Beyond Baby Blues: Systemic Failures in Maternal Care

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Abstract: *The pandemic has made apparent frequent lapses in care experienced by new and expectant mothers. Prior research on maternal mental health has emphasized biological circumstances, especially hormones, and personal circumstances, such as job loss or family death. I argue that this research overlooks the impact of large-scale events and systemic inequality on maternal mental health. Furthermore, my research indicates that due to the overemphasis of scholars on individual factors, the impact of racial discrimination in healthcare is inadequately accounted for, contributing to worse outcomes for racial minorities, especially Black women. As they make judgments impacting their mental health, pregnant people are taking account of genuine external threats like the pandemic and maternal mortality rates, and researchers and practitioners need to recognize and not dismiss these large-scale or systemic concerns.*

Keywords: maternal mental illness, maternal mortality, COVID-19 pandemic, social determinants of health, epistemic injustice

The lack of access to perinatal care during COVID-19 has highlighted just how essential these services are in promoting the psychological and physical well-being of pregnant people.[1] Increasing instances of maternal mental illness since the pandemic began, as well as an upward trend in rates of maternal mortality in the United States, are evidence that the healthcare system is failing women during one of the most emotionally and physically vulnerable times in their lives. Although pregnancy-related health problems are experienced broadly across demographics in the United States, research shows that Black women experience significantly higher rates of maternal mental illness and maternal mortality compared to their non-Hispanic white counterparts, and the pandemic has exacerbated this

disparity (Bower et al., 2023; Hoyert, 2023). The pandemic was and continues to be a deeply traumatic and impactful experience. However, it also gives healthcare researchers and providers the valuable opportunity to illuminate the causes of health problems and poor outcomes that may have been less apparent before March 2020. Moreover, as evidence mounts and confirms that race plays a critical role in mental and physical health for pregnant people, healthcare researchers and providers must acknowledge and address how structural racism and inequality profoundly impact outcomes for specific populations, especially Black women.

Maternal mental illness is frequently attributed to hormonal changes or personal environmental factors (Howard et al., 2017). Although significant evidence indicates that hormonal fluctuations and adverse life events play a role in maternal mental illness, less emphasis is placed on how larger social threats and rising maternal mortality rates also affect poor mental health outcomes. This paper outlines how various layers of substantial risks and systemic inequality have led to poor psychological and physical consequences for pregnant women in the United States. I argue that, despite the overemphasis of researchers and practitioners on the supposedly internal causes of maternal mental unwellness, the COVID-19 pandemic reveals how adverse outcomes cannot be explained by personal circumstances alone and are instead grounded in fundamental gaps and systemic inequities in maternal care. Statistical evidence shows that pregnancy and childbirth are becoming riskier due to real healthcare lapses. These care gaps affect pregnant people of all backgrounds; however, they disproportionately impact racial minorities (Hoyert, 2023).

An outgrowth of my argument is that most pregnancy-related care services lack a nuanced understanding of how more abstract social forces impact outcomes. Institutional oppression and "weathering," which Arline Geronimus conceives as being a theoretical link between social inequality and poor physi-

cal outcomes, leave Black women at a higher risk for adverse physical and emotional reactions during pregnancy (Geronimus, 1996). Still, they are frequently not given the level of attention they require (Martin, 2017). For instance, women at a higher risk for cardiovascular disease require closer monitoring during the postpartum period, but Medicaid coverage does not often allow mothers to extend their postpartum care as long as needed (Martin, 2017). Since Black women are at a higher risk for cardiovascular complications while simultaneously being less likely to have access to adequate care, they are left in a particularly precarious position. Even when Black mothers are aware of their specific risk factors, they are often dismissed in healthcare settings. While this unwillingness to listen is not malicious, these women can experience serious consequences as a result (Cohan, 2019). Whether it is a more widespread threat like the pandemic or identity-based discrimination in the healthcare system, it is clear that the anxiety many women feel during and after birth is not solely a product of personal circumstances but is also a response to systemic inequities.

COVID-19 and Maternal Mental Illness

Perinatal mental illness is a serious and highly prevalent condition that impacts between ten and twenty percent of women during pregnancy or soon after birth (Howard & Khalifeh, 2020; Masters, 2021). According to Howard et al. (2020), "Perinatal mental disorders are common – indeed, the commonest complication of child-bearing – and are associated with considerable maternal and foetal/infant morbidity and mortality" (p. 313). Although perinatal mental illness is undoubtedly a significant threat to women's health outcomes, it is not sufficiently emphasized in research and clinical settings (Howard et al., 2017). Aside from being a distressing experience that impacts a mother's ability to bond with her child and experience the joys of new motherhood, perinatal mental illness also poses acute threats to the safety and well-being of both mother and baby.

Increasing efforts to understand the causes and warning signs of perinatal mental illness have improved the ability of physicians and mental health care providers to make necessary interventions. However, the specific pathogenesis of these conditions is still not understood conclusively (Howard et al., 2017). There are challenges in understanding the exact nature of psychological conditions broadly, but researchers should take the lack of knowledge surrounding how and why mothers develop perinatal mental illness as an indication that existing avenues of inquiry are insufficient.

These existing avenues of inquiry emphasize biological and individual factors. Howard et al. (2017), for instance, explains some of the answers and limitations to understanding perinatal mental illness, stating, "Although the precise pathogenesis is undetermined, there is converging evidence of a subset of women particularly sensitive to dramatic fluctuations in levels of estradiol and progesterone that occur during childbirth" (p. 389). In addition to hormonal causes, personal environmental factors have been shown to influence whether a mother will develop perinatal mental illness. Examples of non-biological risk factors include adverse life events. As Stewart and Vigod (2016) describe, "in addition to hormonal changes, proposed contributors include genetic factors, and social factors including low social support, marital difficulties, violence involving the intimate partner, previous abuse, and negative life events" (p. 2177). Dramatic changes in routine and lifestyle stemming from adverse life events appear to impact the psychological well-being of new and expectant mothers significantly. Yet, while the scholarship emphasizes personal problems like job loss or death in the family, researchers generally ignore larger social threats and systemic inequalities with similar or even greater likelihoods of disturbing daily life.

Women with histories of mental illness are more prone to relapse during and after their pregnancy and are more likely to experience symptoms at a higher severity (Howard et al.,

2017). Aside from being a profoundly distressing experience, maternal mental illness can pose severe risks to mothers and their babies if left untreated. Some of the most common and concerning risk factors include complications from substance misuse, self-harm, preterm births, fetal growth impairments, and in severe cases, suicide. In addition to the risks mentioned above, women with histories of mental illness are at a higher risk for more severe mental disturbances as well as worse physical outcomes, including preeclampsia, antepartum and postpartum hemorrhage, placental abruption, and stillbirth (Howard & Khalifeh, 2020). It is also important to note that some of the poor physical outcomes resulting from untreated mental illness and poor quality of maternal care also exacerbate existing levels of mental distress. Regardless of how reliably healthcare providers can assess the causes of perinatal mental illness, it is a critically important condition that deserves concerted care and attention. Although adverse events such as the pandemic do not necessitate negative mental health outcomes, perinatal women, particularly those with a history of mental illness, might be in physiological states that make coping with disruptions particularly challenging. Acute world events such as the pandemic illuminate a need for more research into the external contributors to maternal mental illness and the warning signs and characteristics that place women at higher risk. COVID-19 unmasks the more existential threats with which new and expectant mothers contend.

Maternal Mental Health on a Broader Scale

Prior to the pandemic, there were gaps in the research regarding how natural disasters place excessive stress on perinatal women, which can lead to higher rates of reported pregnancy-related mental illnesses (Stewart & Vigod, 2016). Although there is still a need for additional research, the pandemic offers significant additional support to this claim and makes manifest the particular perils of uncertainty. The data regarding the long-

term effects of disease contraction is better known now than in the earlier stages of the pandemic. However, clinical understanding continues to evolve today:

> Despite the devastating effects of the COVID-19 pandemic worldwide, scientific studies on SARS-CoV-2 are still developing, and knowledge about the behavior of the virus in the body is not explicit. As such, the shortage of data regarding COVID-19 in the neonatal age represents a further challenge for obstetricians and neonatologists, who are called to face an unknown entity (de Medeiros et al., 2021, p. 399).

The unknown nature of disease progression in pregnant people during the pandemic added another layer of stress to an already tumultuous time.

Further, concerns about experiencing more severe COVID infections and a lack of conclusive evidence regarding vertical transmission left women unsure about attending prenatal appointments. Thapa et al. (2021) state, "The risk may be related to concerns regarding the wellbeing of the unborn child, but aggravated by unintended consequences of preventive measures, such as […] inability to obtain expected level of support and care prenatally as well as during the intrapartum and postnatal periods" (p. 817). Due to social distancing measures and closures, many pregnant people also had to forgo accessing services such as prenatal checkups, a crucial aspect of supporting perinatal mental health (Thapa et al., 2021). During the pandemic, mothers were forced to deal with various layers of anxiety regarding their pregnancy, all without the option to access external support.

Perinatal mental illnesses, including postpartum depression, pose a significant threat to the well-being of mothers, even during otherwise stable periods. Acute events such as the pandemic exacerbated the effects of pregnancy-related mental illness due to the additional stress and uncertainty they cause. During the height of the pandemic, public health officials and

healthcare providers were preoccupied with treating physical symptoms and preventing the spread of disease, leaving vulnerable populations, such as perinatal women, more susceptible to adverse mental health outcomes. Considering that pregnancy and childbirth are not health-neutral events, and pregnancy-related complications are possible even for otherwise healthy women, it is no surprise that one of the leading causes of increases in reported anxiety and depression in perinatal women during the pandemic was concerns about a lack of access to care (Masters, 2021). Along with concerns about a lack of access to critical pregnancy-related care, perinatal women also reported disruptions in support systems due to social isolation measures; increased exposure to personal adverse events; and concerns about the effects disease contraction could have on themselves and their new or unborn baby. In addition to women who had fears of contracting COVID-19, women with other health complications were also placed in a vulnerable position. Chronic conditions such as diabetes and cardiovascular disease put women at a higher risk for adverse health outcomes during pregnancy and birth (CDC, 2023). Managing these conditions during the pandemic was increasingly challenging, and the knowledge that they could lead to pregnancy-related complications likely left women feeling even more anxiety and psychological distress.

Although many countries, such as the United States, have partially removed or eliminated most of their COVID-19 protocols, the experiences of vulnerable populations such as perinatal women during the pandemic have shed light on gaps in research and clinical support. Significant events such as the pandemic offer an opportunity to address how the healthcare system and social programming can improve outcomes for perinatal mental health. Limitations in research became apparent when researchers established differences in pandemic and pre-pandemic levels of reported mental illness. When discussing the results of perceived stress scale evaluations adminis-

tered to perinatal women, Mollard et al. (2021) highlight:

> While the difference in PSS-10 score compared to the established normative sample was statistically significant, current normative data in childbearing women have not been established, and it is unclear whether this stress difference would be clinically significant or contextually relevant when compared to the general population's stress levels during a pandemic (p. 4).

The rise in perinatal mental illness is important regardless of whether researchers can establish a clear causal relationship. As the United States continues to move forward from the pandemic, women's health practitioners and researchers must continue to emphasize addressing rising maternal mortality rates and improving mental and physical outcomes for perinatal women (Hoyert, 2023). What is clear from the lack of normative data is that these efforts to address pregnancy-related health outcomes must include an increased emphasis on studying women's health on a broader scale.

Owing to the already stressful nature of pregnancy and childbirth, researchers also faced difficulty isolating the pandemic as a variable in rising perinatal mental illness. As Mollard et al. (2021) describe, "The stress and mental health challenges associated with perinatal variables in this study such as preterm birth, NICU stay, postpartum hemorrhage, or hypertension may have had no relationship to the pandemic since they are in and of themselves stressors. Alternatively, these stressors may have been exacerbated by the pandemic" (p. 6). Pregnancy and childbirth present substantial stress to perinatal women in the presence and absence of adverse world events. This means that although an increase in the prevalence of these conditions was observed during the pandemic, they will not be entirely relieved with a return to social normalcy. The impact of a lack of resources during the pandemic on perinatal women highlights how essential services such as mental health care and prenatal appointments are in the holistic well-being of

pregnant women and new moms. It also emphasizes the existing threats and systemic injustices they already faced. Osborne et al. (2021) explain that "the closures of physical mental health care spaces and lack of support could have devastating impacts on the health of postpartum women and their newborns. Yet, the pandemic creates an opportunity to innovate in the ways mental health care is delivered to pregnant and postpartum women" (p. 349). It is clear that services supporting perinatal women during their pregnancy and in the postpartum period are critical components of women's health outcomes, and mental health consequences of the pandemic serve as an important reminder that they must be supported.

Maternal Mortality and the Role of Intersectionality

The pandemic exposes deficits in health coverage writ large and the particular perils of uncertainty, yet it also points to other large-scale threats with which new and expectant mothers cope. One of these is the crisis in maternal mortality itself. Pregnancy and childbirth come with substantial physical risks, particularly in the United States. Regarding the discussion of the challenges that the pandemic posed to the health of perinatal women, Osborne et al. (2021) explain, "When the whole country is consumed with thoughts of ventilators, inadequate personal protective equipment, and political wars about masks and vaccines, it's easy to forget that childbirth even outside a pandemic can be dangerous" (p. 350). The World Health Organization defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Hoyert, 2023, p. 1). The United States has the highest maternal mortality rates out of all developed countries, and these numbers have increased significantly since 2019. According to the Centers for Disease Control and Prevention (CDC), "The maternal mortal-

ity rate for 2021 was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019" (Hoyert, 2023, p. 1). The steep incline in maternal mortality rates since 2019 is deeply concerning, especially since the United States had one of the poorest outcomes in maternal morbidity of any developed nation, even before the rise in numbers over the past three years. As the country moves forward from the pandemic, healthcare providers and policymakers need to address the crisis of maternal mortality in the country and implement the necessary safeguards to prevent these tragedies from occurring.

While the national average for maternal mortality is deeply concerning, the outcomes for Black women are substantially worse. According to the CDC, Black women die from pregnancy and birth-related complications at rates significantly higher than their white, non-Hispanic counterparts. At 69.9 deaths per 100,000 live births, the maternal mortality rate for non-Hispanic Black women was 2.6 times the rate for non-Hispanic white women in 2021 (Hoyert, 2023, p. 1). Significantly higher rates of maternal mortality experienced by Black women are frequently explained by citing lower socioeconomic status and limited access to care. Although these factors certainly play a role in placing them at a higher risk for life-threatening pregnancy complications, Lister et al. (2019) argue, "Racial disparity exists in maternal mortality despite correcting for commonly cited reasons. Thus, it is imperative to explore other potential etiologies for the disparities including racial bias" (p. 3). Statistics report higher instances of perinatal mental illness and pregnancy-related deaths for Black women, which are unmistakably related to experiences of racial discrimination in and out of the healthcare system.

In addition to facing higher instances of pregnancy-related death, women of color are also more likely to experience depressive symptoms during and after pregnancy, citing experiences of racial discrimination as a significant disturbance to their mental well-being. Bower et al. (2023) describes, "Respondents who reported feeling upset due to the experience of racism had over

two-fold higher odds […] of experiencing depression during pregnancy compared to respondents who did not report feeling upset due to the experience of racism, adjusted for maternal age, educational attainment, marital status, pre-pregnancy insurance type, region, and pre-pregnancy depression" (p. 2). In the multivariate analysis, variables such as maternal age, education, marital status, and insurance were considered as factors influencing increased levels of depression in Black perinatal women. Although instances of depression were higher before adjusting for external factors in addition to experiences of racism, Black women remain at a significantly higher risk compared to their non-Hispanic white counterparts (Bower et al., 2023). Black women are in particularly vulnerable positions regarding pregnancy-related health complications because they must overcome the same barriers in healthcare that white women face while also managing the racial bias and institutional oppression in many healthcare settings. Many Black women are also aware of their increased risk for pregnancy-related complications but are often dismissed in healthcare settings. Discrediting Black women's knowledge of their unique health positions is both anxiety-provoking and dangerous. Healthcare providers must take the testimonies of Black mothers seriously to ease their psychological strain and create effective monitoring and treatment plans.

Similar to how the pandemic shed light on adverse health outcomes for pregnant women, it also reaffirmed the stark reality of race-based health disparities in the United States:

> The health inequities in the US that impact minority communities were well in place prior to the COVID-19 pandemic. These inequities have become more evident in some cities and states. In Chicago, AAs [African Americans] make up 30% of the population; yet, they represent 50% of COVID-19 cases and approximately 70% of COVID-19 deaths, most of which are concentrated in small numbers of the most vulnerable communities (Alcendor, 2020, p. 2).

Although these statistics apply specifically to COVID-19, data consistently showing poorer health outcomes related to acute disease indicate fundamental inequalities in access to and quality of care. Having to face material inequality and race-based discrimination in the healthcare system and elsewhere places people of color in a position where they are susceptible to overall poor health and at a higher risk for more severe outcomes from acute health events such as COVID-19 and pregnancy.

Systemic oppression and race-based social determinants of health lead to a higher prevalence of underlying conditions, leaving Black women more vulnerable to pregnancy-related complications. Structural inequalities begin with worse access to resources such as clean water, healthy food, and safe housing, all of which play roles in a person's overall health. Next, Black women suffer from inequalities in access to quality healthcare coverage. Then, racial bias in the healthcare system leaves many Black women feeling devalued and disrespected, making them feel less inclined to attend their appointments and bring attention to their concerns. Lastly, enduring acute cases of racial discrimination, along with the lifelong stress of being Black in the United States, have marked psychological and physical effects on Black women, leaving them further susceptible to adverse pregnancy outcomes, which also influence how much psychological distress they experience (Martin, 2017). There are common misconceptions in the United States medical community about why Black people tend to suffer from poorer health outcomes. Racism and bias falsely tell many healthcare providers that Black people are responsible for having a higher prevalence of chronic illness, when in reality, years of systemic inequality and oppression can have marked impacts on the health of this population. There is also mounting evidence that these inequalities of outcomes cannot be entirely explained by socioeconomic factors; implicit and explicit racism and bias have a direct impact on the health and safety of Black mothers

(Lister et al., 2019). Researchers must take the time to identify what is causing Black mothers to die at disproportionate rates so that they can work to eradicate these inequalities.

In an effort to fill in research gaps and connect the statistics on Black maternal mortality with individuals, the investigative journalistic outlet NPR has collected over 200 stories from Black mothers from across the United States describing their experiences with racial prejudice during their pregnancy care experiences. NPR also published an article about Shalon Irving, a Black woman who held a high-ranking position with the CDC before passing away from pregnancy and birth-related complications (Martin, 2017). Irving's story provides further evidence that high maternal mortality rates among Black women cannot be explained by socioeconomic inequality and poor access to healthcare alone. Before Shalon's tragic passing in 2017, she worked with a special division of the CDC that focused on identifying and removing healthcare disparities for Black women. Aside from having a prestigious job, Shalon was also highly educated: "Even Shalon's many advantages – her B.A. in sociology, her two master's degrees and dual-subject Ph.D., her gold-plated insurance and rock-solid support system – had not been enough to ensure her survival" (Martin, 2017, para. 7). Shalon did everything in her power to ensure that she would have a safe, healthy pregnancy, but forces outside of her control led to her tragic and untimely passing. Programs aimed at improving the health and safety of Black mothers must consider how a lifetime of exposure to structural racism impacts how vulnerable they are to pregnancy-related complications. Healthcare providers must also take the time to work on unpacking their biases to take respectful, informed approaches to Black maternal care (Cohan, 2019).

Another critical aspect of the relationship between physicians and patients is their ability to give their patients credit for knowing the care they require. Although there is a level of expertise that patients do not have, providers still need to

take their questions and concerns seriously. Implicit racial biases can lead healthcare providers to disregard their patients in their capacity for knowledge. This type of discrimination is known as epistemic injustice, and it can have a marked impact on healthcare outcomes, particularly in Black mothers: "Gaps in collective hermeneutical resources stemming from prejudice may result in members of marginalized groups being unable to render harmful experiences intelligible to themselves or others" (Fricker, 2007, p. 1). Although bridging these gaps is an essential step toward achieving health equity, even if women can make their experiences intelligible to them, it is up to providers to do the work to educate themselves and confront how their racial bias is impacting their patient outcomes and quality of practice (Cohan, 2019; Falbo, 2022). Epistemic injustice can prevent Black mothers from being able to take agency over their health during their pregnancy and after birth, which can lead to negligence and misdiagnosis. As a result, Black women are more likely to experience high-risk pregnancies due to systemic oppression and are less likely to be taken seriously when they express their concerns. It is even more critical that they are taken seriously and given personalized care that considers the impact that long-term exposure to racism takes on the body (Lister et al., 2019).

When developing programs and interventions to assist women suffering from mental and physical pregnancy-related complications, providers must consider the role intersectional identities and social contexts play in determining outcomes. Baumont et al. (2023) make this point succinctly when they say, "The COVID-19 pandemic has underscored the urgency to rethink our maternal health systems and work together to ensure that everyone seeking maternity care not only survives childbirth but also thrives as a new parent" (p. 962). The pandemic devastated the country's physical and mental health, and vulnerable populations such as perinatal women suffered disproportionately. However, the pandemic also exposed weaknesses

and inequities in healthcare, providing valuable information for improving the quality of care. For example, poorer health outcomes for Black individuals during the pandemic and in pregnancy and childbirth highlight a need to reform doctor-patient relations and increase awareness about the impact that structural racism has on the health of those victimized by it. More broadly, it is clear from women's testimonies that healthcare providers have tremendous power to improve their experiences by granting them credence when they express their concerns and approaching maternal care as a partnership between doctor and patient. The impact of these approaches is apparent from testimonies like those collected by Baumont et al. (2023): "There was mutual respect between my providers and myself. It made things flow more gracefully. I felt I had the best care I could ever ask for" (p. 956). Women do not imagine the risks associated with pregnancy and childbirth, and these risks go beyond personal circumstances. Healthcare providers must acknowledge such realities for all pregnant people and use their testimony to build effective care plans.

A Path Toward Equitable Care

Although providers need to reassure mothers, they must also acknowledge the risks of pregnancy and validate their anxiety. Despite the disproportionate emphasis in maternal mental health scholarship on hormonal imbalances and personal problems, the psychological distress and concerns of mothers regarding pregnancy and childbirth cannot be explained by individual circumstances alone. The pandemic, racial bias in healthcare, and epistemic injustice are examples of material problems impacting the well-being and mental health of mothers in the United States. If left unattended, gaps in care have dire consequences. While providers cannot make changes overnight, there are specific steps they can take to make pregnancy and childbirth safer and more comfortable for all women. The decrease in access to pregnancy care and support during the

pandemic significantly impacted the mental well-being of new mothers. Also, it proved that access to these services is of critical importance. However, access is only the first step. It is also crucial that once mothers begin contact with their care providers, they are guaranteed an experience grounded in mutual respect and a well-rounded understanding of how intersecting social identities can dictate the specific needs of mothers during pregnancy, birth, and the postpartum period. The statistics, evidence, and personal testimonies are clear: women are not treated with the care and respect they deserve. It is now up to researchers and providers to emphasize women's health and challenge themselves to create more inclusive, comprehensive, and responsive care plans—because even though every mother faces systemic failures, every mother is unique, and every mother matters.

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Endnotes

1. To acknowledge that no single term or gender identity can universally encompass the experience of pregnancy and childbirth, this paper uses a combination of gender-neutral terms, such as "pregnant person," as well as female-gendered words, such as "woman" and "mother" (Baumont et al., 2023).

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