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## Reimagining Perinatal Mental Health: An Expansive Vision for Structural Change

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**Abstract**

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

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On its face, *perinatal mental health* can seem to be a broad term. Yet, in practice, it is often shorthand for a specific subset of pregnancy-associated mood and anxiety disorders such as perinatal depression, perinatal obsessive-compulsive disorder, and postpartum psychosis. These diagnoses capture one aspect of perinatal mental health, but they lack context and overlook the full complexities of pregnant and birthing peoples' lived experiences. This narrow scope maintains a distinction between the physiologic and psychosocial aspects of pregnancy, effectively consigning social and emotional perinatal experiences to a highly stigmatized and under-resourced arena of health and health care. However, no pregnancy exists in a vacuum; pregnant and birthing people experience and make sense of the perinatal period as it co-exists with other parts of their lives. Importantly, physical, emotional, and social processes are co-constitutive. For example, stressful life events degrade physical wellbeing, and poor health (or health care) experiences can induce post-traumatic stress disorder or other types of anxiety.

The interrelated nature of mental, physical, and social health is globally recognized. As defined in the Constitution of the World Health Organization, health is a complete state of biopsychosocial wellbeing (1). Adequately addressing perinatal mental health, then,

requires engaging with the totality of the perinatal experience in ways for which the current biomedical orientation of the US health care system is ill-equipped. Reorienting care toward a more holistic approach can only be effective if the initial assumptions underpinning how we conceptualize perinatal mental health are critically assessed and reconfigured. The purpose of this commentary is to reimagine *perinatal mental health*, considering a new paradigm that reorients perinatal health practice and policy toward the holistic wellbeing of all birthing people and their families.

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

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

## **Our Method: Centering Black, Indigenous, and People of Color**

We convened our group using personal and professional networks and the listserv of the Black Mamas Matter Alliance, with the goal of recruiting a wide range of perspectives from advocates, clinicians, creatives, educators, researchers, people with lived experience, and students. We endeavored to center the voices, experiences, and expertise of Black, Indigenous, and People of Color (BIPOC). For example, our thinking was informed by the historical and ongoing state-sanctioned family separation in Indigenous communities and the collaborative advocacy efforts toward family preservation in Black, immigrant, and Indigenous communities. None of the authors are enrolled members of any Indigenous Nation. However, some have studied, trained, and practiced within Indigenous communities and frameworks, and have Indigenous ancestry.

We used a qualitative approach to determine the definition of perinatal mental health and to describe our understanding of the concept (3). Interview and focus group guides

were developed and included questions specific to: 1) the current structure of perinatal mental health care; 2) recommendations for changes to perinatal mental health care; 3) experiences with perinatal mental health diagnostics and treatment; 4) intersections and distinctions in perinatal health care for BIPOC, people with disabilities, women and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) people; and 5) barriers to thriving for pregnant people and their families. All authors participated in the discussions, analyses, and/or manuscript writing according to the guidelines put forth by the International Committee of Medical Journal Editors. All transcripts were read and reviewed using thematic analysis (3,4). The following commentary represent the synthesis of the discussion and highlights a few key themes that are actionable and could be resolved through policy.

### **Mapping Perinatal Mental Health: People, Systems, and Structures**

The way mental health is understood in the US flattens the lived experiences of BIPOC communities, negates cultural truths, and shapes treatment options that are frequently incongruent with pregnant women's and birthing people's needs and, at times, punitive. Fear of being assessed as "crazy" or otherwise incompetent by medical professionals remains a source of stress for many BIPOC people. There is notable cultural incongruence in how assessment and treatment options are designed within the health care system. Mental health stigma, both held within communities and imposed on individuals by the biomedical model of care, can be particularly difficult to navigate and is experienced as oppressive. In our attempt to define and map new domains of perinatal mental health, we determined that there are multiple perspectives necessary to understand the phenomenon. We developed 15 themes that fall under three major categories: people, systems, and structures. The themes included community-based healing, disenfranchised experiences and grief, and unhelpful or harmful health care structures (see Appendix A for the full list of themes) (5).

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

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

Systems have far-reaching effects which are magnified based on the structures in which they are embedded. We contend that these structures encompass the larger socio-legal ecosystem in which perinatal mental health is situated. In BIPOC communities it is impossible to conceptualize perinatal mental health without accounting for structural factors such as mental health stigma, racism, criminalization of substance use in pregnancy and the postpartum period, and the disproportionate impact of surveillance (such as that resulting in child “welfare” interventions in Black, Indigenous, Latinx, Asian, Pacific Islander communities). For example, the use of Child Protective Services (CPS) as a child “welfare” intervention, and the ways in which health care systems collude with CPS and other forms of policing, has been rigorously documented as a structure that is punitively used to target and criminalize Black, Indigenous, and Asian/Pacific Islander mothers (8–10). Acknowledging the recent harms of child separation experienced by immigrants (11) and Indigenous people (9) is one step in disrupting the cycles of harm and the generational trauma that is such a huge part of the history of health care in the US.

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

### Policy Recommendations

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

this could contribute to perinatal mental illness, which could lead to child maltreatment. Further, they must prevent private agencies from separating families, as well.

Perhaps most relevant, however, is the obligation to fulfill human rights. To fulfill this obligation, policy efforts are needed to address the gaps we identified in both systems and structures. In addition to policy changes to existing systems, focused and concerted effort is needed to address deep-rooted inequity in health care systems and structures that negatively impact perinatal mental health, and to reconfigure systems and structures in ways that support perinatal thriving. Using this framing, we briefly review some examples of how policy can be leveraged to address the issues specific to people, systems, and structures.

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

**Systems**—Human rights law mandates that health care services be available, accessible, acceptable, and of sufficient quality for all people (12). Barriers such as cost, lack of insurance coverage (18), and poor geographic distribution of services (19) that disproportionately bar pregnant and birthing BIPOC from accessing needed care constitute human rights violations. Policymakers can respond by universally expanding insurance coverage, such as through Medicaid expansion, so pregnant and birthing people are able to access the care they need without waiting to qualify, extending the length of the pregnancy-related Medicaid coverage beyond 60 days postpartum, and creating and adequately resourcing programs dedicated to supporting the perinatal mental health of pregnant and BIPOC birthing people (18). An example of such a program is the Shades of Blue program ([shadesofblueproject.org](https://shadesofblueproject.org)) that provides comprehensive online and in-person services in BIPOC communities developed with and by BIPOC providers.

**Structures**—Human rights-based approaches to advancing health underscore the importance of also considering social and structural determinants of health (21). Chronic stressors such as worry about how to keep food on the table and a roof over one's head, how to keep oneself and loved ones safe from interpersonal violence, and how to ensure water used to drink and bathe children is safe are clearly detrimental to mental health. Under human rights imperatives, governments have an obligation to address these concerns. Policies that provide universal paid leave, regardless of the outcome of a pregnancy (20), and universal childcare (22); acknowledge and address interpersonal, community, police, and

other forms of violence (23, 24); and ensure environmental protections such as functioning water and sanitation infrastructure (25) are key to supporting a wider view of perinatal mental health.

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

## Conclusion

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

## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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