients' emotions, psychological symptoms, and stressors more effectively. As one MH clinician put it, "It's like the physician is also our client.” Taking on the role of educating OB clinicians was partly driven by expertise—MH clinicians demonstrated an expansive understanding of what constitutes a mental health intervention, and they recognized ways their OB colleagues could address, or in some cases already were without recognizing it, their own patients’ psychosocial needs without leaning on specialized mental health support. But knowledge brokering also served to address the problem of OB clinicians’ over-use of limited behavioral health resources.

Monica, a psychologist, told a story about an experience she had supporting an obstetric colleague through an encounter with a depressed patient. In between patient care, Monica received a message from a medical assistant asking for immediate support. She said “I can touch base really quickly. I met the provider in the hall and she swooped me into her office. She was very distressed because the patient’s PHQ-9 [a nine-item depression scale based on diagnostic criteria for major depressive disorder] was a 12 and she had suicidal ideation.” At the time of this encounter, the behavioral health team was not accepting referrals while they worked on developing their new referral protocol and tended to their waitlist. Feeling stuck, the OB clinician asked Monica, “So what am I supposed to do?” and Monica replied, “You can ask if she has support and safety measures in place. I showed her she has to actually engage and have this conversation in a way she wouldn’t have if she could just pass it on.” At the end of that workday, Monica checked in with the OB clinician’s team and confirmed the patient’s suicidality “was only ideation. She didn’t have a plan, no intentionality. And she had a therapist. But she [OB colleague] still felt like, okay, 'I need my hand held regarding this.’” Similarly, clinical social worker Stephanie had an OB colleague who, when faced with “pretty straightforward postpartum anxiety,” was “pacing around outside my office waiting for me to get done with that patient because he doesn’t know what to do. Then I’d go talk to the patient and learn, you know, she’s not sleeping all night. She has to go back to work in a week, and she's interested in talking to you about medication. And he's like, ‘Oh, I totally missed that.’”

These clinicians’ reflections included acknowledgement that interprofessional education and collaboration is often a regular part of health systems. But many MH clinicians believed their OB colleagues tended to be “scared of emotions,” which limits them in the clinical encounter and leads them to over-rely on their mental health colleagues. Psychologist Lynne explained, “If someone cries it's a crisis client, even if it is just grief, they cry, sometimes that makes them uncomfortable. So, their [OB clinicians’] crisis is different than mine. They don't understand what crisis means to us.” For many of the MH clinicians, their expertise led them to see opportunities for their OB colleagues to be more discerning about what constitutes a mental health crisis and to have confidence to offer more support to their patients. Stephanie illustrated her expansive understanding of patients’ emotions as an example of how she’d like OB clinicians to practice, saying, “This person was just crying and in tears in their visit and I'm like, well, we'll cry. It doesn't mean that they're depressed, you know?” Professional counselor Bethany concurred, saying, “I feel like it helps the clinicians who are not mental health orientated become more competent with even just sitting with someone when they cry, because we used to get a ton of warm handoffs, like ‘This person's crying. I don't know what to do. Can you come talk to them?’” She continued to explain that while she is “happy to support them,” it may not be the most appropriate thing for the patient to have “some random person come in when they’re crying to their doctor who they know really well.” Here she underscores the relevance of the patient-clinician relationship, suggesting that the existing rapport between a patient and their doctor may offer an appropriate degree of support without requiring specialty mental health intervention.

A few MH clinicians, particularly those with longer-term presence in the clinics, shared success stories about collaborating with their OB colleagues and increasing their independence to address their patients' psychosocial needs. Clinical social worker Nicole is one of the MH clinicians at Umbrella Health with the longest tenure. She's been able to develop long-term relationships with OB colleagues and observe their transformations over time. She told a story about her work with one physician at her clinic noting it's "been sort of challenging at times." They shared a patient who Nicole described as having "significant sexual trauma and abuse" and indicated that it is "really hard to see her." At one point, her physician colleague

> closed my office door and said to me 'I don't know what to do,' which was a very vulnerable moment for a male doctor who otherwise really sees himself as the expert all the time. I asked him, 'well, what did you do?' He told me about it, and I thought he did a great job, which I reflected for him. That was three years ago. Last week he called me and left me a message and said, 'Nicole, I guess she's coming back to see me today. I don't know what I'm going to do, but I'm glad I have a sense of what works.' And that felt really full circle. He was already doing a great job. He just, I think, needed the support and the confidence of working with something more complicated.

Nicole's collaborative efforts with her OB colleague revealed and encouraged his ability to care for a patient with complex needs, and it is an example of progress on MH clinicians' course to make emotional and psychological experiences a "normal" part of the perinatal period. But these success stories were relatively rare, and they required longer-term relationships and one-on-one coaching that yielded inconsistent results. The labor-intensive practice of educating their OB colleagues was a drain on behavioral health team resources, and it became less accessible during the COVID-19 pandemic when MH clinicians were inconsistently in the OB clinics. Ultimately, the behavioral health team sought to take advantage of the switch to telehealth, leaning into the natural experiment of eliminating the opportunity for OBs to "hand off" patients to MH clinicians. This became the basis for a new standardized referral protocol.

At Umbrella Health, the COVID-19 public health crisis became an important catalyst for the behavioral health team to raise and reconsider questions about mental health referral workflow and boundaries of their work and roles on interprofessional OB teams. Mental healthcare primarily migrated to telehealth, eliminating warm hand-offs and most other clinic-based contact between clinicians. Though in-clinic work decreased, the demand for mental health services intensified and so did clinician stress. Amid a backdrop of cultural conversations about growing mental health needs, healthcare clinician burnout, and the structural failings of the U.S. healthcare system, MH clinicians felt emboldened to draw more rigid lines around their expertise and purpose in the obstetric setting.

At a behavioral health team meeting in December 2021, the MH clinicians discussed how telehealth reduced or eliminated their physical contact with obstetric clinicians and patients in the clinics. At the time of that meeting, it had been nearly two years that the behavioral health team provided care for OB patients without relying on warm hand-offs initiated by their OB colleagues. They justified their unavailability for warm hand-offs and saw this as one clear way to encourage professional development among their obstetric colleagues and to enforce boundaries for the work of the behavioral health team. One MH clinician claimed, “Warm hand-offs often arise from provider discomfort with the range of behaviors or emotions in their offices,” to which another responded, “Right, how are we enabling them from not learning skills if we continue to rescue them in their warm hand-offs?” The team had an in-depth conversation about “being realistic about the value of warm hand-offs,” with multiple clinicians agreeing it is not necessarily a direct line to future patient engagement, claiming that many behavioral health follow up appointments scheduled during patient warm hand-offs result in patient no-shows. In the end, they determined this change is a welcome transition to a consultant-like role rather than being “continuously available” to OB clinicians. One MH clinician ended the meeting enthusiastically proclaiming, “this is an official death of the warm hand-off!”

Because the behavioral health team’s migration to telehealth during the COVID-19 pandemic effectively led to a “natural death” of warm hand-offs, the MH clinicians were able to experience the effects of a significant change to their practice in a non-confrontational way, without actively pushing the boundaries of the hierarchical interprofessional OB setting. The safety of this situation gave the Umbrella Health behavioral health team perspective about their contributions to OB care and clarified their preferences about how to provide care as mental health experts situated in obstetrics. It helped shape their vision for OB behavioral health integration in the wake of the COVID-19 crisis and encouraged them to assert additional role boundaries. In the absence of warm hand-offs, the behavioral health team also needed to establish a way for OB clinicians to funnel patients into their care, which they accomplished by developing a standardized referral protocol.

Drawing on standardized care logics, the Umbrella Health behavioral health team hired a referral manager to assess each referral that came to their team, and the behavioral health team collectively determined what they understood to be the most time-sensitive and pressing perinatal mental health issues in the OB setting. They developed a new referral protocol with formalized and far stricter criteria for the patients who would be accepted for mental healthcare: patients who had received a diagnosis of a fetal anomaly or experienced other perinatal loss; had an EPDS score of 15 or higher; or needed a medication consultation with the team’s psychiatric mental health nurse practitioner. They would not take new gynecology patient referrals, instead limiting their services to perinatal patients. Though some MH clinicians were disappointed to lose contact with certain patients, such as those from general gynecology, their desire for referral clarity and a more manageable workload won out. Pivoting away from the norm of saying "yes" to referrals, the behavioral health director instructed the referral manager to, "when in doubt, say no." This was a significant shift for the team, and it made an impact: in one stretch of five days, the referral manager triaged 120 referrals, of which only five met the new threshold. Wagering a guess about the nature of the other referrals, she said, "A lot of them are generalized anxiety, maybe 50% of the time."

As they discontinued the practice of warm hand-offs and drew a clear and standardized line around appropriate referrals, the behavioral health team accomplished three key things: first, it reinforced their message to their OB colleagues that they bore some responsibility to address the commonplace emotional and mental realm of the perinatal period; second, determining referral criteria gave MH clinicians an opportunity to claim and demonstrate their expertise; and third, they asserted authority by operationalizing a referral protocol in a standardized way that required their OB colleagues' adherence. As MH clinician Ramona emphasized, it was important for their team to "impose some accountability for midwives and [OB] docs to work with the whole person in their office and not just lean on behavioral health in a pinch to 'take this patient off my hands.'"

As knowledge brokers, mental health clinicians educated their OB colleagues about the continuum of mental health and the normalcy of emotional and psychological experiences in pregnancy and childbirth. They played a key role encouraging the development of their OB colleagues' mental health competency, particularly before the COVID-19 pandemic imposed changes to the organization of behavioral health integration. Educating OB colleagues required considerable labor on MH clinicians' part, and it frequently came up in the wake of frustrating encounters that left mental health clinicians feeling misused by their colleagues. In turn, a strong group identity allowed MH clinicians to moderate the social structure of behavioral health integration in obstetrics as they successfully enforced boundaries around their scope of practice. By defining the terms of what constitutes a mental health referral, they communicated an expert understanding of mental health to their OB colleagues. This served to protect their scope of practice, their time, and it allowed them to reclaim some professional standards of mental healthcare.

Conclusion

This chapter considers the complex process of behavioral health integration in obstetric settings from the perspectives of the interprofessional clinicians on the frontlines of this emerging model of perinatal healthcare. Under the logics of standardized healthcare and the medical management of pregnancy, behavioral health integration in obstetrics is regarded as progress in efforts to address patients’ mental health needs. However, the well-intended interventions of standardized mental health screening and co-locating mental health (MH) clinicians are constrained in their effectiveness. Limited time in the clinical encounter, high patient volume, and obstetric (OB) clinicians’ lack of mental health competence make obstetrics a challenging setting for incorporating patients’ mental health.

Standardizing mental health screening and integrating behavioral health teams in obstetrics may have a legitimizing effect on the significance of mental health in pregnant people’s lives. Routine screening and the presence of mental health clinicians in obstetric settings make mental health more visible, and even brief mentions of mental health in perinatal healthcare visits can have a supportive effect. At the same time, it generates burdensome tasks and clinical uncertainty among OB clinicians who face a double bind of either identifying a mental health issue they do not know how to address or missing a patient’s mental health issues altogether. Mental health is intricate, including diagnostic ambiguity, historical stigmatization, and it varies across a wide spectrum. These qualities make it unwieldy for OB clinicians who are structurally constrained and, for a variety of reasons, experience discomfort addressing their patients' mental health.

Fear and a sense of vulnerability are particularly salient in the highly regulated, risk averse obstetric setting where clinicians are sensitized to risk management as the forefront of perinatal care (Morris 2016; Morris and Robinson 2017; Wolf 2018). Obstetric patients are perceived as always at risk and likely in need of some intervention before or during childbirth (Barker 1998; Brubaker and Dillaway 2009; Mackintosh and Armstrong 2020; Robertson et al. 2004; Stone 2015), and the stakes become even higher for clinicians when they anticipate encountering someone who presents with suicidality or psychosis. Accordingly, I found that diagnostic-driven concern about mental health introduces a new risk discourse that, when combined with the predominance of obstetric authority in perinatal healthcare, requires OB clinicians to monitor and intervene more—in this case by providing mental health screening, treatment, and referral for care. Paradoxically, despite the institutionalization of obstetric authority and expectations of expertise, very few OB clinicians have the know-how to effectively include mental health assessment in their scope of practice. When MH clinicians are brought into the OB setting to compensate for these norms and structural deficits, it alleviates OB clinicians of some responsibility and may improve access to mental healthcare for some people. But this integration of mental healthcare into biomedical spaces unsurprisingly draws on psychiatric diagnostics and the biomedical mind-body distinction, and therefore undermines the development of perinatal healthcare that encompasses the whole person.

Not only does the bifurcation of health and co-location of MH clinicians in obstetrics rely on the structure of the medical model, but they also create new challenges in the organization of perinatal healthcare. Two primary issues that arise are the stratification of health professionals in these settings (Freidson 1972, 1988; Saks 2015; Waring 2014) and challenges in the transfer of knowledge between professionals (Currie and White 2012; Tasselli 2015). Hierarchy in the organization of healthcare is well-documented, with studies showing negative effects of medical authority on patient outcomes (Currie et al. 2019; Green et al. 2017), relationships between health professionals and the public (O'Shea et al. 2019), and job satisfaction of lower-ranking health professionals (Quine 1999). All participants in this study are "rank and file" providers of healthcare (Freidson 1984, 1988) facing the same problem: pressure to respond to stakeholder recommendations for mental health screening in perinatal healthcare in an under-resourced system. Yet OB and MH clinicians are positioned differently in the organization of healthcare. MH clinicians have *clinical* knowledge, but they are outranked by OB clinicians who have *medical* knowledge (Freidson 1994). MH clinicians are brought into obstetric clinics because of their mental health expertise, but they are functionally in the service of their OB colleagues who exist with medical authority at the frontline of perinatal healthcare.

This stratification results in interprofessional relational challenges. MH clinicians perceive they are obligated to respond according to OB clinicians' requests, even if their clinical judgment about a patient's mental health need leads them to a different conclusion than their obstetric colleague. Referrals originate with OB clinicians, positioning them with a degree of power regardless of their lack of mental health competence. As they funneled a high volume of patients to their MH colleagues for care, MH clinicians strived to keep their heads above water under a crushing workload in an environment where they lacked professional clout and felt misused. Ultimately, MH clinicians strategized ways to limit their accessibility to OB colleagues, aiming to protect their time, their expertise, and the integrity of the care they provide.

Numerous scholars have theorized the social phenomena of knowledge mobilization and knowledge brokering in organizational settings (Dobbins et al. 2009; Lomas 2007; Martin, Currie, and Finn 2009). As Currie and White (2012) argue, knowledge brokering allows less powerful professional groups, in this case MH clinicians, to advance their position in a professional organization. It can also facilitate the promotion of something they value, such as the integrity of the mental health model of care and obstetric care that encompasses psychosocial experiences. Knowledge brokering was successful for Umbrella Health's behavioral health team by at least one measure: it did reduce the referrals they received from their OB colleagues, allowing them to implement a more sustainable model of mental healthcare. In some cases, collaboration between MH and OB clinicians improved, and some OB clinicians expressed increased comfort with their patients' mental health.

I argue, however, that Umbrella Health had a *less* integrated model of care following the loss of warm hand-offs and the implementation of the behavioral health team's referral protocol. Biomedical settings grant physicians and medical knowledge the highest status, which hinders efforts to mobilize knowledge across disciplinary boundaries (Currie and White 2012) and makes it infeasible to meaningfully shift the hierarchical order of healthcare. Therefore, in order to leverage power over their work in the obstetric setting, the behavioral health team deployed strategies that further siloed them from their OB colleagues. I contend that this siloing is an inevitable consequence of the organization of healthcare, necessary to sustain MH clinicians' work in a high-volume, hierarchical biomedical setting. True behavioral health integration, which is to say a model of collaborative care with shared power rather than deference to medical authority, would require considerable cultural and structural shifts in the perinatal healthcare system. In the long run, attempts to integrate behavioral health in obstetrics may detract from efforts to develop more whole person (Jonas and Rosenbaum 2021), community-driven approaches to perinatal healthcare, particularly if it is increasingly taken up as a new standard of perinatal healthcare.

In Chapter 3, I consider the emerging trend of whole person health and turn to midwives' and obstetricians' efforts to provide healthcare that validates their patients' experiences and aligns with their philosophies of care, while also illuminating persistent structural constraints that impede these efforts.

CHAPTER 3: Seeing the Whole Person: Implications for Mental Health Integration in Perinatal Care

Introduction

In perinatal healthcare, the stakes for patients and clinicians are high given the intricacies of the parent-fetus/infant dyad and the prominence of mental health issues during this period of life. Problems in the United States' (U.S.) predominant obstetric approach to perinatal care are well-documented, and they point to crucial missing links between people's complex pregnancy experiences and a one-dimensional biomedical approach to care. In this chapter, I consider how the increasing popularity of whole person health (WPH) in U.S. healthcare and health policy evokes questions about its possibilities in the perinatal healthcare arena: Does a shift toward WPH have the potential to change how mental health is taken up in perinatal healthcare settings, improving clinician confidence about addressing patients' mental well-being? Does WPH open the door for a more expansive understanding of what constitutes mental health? And might WPH shed light on how biomedical practices, particularly in obstetrics, impact patients' mental health? This chapter engages these questions while considering whether and how WPH can address the consequences of the biomedicalization of mental health. Instead of siloing mental health as in need of specialized care, might WPH offer a pathway for illuminating how clinicians' approaches to care already contain the ingredients necessary to support pregnant and postpartum people's mental health? Below, I argue that patients' mental health is sometimes addressed within a WPH framework, but also remains clinically overlooked or structurally impeded because of the continued focus on formal treatment, diagnosis, and pathology in perinatal healthcare.

Definitions of Whole Person Health and Healthcare

Whole person healthcare is an intervention that seeks to correct biomedicine's history of separating disease from the person, the consequences of which include invalidating the multifaceted human experience of living with disease (Hutchinson 2017). It is also seen as a response to concerns about health equity and a growing body of research that points to the connections between health behaviors, environment, genetics, and health (National Institutes of Health 2023). Given its rising popularity, defining this elusive concept is important for policymakers, health systems, and clinicians to successfully affect broad changes toward WPH in the provision of healthcare.[4] Hutchinson (2017:19-20) describes whole person care as follows:

> The basic idea is very simple. When people become ill, they want and need two things: they want whatever can be fixed to be fixed or cured, and they want to continue to be treated as full human beings…patients need elements of curing and the facilitation of growth and healing from each healthcare practitioner that they encounter.

Another definition of WPH comes from the Whole Health Institute, a nonprofit organization that promotes WPH by working with health systems, partners, employers, and communities to redesign health care delivery. They define whole person healthcare as an approach that helps people identify what matters to them to build an effective plan for their "journey to whole health. The approach provides tools to help people take good care of their body, mind, and spirit" and it involves a focus on patient-clinician relationships and collaboration across healthcare teams, individuals' social supports, and communities (Whole Health Institute 2023). The United States National Institutes of Health (NIH) defines WPH as a model that considers "multiple factors that promote either health or disease" and empowers "individuals, families, communities, and

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[4] The terms *biopsychosocial*, *holistic*, and *whole person* are sometimes used interchangeably, and they share many characteristics such as a multidimensional and integrated approach to care, but there are distinctions between the concepts that clarify how WPH might be taken up in clinical practice. Mainly, *biopsychosocial* is narrower than WPH and contains clearer definition of its domains (biological, psychological, social), while the term *holistic* is somewhat broader and more amorphous than WPH (Thomas et al. 2018).

populations to improve their health in multiple interconnected…areas." The NIH contends WPH is a shift away from treating a specific disease, instead focusing on "restoring health, promoting resilience, and preventing disease across the lifespan" (National Institutes of Health 2023). Figure 3.1 illustrates the NIH's conceptualization of WPH, showing a spectrum of health and disease that includes individual, family, community, and population well-being in multiple domains (biological, behavioral, social, environmental).

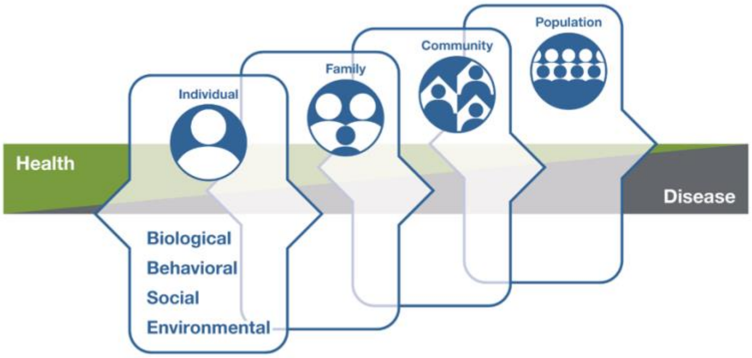

Figure 3.1. Depiction of the NIH's Whole Person Health Model (nccih.nih.gov 2023)

The United States Veterans Health Administration (VA) is just one example of a prominent health system that is transforming the way they provide healthcare to their patients with a focus on what they refer to as "whole health." The VA contends that, beyond illness, injury, or disability, and more than preventative care, "whole health focuses on what is important to you in your life and how you achieve living your best life" (Veterans Affairs 2023). The VA describes a multifaceted program that employs trained veteran peers to help patients explore their personal "mission, aspiration, and purpose," motivates individual pursuit of multiple facets of well-being, offers integrative therapies such as yoga, and provides interprofessional clinical care—all of which is centered on the purpose of empowering patients to "live their life to the fullest." Figure 3.2 depicts the VA's Circle of Health (Veterans Affairs 2023) that conceptualizes whole health as follows: it centers "mindful awareness" cradling "me" at the core. Next is a ring of interlocking circles that includes key elements of the VA's whole health model: moving the body, surroundings, personal development, food and drink, recharge, family, friends and co-worders, spirit and soul, power of the mind. The next ring identifies the components of clinical care the VA offers, including "prevention and treatment" and "conventional and complementary approaches," and the outer-most ring labels "community" as a final element of whole health.

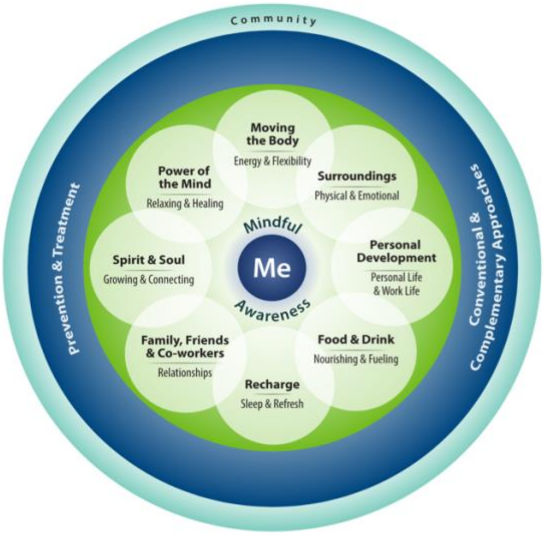

Figure 3.2. Depiction of the U.S. Veterans Health Administration's Circle of Health (va.gov 2023)

Given the emerging nature of this approach to healthcare and its lack of widespread, uniform implementation, research evaluating whole person healthcare in the U.S., such as that offered by the VA, is limited. However, there is some evidence of the efficacy of healthcare models that utilize at least some aspects of WPH. For example, a study with patients in an inpatient psychiatric unit confirmed the importance of having one's self-identity recognized and supported in the container of a positive patient-clinician relationship (Eldal et al. 2019), and another study tested the effects of a team-based, whole-person intervention with people with serious chronic illness that emphasized listening to and knowing patients. Over a period of six months, the program showed moderate improvement in patients' overall experience with interpersonal interactions, access to care, and personal goals compared to patients receiving typical care (Shippee et al. 2018).

Whole Person Health in Perinatal Healthcare

While I found that perinatal healthcare provided by my participants does not overtly or formally follow WPH, I did observe some congruence and leveraging of language, principles, and many practices aligned with WPH. For example, the midwifery approach to care closely resembles WPH, particularly in its ethos of inviting patients' active participation in their care and considering them and their needs within the context of their environments. The Midwives Alliance of North America (MANA) describes midwifery care as nurturing and hands-on and being "with woman," including listening to clients and sharing decision-making (Midwives Alliance of North America 2009). The American College of Nurse-Midwives (ACNM) states, "we believe the best model of healthcare for a woman and her family acknowledges a person's life experiences and knowledge, involves therapeutic use of human presence and skillful communication, and we honor the normalcy of women's lifecycle events" (American College of Nurse-Midwives 2023). Finally, while the philosophy of care in obstetrics is less overtly aligned with WPH, as I will show in this chapter, this lack of formal orientation does not preclude individual obstetricians from engaging with or applying WPH principles in the care of their patients.

Like the other studies of WPH cited above, perinatal health research also shows correlation between health outcomes, patient satisfaction with the care they receive, and components of care such as informed choices, empowered decision making, and the presence of an attentive care provider (particularly during labor and delivery) (Behruzi et al. 2014). In one study of rapport, trust-building, and clinicians' efforts to engage and empathize with their patients (Schulz and Wirtz 2022), when empathy was extended by midwives to patients, these were positively associated with patients' feeling empowered for their upcoming birth, an increased likelihood of a positive birth experience, stronger vital parameters (e.g., blood pressure), and better pain management.

Below, I show how interprofessional perinatal health clinicians attempt to provide healthcare that can be considered congruent with a WPH framework of care and how these practices bear on the mental health of their pregnant and postpartum patients. I first draw on data from patient interviews that illuminate the impact of clinical interactions that attend to their whole person in direct or indirect ways. Next, I analyze data from interviews with community midwives providing care in the home or at free-standing birth centers, hospital-based certified nurse-midwives (CNM), and obstetricians (OB) to show how they mobilize a WPH ethos that makes it logical to invite into the clinical encounter the many layers of their patients' lives. Specifically, I focus on the following key aspects of patient care that emerged in clinician interviews and reflect WPH: soliciting patients' desires or goals related to their well-being; seeing the patient as multidimensional and recognizing mental and physical health as interconnected; and building rapport and trust and practicing informed choice or consent. Finally, I describe how whole person healthcare is structurally facilitated or impeded in different practice settings which results in unique possibilities or barriers for community midwives, CNMs, and OBs as they strive to implement perinatal healthcare that encompasses the mental well-being of pregnant and postpartum people. The data on which this chapter is based are from 43 interviews with 25 patients (of whom 10 were interviewed more than once), and 19 interviews with perinatal health clinicians, including community midwives (n=5), CNMs (n=10), and OBs (n=4) who worked in a total of seven distinct healthcare organizations and three private midwifery practices.

“Who knew me?”: Being Seen as a Whole Person

Interviews with patients provide a clear picture of what patients say is important to them in their healthcare experiences: to be seen as a whole person. In what follows, I also consider how patients’ overall well-being, including their mental health, was impacted by perinatal healthcare interactions that evinced an inclusive ethos that breached typical boundaries between patients and clinicians, and of what is and is not considered relevant for clinical care. Congruent with literature on clinical encounter experiences as a determinant of patients’ satisfaction with the encounter, I found that patients desired and benefited from feeling welcomed, supported, and empowered by their healthcare clinicians (Like and Zyzanski 1987; Wen, Hudak, and Hwang 2007). Participants articulated three key things their clinicians did to cultivate support and empowerment: they took the time to listen and convey empathy; they were open to including the patient’s perspective about their pregnancy and childbirth preferences; and they explained important information about the patient’s health or about navigating the healthcare system. This combination of key behaviors resulted in participants developing a degree of trust in their clinicians, who they described as “nurturing,” “caring,” or “personable.”

Mental health issues arise commonly in pregnancy and postpartum, yet they remain stigmatized, and anxiety and depression can intensify feelings of vulnerability for people seeking healthcare. Participants like Laura, for example, illustrated the importance of communication and access to her clinician, pointing to the meaningfulness of clinicians’ invitations to access care as needed beyond routine prenatal appointments. Describing her OB, Laura said, “she was very informative about everything that was going to happen, she was also very supportive. She would say, ‘If you ever need somebody to talk to, or if you’re feeling down, reach out to me.’” Small gestures such as these, particularly ones that proactively addressed mental health and opened the door for patient-initiated care, facilitated patients building trust in their providers and left them feeling supported through the care they received.

Some participants described how their clinicians successfully cultivated rapport and extended extra care in clinical encounters. Participant Anya said, “The time that they spend to listen and get to know what's at the root of the concern, or whatever the question, I think is the biggest thing.” Laura said her team of care providers “let me vent about how I was feeling,” and followed it up with advice or support that didn’t feel prescriptive. Similarly, Layal said, “When I would tell her [clinician] my concerns, she was all ears and really helpful about next steps, asking me ‘What do you think we should do?’” These examples paint a picture of interactions between patients and clinicians that involved inviting patients to articulate their experiences and, importantly, incorporating patients’ perspectives in any advice or support that was offered.

One particular strategy that resonated with participants was hearing about their clinicians’ personal experiences. Clinicians revealing themselves as multidimensional people served to allay patients’ fears and validate their experiences, while also inviting patients to bring their full experience into the clinical encounter. For Natasha, her clinician was also pregnant, and this shared experience helped forge a connection, facilitating communication that Natasha felt was direct yet supportive:

> I tend to be anxious, and I would go down the Google trail, and she would walk it with me. We were able to get to know each other enough that, when an issue came up, she's like, ‘I know that this [Googling] is where you're going to default. So, here's what it is called. You can look it up, but also be mindful about it. And not in a condescending way, she's just very open and very kind.”

When another patient, Gwen, told her OB she was worried about the amount of weight she was gaining through pregnancy, she said that her OB “would tell me she gained 80 pounds with her pregnancies…She would say, ‘This is normal, don’t feel like you’re alone in this. I don’t have the perfect body, but my body made two humans.’ She would always bring it back to this being normal.” Gestures like these communicated to patients that their clinician saw them with understanding and had a normalizing effect in situations that patient would otherwise find distressing.

The above examples illustrate how clinicians supported patients’ mental well-being with the use of self and as fluidly woven into patient concerns and anxiety about their pregnancies, but some clinicians were even more upfront about addressing their patients’ mental health. Natasha described what she perceived to be an effective way for her midwife to check in on her mental health:

> Every appointment, even though they're rushed for time, every appointment she pauses, and she says, ‘How are you doing? Let's talk about your mental health. Are you getting sleep? Are you getting help around the home? What do you need to support you better?’ I get asked that at all my visits, which I think is really good… So, it goes beyond just blood pressure checks and measuring the belly or whatever. It's a more friendly check-in.

In contrast, other participants described encounters with providers that felt rushed or without enough space to address their questions or concerns. When Yesenia discovered at an ultrasound that she was having a miscarriage, for example, she said, “I just felt like my heart was hurting. I felt pressure in my chest. So, I was so upset and just started crying and just felt hopeless. And I felt like a failure.” She recalled the clinicians briefly explaining that miscarriage is common and “avoiding making me feel more upset,” before swiftly exiting the exam room. In retrospect, she wished she had been offered more physical touch as a gesture of support or a follow up appointment within a day or two to help her process her loss. Knowing from other participants that small, empathic gestures make a considerable positive impact, Yesenia's experience highlights a missed opportunity for clinicians to support her mental health by acknowledging the grief associated with her loss.

These patient data underscore that mental health is an omnipresent aspect of the perinatal experience and that patient-clinician relationships matter when it comes to assessing and addressing the multifaceted nature of health through pregnancy and beyond. As I noted in Chapter 2, it is common for clinicians to either *over*- or *under*react to the mental health aspect of their patients' lives due to its biomedicalization, subsequent perceptions of risk, and a perceived lack of expertise or resource preparedness to address their patients' mental health needs. Yet, study participants reporting on their experiences in clinical encounters highlighted a number of clinician actions that stood out to them and had bearing on their mental well-being: being invited into decision-making; feeling understood by and aligned with their care providers; and being asked directly about their mental health. This illustrates how whole person health is already functioning in some perinatal healthcare, suggesting a potential path forward that may indeed be accessible to clinicians in restrictive obstetric settings and have a positive bearing on perinatal mental health outcomes.

Whole Person Health in Perinatal Healthcare: Listening, Letting Go, and Layered Lives

While I did not ask clinicians specifically about the concept of whole person health, some of them described their approach to providing healthcare in terms that reflect WPH. I found that clinicians' practices of seeing the interconnectedness of patients' mental and physical health, listening to and validating their pregnant and postpartum patients, combined with the concepts of informed consent and informed choice, demonstrate recognition of one's patients and cultivating trust in the patient-clinician relationship, all of which are core elements of whole person healthcare.

Community midwives and certified nurse-midwives (CNM), in particular, talked explicitly about providing whole person or holistic care. When asked to describe her philosophy of care, community midwife Margaret referred to the concept of the "whole person," saying people seeking care deserve to be "respected about their dignity and be cared for by somebody who understands the context of where they're coming from, so that the support they offer them is appropriate." CNM Angela said, "I try to incorporate the whole woman in a holistic way, but also help them figure out what their ideal for healthcare is for them. I try to individualize care so I can help her obtain her most healthy self. I feel like that's really important." CNM Hailey says she aims to "help people see the incredible things that they're capable of, whether that's physically, emotionally, in whatever form that takes. I bring a clinical knowledge, but they bring the knowledge about their bodies and about their families and about their lived experience."

Like their CNM colleagues, obstetricians (OB) demonstrated that they, too, considered some elements of WPH with their patients by pointing to the interconnectedness of social experiences and physical and mental health. Samantha, an OB, said that it is "glaringly obvious" to her that

> the more we realize about health in general, we see that mental health is so integral to people's physical health and there are so many interdependencies, and we're learning about the impact of trauma and ongoing violence and how that really correlates to…health in so many ways.

OB Kathryn took this a step further to describe how she tries to address social and environmental aspects of her patients' lives, saying "We let visitors come to any appointment, including ultrasound, because, number one, I like to see the partner. I like to get a feel for who the partner is and that helps to drive what I'm going to talk about, including safety things."

Clinicians in both obstetric and community-based settings suggested the basic foundation of a WPH approach to care is listening to patients and inviting them to share more of their lives over the course of perinatal healthcare. They described beginning clinical encounters with open-ended questions, asking “How are you?” or “What is occupying your time and thoughts these days?” or simply “Tell me what’s going on.” CNM Angela noted her practice of interviewing and listening saying, “I ask them what they’re wanting. It’s really just talking to them and asking them what they’re needing.” Opening dialogue with their patients served to demonstrate interest and to invite their patients’ participation. Sasha, a CNM, said, “a lot of it is just listening. I listen, I validate their feelings. And from there we create a plan. So, they have a space as an outlet…which most people don't have.” In her statement, Sasha tied her practice of listening and validating to “creating a plan” with her patients. In other words, accomplishing clinical goals is facilitated by patients being heard and understood.

Some clinicians understood listening to and validating patients’ experiences to be crucial for relationship-building given the hierarchical nature of the patient-clinician dyad. Samantha, an OB, explained that her experience has led her to conclude that “the most important thing” she can do is “create a trusting relationship” with her patients by spending a lot of time listening to them, validating their experiences, and “trying to be non-judgmental.” She said, “I very much see my role as just being there as a sounding board. I’m somebody who has a degree behind my name who is attentive to listening to their needs.” In this way, Samantha points to the power of her positionality—as someone with a degree behind her name—and the legitimating, tone-setting signal that her practices of listening, validating, and being attentive to patients’ needs can send. Other clinicians talked directly about the “power structure” of healthcare that assumes the provider has more knowledge and more authority, which makes them “the decision-maker in the room" by default. To counteract this concern, clinicians created safety in the patient-clinician relationship, as described above, and attempted to include patients in their healthcare. Gina, a CNM, said her approach is "meeting women and families where they are," and she further described the multifaceted way she conceptualizes collaboration with her patients:

> That's what I was trained to do, to be skillful and approach every woman and family as an individual unit with specific cultural needs and desires for their pregnancies and birth experiences and contraception needs. It was interesting when trauma informed care stuff started happening, it was like, 'oh, we're good at that.' It means approaching [people] with the utmost respect and information about these really invasive exams we do, things that could be painful, and coming up with creative solutions to not just get the job done, but to find common ground so this could be done in a safer, more collaborative way.

Gina saw her orientation as a midwife as attuned to the "individual unit with specific needs and desires" in her care, specifically highlighting the importance of collaborating with one's patients for the goal of safe and respectful healthcare.

Midwife participants provided examples that demonstrated their widespread belief that they are not in control of pregnancy, childbirth, or their clients' lives. Lindsey, a community midwife, gave an illustrative clinical example of a common midwifery approach to client care. She said,

> Developing that relationship of trust over the course of the pregnancy with these families, that's a huge part of our care. And it allows for trust when decisions come up about testing. Like if somebody decides not to test for one thing, like gonorrhea and chlamydia, we trust that they're not at high risk for gonorrhea and chlamydia. If they tell us that—versus in the hospital setting where there's this assumption that 'you never know,' and maybe in the end that's true—we come from a place of trusting our clients.

Adding to this process of trusting one's clients as Lindsey described, community midwife Sarah said,

> It's important I practice letting go. It's also important to accept that we don't get to choose how all these people's stories are going to unfold. It's not our job, actually. I think many practitioners tend to be like, 'I'm going to keep them off meds or I'm going to keep them at home,' but that's not actually serving.

Instead, Sarah identified the difference between what she referred to as an "ego-driven" approach to more controlling care and a model that she believes is collaborative and inviting. She gave an example of how she might approach a client about whose well-being she is concerned, saying,

> Oftentimes it's a conversation. I'll say, 'This is what I'm noticing,' or I'll validate something from their perspective and ask, 'Are you concerned?' I might explain that sometimes things present in a certain way and that's what I'm noticing and it's making me concerned. But then I ask, 'How are you feeling about that?' And then it's a question of willingness, what is a client willing to do and how can we be advocates for her?

These midwives' accounts offer a description of care that is made possible by accepting an inherent degree of risk in the perinatal period and accepting their limits to influencing how people's experiences will unfold through pregnancy and childbirth.

CNM Hailey concluded that patient-centered practices as described above are tied to "people's emotional well-being around their reproductive healthcare." She suggested, "I think there's a huge connection between people's mental health and the safety they feel coming to their care providers." Importantly, clinicians also described increased satisfaction providing clinical work in a more attuned way. When community midwife Sarah told me about the therapeutic potential in the midwife-client relationship, she underscored the dyadic experience of this for her. She said, "It nourishes me to see and be seen, to not just be measuring bellies and listening to heartbeats. I mean, that stuff is really fun, but it doesn't get at the kind of undercurrent of what is possible for the client and practitioner." Not only do these clinician approaches make it possible and clinically logical to try to understand patients' layered lives, they also point to the mutual human benefit of drawing on the richness of relationship in the clinical encounter.

Structural Constraints to Mobilizing Whole Person Health

How community midwives, CNMs and OBs execute their philosophies of care differs by the nature of their practices. These differences are not just conceptually shaped, as illustrated above, but also infrastructurally fostered or constrained. For example, Kathryn is in a unique position as a solo obstetrician in an independent practice. Though the workload is difficult for her providing all her patients' prenatal care and attending every birth, she experiences gains in her work because "I know my patients pretty well. I have a feel for what are going to be the problems postpartum. They're not seeing a different person every visit. I mean, my staff can predict who's going to be depressed postpartum almost a hundred percent." She explained that, because of the design of her practice, she and her staff know each of their patients, including their personal stressors or detailed life circumstances, which allows them to have confidence to predict their patients' outcomes and "intervene before it gets really serious." The continuity of care that Kathryn can offer her patients comes from being a solo practitioner, having made that choice in part so that she would see all her patients for each of their appointments and that they would have just one OB, Kathryn, throughout their pregnancies.

Community midwives also can offer and prioritize continuity of care, but a distinct feature of how their care is structured is its location: community midwives offer care in their patients' homes. Community midwife Jodi described "gathering data" about her clients during home visits and combining this with her intuition to "pick up on" the well-being of her clients. In the postpartum time, for example, she described assessing "the vibe" in the house, feeling for the stress levels of people in the house—"You know, is everyone overwhelmed?" Forgoing a formal system for assessing the mental well-being of her clients, she explained, "I'm just looking for those kinds of things. You can hear the lack of happiness or see a lack of connection to the baby.

Sometimes you can start to see that the bond is at risk, that there's something a little askew." She readily admitted she is not immune to missing things, recognizing the imperfection of assessment, especially considering the ways people may work to hide certain parts of their experience because of stigma or their sense of shame. Jodi's insight reflects community midwife Sarah's ethos to let go of the illusion of control over people's perinatal experiences. Knowing they cannot rely fully on patients' disclosures or their guaranteed engagement in care, it is interesting to consider how clinicians may rely on *a feel* for their patients, one that comes from building relationship with and understanding life experiences of their patients.

For community midwives like Jodi, providing midwifery care in her clients' homes added a layer of intimacy that is crucial to her model of care. She said, "being the guest in their homes—visiting their space all the time and having their kids sit on my lap while I do appointments—gives me clarity about their lives as I get to know them." By the end of their time together postpartum, Jodi explained that the care she provides rests on environmental cues and the relational closeness she has cultivated with her homebirth clients, saying,

> I'm literally crawling into bed with people. I take off my shoes and bring my stethoscope and thermometer and sit in the bed with a half-naked woman who's nursing her baby. She didn't have to get up. She didn't have to put her baby in a car seat. She didn't have to put on clothes so she can be skin to skin.

As Jodi attests, she can care for a birthing person and their baby in the comfort of their home during an acute period of healing and bonding. These home visits are unique to the community midwifery model of care and provide clinicians like Jodi with richness that contextualizes their clients' lived experiences.

For their part, CNMs primarily work in obstetric settings alongside obstetricians (US Bureau of Labor Statistics 2021), and so share some of the same structural constraints to their ability to provide care that attends fully to the whole person, despite their common understanding of the interconnectedness of physical and mental health. More specifically, routinized standards of care and the characteristics of the practice setting limit how they provide care. Hailey, a CNM, accounted for this when she acknowledged working "in a healthcare system that guides people into making certain decisions about their healthcare," and that often has too few clinicians operating in a team-based model, with short appointment times, clinic and hospital protocols, and a multi-payer insurance system that shapes what and how much care can be offered based on what is and is not covered.

One specific distinction clinicians made that illustrated structural impositions on care concerned the practices of informed *consent* versus informed *choice*. Informed consent is defined as "the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention" (Shah et al. 2023). It is a common and standardized healthcare practice that Gina suggested further "levels that playing field" for a patient and their clinician, especially when it ethically shifts healthcare toward "this idea that consent can be given or taken away." Gina is a midwife in an obstetric setting, however, so she also recognized there is a difference between the ideal or theoretical practice of informed consent that she described and the realities that hinge on the healthcare system mandates that limit her patients' choices.

Not all clinicians expressed comfort practicing informed consent, either, pointing to further complications in the biomedical application of this process in healthcare. OB Rachel explained that, in the absence of relevant information about patients' lives, it is hard to be sensitized to their needs. She gave an example describing one patient encounter, saying,

> No one knew about this woman's trauma, she never brought it forward, none of us asked about it. It turned out the exam was horrible for her because she had all this trauma. So, had we had the information, maybe we could have made it work, or we could have worked in a different way.

It was in her next statement that she further revealed this dilemma, demonstrating discomfort with her role as a clinician tasked with acquiring patients' consent. She said,

> When you ask some women, you know, is it okay if I touch you here or there? And they look at you like you're crazy, like, 'Of course, that's why I'm here.' You know? And I think they mean it. Then other women, when you ask them, it's not enough and it brings up more and more. So we are very bad at figuring that out."

Rachel's conclusion that clinicians are bad at figuring out how to practice informed consent reveals tensions in the obstetric model of care. Obstetrics may be institutionalizing informed consent as a norm, yet its application by clinicians is variable, further encumbered by the far-reaching tendrils of medical authority. Rachel's story suggests there is an expected uni-directionality in healthcare wherein the patient is a passive receipient of the clinician's expertise and discretion, yet is also expected to reveal themselves to their clinicians in order to receive good care. This is a contradiction that makes obtaining informed consent an opaque process that does not neatly fit into the standardized flow of biomedicine.

In contrast, Dana, a community midwife in a homebirth practice, explained their less encumbered practice of what she and other community midwives referred to as "informed choice," which they practice in addition to informed consent. Informed choice is defined as "midwives help[ing] women make informed decisions about their pregnancies and births, including where, how, and with whom they give birth. Midwives endeavor to assist women in understanding the full range of birth options" (Midwives Alliance of North America 2011). Dana expounded:

> [Informed choice] is about people making the best decisions for their own families, whether or not it's what I would choose. What we strive for is a balanced description of risks and benefits for whatever choice a person has and for them to really do what's right for them. And that's so vastly different depending on the client, what the right choice is for their family.

Midwives, especially those practicing in community and home-based settings, provided numerous examples of inviting their patients' informed choices through strategies they use in client care. These included "never telling them what to do," "feeling out" what is driving clients' decision-making, sometimes disclosing a personal choice from their own pregnancy, but adding the caveat that "it might not be right for you," and "offering people empathy all the time." I argue that informed choice differs from informed consent in that it implies patients oversee the healthcare they receive, and it actively signals they have the option to decline. Informed consent, on the other hand, rests on the assumption that healthcare, such as a test or procedure, *will* be provided, and a clinician's responsibility is to inform their patients appropriately to actively receive consent. Both are important practices, but informed choice—informing patients for the purpose of empowering their choices—reflects a different consideration of the tie between healthcare, autonomy, and people's overall well-being. Informed choice is possible in settings where active and partnered decision-making can occur between clinicians and patients, unencumbered by health system protocol and health insurance mandates.

Obstetricians are doubly constrained—by the healthcare system and by their training within the biomedical model that whole person healthcare seeks to disrupt. Danielle, an OB, spoke directly about these two major barriers to addressing her patients' emotional, psychological, or social experiences, namely limited time and biomedically assessed risks:

> The problem is, there's not enough time to really address all of that kind of stuff. Most of the time I'm seeing patients who have several medical problems that I have to address in 15 or 20 minutes and it's complicated and they don't understand, so I have to educate them just so they can get to the postpartum with a baby, let alone keep them alive afterwards.

Danielle was oriented toward the physiological and biomedical aspects of the perinatal period, specifically drawing on what she sees as her ultimate objective: keeping her patients and their babies alive. She described the structural barriers to her accomplishing an array of things in clinical encounters, regardless of her patients' multifaceted needs, and that she is powerless to influence the way her patients experience their healthcare.

One of Danielle's arguments about the constraints of her practice as an OB was that she encounters medical complexity that consumes her time in clinical encounters. OB Samantha had a different take, however, and recognized that while some of her patients are medically complicated, "the truth is that most of these patients I have aren't. And so, we don't need to spend too much time checking off the boxes. Okay, you got your diabetes screen, let's listen to your baby, let's see your kick counts, let's talk about your anemia. Most of the visit can really be focused on the other things that are happening in their lives." Contrasts like these in OB approaches may point to their work with different patient populations, employment in different health systems, varying years in practice, or different temperaments. Of course, there are many variables clinician to clinician, but they all face structural facilitators or barriers that may limit their practice and/or require creativity and flexibility to work around.

Danielle also indicated a singular focus in her work and a relatively limited view of the ways her patients' medical, social, and emotional experiences may be bound together. The OB participants I spoke with referred to their training and philosophy of care as "fact-based" and "scientific," and some described the multiple strands of influence—biomedicine, malpractice concerns, hospital protocols, patient volume, and insurance companies—that impact their clinical decision-making. It is limiting for OBs to juggle these many, sometimes conflicting, aspects of how they provide patient care, and their approach to perinatal healthcare reflects this. Danielle compared her approach to her midwife colleagues, saying,

> As doctors, you're kind of taught to suppress emotion and not put your own emotion into things. The core difference between a midwife and a doctor is that emotional concept, that emotional connection. I completely understand what women love about midwives, it's just a more personal feeling, where we're taught as a doctor to just get it done, just get it done as quickly and safely as you can.

Danielle’s account reflects the WPH critique that biomedicine separates the disease from the person. She suggests that obstetric training emphasizes an emotionless approach to accomplish assessments, procedures, and other clinical responsibilities. Her statement also implies a disease-model orientation that clinical intervention can be accomplished “quickly and safely” without a connection to one’s patient or without compromising patients’ well-being. There is discordance for OBs in this model, which researchers have described as an “illusory system of control and safety” (Wahlberg, Högberg, and Emmelin 2020) that gives OBs a perception of risk management. Yet, they are not inoculated from experiencing the inevitably uncontrollable aspects of their work, such as patients living in precarious situations or patients dying. In fact, a practice of suppressing emotion in clinical encounters will not protect clinicians from *having* emotions when something challenging arises in their work.

In our interview, before Danielle explained the biomedical demands of the care she provides which limit a more patient-centered approach, she shared a difficult story about a patient with whom she had developed a close relationship. She said that when this patient returned for birth control postpartum, she “found out her baby died, and that broke me.” She continued to explain, “I feel bad if somebody tells me their baby dies, obviously, but when it's [the patient relationship] that close, it’s that much more difficult to deal with.” Rachel, also an OB, further captured this challenge, which she saw as unique to obstetricians’ professional role and reflective of who she is personally. She said, “I’m one of those ‘lift yourself up by the bootstraps’ kind of people” which she concluded made her “not the best provider” for mental health-oriented care. Further, she suggested that overtime "you need to become like that in OB" to protect oneself. She said, "one of my colleagues is struggling a little bit because she gets so invested in some of that, it's really hard for her to move on and we can have such crazy things happen that if you get that invested, it just gets really hard." Here, I argue these OBs' accounts reflect a doubling down on the biomedical orientation to providing perinatal healthcare in the wake of the inevitably emotionally-taxing issues that arise during patient care. It becomes another way for OB clinicians to maintain a narrow, biomedically-endorsed view of what matters in perinatal health, in addition to preserving an illusion of control over patients' perinatal experiences and health outcomes.

Seeing the Whole Person as Mental Health Intervention

My study participants' conceptualizations and practices of soliciting patients' goals related to their well-being, seeing the patient as multidimensional and recognizing mental and physical health as interconnected, building rapport and trust, and practicing informed choice or consent all contribute to a more expansive consideration of their patients' mental health. For example, midwives described themselves as experts in "normal" perinatal experiences, which includes their understanding that the perinatal period is always mentally destabilizing. When combined with the rapport and trust in relationship with their clients, this framework furthers their capacity to engage with their clients' mental and emotional experiences through the perinatal period.

I found that midwives' and OBs' approaches to caring for their patients extend beyond the physical realm of the perinatal period, and at times they organically integrate the emotional well-being and mental health of their clients. Lindsey, a community midwife, spoke to "the emotional piece," saying, "If we didn't address that in our care, we would be missing this whole piece of somebody." Some study participants described their approach to their patients' mental health in a way that linked physical and mental health experiences and outcomes, with midwives in particular saying, "We come at it in a holistic way," and "We look at everything that goes into your state of being." Participants knew that the potency of somatic and social experiences in pregnancy and childbirth mean people's mental well-being is at stake. Angela, a CNM, noted,

> Some people just tend toward anxiety and depression, and some people are really reactive to certain hormones in their body. Pregnancy seems to just bring that out. Plus, bringing a human in the world, we naturally want to control and make this tiny human safe and know as much as we can. But it's inherently something we can't know everything about. We can't make sure there's never anything bad going to happen with our bodies or our babies. And that's anxiety provoking for people. It's scary, really, really scary. And I think pregnancy, especially in COVID times is super isolating. It's just, it's so hard.

In this example, Angela is sensitized to the inherent vulnerabilities of the perinatal period, articulating that the nature of the perinatal experience positions many people to face fear and isolation in addition to physical challenges that might also have bearing on mental health. Accordingly, clinicians like Angela contextualize patients' lives and address their multifaceted experience.

Knowing patients well allowed clinicians to tailor care based on their patients' needs. This could mean knowing details about a patient's birth experience even if they were not present for the birth, it could mean experiencing continuity of care through pregnancy and postpartum, or it could mean intimacy that is cultivated by being in patients' homes and around their families. Having detailed knowledge that stems from a relationship with a patient leads some clinicians to successfully tailor the care they offer with consideration of their patients' multidimensional needs. Gina, a CNM, explained, "especially if someone's had a traumatic birth or has a history of depression and then had a traumatic birth, we come up with a plan for them, like having an hour-long telehealth visit one week postpartum. And I can just carry them with a little more gentleness and care during that time."

Numerous participants pointed to a confluence of issues that connect at the nexus of "mother blame," taxing people's mental well-being through pregnancy and, especially, in the postpartum period. OB Kathryn, the solo practitioner we met above, explained that she encourages her patients to stay in her care for at least six months even though this is far from the standard of perinatal healthcare in the U.S. She does this so she can support them through the early stretch of recovery and parenting, mainly focusing on helping them get enough sleep, "because sleep is almost always a part of it." She spends time asking how breastfeeding is going, recognizing "it's such a struggle, it is so depressing for moms," and she expounded on the weight of the responsibility she observes her patients carry:

> There's so much guilt that moms carry. I call it the societal mom guilt. If their baby doesn't feed well, it's their fault. If their breasts don't produce enough milk, it's their fault. If they're not interested in having sex at six weeks, it's their fault. It is crazy, right? The expectations that we put on new mothers is crazy. And oh, by the way, you gotta be back at work in six to 12 weeks and performing at your normal.

Kathryn and others shared many accounts of their patients grappling with their emotions about stopping breastfeeding because they have to return to work and lack adequate support for pumping; others discussed the mismatch between patients' expectations and the realities of their experiences, noting this generates anxiety or causes people to "feel down."

Samantha, another OB, offered a story about a patient who expressed overwhelm about the "baby industrial complex," a phrase Samantha used to refer to the imperative to take childbirth classes and the endless list of baby items to buy. Samantha offered encouragement for her patient to let go of her expectations about what she *should* do in preparation for her baby, reassuring her that "'all your baby really needs is a swaddle' …I explained you don't need any of that stuff. And her husband came back the next time and said, ‘You know, it was really helpful for you to give her permission, not to get wrapped up in this.’” Situating their patients within the whole of society shows that these clinicians notice the intrinsic stressors present in the lives of U.S. parents. Pregnant people and new parents are living in an era with a glut of information, they face pressure to consume copious material goods, and they endure conditions that offer very little meaningful support. Making the structural visible in their patients’ real-life contexts is a crucial way for clinicians to engage WPH and provide relevant care that affects the mental health of their patients.

Clinicians demonstrated other ways they tried to attend to psychosocial aspects of the perinatal period with their patients. They described attempts to reduce shame, as CNM Angela indicated,

> A lot of people feel a stigma with mental healthcare and don't want someone to psychoanalyze them or whatever. I try to just tell them it's so normal to feel these ups and downs in pregnancy, even in the very best normal, everything's perfect, case scenario. I talk about the pressure of bringing another human into the world, that’s real and okay to talk about, and this is a safe place. Most women in pregnancy need a little mental health support.

In this effort to normalize what has the potential to be a stigmatizing or alienating experience, Angela suggests that most people need mental health support in pregnancy. In another case, Samantha had a patient who she noticed had anxiety and depression listed on their medical record. She described this person as “a professional who is partnered and white, and this is her first baby,” and she spent much of her prenatal visits wondering about vitamins and worrying if she was going to have “the perfect pregnancy.” She would ask Samantha, “What if I can't do this? What if there's something wrong with my pregnancy? What if I didn't do absolutely everything I could to maximize the chances that I will have the most healthy pregnancy that we can?” Samantha explained, “That’s often how mental health comes into play in those encounters, that’s what I deal with. So, I spend a lot of time just kind of normalizing and reassuring them.”

Conclusion

Considering the many crises facing perinatal health and healthcare in the U.S., the quest for solutions to improve health outcomes is urgent. This chapter has shown that patients desire a model of perinatal healthcare that offers continuity and accessibility to clinicians, in addition to clinician engagement that cultivates trust and empowers patients through their perinatal experiences. Pregnant and postpartum participants described that being understood—or *known*—in their whole personhood by their clinicians was demonstrated through both small, informal gestures and pointed questions. When clinicians proactively opened the door for patients to discuss the layered aspects of their lives, this had the effect of priming the patient-clinician relationship for future patient engagement—an outcome that can be particularly important when patients need mental health support. On the other hand, patients were discouraged by reductive explanations of a health issue (e.g., “miscarriage is common”), clinician avoidance of patients’ emotional states, or lack of empathy in clinical encounters. Across both cases, however, patients’ well-being can be seen as tied not just to their personal perinatal experiences but also to their healthcare encounters, underscoring the relevance of a WPH framework, which emphasizes the value and impact of the patient-clinician relationship, in the perinatal healthcare arena.

This chapter also examines how some clinicians at the forefront of perinatal healthcare—community midwives, CNMs, and OBs—seek to provide patient care in ways that could be considered aligned with WPH. There is a range of practices within perinatal healthcare that try to account for the whole person, and I show how clinicians can successfully incorporate the multidimensionality of their patients in the clinical context. For community midwives, home-based care is particularly effective for contextualizing patients' lived experiences. Certified nurse-midwives uniformly described a practice of interviewing and listening to patients with the goal of understanding their ideal health experiences. And OBs spoke pointedly about understanding the interconnectedness of patients' social experiences and their mental and physical health. Many clinician participants demonstrated a concern for one of the basic tenets of whole person health, that is, treating patients as full human beings (Hutchinson 2017). Clinician participants did not practice in healthcare settings that had formalized whole person healthcare programs (which include non-clinical approaches to patient health, such as in the VA), but I show how they already are providing WPH-aligned care in some cases and, importantly, to the extent their clinical context and environments allow. I showed how WPH-aligned practices of listening to and validating their patients and applying informed consent and informed choice, all served to cultivate rapport and build trusting relationships with their patients, and significantly, produce positive mental health effects for pregnant and postpartum people.

I argue WPH is a compelling framework for perinatal healthcare especially because of its synthesis of human qualities, interpersonal relationships, and environments—all profoundly impacted by and affecting of pregnancy, childbirth, and early parent-infant experiences. Specifically, by shifting away from a disease- or pathology-centric model of perinatal care that maintains a mind/body distinction (e.g., biomedicine) and toward WPH that promotes interrelation, mental health is inherently incorporated. This could have the effect of bringing perinatal mental health to the fore instead of maintaining its distinction at arms' length that requires specialized attention. That is, my data make visible how clinicians' WPH-aligned approaches to care *already are* interventions *for* pregnant and postpartum people's mental health.

This is important because, as I show in Chapter 2, perinatal health clinicians are fearful of mental health, believing they are undertrained or otherwise incapable of addressing patients' mental health. This leads to avoidance of and underreaction to patients' needs, or overreaction that diminishes their own capabilities to attend to their patients' mental well-being and burdens under-resourced behavioral health services. Reorganizing perinatal healthcare for WPH could reorient clinicians' beliefs about what mental health is and make visible the skills they already have within the patient-clinician relationship to effectively support their patients' mental well-being.

This chapter has shown that perinatal health clinicians have a desire and an ability to understand their patients' multidimensional lives, including their mental health. But many clinicians, particularly CNMs and OBs, face forces within biomedicine and the U.S. healthcare system that constrain their ability to implement whole person healthcare. When biomedical training emphasizes risk and maintains a mind/body binary, OBs are sensitized to see patients in a disease-oriented way, and when hospital protocol or insurance mandates impose treatment requirements, informed choice is a limited practice for clinicians and their patients. To address the gap between what patients and clinicians desire in perinatal healthcare and what is currently possible, policy change must address the structural and systemic barriers (e.g., insurance reimbursement rates; obstetric standards of care) that prevent the implementation of whole person healthcare.

In Chapter 4, I take a deeper look at obstetrics' impact on patients' mental health, further tracing the deleterious effects of the organization of perinatal healthcare on perinatal health outcomes.

CHAPTER 4: Obstetric Surveillance, Constructions of Risk, and the Production of Perinatal Anxiety

Introduction

Mental health experts increasingly raise concerns about the prevalence of perinatal anxiety, which is estimated to occur in 25% of pregnant and postpartum people (Leach, Poyser, and Fairweather-Schmidt 2017). Indeed, multiple clinician participants in my study claimed anxiety is the most prevalent mental health issue they encounter among their pregnant patients. As a perinatal mental health clinician, I, too, have witnessed the high occurrence of anxiety in my hundreds of clients through the past 15 years. Yet, the perinatal health literature and popular discourse tend to downplay the presence and impact of anxiety in the perinatal period; instead, they normalize increased anxiety as part of the pregnancy experience. As I noted in Chapter 2, even the behavioral health team at Umbrella Health did not make anxiety an inclusion criterion for referrals to their care, despite their own estimate that half of all referrals they received from obstetric clinicians were for patients' anxiety. A recent editorial about the challenges of identifying perinatal anxiety accounts for this phenomenon of normalization, explaining that "most women experience anxiety in the perinatal period; it is a common emotional response, which is rational and sometimes beneficial in certain situations" (Harrison and Alderdice (2020:1). While there may indeed be evolutionary, brain-based explanations for heightened states in the perinatal period, rationalizing people's anxiety serves to entrench the idea that perinatal anxiety is normal, and thus not something that should be taken as a serious health concern in perinatal care.

No matter how common perinatal anxiety is, there can be profound and long-lasting consequences of anxiety through pregnancy and early parenthood. Serious cases of perinatal anxiety can have catastrophic outcomes, including death; more commonly, perinatal anxiety manifests as persistent worry and intrusive thoughts, insomnia, vigilance, and a sense of hopelessness—all of which diminish people's well-being, can affect their and their children's quality of life, and persist for many years (Austin and Priest 2005; Chen, Selix, and Nosek 2021; Leach, Poyser, and Fairweather-Schmidt 2017). This chapter takes a sociological look at this predicament, specifically engaging questions that lie at the intersection of obstetric care and mental health. Drawing on theories on the social construction of risk and cultural health capital, I argue two main points: that routine obstetric care is anxiety-inducing; and obstetrics neglects perinatal anxiety as a predominant health concern for which it bears some responsibility. Considering its dominance in the perinatal healthcare arena, what is the obstetric community's obligation not only to identify and address mental health issues, but to consider its very impact on the mental well-being of pregnant and postpartum people?

Obstetrics as a biomedical specialty and the healthcare system in which it is situated are at times criticized for their risk aversion at all costs, with advocates and scholars pointing to insurance reimbursement mandates, healthcare system protocols, and malpractice concerns as primary drivers of obstetric decision-making (Bridges 2011; Morris 2016; Morris and Robinson 2017; Wolf 2018). Access to obstetric surgery is considered a life-saving advancement in perinatal healthcare, yet obstetrics also plays a key role in the much broader biomedicalization of pregnancy and childbirth (Barker 1998; Davis-Floyd 1994, 2018, 2022). Obstetric intervention in the United States (U.S.)—namely caesarean section and labor induction—occurs at persistently high rates that surpass World Health Organization recommendations (WHO 2015) and contribute to deleterious health effects (Morris 2016; Morris and Robinson 2017; Tilstra and Masters 2020), particularly for Black and Indigenous birthing people and their babies (Bridges 2008; Chambers et al. 2019; Collins and David 1990; Scott et al. 2019; the GVtM-US Steering Council et al. 2019). Nonetheless, the dominance of biomedical obstetrics in the U.S. has led to a nearly universally accepted "problematization of the normal" (Clarke et al. 2003, 2010). Even uncomplicated pregnancies are subjected to institutional categorizations of risk and subsequent obstetric screening, plus careful self-monitoring, making it "impossible not to be 'at risk'" (Clarke 2003:172). It is these normalized aspects of the pregnancy healthcare experience in the U.S. that I argue contribute to the very production of patient anxiety.

In this chapter, I draw on scholars of surveillance medicine and risk (Foucault 1973; Lupton 1999; Petersen and Lupton 1996) who have analyzed how symptoms of illness or signs of disease have transformed to become risk factors, thus shaping not just the provision of healthcare but also peoples' daily lives as they seek to minimize health risk. Sociologist David Armstrong (1995:400) writes,

> Surveillance Medicine takes these discrete elements of symptom, sign and disease and subsumes them under a more general category of 'factor' that points to, though does not necessarily produce, some future illness. Such inherent contingency is embraced by the novel and pivotal medical concept of *risk*. It is no longer the symptom or sign pointing tantalizingly at the hidden pathological truth of disease, but the risk factor opening up a space of future illness potential.

Drawing on Foucault's (1973) theories of surveillance and the medical gaze, scholars have traced how, since the 20th century, surveillance medicine has permeated society at the population level, leading to the rise of this new form of medicine which serves to monitor what Armstrong (1995) calls "precarious normality." In the case of pregnancy and childbirth—an arguably common and normal aspect of life—the precariousness of normality is made visible by the monitoring of pregnant people and their fetuses as if they are teetering on the edge of a problem, always already at risk, and extending to the self-management of pregnant people's everyday behaviors. In the U.S., the powerful medical gaze enacted by the institutionalization of obstetric care compels pregnant people to pursue medically sanctioned approaches to pregnancy and childbirth, lest they face the dire consequences of deviation (e.g., death). As anthropologist Robbie Davis-Floyd (2018:12) explains in her definition of the technocratic obstetric model of birth, obstetrics has normalized aggressive intervention with an emphasis on short-term results, motivated by an underlying fear of catastrophic outcomes and professional consequences that ensue. Obstetrics works to keep fear at bay, "giving…the illusion of control," and it has institutionalized a stratified risk paradigm wherein perinatal anxiety and its sequelae are deemed acceptable, while other complications are not.

This chapter shows the consequences of the social construction of risk in obstetric care in the U.S., arguing that obstetrics routinely takes up of some aspects of health (e.g., high blood sugar) as cause for concern while diminishing the clinical significance of others (e.g., anxiety, depression). As Petersen and Lupton (1996:18) state, "some dangers are singled out and labelled as 'risks,' while others are not; this selection process is inevitably shaped by sociocultural and political context." Specifically, I show how obstetrics' current form as surveillance medicine directly shapes people's mental health. Many scholars account for the consequences of medical surveillance in pregnancy and childbirth, particularly as a mechanism of social control and the disparate consequences that ensue. For example, the institutionalization of risk and surveillance in perinatal healthcare is linked to child welfare intervention (Flaherty et al. 2000; Roberts 2022; Roberts and Nuru-Jeter 2012) and the criminalization of perinatal substance use (Flavin 2008; Knight 2015)—both mainly impacting poor, Black, and Indigenous women. Scholars also address the tensions in medical ethics and decision-making that are exacerbated by obstetric surveillance that dichotomizes maternal and fetal health and often fails to contextualize pregnant peoples' decisions (Harris 2000; Markens et al. 1997). This chapter brings an emerging realm of the perinatal experience to the fore, telling a new story that considers the widespread negative impact of obstetric care on mental health.

The data on which this chapter is based are from 43 interviews with 25 pregnant and postpartum people. Eight people participated in three longitudinal interviews: the first interview took place in the first 20 weeks of pregnancy, the second interview was conducted between weeks 32-40 of the pregnancy, and the final interview occurred between six and ten weeks postpartum. Two participants were enrolled later in pregnancy and completed two interviews in this longitudinal series. Finally, I completed single interviews with an additional 15 people who had given birth in the past year. Beginning with patient accounts of the emotional impact of routine obstetric (OB) screening and intervention, this chapter shows how the normalized surveillance of pregnancy via obstetric oversight has deleterious effects on people's mental well-being. Next, I contend that OB screening and interventions come to be sites where patients must negotiate and navigate challenging interpersonal interactions with OB clinicians, where they sometimes weigh their personal interests against their relationships with their clinicians, and this patient trajectory becomes another source of anxiety. I then show how despite this experience, patients turn to obstetric care for emotion management when concern or fear about their pregnancies arises, specifically by seeking reassurance from obstetric clinicians and technologies throughout their pregnancies. Finally, this chapter shows that patients' efforts to gather information, weigh risks, and self-advocate did little to shape their pregnancy and childbirth decisions. Instead, ultimately, patients mostly deferred or acquiesced to obstetric power and its constructions of risk.

Risk Assessment in Prenatal Care: "The Panic of Best Practices"

In prenatal care, patients face routine testing because of standardized obstetric care that is organized around risk assessment and mitigation. As an arm of surveillance medicine, obstetric care is rooted in norms to anticipate complications, complete physical health screening early and often, and err on the side of caution when making recommendations for patients' management of pregnancy. The obstetric risk paradigm has permeated society to such a degree that it has an inescapable effect on pregnant people's lives. Yet despite its acceptability across U.S. society, it is not benign. One effect of institutionalizing the precariousness of normal pregnancy and childbirth is patients' increased concern and caution, regardless of the presence or absence of complications. From early pregnancy confirmation, to provisional diagnoses following ultrasounds at 18-20 weeks' gestation, prenatal discussions about labor induction, and to the label "advanced maternal age," participants reported encounters with various obstetric norms that heightened their pregnancy-related vigilance and caused worry. Many participants described emotional consequences, such as being "terrified" of routine obstetric screening results and intervention, pointing to an unspoken complication of obstetric care itself, specifically the toll it takes on patients' mental health throughout pregnancy and potentially beyond.

Participant stories about their encounters with routine obstetric testing typically involved the use of ultrasound technology, which is a known source of anxiety for pregnant people (Harpel 2008). Jasmine, pregnant for the first time, described an uncomfortable ultrasound experience early in her pregnancy during which she reported receiving little explanation about why a physician was called in to help with the ultrasound. The inclusion of a physician in the absence of clear information prompted Jasmine to think, "Oh no, something must be wrong." The health system in which Jasmine received care subscribes to the health movement known as

OpenNotes (OpenNotes 2023) which advocates for patients' immediate access to test results, so she received her ultrasound results immediately and read the results independently. The notes contained terms she did not understand and caused her concern, and she said, "I had an 18-hour period where I was like 'Is my baby totally effed?'"

Another postpartum participant, Jo, recalled facing uncertainty following a mid-pregnancy ultrasound:

> I had the 20-week ultrasound and they couldn't get a good look at his face. And then he had a spot on his heart. And so, they were concerned that those are both markers for potential, um, Down syndrome. I remember so vividly getting the call from my doctor, being like, 'Don't freak out about what's happening, here are the things you need to do.'

Jo received the news that her ultrasound revealed markers for Down syndrome in her developing fetus, in addition to being told that her placenta was positioned low in her uterus. This rare complication is known as placenta previa and occurs in approximately 0.5% of pregnancies (Resnik 2019); it introduces risks for the remainder of pregnancy and during childbirth. Jo was told by her obstetrician to stop having sex to avoid potential complications related to her low-lying placenta but was otherwise left to navigate uncertainty in the wake of these inconclusive ultrasound results. Despite her OB's encouragement to "not freak out," along with a prediction that the placenta would move over the course of pregnancy, Jo had "these two things [the possibility of Down syndrome and placenta previa] kind of hanging there," and grappled with lingering questions such as, "Does my kiddo have Down syndrome? Do I need to figure out how to prepare for that? Is my placenta going to be in a place that means I can't deliver the way that I expected? Am I going to have a c-section?"

For Jo, these ultrasound results were blindsiding. She said, "Part of the reason it stands out so much to me…was it was something I didn't expect." Ten weeks later, Jo had a follow-up ultrasound that showed the spot on her fetus' heart was gone, clearer images of the fetus' anatomy did not reveal markers of Down syndrome, and Jo's placenta had moved. Jo could move forward with reassurance about her pregnancy, but only after enduring months of ambiguity and anxiety. Importantly, these experiences in prenatal care set the tone for her perinatal mental health. When reflecting on the whole of her perinatal experience, Jo explained, "It feels like my anxiety went up and then my anxiety never really subsided itself." In her experience, routine prenatal testing and the resultant provisional diagnoses "started this whole chain" of stress and anxiety that deteriorated her mental well-being and, potentially, depleted her postpartum resilience.

Like Jo, Natasha shared her emotional state in the wake of hearing she may have placenta previa saying,

> I was shocked because apparently placenta previa is rare. It's not super common. I was very shocked, and I was also terrified. I am still worried if this resolved or not—we will figure it out actually next week. So, I was shocked and scared because when I read about previa online, only a few percent of women, but still a few percent of women, had to remove the uterus after the baby arrived because the placenta stuck to the wall. So, since my husband and I plan to have another baby…I'm anxious about it. I couldn't stop thinking about far things that could happen in the future. So yeah, definitely anxious and scary.

Haruko was another participant who had a provisional placenta previa diagnosis following the routine mid-pregnancy ultrasound that confirms fetal anatomy development. Haruko, pregnant for the first time, recalled, "My doctor explained that I have placenta previa. We will have another ultrasound, which apparently normally people don't do if there are no abnormalities." Haruko's ultrasound was at week 19 in her pregnancy, and her OB explained that a diagnosis of placenta previa at 19 weeks' gestation usually resolves "towards the end of pregnancy as the belly grows bigger and bigger." Haruko articulated what it was like for her to receive this news: "Now I'm one of the women who has a rare thing. And so, if it doesn't resolve … then we are gonna schedule a c-section and I'm terrified." Haruko had to wait until week 34 of her pregnancy to check on the placenta's location in her uterus, and in our follow-up interview near the end of her pregnancy she confirmed that the placenta previa "has been resolving. It's a low-lying placenta, but they said it's far enough from the cervix." But between 19 and 34 weeks gestation, she, like others, lingered in a liminal place of concern and caution based on obstetric norms of risk assessment. For over a third of her pregnancy, Haruko carried a provisional diagnosis and the uncertainty that accompanied it, only to learn near the end of her pregnancy that the threat was benign.

Though placenta previa is not the only pregnancy complication study participants encountered, it was what they discussed most. It could be that provisional diagnosis of placenta previa is becoming more common because of increased use of ultrasound technology at earlier points in pregnancy. The significance of placenta previa experiences for participants may also reflect the distressing nature of receiving a provisional diagnosis of a pregnancy complication that carries serious risks to their and their fetuses' health, then having to wait many weeks for confirmation. Participants were caught off-guard by ultrasound results, and they also described feeling "anxious" and "scared," constantly preoccupied by concerns of potential pregnancy complications. Beth was another participant who received a provisional placenta previa diagnosis and had to grapple with the tensions of routine testing and risk assessment in obstetrics throughout her pregnancy. After she received additional information about risks associated with placenta previa she understood that "most of the time it resolves in like 90% of women." Yet, her mental well-being was impacted by obstetric-generated uncertainty and risk possibilities: "The big thing is, there's nothing you can do to make it resolve or not resolve. You just have to wait. That's the hardest." She referred to the experience of early provisional diagnosis and risk mitigation in obstetrics as "the panic of best practices. No other country freaks out like this," she said, comparing the high-intervention nature of U.S. perinatal healthcare to that of other countries. Though obstetric routines in the U.S. may be couched as “screening” and “monitoring,” they often take on the form of intervention and treatment. For example, the *potential* for placenta previa becomes a provisional *diagnosis* for patients to face and address with behavior modification for weeks or months of their pregnancies. This trend is emblematic of biomedicalization (Clarke et al. 2003, 2010), in which an increasing focus on the elaboration of risk, surveillance, and potential optimization become standard practice in healthcare. In the case of prenatal care, screening leads to more cause for concern. Importantly, Beth’s reference to the “best practices” of obstetrics underscores how it has become routinized to apply the most risk-averse levels of screening in patient care, normalizing not the middle of the curve of risk and possibility, but the highest degree. In her phrase “panic of best practices,” Beth appropriately identified that the institutionalized risk aversion of obstetric surveillance is bound up with obstetric anxiety, which has the unfortunate effect of simultaneously causing and normalizing patients’ anxiety. In other words, obstetric problematization of normal pregnancy has a powerful signaling effect, leading patients to conclude, *I should be worried.*

Participants like Natasha and Beth clearly described a discrepancy between what they *understood* and how they *felt*, showing how obstetric screening disrupted their mental well-being. Despite intellectualizing her healthcare experience and contextualizing her provisional diagnosis of placenta previa, Beth’s experience being pregnant was negatively impacted by her obstetric care. She said, “For me, it really did make me not be able to enjoy that chunk of my pregnancy because I was constantly thinking about it.” Jo described a similar discrepancy in her experience, saying,

> I was worried. And there was a little bit of like, did I do something [to cause this]? Even though it's…rationally and logically…there's nothing that I could do to control this. And

> there's nothing that I can do to control what the outcome is. All I can do is abide by the restrictions that [my OB gave] me and go from there. It was kind of isolating. I really, I love my OB. She's great. But she was like, ‘don't go down the Google trail too bad. Like you're gonna freak yourself out. I know that's the first thing you’ll want to do.’ I felt like, what does that mean?

Not only did outcomes from obstetric screening cause Jo to worry, but she also wondered if she was to blame for the potential complications to her pregnancy and fetus. Preoccupation with worry for her and her fetus’ health was thus compounded by self-doubt and shame associated with her experience. She tried to reconcile with herself that the only thing in her control was following her OB’s advice, yet her OB’s suggestion to not “go down the Google trail” left her wondering what terrible information she might encounter in a Google search. Rather than bringing relief or clarity, this advice served to induce even more anxiety.

For people over age 35, the intensity of obstetric surveillance via routine screening norms is further amplified. One obstetric risk concern that is heightened for older pregnant people involves deterioration of the placenta over time and an increased incidence of stillbirth past 40 weeks’ gestation. Accordingly, prenatal care commonly involves discussions about obstetric recommendations for mitigating this risk—primarily labor induction—and patient and clinician preferences about how to proceed. In the wake of an initial conversation about labor induction with her OB, Tabitha, pregnant for the second time and over the age of 35, was upset because she felt pressured to consent to induction when her preference was to wait for labor to begin spontaneously. She recalled her reaction to this pressure, saying, “I was crying constantly, bursting into tears every five seconds.” Ultimately, obstetric risk assessment generated enough concern about risks associated with her “advanced maternal age” that Tabitha conceded to her OB’s insistence about inducing labor.

Some participants identified that being labeled with “advanced maternal age” was an added stressor that changed their relationships to obstetric care and impacted their healthcare experiences through pregnancy and childbirth. Natasha perceived “a stigma in the medical world of having a baby at advanced age,” and described the routine “stress tests [contraction stress tests to measure fetal heart rate during stimulated contractions] I had to do” near the end of her pregnancy because of her age: “Being older, you get tons of more testing. So, either it scares you or you get reassured constantly because there's so much more testing.” Natasha’s suggestion—that more routine testing is either scary or reassuring—is important to understand the impact of obstetric care on the mental well-being of patients: I found that routine testing can be *both* scary *and* reassuring. I return to this double-sided nature of obstetric surveillance later in this chapter.

False Choices and the Burden of Negotiating Relationships with Clinicians

As shown above, routine obstetric screening, risk assessment norms, and subsequent recommendations feel both necessary *and* intrusive to patients and cause for alarm. Yet there is often little space for patients to articulate concerns, ask questions, or otherwise seek support from their OB clinicians due to the brevity of OB appointments, plus the social power of healthcare professionals and challenges in patient-centered communication (Diamond-Brown 2018; Timmermans 2020). Importantly, not only do OB screening and interventions generate emotional discomfort for patients, but they often instigate negotiations with OB clinicians. In these cases, patients may face difficult decisions about their healthcare and their relationships with their clinicians, calculating whether their personal health warrants what could be challenging conversations with clinicians on whom they depend heavily for pregnancy care. I found that among my participants, this interactional navigation and the weighing of costs and benefits—of asking questions, pushing back, and otherwise negotiating the parameters of perinatal healthcare—can be understood as the deployment of cultural health capital (Shim 2010) toward a practice of intensive parenting (Reich 2014).

Cultural health capital (CHC) is defined as "the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships" (Shim 2010:1). In pregnancy and preparation for childbirth, people in the U.S. face a cultural emphasis on self-surveillance that lauds the accrual of knowledge about pregnancy and fetal development, abilities for self-care that prioritizes fetal well-being, and a commitment to pursuing positive health outcomes. When people successfully present a "coherent collection of skills" (Shim 2010:3) such as these in healthcare encounters, it has the potential to improve their relationships with clinicians and influence the care they receive. Below, I show how participants deployed CHC as they sought individual choice within obstetrics, yet encountered interactional ambiguity and negotiations that highlight the rigidity of obstetrics as a routinized system with an intensive monitoring imperative, opening the possibility for inequities in perinatal healthcare and patient-clinician relationships to emerge.

Patient-clinician negotiations sometimes arise from tensions about and differences in how obstetric risk is interpreted and acted upon. This can be seen in Ellen's birth experience: after an uncomplicated twin pregnancy, Ellen gave birth to her babies in a hospital setting and described multiple encounters through prenatal care, labor, and delivery that induced anxiety and presented opportunities for self-advocacy. When recounting the delivery of her twins she explained,

> I felt really emotional about how medicalized they try to make everything. I felt almost—I tried not to express it in this way—but I felt internally combative. Like, people have been having twins forever. I don't need to deliver in an [operating room] unless something's wrong, you know?

Ellen grappled with her preferences for a less-medicalized delivery experience alongside risks associated with her twin pregnancy. She acknowledged that it is possible to deliver twins without obstetric intervention and was interested in allowing normal physiologic labor and birth—that is, a labor and birth that is powered by the innate human capacity of the birthing person and fetus (ACNM, MANA, and NACPM 2013)—to unfold for her and her twins, saying, “I just don't see physiologic labor as risky the way that they do.” She recalled frequent encounters with obstetric clinicians that she described as “fear mongering,” reporting they challenged her labor and delivery desires by “bringing up risks pretty immediately in prenatal visits.” Her way of coping with these interactional tensions was to actively remind herself that she is in charge of her body:

> At first, I was really anxious, getting worked up and asking a ton of questions and I was getting quite stressed by it. And I decided that wasn’t necessarily helping me. They can’t make me do any of it. And even they would say ‘Well, we can’t *make* you have an epidural.’ So, as far as I’m concerned, it’s all optional.”

Navigating such tensions from a vulnerable position was anxiety-inducing and challenging for participants like Ellen, who described feeling “internally combative” while trying to communicate her needs without igniting interpersonal conflict that could compromise the care she received. Ellen understood the sensitivity of the interpersonal dynamics of patient-clinician relationships in obstetric care when she pivoted her approach to coping with the “fear mongering” that was upsetting her. Rather than resisting her OB clinicians outright, she shifted to an internalized process of believing she is in charge of what happens to her body. Though she remained “*internally* combative,” Ellen’s interactional style with her OB clinicians and otherwise inward approach to supporting her pregnancy and delivery desires were choices she made to protect her relationships with clinicians and the care she received.

Ruth also resisted what she perceived to be a risk-averse approach to obstetric care. She turned 35 shortly prior to becoming pregnant for the first time, and she worried about being tracked toward obstetric protocols based on guidelines for pregnant people aged 35 and older. She described her efforts to self-advocate:

> From the get-go I said, 'If you're making any recommendations based on those four months [that make me] advanced maternal age, please don't. I don't think that's a reason.' And I think some of that is also where the potential practitioner shift [having to see various clinicians] made me nervous, because I've had those conversations and set those expectations or boundaries with my OB, and then to think about having to go through all of that again [with different clinicians] feels a little bit overwhelming.

Ruth positioned herself defensively to deal with the "advanced maternal age" label and the obstetric interventions that ensue, and this was not without a mental cost—she indicated that facing the organization of obstetric care with its rotating cast of clinicians made her nervous and overwhelmed, in part because this meant that she would have to repeatedly engage in the taxing work of setting boundaries again with each new clinician.

Later in her pregnancy, Ruth's OB presented research that cited better outcomes with labor induction in some instances, and Ruth again resisted the recommendation to induce based on gestational age. When her OB asked if she would at least consider non-stress tests near the end of pregnancy, Ruth said, "Yeah, totally. I'm all about that information. But, if there's nothing wrong with the baby, I don't see any reason to start labor early. If we see signs of stress in the baby, I'm all for it. But, yeah, the [minimal] risks don't feel worth it [induction]." Here, too, Ruth was able to deploy CHC for the benefit of her healthcare experience. Like Beth, Ruth perceived the need to delicately balance interpersonal relationships in obstetric care, that in turn produced the stress she experienced, especially when she was compelled to repeatedly set boundaries with the multiple, rotating clinicians from whom she received care. Also, by demonstrating nuanced knowledge of medical topics, communicating effectively with clinicians, and adopting a proactive yet conciliatory interactional approach, Ruth purposefully leveraged her CHC to engage her clinicians. Her efforts allowed her to feel successful in her self-advocacy while preserving the patient-clinician relationship, but this was not without strain. When describing her feelings about advocating for herself, Ruth reflected, “There is so much time and work and decision-making in that…really having to parse it all through,” which touches on the burden of self-advocacy. It also underscores that as gatekeepers to care, clinicians hold power in their ability to choose which patient behaviors, dispositions, and actions are appropriate or inappropriate. This power relation, specifically OB clinicians’ positionality to adjudicate and then either reward or penalize patient behaviors, is what patients feel vulnerable and anxious about. That is, it is not just that qualities of CHC are deployed by patients like Ruth, but rather that they are embedded in and determined by a field of unequal relations where CHC becomes a form of currency and exchange (Shim 2010).

Both Ellen’s and Ruth’s spouses are physicians whom they relied on to read scientific literature about obstetric interventions, health outcomes, and for understanding the statistical significance of complications referenced by their OBs. This information gathering (and parsing through it all) is reflective of gendered expectations of highly-involved mothering (Bobel 2010; Hays 1996; Lareau 2003, 2011) and can be considered the beginning of a trajectory of intensive parenting, most prominent in middle and upper class families, that optimizes children’s health and “ties women’s identity and sense of self-efficacy to children’s well-being” (Reich 2014:698). Neither Ellen nor Ruth was interested in decision-making about their pregnancies and deliveries based on the status quo of prescriptive surveillance obstetrics, and so they engaged in considerable labor and deployed CHC to navigate through obstetric norms and protocol that did not align with their personal desires for their pregnancies and deliveries. Their efforts also constitute what Berkowitz and Mann (2023) identify as strategic identity work of pregnant women of “advanced maternal age” that is informed by their class-privileged social location. Ellen and Ruth are examples of women who strived to individualize otherwise standardized procedures of healthcare, becoming advocates for themselves and their unborn children.

In contrast to Ellen and Ruth, Sasha’s experience navigating perinatal healthcare shows a different kind of patient experience with further implications for health equity. Sasha’s peers in a group prenatal care session encouraged her to advocate for herself when she said she felt judged after being weighed at prenatal visits, but she described how self-advocacy is difficult for her:

> I always feel really flat-footed because the system feels mysterious to me. I don’t always know where or how to advocate. I could say no, but I also feel like I don't always like it [saying ‘no’]. It isn't transparent to me where the opportunities to advocate for myself are.

Sasha’s concerns reflect a significant and common challenge for many pregnant people, to discern where the opportunities for self-advocacy exist in obstetric care. In contrast to the specific ways Beth and Ruth deployed CHC to benefit their obstetric experience while also protecting their patient-clinician relationships, Sasha’s experience reflected more limited access to CHC. She perceived the obstetric setting as “mysterious” and opaque, making her unsure of when and how she could “say no,” and so she tended to acquiesce to obstetric routines. These interactional differences illuminate the potential for the production of inequalities in obstetrics and disparate perinatal health experiences and outcomes. To further emphasize this possibility, Sasha’s experience can be situated alongside well-documented inequities in perinatal health that result from multiple social and structural determinants, such as health system deficits, lack of paid family leave, and differences in access to respectful, culturally appropriate care (Crear-Perry et al. 2021). Further, Reich (2014:700) refers to a “jagged landscape of parental freedom” wherein there exist unequal consequences, largely imposed by the state, to people’s behaviors in the context of healthcare and decision-making about their children (born or not). Where some women experience considerable freedom to make healthcare choices for themselves and their children, others paradoxically face threats to their and their children’s freedom in the wake of their healthcare decisions.

While these healthcare inequities are prominent and have far-reaching consequences, I contend that obstetrics is so broadly confining with powerful influence on pregnancy and childbirth that, in this particular healthcare arena, there is far less freedom of choice than some participants’ efforts suggest. Even for participants who described using self-advocacy strategies at various points through prenatal care, labor, and delivery, there were interpersonal risks associated with their dissent and deleterious effects on their mental well-being, and, ultimately, they encountered limitations to the efficacy of their resistance or advocacy efforts. Even Ellen—a person with a strong commitment to her vision for her pregnancy and delivery and who had a physician spouse and a doula’s support during labor—ended up deferring to nursing protocols in the hospital that limited her mobility throughout her labor:

> It's uncomfortable pushing against what you perceive them to be comfortable with, even though the babies were doing fine, there were no issues on the monitor the whole time. It's hard, too, because you don't want frustrated providers, either. They're taking care of you. So, there's also that emotion management, or that relationship management that I think sometimes gets in the way of advocating. You're trying to be careful in that way, which shouldn't be the case. But I think that's the reality.

Considering the enduring power of obstetric authority, Ellen and others show how taking on the interpersonal challenges of self-advocacy was daunting for most, even if differently so, and not without potential costs to their mental well-being or the cohesion of the patient-clinician relationship.

Enduring Obstetrics: Acquiescence and Deference to Obstetric Care

In addition to engaging in self-advocacy, as shown above, some patients try to make their own judgements about risks rather than relying solely on the advice of their providers. Accordingly, they gather information about pregnancy, their health, and incidence of complications, deploying CHC to shape their perinatal health and healthcare experiences to align with their preferences and values. However, I found that such information gathering did little to substantially change participants’ healthcare choices throughout pregnancy and childbirth. The nature of obstetric dominance in the U.S. leads to pregnant people’s multifaceted reliance on obstetric care through the perinatal period, whether or not they actively resist its routines and norms. I found that many participants’ healthcare trajectories unfolded in ways that evinced constrained choices and some amount of acquiescence and deference to obstetric power, ultimately taking a toll on their mental health. Even when obstetric care is a means for patients to cope with discomfort or allay their fears associated with uncertainty in pregnancy, obstetrics is still a root cause of patients’ concern. This double-sided nature of obstetrics is a paradox: its surveillance may heighten anxiety, but it is also a primary and legitimized means of seeking reassurance by obtaining information about pregnancy.

In fact, I argue that reliance on obstetrics as a technology of normalization is so culturally significant that obstetric-influenced anxiety begins prior to pregnancy and shapes—even constitutes—people’s earliest pregnancy experiences, including their proactive engagement with obstetric care and technologies. Jasmine, for example, requested a transvaginal ultrasound very early in her pregnancy, around seven weeks, and she recalled telling “the person who did the transvaginal ultrasound for me ‘I know I took a pregnancy test, I’m sure I'm pregnant. But I really didn't feel a hundred percent convinced until you guys confirmed it.’” She further reflected, “I felt like I needed a medical professional to confirm it was true, so that helped allay the fear.” And when Layal, pregnant for the first time, went to the hospital at eight weeks gestation for intravenous fluids because of persistent pregnancy-induced nausea and vomiting, she asked hospital staff, “Can you guys just check the heartbeat and see if you can hear it?” She explained, “That was the first time we were able to hear it, so that was reassuring because this is my first experience with pregnancy,” and she concluded, “It was worth going through all the nausea and stuff just to hear that heartbeat.”

Amy, a postpartum participant, described persistent anxiety that endured through the first half of her pregnancy until she was able to have the routine 20-week ultrasound. She said,

> I had a lot of anxiety at the beginning before I could really feel the baby moving on the regular and before I had seen the ultrasound images to know that everything was okay, and his body was developing in a normal way from what they could tell in the images. After that it was a lot more reassuring. But before that point it was sort of like I had to think myself out of the anxiety, I didn't have any evidence that things were okay.

Amy’s mention of biomedical evidence suggests an ultimate deference to obstetric oversight and a reliance on the visibility made possible by ultrasound technology, despite other affirming physiological signs that may have been present in her body, such as pregnancy symptoms or a growing abdomen. Significantly, Amy’s anxiety occurred despite a *lack* of indication that anything was wrong with her pregnancy or fetus, illustrating what is always already at risk as her pregnancy existed in a state of “precarious normality” (Armstrong 1995).

Shifting some perinatal healthcare to telehealth platforms in recent years revealed anew the reliance of obstetrics and medical surveillance for reassurance. Though some participants liked the convenience of telehealth, others found it dissatisfying. Ruth explained, “It’s nice to go in person because of course you want to hear your baby’s heartbeat every time, right? You just want that reassurance, especially being older.” Here, Ruth illustrated two effects of obstetric risk assessment and surveillance norms: belief that being older is a problem in need of more oversight, and that fetal monitoring is a pathway to acute reduction of pregnancy-related anxiety. It is impossible to separate pregnancy from obstetrics, and collective conditioning to acquiesce to obstetric authority inherently diminishes one's own embodied sense of and trust in pregnancy. These participants all suggest there is a baseline of anxiety and uncertainty about pregnancy that obstetrics both produces *and* serves to relieve. Jasmine's, Layal's, Amy's and Ruth's experiences illustrate their reliance on obstetric expertise, screening, and technologies—all of which have "problematized areas of life as pervaded by risk" (Lupton 1999:88)—in the pursuit of their healthiest, most reassured, pregnant state.

This problematization of pregnancy as risky, combined with reliance on obstetric expertise, sets the tone for people's relationships with their pregnancies and ultimately influences their mental well-being throughout. For example, the perspectives Beth solicited from her family members became justification for acquiescing to the obstetric recommendation to stop running due to a provisional placenta previa diagnosis, despite her concerns about how this might otherwise affect her well-being. Beth said,

> My cousin gets it because she's a collegiate athlete, too. She's like, 'I get it. I know you, and I know [running is] a priority for you. I wouldn't tell you to just stop running unless I thought there was an issue or a risk. I think until you know more information, when they rescan you at 26 or 28 weeks, you're going to have to just bite the bullet and make the right choice.'

Through my conversation with Beth, it was clear she was resistant to the recommendation to stop running based on a projection that she *might* develop placenta previa, yet she was trapped by the persistent obstetric rhetoric of risk and subsequent social pressure to "make the right choice." Here, it is evident that obstetrics is a disciplining power, a key force in biomedicalization that has created a regime that disciplines pregnant people (and others with whom they have contact) to self-surveil through pregnancy and childbirth. Importantly, part of its disciplinary power is that it carries a tone of morality, presenting very clear pathways for pursuing a “healthy” pregnancy in the service of producing a “healthy” baby. This generates collective panic about pregnancy, and it reinforces what it means to be a responsible agent of reproduction, thus limiting individual agency through pregnancy (Foucault 1973).

In the end, Beth turned to her spouse for a final decision, saying, “I’m trying to be respectful …It is my body, but it’s also his baby;” his decision was that “if we can figure out another way for you to exercise during this, it sounds safer for our baby if you just don't run.” Yet, this acquiescence, combined with routine obstetric monitoring of her weight, compromised Beth’s mental health, activating anxiety and body dysmorphia. She explained how her image of her pregnancy changed when she stopped running, saying,

> Especially with losing running, I've tried really hard not to fixate on the weight gain…I mean, they shouldn’t even tell you [your weight], only if there’s a problem. Because I feel like they weigh you and you're like, *holy shit*. I've never seen that number before. I'm not very big. I'm only five one. So, for me to see a number that's over 130 pounds is a lot. It totally stresses me out. I think about it all the time, which is funny because I'm not somebody who would, like, put myself in the body dysmorphic eating disorder category. I wouldn't put myself in that category normally.

The trajectory of Beth’s pregnancy experience—one that she described as stressful, consuming, and unenjoyable—was set in motion by routine obstetric care. Mid-pregnancy ultrasounds and obstetric recommendations for patients to err on the side of caution by changing health behaviors are routine practice in obstetrics—perhaps considered mundane or harmless by clinicians—but participants’ experiences elucidate the potency of this approach to perinatal healthcare on patients’ mental health.

For participants like Natasha who explained she “*had to* do” additional testing because of her age, deference to obstetric routines was an unquestioned, default response. This can be seen, too, when Tabitha encountered challenges near the end of her pregnancy and her OB began discussing when to schedule labor induction. Knowing she had a spontaneous labor with her first pregnancy and that she preferred to approach her second labor similarly, I asked why her OB was encouraging induction. She said she wasn't sure, but suggested,

> My doctor just said that I didn't really have Braxton Hicks [contractions]. I had a couple bouts of it, but I didn't really have many. And she wanted to get it on the books… I don't know. She was basically like, 'I don't want you to be more than two weeks past due date.' But even then, she wasn't super comfortable with that. So, we decided a week [past due date] was what I felt okay with. I didn't want to induce right away. I wanted to let my body kind of do what it needed to do.

Over the course of routine prenatal appointments, Tabitha's OB continued to nudge her toward induction. Tabitha related that she never quite grasped a clearly articulated rationale from her OB about her recommendation to induce. Her OB referenced few Braxton Hicks contractions and gestational age as indicators for induction, but Tabitha was not offered evidence-based information about incidence or significance of complications, nor was she supported to make her own informed decision. At best, Tabitha was offered by her OB a compromise on the timing of an induction, but not *whether* it would be done if the pregnancy continued past its due date. In her re-telling of her prenatal care experiences, Tabitha expressed resignation. In the end, after multiple emotionally charged OB visits, Tabitha ended up inducing labor at 41 weeks pregnant at the urging of her OB. Though this was not what Tabitha wanted, she concluded, "as an older mom, they tell you it can get really dangerous. She [the OB] just said, 'We need to have you come in; we need to try.'" Deferring or acquiescing to obstetrics can be a fraught experience, yet the obstetric risk paradigm routinely eclipses patients' desires for their pregnancies and deliveries, presenting the too-high stakes as reason alone for personal choice to carry any weight. Because of this, patients endure the prevailing obstetric approach, but it is not without a personal cost.

Even seemingly successful pregnancy and birth outcomes may come with lingering negative effects for patients who received obstetric care that did not align with their personal desires. Ellen finally conceded to labor induction, and was able to deliver her twins, one of whom was breech, vaginally, and she had only minor tearing that did not require stitches. Because of this rare twin delivery and positive physical outcome for her and her babies, Ellen explained she felt "not justified in feeling sad, given how it went." But she said,

> [I] did feel sad about it. I know it is probably not helpful, but I think it probably started with them trying to induce before my gut felt ready. That felt like it was a result of the pressure from the [maternal fetal medicine doctors]. I just didn't feel like they [the babies] were ready yet.

Ellen touched on the compounding mental health effect of having positive physical health outcomes yet still feeling upset by how her prenatal care, labor, and delivery transpired. Not only did Ellen feel sad about how her birth experience unfolded, but she also second-guessed and diminished the value of her feelings considering the seemingly positive results of her pregnancy and delivery. Ellen's experience sheds light on the downside of an enduring obstetric approach to pregnancy and childbirth that fixates on end results at the cost of patients' mental well-being.

Thus, despite patients' desires and self-advocacy, I find that the power of the obstetric model and its impact on patients' mental health (i.e., heightened vigilance, increased anxiety) ultimately limit the degree to which people can have full autonomy during prenatal care, labor, and delivery. In her book *Ordinary Insanity,* writer and mother Sarah Menkedick (2020:98) accounts for this when she addresses the prevailing ideology that overlays pregnancy in the U.S.—*why risk it?* She writes,

> This is the brutal rhetoric of reproductive risk: every choice is presented as being simple to make, so simple that it is not really a choice at all. The disorientation and pressure produced by this simultaneous casualness—it's so easy—and grave insinuation—damaged for life—is so disconcerting that it seems outrageous for a woman to exercise any defiance.

As Menkedick argues, despite people's efforts to gather information, weigh risks, and make informed and autonomous decisions, they ultimately understand that the "right decision" is to heed obstetric warnings regardless of the potential cost to their mental well-being. This is the primary consequence of the social construction of risk: that it is our *understanding* of dangers and hazards, which eclipse the nature of the threat and are constituted through social, cultural, and political processes, that primarily shape our health and healthcare experiences (Petersen and Lupton 1996). In other words, since obstetrics is the ultimate disciplinary power in pregnancy and childbirth (Foucault 1973), who could bear the consequences of making a dissenting choice in the face of obstetric warnings of a potentially catastrophic outcome?

Conclusion

This chapter addresses the underexamined phenomenon of the production of patients' anxiety in obstetric care. I argue that the institution of obstetrics not only has a role to play in the screening and treatment of perinatal mental health, but it also has a responsibility to address its impact on pregnant peoples' mental well-being. Pregnancy and postpartum experiences never occur in a vacuum, and one of the primary social influences on pregnancy is obstetric surveillance. I argue that the construction of the pregnant person as always already at risk and its institutionalization in obstetric care is anxiety-inducing for obstetric patients. The problematization of the normal pregnancy (Clarke et al. 2010) encourages pregnant people *to be worried*, in turn normalizing the presence of perinatal anxiety. Accordingly, although perinatal anxiety is common, disruptive, and recognized as such by perinatal clinicians, it is not considered an intervenable, let alone preventable, problem. This is mainly due to obstetrics' stratified risk paradigm: routinized obstetric care is based on the highest degree of risk possibility while it diminishes the effects of other risks it regards as acceptable.

Obstetric norms about risk reveal that obstetrics has its own anxiety problem. Many scholars (Morris 2016; Wolf 2018; Barker 1998; Davis-Floyd 1994, 2018, 2022) have addressed the multitude of reasons (e.g., malpractice, death-avoidant culture) that fear is at the center of the predominant model of perinatal healthcare in the U.S. The fear of maternal, fetal, and infant death have long pervaded the institution of obstetrics, and in recent years the issue of pregnancy-related death has been further spotlighted as mortality rates, particularly for Black and Indigenous women, continue to rise (Carroll 2017). It is crucial to elevate the seriousness of this issue to improve the quality of healthcare and reduce health inequities. Yet, organizing the whole of perinatal healthcare around the fear-driven idea that pregnancy and birth should be managed by obstetric surveillance and thereby are controllable has not reduced pregnancy-related mortality, and I argue it has diminished quality of life for both clinicians and patients. We must also engage with other difficult truths if we aim to improve perinatal health outcomes holistically: some pregnancy-related death is unavoidable and mental and physical quality of life matter. Engaging in obstetric surveillance norms gives both clinicians and patients a false sense of guarantee while simultaneously pressuring continued surveillance to keep insecurity at bay. This defeating cycle ultimately compromises patients' mental well-being by inducing anxiety, and it moderates the capacity for patient-clinician connection throughout pregnancy and childbirth. Further, obstetric surveillance based on the highest risk possibilities shrinks the availability of resources to attend to the far-more prevalent morbidities, such as anxiety and depression, that impact people's well-being during and after pregnancy.

In this chapter I show multiple dimensions of obstetric-induced stress and anxiety: the emotional fallout participants experienced from routine ultrasounds; provisional diagnoses that placed them in a nagging; sometimes debilitating, state of limbo for months at a time; and heightened vigilance about their “advanced maternal age.” Specifically, they described being “blindsided” and “shocked” by obstetric findings, such as placenta previa, which led to ambiguity, health behavior changes, and worry about c-sections, loss of their uteruses, and death. For some, this resulted in pregnancies that were unenjoyable—marked by unrelenting worry and sometimes persistent anxiety that failed to subside postpartum. Because obstetric surveillance perpetuates the idea that pregnancy and childbirth are controllable, some participants internalized imperfections in their pregnancies, worrying they were somehow to blame for complications.

I found that, even when participants were frustrated by or felt fearful of their obstetric care, or when their desires for their pregnancies or deliveries did not align with obstetric recommendations, they weighed their personal needs against the potential cost of being perceived by clinicians as difficult. This generated another layer of stress and anxiety for some as they faced decisions about whether and when and how to negotiate with clinicians. Some participants deployed cultural health capital and engaged interactional styles that served to maintain the patient-clinician relationship, some gathered information for self-advocacy purposes and attempted to optimize their healthcare for their and their unborn child’s well-being, and others more passively coped with the opaqueness of the obstetric system. In many cases, discomfort with obstetric protocol sat alongside the anticipated consequences of patient-clinician conflict or catastrophic outcomes, so participants often opted to avoid both by accepting obstetric norms and recommendations.

Participants' experiences uniformly involved some acquiescence or deference to the enduring power of obstetrics. This aspect of their experiences underscores that obstetrics operates as a disciplinary power (Foucault 1973), and it reflects a widespread diminished trust in the embodied process of pregnancy which further takes a toll on patients' mental well-being. Even when participants demonstrated strong conviction about their personal pregnancy and childbirth desires, they were trapped by the obstetric paradigm of risk that persistently insists: *why risk it?*

In this chapter, I strive to amplify perinatal anxiety as a common pregnancy-related problem worth greater attention, but I take a sociological approach to turn our gaze toward a predominant structural issue—the institution of obstetrics—that has considerable bearing on the prevalence of perinatal anxiety. My analytic approach, combined with my expertise from many years of clinical work in the arena of perinatal mental health, leads me to confidently reason that individualizing anxiety as only a pathological phenomenon requiring specialized mental healthcare misses a main point, and it maintains biomedicalized, siloed, and downstream interventions that have limited reach. I further argue that perinatal anxiety may become easier to intervene upon and its incidence reduced if we tackle its upstream influences, namely the obstetric care that profoundly shapes most pregnant peoples' experiences in the U.S. Indeed, if we are to make substantial gains toward improved mental health for pregnant and postpartum people, I contend we must reconsider our approach to perinatal healthcare across-the-board, shedding the fear-driven surveillance model of care we have come to accept as necessary and inevitable.

CHAPTER 5: Conclusion

Twenty years ago, I became a social work student intern in the neonatal intensive care and labor and delivery units of a hospital. That early career experience began the thread of my work since, mainly supporting people in the wake of perinatal loss or through mental health disruption that coincides with their fertility, pregnancy, or postpartum experiences. I continue to find reward from my practice as a mental health therapist, and I know the tremendous value of showing up to be with vulnerable people who are structurally under-supported and suffering. Yet, over the course of my career I faced periods of disillusionment: First, I learned how taxing it is to be a marginalized healthcare professional, especially in the context of interdisciplinary work in biomedical settings. Second, I became discouraged by the growing subspecialty of perinatal mental health because of its emphasis on professionalization, diagnostics, and psychiatric treatment. Further, as I developed an awareness of the tie between my clients' mental health and their financial stressors, the lack of paid family leave, inaccessible childcare, persistently gendered divisions of labor, and generally low social support, I could not stop thinking about the importance of larger-scale change to promote better health outcomes.

In my vision, to really improve perinatal mental health and people's holistic experiences through pregnancy and early parenthood, a sea change in U.S. culture and structure is required. This dissertation is a contribution to move us forward with my analysis of one response that intends to address the disconnect between people's health experiences in the perinatal period and the healthcare available to them: the integration of mental healthcare in obstetric settings, including standardizing mental health screening and co-locating mental health clinicians in obstetric settings. In this conclusion, I summarize the empirical chapters of my dissertation, present the theoretical contributions of my work, discuss implications for policy, practice, and the organization of healthcare, point to future directions of my work, and offer closing remarks.

Summary of Dissertation Findings

In Chapter 2, I described how obstetric clinicians are hamstrung by a confluence of structural constraints that limit their ability to adequately address their patients' mental health at the same time they are facing pressure to screen their patients' mental health. I argued this becomes a new risk discourse for obstetric clinicians to navigate and a problem for health systems solve, and I analyzed one response to these quandaries: the co-location of mental health clinicians into the obstetric setting to provide care. While I found that the presence of mental health clinicians alleviates obstetric providers of some clinical responsibility, I also showed the burden this placed on under-resourced behavioral health teams.

Specifically, I illustrated the multifaceted role that mental health clinicians faced in obstetrics: not only are they tasked with patient care, but they must also educate their obstetric colleagues about the mental health of their patients to improve obstetric clinicians' mental health competence. I further described the strategies mental health clinicians leveraged—knowledge brokering and standardized care logics—to manage a crushing workload and their marginalized status in this interdisciplinary situation. I ultimately argued that one result of behavioral health co-location in obstetrics is a siloed model of perinatal healthcare, despite its intent to provide integrated care.

In Chapter 3, I considered whether the increasingly popular framework of whole person health can illuminate how perinatal clinicians' approaches to providing care already contain the ingredients necessary to support their patients' mental health. This chapter showed that patients seek rapport with clinicians and empowerment in perinatal care, preferring a model that offers continuity and accessibility to clinicians. I found that clinicians can successfully meet these patients' expectations and, at times, can incorporate the multidimensionality of their patients' lives in care. At the same time, I analyzed how common constraints that clinicians face in biomedical healthcare limit their ability to implement whole person healthcare.

I argued that policy change must address the myriad structural and systemic barriers that prevent the implementation of whole person healthcare, emphasizing that whole person health provides a potential pathway for shifting perinatal healthcare away from the mind/body distinction maintained by biomedicine. By emphasizing the centrality of mental health in pregnancy and postpartum, a new model that promotes the interconnectedness of people, their environments, their relationships, and their minds and bodies, in which mental health is inherently incorporated, is possible. I showed through this chapter how clinicians and patients are already striving to achieve this.

In Chapter 4, I took a sociological approach to analyzing the normalization of perinatal anxiety in perinatal healthcare. Focusing on obstetric surveillance as one of the primary social influences on pregnant people, I showed that obstetrics contributes to patients' stress and anxiety. For example, routine ultrasounds lead to provisional diagnoses that place pregnant people in stressful states of limbo for week or months at a time, and labels such as "advanced maternal age" contribute to heightened vigilance for pregnant people. I argued that the highest risk categories for complications have been institutionalized, determining routine care in obstetrics. Thus, obstetric care constructs the pregnant person as always already at risk and, in turn, patients experience fear, anxiety, and engage in self-surveillance vis-à-vis obstetric care.

Further, I found that pregnant people weighed their personal needs against potential costs in their obstetric care, even when their desires misaligned with obstetric recommendations. This generated more stress and anxiety, and I showed they were trapped by the obstetric paradigm of risk and individual obstetricians' caution that led to acquiescence and deference to obstetrics. The institution of obstetrics, as the gatekeeper of perinatal healthcare, has an obligation to consider the impact of its standardized surveillance approach on its patients' mental health. Because of its negative impact on people's mental well-being, I further argued that substantial gains toward improved mental health for pregnant and postpartum people is not possible within the paradigm of contemporary obstetric care, pointing to the need to dismantle the model of care we accept as necessary and reconsider the approach to caring for people in the perinatal period.

Theoretical Contributions

This dissertation contributes to the theoretical literature on medicalization, biomedicalization and constructions of risk and the organization of interprofessional healthcare. I provide a case study of perinatal mental healthcare as an example of medicalization. Similar to other studies of medicalization, recent trends to integrate perinatal mental health into obstetric care decenter social and systemic processes and maintain society's gaze on pathological and individualistic explanations of mental illness. I argue that instead of resourcing solutions to structural problems that bear on mental health, medicalization results in an emphasis on individual-level application of treatment in the quest to improve perinatal mental health. Further, when behavioral health is incorporated in the wake of the medicalized field of perinatal mental health, it reconfigures the interprofessional landscape. Mental health and its clinicians socially benefit from the legitimacy that can only be offered by authorized adjacence to biomedicine. For example, some aspects of the mental health field, as in the case of perinatal mental health, are taken more seriously by health professionals and the public when addressed by biomedicine. Mental health clinicians who work within biomedicine, especially those with master's-level training, receive more pay than their peers in most other settings and benefit from the prestige of biomedical association. Yet, this social arrangement also compromises their professional integrity and satisfaction. To further account for these consequences, I draw from and build on theoretical concepts in the organization of healthcare, specifically professionalization and knowledge brokering.

All the participants in my study are what Freidson (1982, 1988) refers to as "rank and file" providers of healthcare, the frontline of perinatal care provision, yet medical authority leads to the outranking of mental health clinicians by obstetric clinicians. All interprofessional clinicians ostensibly bore responsibility to respond to demands for mental health integration in obstetrics. The new institutional arrangements for co-location of mental health with perinatal services and the imperative to implement screening were intended to bring more resources, and spread them out broadly, to identify and intervene on mental health issues. But when overlaid onto professional hierarchies, obstetric clinicians yet again turned away from their patients' mental health, instead leaning heavily on the mental health clinicians in their clinics to address the psychosocial needs that arose in their clinical encounters. Thus, my dissertation shows how, on the ground, the unfolding of efforts to integrate mental healthcare reflect and reinforce medicalized hierarchies that privilege "physical" over mental health and concurrently, the health professions whose jurisdictions these domains are perceived to belong to.

I also uncovered a new aspect of interprofessional interactions that further sedimented professional hierarchy. For mental health clinicians in obstetrics, their allegiance to their professional philosophies and modes of patient care were inherently compromised by calls to respond to their obstetric colleagues. This top-down unidirectionality caused mental health clinicians to defer their clinical judgment at times. It also positioned them to take most of the responsibility to cultivate and maintain interprofessional relationships. Indeed, mental health clinicians in my study spent considerable energy reflecting on interactions they had with their obstetric colleagues and wondering how they were perceived in the order of the obstetric clinic. Relatedly, they faced an additional unspoken expectation as clinicians on interprofessional teams, that is, they were positioned to treat their obstetric colleagues with sensitivity and care and, at times, they discussed being stuck in situations that felt like providing informal “therapy” for their obstetric colleagues. This interactional dynamic emphasizes the mental health clinicians’ duty to attend to—to serve—their obstetric colleagues’ needs and demands, whether personal or professional. It is easy enough to minimize this situation and its impact on mental health clinicians, waving off concerns about this dynamic because they are seen as “natural” empaths who easily slip into a therapist role regardless of the situation, or as the usual give-and-take and collaborative support expected in teams. However, this aspect of their role in obstetric clinics occurred non-consensually and is a result of their low rank in the order of health professionals, which ultimately affords them little agency to enforce interpersonal boundaries with their higher-ranking colleagues.

Across my interviews, it was mental health clinicians who directly spoke about a negative impact of interprofessional hierarchy on their work and job satisfaction, whereas midwives and physicians uniformly underscored the positive impact mental health clinicians had on their work. This brings to light concerns about who primarily benefits from the project of behavioral health integration in the hierarchical order of obstetrics and what this costs individual mental health clinicians and the field of mental health as a whole. Much as the profession of nurse-midwifery faces compromises to its philosophies of care because of obstetric dominance, in a similar way integrated mental health must bend to the form of the dominant biomedical model. Beyond the known interprofessional challenges between the fields of midwifery and obstetrics in perinatal healthcare, my analysis traces what happens when additional professions are added to the mix, shedding new light on the persistent inequalities found in interprofessional work in biomedicine.

Turning toward the sociology of illness experience and the patient experience of contemporary healthcare, I join scholars who take up biomedicalization theory to argue that the construction of the pregnant person as always already at risk has become institutionalized in obstetric care and has deleterious effects on patients' mental health. I argue there are new socialities and consequences created by the pervasive use of technologies and other screening tools that seek to reduce risk and optimize pregnancy outcomes. In this landscape, health optimization and pregnant people's hypervigilance about their and their fetuses' bodies are co-constituting, which results in stress and anxiety about pregnancy and leads to people's over-reliance on biomedical surveillance for reassurance about their pregnancies, often in a cyclical fashion. In other words, obstetric health optimization has created a field of awareness for people, pregnant or not, that pregnancy should be monitored, and health behaviors in pregnancy can control outcomes. This makes people anxious and vigilant. To allay their anxiety, they look to the biomedical authority on health optimization and leverage routinely deployed screening tools for monitoring and reassurance. Relief is brief, however, because obstetric care continues through the whole continuum of the pregnancy experience and is always raising new possible causes for concern. Thus, the anxiety-vigilance-reassurance cycle repeats.

At the same time, obstetrics deploys a stratified risk paradigm that diminishes the causes and effects of perinatal anxiety, meanwhile organizing *routine* care based on the *highest* possible degree of risk. Because standardized obstetrics is constructed to avoid catastrophic outcomes, it aggressively deploys biomedicine that is deemed necessary to avert disaster, while chronically neglecting the more common health-related experiences and needs for pregnant people. Paradoxically, when mental health screening and treatment is brought into the obstetrics setting for management, rather than widening the field of perinatal healthcare, it is inevitably folded into obstetrics' narrow field of heightened risk. The mental healthcare provided then calibrates to address *its* highest possible degree of risk as well. This further solidifies perinatal mental health's medicalized form and overemphasizes the need to be vigilant about rare mental illness, while forsaking the common, yet socially and emotionally disruptive, mental health issues in the perinatal period, some of which are generated or worsened by obstetric care itself.

To further theoretical accounts of the patient experience in obstetrics, I engage with the work of feminist scholars who have theorized about the gendered expectations of intensive mothering and the identity work that ensues, most notably among middle- and upper-class women. I add dimension to important conversations about perinatal health inequities, pointing to the far-reaching constraints and patriarchal impositions of standardized obstetric care that have unequal impact yet are arguably felt one way or another by all pregnant people. Though some patients can engage cultural health capital and strategically navigate their healthcare encounters, their efforts have limited bearing on how their prenatal care or childbirth experiences unfold. In fact, based on obstetrics' field of risk described above, patients' individual efforts to manage their obstetric experience can have a negative impact on their overall well-being. These efforts are intended to manage some patients' social identity as discerning, proactive parents who individualize their pregnancy, labor, and delivery experiences toward their optimal visions. Their efforts may look like empowerment and self-advocacy on the surface, but these patients' intensive approaches in the constraining arena of surveillance medicine contribute to stress and anxiety, rather than diminishing it. Thus I reveal the cost to mobilizing cultural health capital to navigate obstetric interactions whose standardization and medicalization often render them rigid and controlling.

Implications

As my dissertation demonstrates, merely integrating behavioral health teams into the current biomedical system of care is not a sustainable nor far-reaching solution to address the predominance of mental health issues in pregnancy and postpartum. Without policy change and a restructuring of the perinatal healthcare system, mental health clinicians will continue to have limited impact on mental health outcomes. And mandating mental health screening in perinatal healthcare, as increasingly popular legislation is trying to do, is an unsurprising approach to addressing perinatal mental health in the United States. These interventions nudge incremental change toward the expansion of mental healthcare for people in the perinatal period, but come with potential unintended and undesirable consequences. With the standardization of any health screening process comes risk of (re)producing health inequities that exist primarily for people who are subject to interpersonal and institutionalized discrimination in healthcare (Phelan and Link 2005; Phelan et al. 2010). Furthermore, the efficacy of standardized mental health screening in biomedicine is disputed because of inconsistencies in administering screening tools and variable patient engagement with them (Forder et al. 2020; Hsieh et al. 2021; Krantz et al. 2008; Xue et al. 2020), and it places additional burdens on obstetric clinicians in an already-strained system. Given these problems, this dissertation offers insights for health and social policy and healthcare that both improves biomedicine and looks beyond it for opportunities to better address perinatal mental health.

Implications for Health and Social Policy

The number one structural barrier to sustaining behavioral health programs in obstetrics is the quagmire of managing multiple private and public insurance plans' demands, limitations, reimbursement inconsistencies, and so on. The bureaucratic U.S. healthcare system across health services, including mental healthcare, is well known. However, this is a particularly acute problem in the case of mental healthcare because it is structurally neglected, underfunded, and uniquely relies on grants and other special funding programs to compensate for the insurance system's deficits. The entanglement of the insurance industry also presents barriers to patients' access to healthcare, creating a confusing healthcare landscape that can be overwhelming, sometimes impossible, to navigate.

While a single-payer healthcare system could solve a lot of this, it can only alleviate issues that impact the sustainability of behavioral health integration and people's access to care *if* there is parity in the design, provision, and reimbursement of mental health services. At a minimum, health policy must address the major problem of unequal insurance reimbursement rates. Biomedical dominance has resulted in disparate value assigned to the types of health and healthcare provided by varying health professionals. Mental health clinicians and midwives, particularly community midwives, point to this issue—highly demanding work and little pay—as a primary stressor that negatively impacts their ability to thrive, leading to burnout and high clinician turnover in health systems. For patients, insurance reimbursement issues may occur behind the scenes, but they inform the development of treatment protocols and shape the healthcare workforce, both of which confine patients' choices about interventions and care providers. Leveling the playing field of reimbursement would improve work conditions for under-compensated healthcare professionals such as counselors, social workers, midwives, and lactation consultants, and it would offer patients more autonomy in their healthcare.

If we are to make gains in perinatal mental health, we must also address the structural and social conditions, such as racism, poverty, and gender-based oppression, that are fundamental causes of disease and illness (Bailey et al. 2017; Crear-Perry et al. 2021; Foster et al. 2021; Link and Phelan 1995). Mental well-being during pregnancy and, especially, in postpartum and early parenthood, is directly tied to poverty and the unrelenting demands and constraints of U.S. capitalism. One recent study found that longer maternity leave may decrease rates of both mental and physical health issues, and it found that longer maternity leave leads to more positive mother-child interactions, decreased infant mortality, and longer breastfeeding (Whitney et al. 2023). Addressing employment expectations, the devaluing of caregiving, and the pervasive and growing wealth disparity in the U.S. is a massive undertaking, yet it should be a focal point in conversations about developing interventions for perinatal mental health and family well-being. Reproductive justice further stresses that we attend to the human rights of people to make autonomous decisions about their reproductive lives, to live in safe and resourced communities, and to parent their children without the looming threat of state intervention (Luna and Luker 2013; Roberts 1997; Sistersong 1997). Pursuing reproductive justice would improve mental well-being at the population level, especially for people most harmed by restrictive reproductive health policies, state violence, and poverty.

Stakeholders who care about perinatal health outcomes should fervently advocate for social and structural improvements that would prevent many mental health issues, in addition to pushing for more resources to address mental illness when it occurs. For example, generous paid family leave, particularly at the federal level, could solve many problems that negatively bear on perinatal mental health, such as shifting cultural notions about the value and vulnerability of the postpartum period for new parents and their babies; promoting new social norms about domestic life and the importance of caregiving; and providing financial security. Additionally, work precarity, particularly work with routine instability, is shown to negatively impact mental health, especially for mothers (Luhr, Schneider, and Harknett 2022; Schneider and Harknett 2019). This points to the importance of policy-making that addresses work as a social determinant of health and should encourage the uptake of universal basic income programs that alleviate employment-related stressors.

Last, but no less important, policy is necessary to create new and generous wage standards for early childhood educators and caregivers. Doing so would recognize childcare as the essential part of society that it is and improve the conditions of work for childcare providers. This in turn affects the availability of childcare in communities and the quality of care that children receive, which ultimately affects parents' mental health. Some states are slowly expanding programs for subsidized childcare and universal pre-K, but making this federal policy would have a more sweeping cultural and structural impact, reducing regional inequities and improving families' safety and stability by addressing the economic problems that deteriorate mental health and hinder families' ability to thrive.

Implications for the Organization of Healthcare

Postpartum is the highest risk period for pregnancy-related complications, especially mental health issues. Yet, people typically have two or fewer visits with their healthcare clinician after giving birth, only at two and/or six weeks postpartum, and over half of birthing people have no postpartum follow-up. This current systemic lack makes for a situation that is fertile ground for the development of new models of care, especially approaches that are sensitized to mental health needs. For example, postpartum healthcare development could center community-driven models of care that do not rely on biomedicine, such as the expansion of community midwifery, well-funded group-based support, in-home postpartum lactation support, postpartum doula care, and improvements in the accessibility of community mental healthcare.

In the same vein, we must reconsider who is best suited to provide healthcare through the perinatal period and how. As noted in this dissertation, multiple professions are tasked with addressing perinatal health, yet this healthcare territory is dominated by obstetricians. Trained surgeons, these clinicians have a specialized skillset that can be lifesaving. And yet, the large majority of pregnant people do not require lifesaving measures in their perinatal healthcare. Obstetric dominance maintains a problematic hierarchy in perinatal healthcare, limits the influence of midwives and mental health clinicians (among others), and negatively impacts pregnant people's embodied experiences of pregnancy and childbirth. Culturally in the U.S., people have come to accept that obstetrics provides necessary oversight through pregnancy, thus diverting perinatal care away from obstetrics is an incredibly hard sell. But by every other measure, it makes sense to restructure the model of perinatal healthcare to promote family practitioners and midwives as the primary care providers, reserving obstetricians to contribute their expertise as necessary, not as default. Doing so could elevate the midwifery model, a known approach to perinatal healthcare that encompasses patients' mental well-being, to have greater impact on patient care. It could also improve the quality of life for clinicians by potentially reducing workload and clarifying interprofessional roles. Further, reducing reliance on costly biomedical care, such as the compulsory hospitalization of people during labor and delivery, could reallocate resources to bolster mental healthcare and other supportive services that bear on perinatal mental health.

Implications for Clinical Practice

One main aim of this dissertation is to show that biomedicine does not hold all the answers when it comes to addressing health, including mental health. In fact, one of the consequences of framing mental health in biomedical terms, particularly in obstetrics, is that perinatal mental healthcare then becomes an especially risk-laden enterprise. Clinicians in this study were overly reliant on psychiatric diagnoses and anecdotes about severe mental illness to organize their approach to addressing patients’ mental health. Because of this orientation, many of them expressed fear about and avoided addressing their patients’ mental health. This caused them to overestimate what is required in general mental healthcare and miss accessible opportunities to briefly intervene for the mental well-being of their patients. I contend this arrangement is not inevitable, and I offer some potential directions for perinatal health clinicians to improve their mental health competence and have a positive impact on patient care.

Attentive communication skills and rapport building are impactful in clinical care and an essential component to understanding and addressing patients’ mental health. Despite significant structural constraints, this dissertation shows that patients and clinicians can make gains for mental health by drawing on the interactional potential in the patient-clinician relationship. When clinicians make small gestures such as eye contact, thoughtful touch, or a direct question about their patients’ mental well-being, the effect on the patient experience is positive and should not be an underestimated quality of mental health-inclusive clinical practice. Since these interpersonal skills are cultivated through practice and have the effect of sensitizing clinicians to their patients' emotions and mental states, it is a fruitful and accessible opportunity for professional development and should be considered a core mental health competency for perinatal clinicians.

Much like perinatal health, mental health lies on a spectrum and catastrophic outcomes are rare. Mental health clinicians who participated in this study made the argument that clinical practice in perinatal care does not benefit from an orientation around catastrophe avoidance, and they tried to teach it to their colleagues by emphasizing that not every mental health need is a crisis. As such, perinatal clinicians can follow their mental health colleagues' lead, expanding their vision of what constitutes mental health and healthcare. Midwives in obstetrics already demonstrate a practice of resisting obstetric risk aversion and narrow biomedical explanations of common perinatal experiences, making it feasible to extend this practice toward their patients' mental health, too. These suggestions are rooted in the belief that perinatal clinicians already have much of what it takes to care for their patients' mental health, which should come as a relief. Specialty mental health skills are important, but they are not always necessary, nor are they the only way to provide effective mental healthcare, Conceptions of what "effective" means and what constitutes "mental healthcare" can and should be reconfigured in ways that are actually quite within reach.

For their part, mental health clinicians in obstetrics face a unique challenge in their clinical practice, in some ways socially benefiting from biomedicine's legitimizing effect on their work while also struggling with the compromises they must make when working within its model. As long as they engage with behavioral health integration projects, they will be forced to navigate demands for their expertise alongside their marginalized positionality, and they will face the challenge of providing mental healthcare to people who have been harmed by the very obstetric system in which they work. This is a situation that does not have a positive effect on their clinical practice. Yet, actively resisting a process of acculturation in biomedicine is one way individual mental health clinicians can protect the integrity of their work. This could include: approaching child welfare concerns that arise through patient care critically with attention to structural oppression, modeling anti-oppressive engagement with mandatory reporting procedures; prioritizing their clients' mental well-being in cases where they were harmed by obstetric violence and advocating for trauma-informed care, rather than striving to protect interprofessional relationships with obstetric clinicians by deferring to the inevitability of the obstetric model; and confidently asserting their clinical judgment. I encourage mental health clinicians to critically examine their tendency to be obliging, which stems from professional ethos and interprofessional hierarchy, asking themselves guiding questions such as: *For whom is this helpful? What will this cost me? And how does this impact my clients?*

Future Directions

Before I expand on this project or pivot to something new, I have plans to prepare a webpage synthesizing my dissertation's results that I will share with my research participants and community stakeholders who otherwise engaged with this project.

The COVID-19 pandemic had a significant impact on my ability to execute this study as I originally designed it, so in many ways it feels unfinished. I see opportunity to expand data collection for the purpose of improving representation in my sample of pregnant and postpartum people—this would enhance insights about the diverse impact of mental health integration in perinatal care settings. The longitudinal interviews I conducted with people through pregnancy and into the postpartum period were especially rich, providing unique information about the temporal changes to mental health across the perinatal period and as influenced by their healthcare experiences. Because of this, I intend to conduct more research in this vein, both expanding my sample for this study and in the design of future research. Lastly, I aim to interview and conduct ethnographic observations with more obstetric clinicians, particularly physicians, about interpersonal dynamics on interdisciplinary teams and their experiences with standardized mental health screening. This is a difficult-to access group for the purposes of research, doubly so in the context of COVID-19, yet, they have many contributions to make to further research on perinatal health professions and in the quest for mental healthcare solutions in perinatal care.

Because of the prevalence of health complications following childbirth and under-developed healthcare and policy to address this, one arm of my future work will focus on the postpartum period. I will continue researching with a midwifery research collaborative that aims to support the development of the midwifery model of perinatal healthcare given its whole person and dyadic approach, plus its unique model that extends postpartum. More broadly, my future work will remain focused on gendered health processes, health issues that are especially socially complex, and the ways healthcare is organized to address them. I intend to turn my attention toward pediatrics as a site grappling with parents' postpartum well-being, and to consider questions about the prevalence of postpartum substance use and its impact on family health.

Closing Reflections

Developing new models of perinatal healthcare and improving perinatal mental health outcomes are complicated endeavors. Because people’s mental health is significantly impacted through pregnancy and postpartum and bears on the whole family, it makes sense to elevate this as cause for concern. And yet, successfully addressing perinatal mental health is hamstrung by myriad structural barriers and biomedical dominance. With the goal of better understanding the perinatal healthcare landscape and how we might make it mental health-inclusive, my work draws on the experiences of perinatal health clinicians and pregnant and postpartum people, all of whom are doing their best to provide and receive care with the resources they have at hand.

Through my ethnographic field work with Umbrella Health’s behavioral health team, I got to see multiple iterations of their attempts to integrate mental and perinatal healthcare, and its many growing pains, particularly given the immediacy of the COVID-19 pandemic. I witnessed mental health clinicians’ frustrations, enjoyed grappling with clinical puzzles alongside them, and admired their meaningful, if imperfect, team cohesion. I cannot be sure, but I suspect the timing of my research coinciding with a devastating, society-shaping public health disaster led to an irreplicable intimacy between my study participants and me. I certainly saw how the pandemic influenced their relationships with one another and pushed them to change how they provided healthcare. We know by now that COVID-19 laid bare all the cracks in the façade, worsening problems that existed long before.

Like everywhere else, COVID-19 massively strained Umbrella Health. They rapidly closed multiple clinics, clinicians quit at extraordinary rates, and I saw interpersonal rifts between administrators and the clinicians who were facing harder work for lower pay due to the economic crisis brought about by the pandemic. In this dissertation, I could have included a more focused analysis about the impact of COVID-19 on mental health and the organization of perinatal healthcare—there are compelling reasons to explore those dynamics. However, though it was in the foreground of my fieldwork, I chose to position the pandemic as background to my analysis for the purpose of highlighting the complex and long-standing nature of the puzzles and problems at play in efforts to integrate mental health in perinatal healthcare.

In Chapter 2, I did address one COVID-era change Umbrella Health's behavioral health team made to their program because of its migration to telehealth. Observing this transformation helped me clearly see the win-some-lose-some proposition of mental health integration in obstetrics. Below is the behavioral health director's account of this predicament and the costliness of their limited options:

> In mental health, when we try to simplify things, we end up not being responsive to our community. So, an example of that is these structured programs that are pretty defined. The criteria to get into the program are specific. It's staffed in a certain way, and you only do these things, and everybody has these defined roles. So, if we did that, our lives would make a lot more sense, but then we would not do all these other things we do, like start seeing patients at different points in care—maybe they're preconception, or maybe they have all these different things happening, or they need options counseling. We would shut that door. So, there's this path of distilling things down, taking it away, and then really focusing in. That's how you do something that's really quality and evidence-based. But then you don't create access. So, then there's this other path where you create access, but it's more confusing. It's harder to do something that's standardized and provides quality and consistency. But what you get is a system that's more responsive but it's a little more chaotic. So, you know, I think it's hard to find something in the middle, like creating some standards so that people feel they can do the work, but be accessible, and then make it sustainable at every level.

After she described weighing the costs and benefits and the difficult choices she must make about the design of the program, she offered a final comment about how they "don't have a slush fund," meaning that, at the end of the day, the bottom line in her decisions for her team came down to money. While no solution is perfect, the compromises required for behavioral health integration in biomedicine reflect barriers imposed by a capitalist, largely for-profit healthcare system in the U.S., not sound choices about what is best suited to meet clinicians' and patients' needs. There is no balance, no middle ground to be found, when scarcity is institutionalized.

Over the course of conducting this research, I came to understand the incredible accomplishment it is that midwives, obstetricians, and mental health clinicians find ways to work around and within the system we have. I certainly observed their dedication to patient care and saw the day-to-day value of mental health clinicians in obstetric settings. As an informed optimist, I know it can and should be different, though. Clinicians' work is worth more pay and it should not be this tough a grind. Although it is treated as such, pregnancy alone is not a disease. The postpartum period needs more attention. And mental health deserves far more prominence in the landscape of healthcare and policy. In this dissertation, I sought to understand perinatal mental health when situated in obstetric care, and in doing so I unveiled the gulf between what perinatal clinicians and patients get in healthcare and what they need and deserve.

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