

Integrating Holistic Services for Birthing People into a Hospital Setting

Kristin Marie Hayes

A thesis

submitted in partial fulfillment of the  
requirements for the degree of

Master of Social Work

University of Washington

2020

Committee:

Michael Spencer

Kristian Stone

Program Authorized to Offer Degree:

School of Social Work

©Copyright 2020

Kristin Marie Hayes

University of Washington

**Abstract**

Integrating Holistic Services for Birthing People into a Hospital Setting

Kristin Marie Hayes

Chair of Supervisory Committee:

Michael Spencer

School of Social Work

Perinatal mood disorders, experienced by over one in ten pregnant people in high-income nations, are considered the number one concern impacting the health and well being of the pregnant person and their child during birth (Milgrom & Gemmill, 2014). The vulnerability to mood disorders pregnant and birthing people face, compounded by discrimination and obstetric violence in the birthing space along with racial disproportionality in maternal health outcomes, invites the question of how to improve the mental health and birth outcomes of pregnant and birthing people in the United States. *Methods.* This exploratory, cross-sectional, qualitative study included 30-60 minute interviews with 18 maternity providers in the United States, including behavioral health specialists, doulas, midwives, Obstetrician-Gynecologists (OBGYNs)/family physicians, health researchers, and labor & delivery registered nurses (RNs). The interview questions investigate provider opinions on the accessibility of maternal health services in a hospital setting, the integration of behavioral health and doula services, knowledge of culturally-responsive care, and racial disproportionality in maternal health outcomes. *Results.* Key findings

of this study include a unanimous participant belief that inclusion on inter-professional teams and culturally-relevant patient-centered care are essential for successful integration of holistic maternity services into a hospital setting. The majority of participants indicated the impact of racial bias and discrimination in birth outcomes, some speaking more explicitly about racism and white supremacy than others. There is an overall indication from participant interviews that integrating holistic services can work, but it is complex and multi-faceted. *Conclusions.* This study implies the need for future research, further investigating the integration of holistic services into hospital settings and expanding the definition of culturally-relative mental health treatment/interventions. Future studies must also explore the lack of diversity among maternity providers and how the current academic system may not be meeting the needs of non-white individuals.

Key Words: Birthing, Obstetric, Obstetric Violence, Perinatal Mood Disorders, White Supremacy, Social Work

## Dedication Page

Healthy pregnancies and birthing experiences are too often stolen by a system that favors certain people and social identities over others. White bodies are held at a higher level of importance than Black and Brown bodies in the United States. I am publishing this research at a time of great despair in our country, grounded in over 450 years of racism and white supremacy. Before moving forwards, I would like to honor George Floyd, Breonna Taylor, Ahmaud Arbery, Tony McDade, and the many other Black individuals who have lost their lives at the hands of racist police brutality and other forms of state-sanctioned violence. These blatantly violent acts represent the white supremacist nation we live in.

Police brutality is not the only mechanism of racism and violence in the United States. Violence and racial discrimination are alive in our health care system, education system, access to employment, access to secure housing, the prison industrial complex, the war on drugs, immigration policies, and so many other avenues. It is imperative for research to illuminate how dangerous our systems can be for communities who are not white. As a white researcher and white health care provider, I will never know what it feels like to experience such discrimination and violence based on my race, ethnicity, or culture. I will further explain my limitations as a white provider below but wanted to center this truth at the beginning of my research.

It is with deep admiration that I write about pregnant and birthing people's experiences in the health care system. The perinatal period is an incredibly vulnerable and transformational time for people and deserves to be presented with the utmost empowerment. This research is dedicated to every person who has experienced a perinatal mood disorder and/or discrimination/violence in the health care setting at the hands of white supremacy. I see you, I hear you, and I validate you. You are more powerful than you know.

## Integrating Holistic Services for Birthing People into a Hospital Setting

### Introduction

Maternal mental health is one of the top concerns impacting pregnancy, childbirth, and the postpartum period (Glover, 2014). Research indicates that perinatal mood disorders impact over 10% of pregnant people in high-income nations, which increases during the postpartum period (Milgrom & Gemmill, 2014). Postpartum depression and anxiety are the most common perinatal mood disorders, but others include bipolar II, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and postpartum psychosis (Lomonaco-Haycraft, Hyer, Tibbits, Grote, Stainback-Tracy, Ulrickson, Lieberman, van Bekkum, & Hoffman, 2018; Keefe, Brownstein-Evans, Rouland Polmanteer, 2016). Prenatal maternal stress can impact the birthing person's physical condition, including their immunological and metabolic health, emphasizing the importance of treating and assessing changes in mood and overall stress (Rosenthal & Lobel, 2011). Individuals who experience depression during pregnancy are commonly found to have poor self-care and nutrition. Some go into labor prematurely and/or encounter obstetric challenges (Milgrom & Gemmill, 2014). Obstetric challenges may include spontaneous preterm birth, an enhanced need for a cesarean section, and a higher likelihood for baby to be admitted to the Neonatal Intensive Care Unit (NICU) (Dayan, Creveuil, Marks, Conroy, Herlicoviez, Dreyfus, & Tordjman, 2006; Chung, Lau, Yip, Chiu, & Lee, 2001). Research continues to indicate that perinatal mood disorders and maternal stress impact birth outcomes at a disproportionate rate, impacting the high maternal mortality rate among communities of color.

#### *Racial Disproportionality*

The pregnancy-related mortality rate among birthing people in the United States has increased significantly since the early 1990s and displays troubling racial disparities (Creanga,

Syverson, Seed, & Callaghan, 2017; Berg, Callaghan, Syverson & Henderson, 2010). Research indicates that Black and American Indian/Alaska Native individuals experience pregnancy-related mortality at a significantly higher rate than white birthing people in the United States (Centers for Disease Control & Prevention, 2018; The National Partnership for Women & Families, 2019). It is essential to highlight the disproportionate rate of non-white birthing individuals dying from pregnancy-related complications as institutional racism plays an enormous role in the diverse birthing experiences of families across the United States. The experience of perinatal mood disorders and racial discrimination in the medical setting is a deadly combination. Particularly among birthing communities of color with a history of forced sterilization, deepening their mistrust of medical professionals (Rosenthal & Lobel, 2011; Aizer & Currie, 2014; Horsburgh; 1995).

As if perinatal mood disorders are not enough of an obstacle to healthy birth outcomes, birthing individuals of color carry the weight of historical trauma with the medical system while continuing to experience obstetric violence today (Berman, Mason, Hall, Rodger, Classen, Evans, Ross, Mulcahy, Carranza, & Al-Zoubi, 2014; Beck, 2004; Chadwick, 2017). Holding the unique lived experiences, past and present, of birthing people is essential in understanding the role of psychological wellness within the perinatal period. Providing culturally-relevant holistic health care is imperative for the birthing person, as they navigate the intimate transition from pregnancy to postpartum. Health care systems must center the need for services and treatment to be culturally-congruent, while recognizing how historical trauma within the medical system may impact levels of trust, “medical compliance,” and honest disclosure of symptomatology.

### *Culturally-Relevant Mental Health Services*

To increase overall maternal wellness in the United States, we must understand the impact of culture on mental health care/treatment and where our system is currently not meeting the unique needs of birthing people and their mental health. Mental health treatment needs to be accessible, culturally-relevant, and patient-centered. Literature suggests a consistent lack of provider understanding in how perinatal mood disorders (most notably postpartum depression) impact diverse communities and an overall lack of confidence in serving them with cultural humility (Teng, Blackmore, & Stewart, 2007). The lack of confidence among maternity providers to offer culturally-relevant care can impact health outcomes, appropriate referrals, and the client's feelings of empowerment. A lack of cultural humility among providers can be dangerous for non-white birthing individuals, especially due to the glaring racial differences regarding access to maternal mental health treatment (Goodman, 2009; O'Mahen & Flynn, 2008).

Research demonstrates that white women are more likely to engage with formal mental health treatment than Black women, while Black women are more likely to receive support from their mothers and/or spiritual communities during the postpartum period (O'Mahen & Flynn, 2008; Amankwaa, 2003). This is demonstrative of the need for more diverse mental health treatment options and the recognition that intervention does not always need to look the same. Previous literature on the mental health experiences of marginalized communities within the postpartum period indicates the need for more research on a larger, more robust scale (Templeton, Vellemanm, Persaud, & Milner, 2003). Previous research also highlights the importance of diversifying future studies in their approach to treating postpartum depression, where cultural differences and culturally-congruent health responses are centered (Amankwaa,

2003). This invites the questions of how to move towards a health care system that incorporates providers outside of the westernized approach to medicine. Culturally-nuanced mental health treatment plans are imperative for the wellbeing of new parents and their infants, highlighting the demand for holistic maternity providers within primary care and hospital settings.

### *Integration of Mental Health and Doula Services*

Integrating mental health services into primary care and OBGYN offices could be a step towards enhanced treatment for perinatal mood disorders prior to birth, paving the way for more integrative services into the hospital setting. Research has addressed the need for more integrative services within primary care and OBGYN clinics to enhance the levels of trust, decrease stigma, and provide more accessible mental health services (Goodman, 2009). Previous research indicates that pregnant individuals are more willing to seek psychotherapy if the mental health provider is in the same location as their OBGYN provider (Goodman, 2009). Other studies illuminate the importance of the primary care provider in assessing for ongoing mental health challenges, as pregnant and postpartum individuals interact frequently with primary care providers during the perinatal time (Lomonaco-Haycraft, et. al., 2018). Providing holistic maternal health services, with multiple providers in one clinic, may increase the likelihood for individuals to access and receive ongoing mental health treatment throughout their prenatal care. This is where the integration of other maternal health supports may not only be helpful, but critical in the wellbeing of parent and child.

The integration of doulas into maternal health care teams can also be incredibly powerful in addressing specific cultural and socioemotional needs. The role of a doula is to “empower a woman to communicate her needs and perceptions and actualize her dream of a healthy, positive birth experience” (Gruber, Cupito, & Dobson, 2013, p. 49). Doulas offer a realistic solution to

what western medicine lacks. Research indicates healthier maternal and infant outcomes when there is ongoing support throughout the childbirth process, catering to the specific needs of the person giving birth (Ireland, Montgomery-Andersen, & Geraghy, 2019). Doulas can offer support to vulnerable birthing communities, who may not get their needs met in a white-centric, cisheteropatriarchal medical system. Doulas are another voice in the medical room advocating for their patients to access the socioemotional support they need and mitigate any oppressive behavior from the medical staff throughout the childbirth process (Ireland, Montgomery-Andersen, & Geraghy, 2019). In order to support the unique needs of the patient, health care teams must meet the individual where they are and recognize how intersectional identities impact one's relationships and perceptions of their own health.

It is critical to examine how health providers assess, treat, and provide necessary resources for pregnant and birthing people in the hospital setting, as most births in the United States occur in the hospital (MacDorman & Declercq, 2019). The hospital setting presents different challenges to the integration of care than OBGYN and primary care offices. It is essential to investigate how team members interact and provide space for each to do their job well. This collaboration becomes particularly important in the relationships between doulas and other hospital health providers. There are studies that investigate the relationships between birthing people and their doula, but little literature focuses on the physical implications of doula support (Gruber, et. al., 2013). There is a need to investigate how emotional advocacy impacts birth outcomes, representing an avenue for progression in the field of maternal health.

Furthermore, there are gaps in the literature that focus on the integration of holistic maternity services, specifically in a hospital setting. More research needs to be done to further understand the relationship between doulas and health care providers in order to address the obstacles to

integration (Neel, Goldman, & Nothnagle, 2019). Lastly, research indicates that hospital health providers, most notably nurses, may not be meeting patient expectations due to being understaffed and overworked (Gruber, et. al., 2013). This highlights the opportunity for the integration of more doulas into a hospital setting, in hopes of enhancing support for the individual giving birth and hospital medical staff.

*Framework: Social Ecological Model*

Social work grounds itself on the social ecological model, where people are understood in the context of their environment. The social ecological model holds the complexity of the interconnectedness of human life, organizing the primary factors from a micro, mezzo, and macro perspective (Mattaini & Holtschneider, 2016). The micro factors start with an individual's identity, lived experiences, and family demographics. Outside of the micro perspective lies the mezzo perspective, where community services and institutions impacting the individual are highlighted. The macro perspective recognizes systems and structures that play a significant role in the individual's lived experience. This framework also recognizes individual dependence on community wellness for personal health and vice versa (Mattaini & Holtschneider, 2016). The perinatal period presents a unique time to explore how the birthing person is interconnected with their community and larger systems as they bring a new child into the world. The onus of healthy babies and healthy birthing people is on everyone, yet the individualistic nature of human life in the United States has reallocated the onus on the birthing person themselves.

**Purpose of Study and Research Questions**

The integration of holistic maternity services re-centers the necessity for hospitals to recognize the need for birthing people to see themselves, their communities, and their cultural backgrounds reflected in their birthing experience. This research is ultimately interested in

exploring the integration of holistic, culturally-responsive maternity services into the hospital setting. In attempts to mitigate the ambiguity of this exploratory study, there are four research aims categorized to explore the multiple variables that impact the relationship between culturally-responsive holistic maternity services and integration into a hospital setting. Research aims include: accessibility of services, behavioral health & doula services, provider knowledge of unique/diverse needs, and racial disproportionality in maternal health outcomes. The researcher estimated that participants would reflect the need for integrating behavioral health services into maternity units with varied perspectives on how to center cultural/traditional birthing norms within these services. Additionally, the researcher predicted that participants would articulate diverse responses and feelings regarding the accessibility of maternity services and the racial disproportionality of maternal health outcomes. Lastly, the researcher estimated that participants' individual racial/ethnic identity, number of years in the field, and professional role would likely impact perspectives and how important/urgent they feel the integration of holistic maternity services are into a hospital setting.

## **Methods**

### **Research Design**

This is a cross-sectional, qualitative, exploratory study, which aims to explore the integration of holistic birthing services into a hospital setting. This qualitative study investigates the perspective of a variety of maternity health providers, including OBGYNs, family physicians, labor and delivery nurses, midwives, doulas, behavioral health specialists, and public health practitioners/researchers. Data was collected between January 14<sup>th</sup> and April 14<sup>th</sup> 2020. After applying to the UW's IRB, this study was considered IRB exempt. No further review was required at EvergreenHealth, beyond the UW's IRB approval/exemption.

Eighteen qualitative interviews were conducted. The same interview questions were asked to each participant with verbal probing when appropriate, as this is an exploratory study with the intention of seeking new themes for future research/program development. Interviews were held in a private space or over the phone and lasted for 30-60 minutes. The researcher recorded interviews on an electronic device to refer back to and transcribe. Electronic devices were stored in a safe space to protect confidentiality and deleted permanently after verbatim transcription occurred. There were no additional resources needed.

### **Sample**

The researcher's graduate practicum placement was at EvergreenHealth in the Women and Children's Units. The researcher interviewed several EvergreenHealth medical and behavioral health staff members who were gathered with a nonprobability sample, using a convenience sampling strategy. The researcher's practicum instructor (Manager of Care Management) sent out the description of research to maternity health providers within EvergreenHealth with whom they had a connection to and believed would be interested in participating. The researcher sent out follow-up emails to the individuals who expressed interest in participating to schedule an interview time. It was important for the researcher to explain their internship role at EvergreenHealth and briefly describe the study in the email.

Participants outside of EvergreenHealth were gathered through a snowball-sampling strategy. These participants, who are not connected to EvergreenHealth, were identified through people the researcher knew, fellow participants, or Facebook posts. It was the researcher's hope to interview folks with a variety of perspectives to understand the current landscape of maternal health services in a hospital setting across the United States. Most participants (14) identified that they are currently practicing in Washington State, while four participants are practicing

outside of Washington State. One participant currently works in Arizona, one participant is working in California, one participant is working in Pennsylvania, and another in Massachusetts.

Four of the participants (22%) identify as registered nurses, who specifically work in Labor & Delivery units. Some of those nurses also work in outpatient OBGYN clinics, which are located within a hospital campus. Six out of the 18 participants (33%) identify as doulas, two participants (11%) identify as midwives, two (11%) identify as behavioral health specialists (psychiatric nurse practitioner and psychologist), two (11%) identify as public health/epidemiologist & health disparity researchers working within maternal communities, and two (11%) identify as physicians (one OBGYN resident & one family physician). Participants were asked how long they have been working in their respective field. Responses varied between three months and 41 years. The last piece of demographic data collected inquired about racial/ethnic identification. 14 participants (78%) identified as white or Caucasian, one participant (5.5%) identified as Hispanic/Latina, one participant (5.5%) identified as Biracial, one participant (5.5%) identified as Black American, and one (5.5%) identified as Multiracial (Indigenous, Mexican, Filipino, and Jewish). All demographic data can be found in Table 1.

## **Measurement**

The researcher chose to utilize qualitative interviews as a method of data collection and inquiry due to the exploratory nature of this study. The qualitative approach endorses the use of open-ended questions while exploring the participant's environment, personal experiences, and values (Creswell, 2009). This collaborative, advocacy-focused method implies opportunity for change and development based on study results (Creswell, 2009). The interview questions investigate the accessibility of maternal health services, the integration of behavioral health and doula services, provider knowledge of culturally-responsive care, and the racial

disproportionality in maternal health outcomes. For example: How do you/have you respond(ed) to a scenario where someone's cultural identity impacts the way you provide(d) care? Where do you see gaps or barriers to care/maternal services? How do you think we could work towards eliminating these? The entirety of the interview questions can be found in the appendix. In this study the independent variables are as follows: social identity of the practitioner (age, years in the field, race/ethnicity, gender, etc.), profession/field of study, and ethical orientation/medical philosophy. Maternal health & birth outcomes act as the dependent variables, though these will not be measured in numeric value.

### **Data Analysis**

The researcher will utilize the qualitative method of content analysis to search for consistent themes within the interviews and code accordingly. With the use of content analysis, themes will be categorized and summarized according to similarity and thematic pattern. This research topic is complex and multifaceted, where knowledge on the topic is often presented in silos, distancing the integration of physical, behavioral, emotional, and spiritual maternal health services. Due to the exploratory nature of this research and lack of previous literature on the topic, the researcher will take an inductive approach (Elo & Helvi, 2007). The inductive approach will organize “quantified phenomena” found within participant interviews to allow for further description and understanding of results (Elo & Helvi, 2007, p. 108). The researcher first read through all of the interview transcripts to develop initial themes and definitions. After three themes were defined, the researcher coded the transcripts and highlighted exemplary quotes after the coding process was complete. The chosen quotes specifically reflect theme definitions, add circumstantial context, and further illustrate provider perceptions of maternity care/services.

Descriptive statistics will also be utilized for data analysis, along with other inferential statistics when appropriate.

## **Results**

Three major themes were identified from the 18 qualitative interviews: 1) Inclusion on Inter-professional Teams, 2) Culturally-Relevant Patient-Centered Care, and 3) White Supremacy. Themes and theme definitions can be found in the table below (see Table 2).

### **Inclusion on Inter-professional Teams**

Inclusion on inter-professional teams recognizes the need for interdisciplinary teams to eliminate hierarchical power structures in the hospital setting and invite an equal distribution of respect among providers. This includes respectful communication and team building skills that honor the individual expertise of each provider, strengthening the team as a whole. This is particularly difficult when mental health treatment and medicine are perceived as separate and held at different levels of importance. All 18 participants discussed inclusion on inter-professional teams in their individual interviews. Each expressed their unique perspective of teamwork, provider hierarchy, and the need for understanding one another's roles, as they explored equity on interdisciplinary teams. One participant spoke directly to the differences between OBGYNs and nurse practitioners/certified nurse midwives in their perception of expertise,

There is very much a power differential that exists...there's sort of this belief in society and also through the medical profession that OBGYNs are superior to nurse practitioners and nurse midwives. However, what we're really trying to do is actually highlight the facts that we're both experts in different things. So we're [nurse midwives] experts in

normal physiological birth. They're [OBGYNs] experts in high-risk birth and that there can be a partnership recognizing expertise across the board.

Participant responses suggest that maternity provider hierarchies exist out of a misunderstanding of provider expertise and an unwillingness to level the playing field. An OBGYN resident indicated the gaps in their training, especially when working with suicidal or psychotic pregnant/birthing patients who need intervention and an inpatient psychiatric placement. This participant states,

...as an OB [OBGYN], what am I going to do? I don't have the ability to help someone with that aspect. It's not in my training. I don't have the resources or the connections or the ability to admit someone to an outside inpatient psych facility.

This statement also reflects the need for behavioral health providers on interdisciplinary teams, due to a gap in provider training and expertise.

Participants frequently commented on the need for collaborative interdisciplinary teams in order to best serve the patient, indicating the central goal of quality patient care. While specific goals and frameworks of providers may differ, the goal of patient-centered care seems to remain consistent. One participant specifically highlighted the need for more "integration and collaboration between mental health professionals and those who provide maternity care." This participant recognized the amount of time nurses and doulas spend with patients and the need for increased training on how to address mental health wellness. Hospital staff may be the only maternity providers that a birthing person encounters during the perinatal period, requiring staff to be equipped with the tools to address mental and physical health and wellbeing.

## **Culturally-Relevant Patient-Centered Care**

Another identified theme is the need for culturally-relevant patient-centered maternity care. Whether or not participants agreed on the way for care to be administered, everyone recognized that cultural and racial/ethnic background does impact how care is provided and how individuals may have different needs/goals dependent on their identity. Participants discussed the importance of centering the patient in their care/birth plan and respecting their vocalized needs. Participant's responses differed in whether or not they identified how their personal identity and/or personal bias impacted the way they may have provided care in the past. Multiple participants articulated how their personal desires and cultural backgrounds differed from their patients'. One participant noted,

...I remember there was a case where this doula...[it] was driving me nuts because I tend to enjoy a quiet, peaceful room, you know. And I think patients labor better that way...so the doula was a young black woman. The patient was also a young black woman. And it was just the antithesis of the room that I would think would be conducive to laboring. It was loud, it was bright...It was not my vision of what a labor would necessarily be but for whatever reason it seemed to meet this gal's needs.

In this participant's perspective, their patient's birthing needs varied greatly from their conception of a perfect birthing environment. This participant recognized where their personal bias came into play and worked to re-center the needs of the patient, understanding that a patient's racial and/or cultural background may impact goals of care.

Other participants explained how not all patients are able to articulate or access their needs, which is particularly dependent on their racial/ethnic background. One participant identified how the "...expectations are so different from people based on their social

identity...their cultural background,” highlighting systemic discrimination in hospital maternity settings, where behavior is often controlled or policed. This not only indicates negative experiences of childbirth in a hospital setting based on a lack of cultural inclusiveness, but also suggests where trust between patients and providers may be broken, indicating gaps in the quality of care throughout the perinatal period. In one participant’s response, they remarked on their incongruence with a patient who identified as an East African immigrant. This participant described how their patient did not consistently take their blood pressure medications throughout the prenatal period and suggested how their cultural background and mistrust of Western medicine administered by white providers could have impacted this behavior. The participant described how it “...wasn’t a not understanding issue, it was cultural. She just didn’t want to [take the medications] and she didn’t understand why we wanted her to.” It is critical for providers to recognize their positionality, particularly when working with marginalized communities with vastly different lived experiences. Culturally-responsive patient-centered care is imperative in providing quality maternity care.

### **White Supremacy**

Providing culturally-responsive patient-centered care is complicated by racial bias in the United States’ healthcare system, where black and brown birthing people are disproportionately dying from pregnancy-related complications. The third research theme is white supremacy in the health care system. 13 out of 18 participants explicitly described how racism and white supremacist values impact pregnant and birthing people, while the remaining 6 participants discussed implicit bias and/or unconscious/conscious racism in the medical field. Participant responses consistently emphasize the current literature, highlighting how people of color experience obstetric discrimination and pregnancy-related mortality at a disproportionate rate to

white birthing people. Some participants focused primarily on the research, while others described how their personal identity and larger structural oppression impacts patients' experiences in the healthcare system. One participant spoke to the structural factors contributing to discrimination and oppression and how white male maternity providers have displaced community women of color, stating,

...the root of the profession [Obstetrics and Gynecology] is rooted in violence towards women of color...that violence is still kind of there in the system and we see that reflected in maternal mortality and disparities...So I think there's this deep level of implicit bias, that's not only perpetuated by providers, but also in the very way that we medicalized and systematically made birth a profession dominated by a field of white men when prior... [midwifery] was a profession of community women and particularly community women of color.

Some participant responses, including the participant quoted above, articulate how cisheteronormative, capitalistic white supremacy dominates the medical field and particularly found within the professionalization of OBGYN services and reproductive justice.

Another participant spoke to the lack of awareness in the medical field of how "white male patriarchy" and the "power structures of OBs" impact birthing experiences and birth outcomes. Furthermore, they commented on how these power structures have turned a life process "into a medical event for capitalism." The centering of structural oppression in the birthing process is reflective of many participant responses as they describe their observations of obstetric violence and the silencing/dismissal of patients of color and their cultural birthing traditions/preferences. One participant portrays their observations of labor and delivery nurses, stating how, "...nurses would be super respectful about folding [Mormon patient's] spiritual

undergarments” yet “won’t let a woman wear a hijab in labor in some hospitals.” Blatant racial discrimination is evident in multiple participant responses, mirroring white supremacy and racist behavior among maternity providers.

Participants also debriefed the importance for diversifying the racial/ethnic profile of maternity providers in order to reflect and best serve patient communities. One participant remarked that, “...it does seem that people are more comfortable with people of their own race and language,” while another participant indicated that provider/patient racial congruence isn’t necessary for culturally-responsive patient-centered care, as long as there is acknowledgement of racial difference, collaboration, and teamwork. One participant questioned whether or not true integration of holistic services into a hospital setting could ever truly be culturally-responsive, due to the history of white-centric medical settings co-opting practices created and made for communities of color to “further perpetuate the same violence.” Medical trauma and colonization must be centered in the analysis of integrating holistic services into a hospital setting for care to be truly culturally-responsive and patient-centered.

Table 2

Theme	Definition
1. Inclusion on inter-professional teams	The integration of behavioral health, doula, and culturally-relevant services/providers in close proximity can increase accessibility for people during the perinatal period. The integration of these holistic services requires effective communication across the interdisciplinary team and the respect/knowledge of diverse provider frameworks/disciplines.
2. Culturally-Relevant Patient Centered Care	Birthing people need to be listened to while receiving care from maternity providers. In order to support the whole birthing person (mind, body, and soul), it is essential to empower their natural supports and toolkits instead of removing or questioning them. Culturally-relevant birthing norms and traditions must be centered in all treatment plans when able.

3. White Supremacy	The medical setting is not a safe or equitable place for all birthing people. There is an urgency of care that prioritizes quantity over quality. Obstetric violence and racism occur frequently, displacing power from the birthing person to the medical staff. The lack of racial and ethnic diversity among maternity providers polarize the power dynamic and disproportionately reflects the cultural norms of whiteness.
--------------------	---

### **Discussion**

This study investigates the integration of holistic maternity services into a hospital setting through the exploration of accessibility of services, behavioral health & doula services, provider knowledge of unique/diverse needs, and racial disproportionality in maternal health outcomes. Participants’ responses to the specific research aims were organized into three themes, which include inclusion on inter-professional teams, culturally-relevant patient-centered care, and white supremacy. The researcher’s estimations prior to conducting research were accurate regarding the varied perspectives of maternity providers on the integration of hospital behavioral health services and the centering of cultural/traditional birthing norms. All providers articulated the need for behavioral health services in a hospital setting but described the severity of this need differently.

#### *Discussing Research Aims*

Midwives, doulas, and behavioral health specialists reported similar opinions on the need for more integrative behavioral health services, speaking particularly to the need for effective communication and equity among maternal health interdisciplinary teams. Nurses and OBGYNs/family physicians recognized and articulated the unique role behavioral health providers play in a birthing person’s medical journey, yet their responses varied most in terms of how possible this integration could be in the hospital setting. Nurses spoke to their struggle in balancing the emotional and physiological needs of their patients in a timely manner, while MDs

expressed their limitation in providing adequate mental health services due to their training and discipline. The maternal public health research participants articulated a similar need for integrative services, yet provided a more systems-level perspective, speaking to their observation of maternal health systems administering white-centric and often inaccessible services to birthing people. The need for culturally-responsive patient centered care was identified by all participants, but spoken about in more detail by doulas, midwives, and behavioral health specialists.

Results show that the integration of holistic services into a hospital setting can work but it is complex. It is important to ask about alternative ways to engage in mental health interventions or treatments, as traditional methods, such as sitting in a clinic across from a behavioral health specialist, do not work for all individuals (O'Mahen & Flynn, 2008; Amankwaa, 2003). Mental health interventions might also include seeking community-based resources within their faith community (Amankwaa, 2003). Some participants, mostly doulas, spoke about the need for hospital assessments to expand the definition of mental health treatment and include more culturally-inclusive interventions. Other participants centered the importance of hospital staff recognizing current and historical trauma among vulnerable populations, to ensure that the integration of culturally-inclusive practices is not co-optive and/or doesn't further perpetuate harm. The question of whether or not integration can work requires further investigation and is likely dependent on community need, institutional values, and buy-in from hospital staff.

The researcher also predicted that participant responses about the accessibility of maternity services and the racial disproportionality of maternal health outcomes would vary across discipline. The most glaring difference among provider responses was their engagement in the topic of racial disproportionality in maternal health outcomes. Disciplines such as

midwifery, doulas, and behavioral health, ground themselves in recognizing the importance of social identity, intersectionality, and the whole-person while providing care (Gruber, et. al, 2013; Keefe, et. al., 2016; Reime, Klein, Kelly, Duxbury, Saxell, Liston, Prompers, Entjes, Wong, 2004). The medical field, including OBGYNs and family physicians, focus primarily on curing and tending to physiological health (Reime et. al., 2004). All providers offer important components of a birthing person's wellbeing, yet participant responses suggest that there is a gap of understanding in how knowledge of health disparities differs from recognizing disparities as they occur in front of them. This also plays into the researcher's estimation that professional role will impact participant responses, as it is clear that providers who feel more limited in their time with patients and perceive their role to include only physical health are less engaged with behavioral, cultural, and spiritual health.

#### *Role of Participant Demographic Information*

The participant's individual racial/ethnic identity impacted how participants spoke about their involvement with racial bias and understanding of diverse patient needs. The extent to which participants directly addressed concepts like white supremacy differed, yet all participants identified disproportionality in maternal health outcomes. Nearly all of the non-white identifying participants indicated a heightened need to diversify the racial/ethnic makeup of maternal health providers to better reflect the communities they serve. The most striking differences among participants regarding years in the field was the urgency of needed changes and the expression of more recent terminology. Participants newer to their profession, suggesting more recent engagement with academia, appeared more enthusiastic about structural changes, which include the integration of holistic maternity services into a hospital setting.

## **Implications**

The participant responses and research themes imply the need for micro, mezzo, and macro level changes in maternal health care in the United States.

### *Micro-Level Implications*

Starting with the micro level implications and following the participant discussion regarding inclusion on inter-professional teams, there is an apparent need to break down hierarchical norms on maternity interdisciplinary teams, increase knowledge of one another's expertise, and enhance effective communication and collaboration skills. As one participant stated, "...people don't really know how to communicate with each other...I truly believe working together is one of the hardest things for humans to do." This quote indicates the importance of interdisciplinary teams becoming more efficient in their communication while recognizing the difficulty human beings face in performing at a high level on a team. Proficient and equitable teamwork is harder to master in a fast-paced, high-pressure environment like the hospital, where patients and families are trusting providers with high-risk health situations (Thomas, Sherwood, Mulhollem, Sexton, & Helmreich, 2004). The pressure and fragility of tending to newborns and birthing people can magnify stress among providers, acting as another barrier to efficient communication and respect of one another's expertise (Thomas, et. al., 2004). It is essential that these truths are understood and acknowledged among the interdisciplinary team as everyone works together to create a culturally-responsive, patient-centered care experience for the birthing person, their newborn, and other family members.

Other implications for micro practice with birthing communities in the integration of holistic maternal services, is the added emphasis on cultural and spiritual birthing norms when assessing the patient's psychosocial needs. Many participants also spoke about the importance of

disseminating consistent information to all of the patient's maternity providers. Literature on maternal mental health assessment tools indicates how critical the integration of these tools are, as pregnant people experience a specific vulnerability to mood disorders during the perinatal period (Milgrom & Gemmill, 2014). It is imperative to use effective screening tools during perinatal visits to determine the need for mental health services (Dennis & Chung-Lee, 2006).

Culturally-responsive and inclusive screening tools must be centered in future research particularly in context to the glaring racial disparities among access to formal mental health treatment in the United States (Goodman, 2009; O'Mahen & Flynn, 2008). One participant described the importance of implementing "universal [behavioral health & psychosocial] screening for women who are pregnant...[so] when you find a positive screen...you don't have to think about it. It if happens...you want to be able to just connect it." Early identification of perinatal mood disorders is key in providing birthing people with the care they need. It is also essential that cultural and spiritual beliefs be centered in the evaluation of psychosocial needs.

#### *Mezzo-Level Implications*

As maternal health professionals, it is critical to recognize and identify how groups and organizations impact the patients we engage with ("Micro, Mezzo, and Macro Practice," 2020). This is considered mezzo level interaction, where the individual is recognized within the context of their community. Groups and organizations found in pregnant and birthing people's communities impact the health of this population and the wellbeing of their future child. It is essential that we center these neighborhood/community factors in the organization/delivery of care plans and interventions. This is particularly relevant when speaking to the topic of health care accessibility. Participants remark on the recurrent theme of money and health insurance being the largest barrier to accessibility for pregnant and birthing people. This is particularly

relevant to some immigrant/refugee populations who do not have access to health insurance due to health care policy in the United States. One participant spoke about their experience working with pregnant and birthing individuals who do not have US citizenship and how accessing health services are especially difficult for this population. This participant states,

...We have so many undocumented Hispanic moms who just don't get the same resources because they don't have insurance and they can't pay for things. There's a maternal package that lets them pay cash...but some of them can't really even afford that, so they don't get prenatal care which...is the number one cause of death for a pregnant woman.

Lack of access to health care, particularly prenatal care, limits the opportunity for pregnant people to discuss potential complications while evaluating other aspects of their health (Boerleider, Wiegers, Manniën, Francke, & Devillé, 2013). If pregnant and birthing people cannot access healthcare in their own community, or access health care at all, the implications can be fatal.

Another example of mezzo level care implications for pregnant and birthing people is the health and wellbeing of the family unit. The individualistic nature of human life in the United States limits the opportunity for child rearing to exist in a community-oriented way (Bernstein, 2016). The social expectation for female-identifying people to succeed in their professional lives and as a parent creates an immense amount of pressure on pregnant and birthing individuals. The fear of failure is rampant among this population, which is reflected in many participant responses. In one participant's interview, they express the Western expectation for women to "run 5 miles a day," cook, and do everything on their own, even after the birth of their newborn. And when people are not able to live up to this expectation, "they feel like a failure." It is

essential that maternity health providers recognize the incredible social pressure pregnant and birthing people feel, particularly within a Western context.

Many participants commented on the isolation people feel after they deliver their baby and how this impacts emotional health and their ability to access organizations in their community, like a postpartum appointment. It is critical to acknowledge the role of Westernization in the existence of isolation, as this differs across cultures. One participant speaks to this concept as they describe how before they became a doula, they hadn't witnessed a birth and how "not all cultures have a history of...social birthing." While Western culture may not practice collectivism in child rearing and integrate birthing into cultural norms, communities with different cultural/ethnic/spiritual norms may exist more collectively. As maternity providers recognize the mezzo level impacts of birth and child-raising, it is again essential to center cultural and traditional birthing norms when working with individuals in the perinatal period.

### *Macro-Level Implications*

Understanding how the marco level (systems and structures) impacts pregnant and birthing communities is critical in making long-term, sustainable change. The health care system in the United States is representative of colonization, particularly among maternity services where, as one participant articulated how, "...modern gynecology created the field out of these anesthetized surgeries and experimentations on black slave women." It is crucial that maternity health care providers recognize the historical trauma many communities of color face when engaging in formal health care systems, particularly black women. Obstetric violence continues to occur today, as many participants addressed in their interviews.

The medicalization of childbirth has profited the very population who first performed violent surgeries and experimentations on poor, women of color: white, male doctors in the

United States (Horsburgh, 1995; Wall, 2006). The field of obstetrics and gynecology, and the health care system in general, is also profiting from childbirth being understood as a sickness, as opposed to a natural phenomenon that has occurred since the beginning of time. One participant speaks directly to this point as they state, "...even in birth...it's all based on the power structures of the OBs taking over and...taking this life process and making it into a medical event...for capitalism." Recognizing the impacts of capitalism, structural racism, and sexism within the process of birth in a hospital setting are imperative as maternity providers work towards integrating holistic, culturally-responsive, patient-centered services.

In thinking about how to address barriers to care and structural racism in a hospital setting, many participants mentioned implicit bias training. Participants varied in their perspectives on how effective this training is. In one participant's interview, they express how,

Implicit bias is alive and well when it comes to pregnancy and birth. And there's a reason that we have such stark health disparities for Black women and Black families. Most of it is attributed to racism...It's not even implicit bias, there's some explicit bias...and...implicit bias training doesn't actually work...

Many participants spoke about the need for more trainings, continued supervision, and opportunities for education outside of their discipline/framework. Widespread communication and massive dissemination of research and culturally-responsive practices are vital to breaking down individual bias/stereotypes and recognizing how our personal identities/beliefs may impact the patients we are working with. In order for massive dissemination to result in training opportunities, there must be buy-in from leadership and stakeholders as funding must be allocated to provide accessible and affordable continued education for providers. Pairing continued supervision with the completion of trainings is another important aspect of widespread

communication. One participant states, “I think we need massive dissemination programs. We need that. We already know it works, right?” As we think about the most efficient ways for maternity providers to understand the macro level of hospital services, we must address the larger systems and structures that lay the foundation of our work.

### **Limitations**

One of the greatest limitations of this study is the researcher’s identity as a white provider, which limits the understanding of cultural norms and traditions outside of their own. The biases and privileges held by a white person in a capitalistic, white supremacist world, impacts how they engage with the concept of holistic culturally-responsive, patient-centered services and the extent to which the researcher was able to write about the topic. The lack of diversity among providers is another limitation of this study. The researcher’s identity as a white provider affects the participants they were able to gather due to their social networks and the level of trust providers of color may feel when engaging with them. As mentioned earlier, there is an overall lack of non-white maternity providers in the United States, which plays a role in the lack of participant diversity as well. The utilization of nonprobability and convenience-sampling strategies limits the generalizability of this study, where participation required some level of connection with the researcher. To decrease threats to external validity, the study could implement other sampling strategies to increase randomization. Lastly, there is a lack of equity among discipline representation among participants. Registered nurse participants (four) and doula participants (six) outnumbered other providers, reducing the generalizability of health professional opinions and perspectives.

## **Strengths & Future Research**

The exploratory nature of this study left the researcher with more questions than answers, creating an opportunity for future studies. The investigation of interdisciplinary perspectives is deeply needed in research, as the medical field is becoming more integrated. Ideally, this interdisciplinary research approach will emphasize the importance of integrating holistic, culturally-responsive, patient-centered services in a hospital maternity setting. Future research could also address the need for OBGYN services to be grounded in an intersectional lens, as pregnant people of color experience significant disparities in accessing mental health treatment, while also at a heightened risk for maternal mortality (O'Mahen & Flynn, 200; Creanga, Syverson, Seed, & Callaghan, 2017). Continued research must also explore the lack of diversity among maternity providers and how the current academic system may not be meeting the needs of non-white individuals. The track to becoming a health provider requires engagement in academia that is grounded in the same principles our healthcare system is: white supremacy and capitalism (Romano, 2018). There is a need for more exploration on this topic and how it interacts with the lack of diversity among maternity health providers in the United States.

There is strength in grounding this research in the ecological systems theory and social work perspective. As stated by Keefe, Brownstein-Evans, and Rouland Polmanteer (2016) in their article that addresses service barriers for those at risk of a perinatal mood disorder, "social workers are perhaps the most well trained professionals to work with new mothers living with perinatal mood disorders (p. 6)." Social workers are an essential part of interdisciplinary teams and a needed perspective in research. The ecological systems theory that grounds social work practice mirrors the experience of the perinatal period, where the individual becomes the collective as new life is brought into their intimate circle. This indicates the need for more

research on perinatal mood disorders, service barriers, and the integration of behavioral health into maternity care to be conducted from a social work perspective.

### **Conclusion**

Perinatal mood disorders impact over ten percent of pregnant and birthing people in high-income nations (Milgrom & Gemmill, 2014 & Brunton, et. al., 2015). With such a high number of individuals experiencing perinatal mood disorders, it is essential that maternity providers examine the current system to question what isn't working. In further examination, it is critical that we center the communities who are most likely to die from a pregnancy-related cause: Black and American Indian/Alaska Native individuals (Creanga, et al., 2017). The blatant racial disproportionality in rates of pregnancy-related mortality begs the question, what are we doing wrong? This study incorporates the themes of culturally-responsive patient-centered care, inclusion on inter-professional teams, and white supremacy when exploring how holistic services can be integrated into a hospital maternity environment.

This study investigated the topic from various angles, including accessibility of services, behavioral health & doula services, provider knowledge of unique/diverse needs, and racial disproportionality in maternal health outcomes. Based on the results, it is clear that participants believe maternity services in a hospital setting need to incorporate cultural-responsiveness in order to be meaningful for communities who have a history of medical trauma and continue to experience obstetric violence and discrimination today. This study provides a foundation for future research on culturally-humble, patient-centered health interventions, while questioning the hospital's ability to integrate holistic services without co-opting/perpetuating further harm. As future studies investigate maternal mental health and maternity services at large, they must center

the populations who experience the most harm and challenge the very foundation of our health care system.

## References

- Aizer, A. & Currie, J. (2014). The intergenerational transmission of inequality: Maternal disadvantage and health at birth. *The Science of Inequality*, 344(6186), 856-861. doi: 10.1126/science.1251872.
- Amankwaa, C., L. (2003). Postpartum depression among African-American women. *Issues in Mental Health Nursing*, 24(3), 297-316. doi: 10.1080/01612840305283
- Beck, C. T. (2004). Birth trauma: In the eye of the beholder. *Nursing Research*, 53(1), 28-35. Retrieved from: <https://ovidsp-dc2-ovid-com.offcampus.lib.washington.edu/sp-4.05.0b/ovidweb.cgi?QS2=434f4e1a73d37e8c1b4a447f0f0a848dd68908830c6e25ac5dff5f2c270e9581333ded821a35c6ef6ea2df20b9266b45003b55f6191c1ea9371fe959634059c3a1bb5aa69bf82f378c5675b62f97db00c711366172497b2597b6de9017529c69af726bf0398b1803fc139dc4f4303f6dc05ccbdb33ea95027fa1bfdb6dbcdcc494eabaeef9a196d4daf159b633f6534b280890cdee7e57e26c02757d2b2b48ba7420e9de403aaeabc63ccaf3a9af7c16f18d9c61348485359dbc4d3e92a51fb872bf887ffc9f7fff90ec5b4cf7d74a61bfe0aa1455e2fce92b810caa9e7d7fcaa2e42690a2c2a7a9faac1ff1a42c48fe108843ba6234f60c4b7796ca8e09b4363428814899f97e>
- Berg, C., Callaghan, W. M., Syverson, C., & Henderson, Z. (2010). Pregnancy related mortality in the United States, 1998 to 2005. *Obstetrics & Gynecology*, 166(6), 1302-1309. doi: 10.1097/AOG.0b013e3181fdff11
- Berman, H., Mason, R., Hall, J., Rodger, S. Classen, C. C., Evans, M. K., Ross, L. E., Mulcahy, G. A. Carranza, L., & Al-Zoubi, F. (2014). Laboring to mother in the context of past trauma: The transition to motherhood. *Qualitative Health Research*, 24(9), 1253–1264. doi: 10.1177/1049732314521902
- Bernstein, R. (2016, July 19). *Parenting around the world: Child-rearing practices in different cultures*. Retrieved from: <https://www.tuw.edu/health/child-rearing-practices-different-cultures/>
- Boerleider, A.W., Wiegers, T. A., Manniën, J., Francke, A. L., & Devillé, W. L. G. M. (2013). Factors affecting the use of prenatal care by non-western women in industrialized western countries: A systemic review. *BMC Pregnancy and Childbirth*, 13(81), 1-11. Retrieved from: <http://www.biomedcentral.com/1471-2393/13/81>
- Centers for Disease Control & Prevention. (2018) Pregnancy mortality surveillance system. *Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion*. Retrieved from: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>
- Chadwick, R. (2017). Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism & Psychology*, 27(4), 489-509. doi: 10.1177/0959353517692607

- Chung, T., Lau, T. K., Yip, A., Chiu, H., Lee, D. (2001). Antepartum depressive symptomatology is associated with adverse obstetric and neonatal outcomes. *Psychosomatic Medicine*, 63(5), 830-834. Retrieved from: [https://journals.lww.com/psychosomaticmedicine/Abstract/2001/09000/Antepartum\\_Depressive\\_Symptomatology\\_Is\\_Associated.17.aspx](https://journals.lww.com/psychosomaticmedicine/Abstract/2001/09000/Antepartum_Depressive_Symptomatology_Is_Associated.17.aspx)
- Creanga, A. A., Syverson, C., Seed, K., & Callaghan, W. M. (2017). Pregnancy-related mortality in the United States, 2011-2013. *Obstetrics & Gynecology*, 130(2), 366-373. doi: 10.1097/AOG.0000000000002114.
- Creswell, J. W. (2009). Research Design: Qualitative, quantitative, and mixed methods approaches (3rd ed.). *SAGE Publications, Inc.*: Thousand Oaks, California.
- Dayan, J., Creveuil, C., Marks, M. N., Conroy, S., Herlicoviez, M., Dreyfus, M., & Tordjman, S. (2006). Prenatal depression, prenatal anxiety, and spontaneous preterm birth: A prospective cohort study among women with early and regular care. *Psychosomatic Medicine*, 68(6), 938-946. doi: 10.1097/01.psy.0000244025.20549.bd
- Dennis, C. & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *BIRTH*, 33(4), 323-331. doi: 10.1111/j.1523-536X
- Elo, S. & Kynga, S. H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x
- Glover, V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best Practice & Research Clinical Obstetrics and Gynecology*, 28, 25-25. doi: 10.1016/j.bpobgyn
- Goodman, J. H. (2009). Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. *BIRTH*, 36(1), 60-69. Retrieved from: <https://onlinelibrary-wiley.com.offcampus.lib.washington.edu/doi/epdf/10.1111/j.1523-536X.2008.00296.x>
- Gruber, J. R., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on health birth outcomes. *The Journal of Perinatal Education*, 22(1), 49-56. doi: 10.1891/1058-1243.22.1.49
- Horsburgh, B. (1995). Schrodinger's cat, eugenics, and the compulsory sterilization of welfare mothers: Deconstructing an old/new rhetoric and constructing the reproductive right to natality for low-income women of color. *Cardozo Law Review*, 17(3), 531-582. Retrieved from: [https://heinonline-org.offcampus.lib.washington.edu/HOL/Page?collection=journals&handle=hein.journals/cdozo17&id=554&men\\_tab=srchresults](https://heinonline-org.offcampus.lib.washington.edu/HOL/Page?collection=journals&handle=hein.journals/cdozo17&id=554&men_tab=srchresults)
- Ireland, S. Montgomery-Andersen, R., Geraghty, S. (2019). Indigenous doulas: a literature review exploring their role and practice in western maternity care. *Midwifery*, 75, 52-58. doi: 10.1016/j.midw.2019.04.005

- Keefe, R. H., Brownstein-Evans, C. & Rouland Polmanteer, R. S. (2016). Addressing access barriers to services for mothers at risk for perinatal mood disorders: A social work perspective. *Social Work in Health Care*, 55(1), 1-11, doi: 10.1080/00981389.2015.1101045
- Lomonaco-Haycraft, K. C., Hyer, J., Tibbits, B., Grote, J., Stainback-Tracy, K., Ulrickson, C., Lieberman, A., van Bekkum, L., Hoffman, MC. (2018). Integrated perinatal mental health care: A national model of perinatal primary care in vulnerable populations. *Primary Care Research & Development*, 20(e77), 1-8. doi: 10.1017/S1463423618000348
- MacDorman, M. & Declercq, E. (2019). Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017. *Birth*, 46(2), 279–288. doi: 10.1111/birt.12411.
- Mattaini, M. A. & Holtschneider, C. (2016). Social work with individuals. In M. A. Mattaini, C. Holtschneider & Lowery C.T. (Eds.) *Foundations of social work practice: A graduate text* (5<sup>th</sup> ed., pp. 117-142). Washington, DC: NASW Press.
- Micro, Mezzo, and Macro Practice*. (2020). University of Wisconsin-Madison School of Social Work. Retrieved March 20, 2020 from <https://soework.wisc.edu/about/micro-mezzo-macro-practice/>
- Milgrom, J. & Gemhill, A. W. (2014). Screening for perinatal depression. *Best Practice & Research Clinical Obstetrics and Gynecology*, 28, 13-23. doi: 10.1016/j.bpobgyn
- Neel, K., Goldman, R., & Nothnagle, M. (2019). Integrating doulas into hospital births: provider perceptions of doulas and doula care. *Obstetrics & Gynecology*, 133(5), 37. doi: 10.1097/01.AOG.0000559443.76117.4a
- O'Mahen, H. A. & Flynn, H. A. (2008). Preferences and perceived barriers to treatment for depression during the perinatal period. *Journal of Women's Health*, 17(8), 1301-1309. doi: 10.1089/jwh.2007.0631
- Reime, B., Klein, M. C., Kelly, A., Duxbury, N., Saxell, L., Liston, R., Prompers, F. J. P. M., Entjes, R. S. W., Wong, V. (2004). Do maternity care provider groups have different attitudes towards birth? *BJOG: An International Journal of Obstetrics and Gynaecology*, 111, 1388-1393. doi: 10.1111/j.1471-0528.2004.00338.x
- Romano, M. (2018). White privilege in a white coat: How racism shaped my medical education. *Analysis of Family Medicine*, 16(3), 1-3. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5951257/pdf/0160261.pdf>
- Rosenthal, L. & Lobel, M. (2011). Explaining racial disparities in adverse birth outcomes: Unique sources of stress for Black American women. *Social Science & Medicine*, 72, 977-983. doi:10.1016/j.socscimed.2011.01.013.
- Templeton, L., Vellemanm R., Persaud, A., & Milner, P. (2003). The experiences of postnatal

- depression in women from black and minority ethnic communities in Wiltshire, UK. *Ethnicity & Health*, 8(3), 207-221. doi: 10.1080/1355785032000136425
- Teng, L., Blackmore, E. R., Stewart, D. E. (2007). Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study. *Archive of Women's Health*, 10, 93-101. doi: 10.1007/s00737-007-0176-x
- The National Partnership for Women & Families. (2019). Tackling maternal health disparities: A look at four local organizations with innovative approaches. Retrieved on March 15, 2020 from <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>
- Thomas, J. T., Sherwood, G. D., Mulhollem, J. L., Sexton, J. B. & Helmreich, R. L. (2004). Working together in the neonatal intensive care unit: provider perspectives. *Journal of Perinatology*, 24, 552–559. doi: 10.1038/sj.jp.7211136
- Wall, L. L. (2006). The medical ethics of Dr. J. Marion Sims: A fresh look at the historical record. *Journal of Medical Ethics*, 32(6): 346–350. doi: 10.1136/jme.2005.012559

Table 1

*Participant Demographics***Maternity Health Position**

Behavioral Health Specialist	2
Registered Nurse (RN)	4
Doula	6
Certified Nurse Midwife	2
OBGYN resident	1
Family Physician	1
Research Practitioner	2
Total (N= 18)	18

**Length of time in the field**

0-9 years	9
10-19 years	4
20-41 years	4

**Racial/Ethnic Identity**

White/Caucasian	14
Black American	1
Biracial	1
Hispanic/Latina	1
Multiracial (Indigenous, Mexican, Filipino, Jewish)	1

## Appendix

Research questions-

Tell me about your experiences working with other maternity health providers. How does your relationship with them and the health care facility you are working within impact your work with birthing people/families?

How have you seen social identity, particularly race and ethnicity, play a role in pregnant/birthing people's lives?

How do you/have you respond(ed) to a scenario where someone's cultural identity impacts the way you provide(d) care?

How do you feel mental health plays a role in overall wellness during pregnancy/birthing period? In your opinion, how important is the integration of maternal mental health services (med management, individual/group therapy, etc.) into a hospital setting?

How accessible do you feel maternal health services are? Are certain services more accessible than others? How do you see social identity impact one's accessibility?

Where do you see gaps or barriers to care/maternal services? How do you think we could work towards eliminating these?