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The intersection of traumatic childbirth and obstetric racism: A qualitative study

Amelia Dmowska MS[1] | **Priya Fielding-Singh PhD**[2] | **Jodi Halpern MD, PhD**[1] | **Ndola Prata MD, MSc**[3]

[1]University of California Berkeley and University of California San Francisco Joint Medical Program, Berkeley, California, USA

[2]University of Utah, Salt Lake City, Utah, USA

[3]Child and Adolescent Health, University of California Berkeley School of Public Health, Berkeley, California, USA

Correspondence
Amelia Dmowska, University of California Berkeley and University of California San Francisco Joint Medical Program, Berkeley, California, USA.
Email: amelia.dmowska@ucsf.edu

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Abstract

Background: Traumatic childbirth experiences are common in the United States – affecting a third to a fourth of mothers – with significant negative impacts on maternal health. Yet most research on traumatic childbirth focuses on white mothers' experiences. Drawing on a racially and ethnically diverse sample of mothers who experienced traumatic childbirth, this exploratory qualitative study examined Black, Latina, and Asian mothers' traumatic birth experiences and the role of obstetric racism in shaping these experiences.

Methods: In-depth, semi-structured interviews were conducted in 2019–2020 with 30 mothers who identified as women of color (37% Black, 40% Latina, and 23% Asian) who gave birth in the US and self-identified as having experienced a traumatic childbirth. Data were analyzed using qualitative content analysis.

Results: Mothers reported obstetric racism as core to their traumatic birth experiences. This racism manifested through practitioners' use of gendered and racialized stereotypes, denying and delegitimizing mothers' needs. Mothers shared key consequences of the obstetric racism they experienced, including postpartum anxiety and depression, increased medical mistrust, and decreased desire for future children.

Conclusions: Mothers' reports suggest that obstetric racism played a role in their traumatic birth experiences. Particularly, practitioners' deployment of gendered and racialized stereotypes influenced mothers' treatment during birth. These findings point to opportunities to address obstetric racism during childbirth and improve patients' experiences through enhancing their agency and empowerment. The findings, in addition, highlight the need for increased practitioner training in anti-racist practice and cultural humility.

KEYWORDS
maternal health, obstetric racism, obstetric violence, qualitative research, traumatic childbirth

Amelia Dmowska and Priya Fielding-Singh contributed equally to this paper.

1 | INTRODUCTION

Traumatic childbirth – defined as an actual or threatened serious injury or death to a mother, birthing person, or their infant, or feelings of intense fear, helplessness, and horror during a birth experience – is common in the United States. Between a fourth and a third of mothers who give birth report their experience as traumatic[1] (because scholarship to date has focused exclusively on cisgender mothers' experiences,[2] the term "mother" is used for precision in reference to this scholarship). Research on traumatic childbirth has shown that birth experiences viewed as routine or medically "normal" by clinicians may be experienced by mothers as traumatic,[3,4] and that a mother's experience of traumatic birth relates more to practitioner maltreatment than to the number of "adverse" events.[5,6] Non-medically complicated births can be perceived by mothers as traumatic if accompanied by feelings of neglect and dismissal by practitioners.[7,8]

The type of practitioner maltreatment associated with traumatic childbirth is also known as obstetric violence, or the gender-based subordination of obstetric patients during pregnancy, childbirth, and postpartum.[9] Obstetric violence manifests when practitioners ignore obstetric patients' wishes or when practitioners treat patients disrespectfully.[10–12] Much research on obstetric violence has been spearheaded by scholars and activists in Latin America,[9,13] who emphasize that intersecting inequalities make patients of color particularly vulnerable to this violence.[14–17] Obstetric violence's distinct manifestations in the United States are influenced by historical legacies of medical racism, discrimination, and inequality.[18,19] Indeed, the concept of obstetric violence must be interrogated in relation to racism, as obstetric violence has origins not only in gender-based violence but also in racialized and racializing violence.[20] In the United States, scholars have documented extensive medical racism that occurs when a patient's race influences a practitioner's treatment or diagnostic decision,[18] as well as obstetric racism, which specifically refers to the dehumanizing and neglectful treatment of patients of color.[19] Obstetric racism is prevalent in the United States. In clinical encounters with obstetrics practitioners, Black, Latina, and Multiracial women report experiencing discrimination, racism, and dismissal of their concerns.[16,21,22]

Obstetric racism in the United States rests upon historically rooted, damaging, and intersecting gendered and racialized stereotypes. Women of color in the United States report more stereotype-related gendered racism than white women in obstetric encounters.[23] Black and Latina American women face longstanding gendered and racist stereotypes such as associations with promiscuity, sexual availability, and having many children at a young age.[23] Black women risk being stereotyped as demanding and unreasonable,[24] aggressive,[25] tough "superbodies,"[18,26] or irresponsible and negligent.[27] Latina women may be viewed as "reproductive threats" to society, viewed as having high fertility and overusing medical and social services.[28] Asian American women report being sexualized as "exotic" and submissive/passive[29] or as excessively weak and having a "low pain threshold" in obstetric settings.[30]

Traumatic childbirth, obstetric violence, and obstetric racism all have negative documented impacts on maternal and infant well-being. Traumatic childbirth is significantly associated with postpartum depression,[31] with negative implications for mother–infant attachment and child development.[32,33] Mothers who experience traumatic childbirth may also experience elevated symptoms of general anxiety[31] and post-traumatic stress disorder (PTSD).[34,35] Relatedly, while obstetric violence and obstetric racism do not inevitably lead to birth trauma and its resulting sequelae, these practices still constitute abuse, non-consented care, and loss of maternal bodily autonomy, and thus often contribute to poor maternal health outcomes.[36,37] Obstetric racism further influences racial/ethnic disparities,[19] with the maternal death rate among Black women in the US almost three times higher than the rate for white women.[38]

Despite the fact that traumatic childbirth and obstetric racism are linked to practitioner maltreatment,[39] little research has examined mothers' experiences of obstetric racism within the context of traumatic childbirth. This may be, in part, because most research on traumatic childbirth in the United States has focused on white mothers. Yet, understanding the impact of obstetric racism on the traumatic childbirth experiences of mothers of color is essential to designing effective clinical interventions to dismantle obstetric racism and prevent the resulting trauma. Thus, this exploratory qualitative study examines Black, Latina, and Asian mothers' traumatic birth experiences and the role of obstetric racism in shaping these experiences.

2 | METHODS

This study uses in-depth interview data from a larger qualitative study of US mothers' experiences of traumatic birth ($N=46$). The inclusion criteria for the parent study included: having given birth to a living child in the United States two or more months prior, defining the birth experience(s) as traumatic, and speaking proficient English. Having experienced obstetric violence or obstetric racism during birth was not an inclusion criterion. For the present study, we restricted the sample to the 30 mothers of color (excluding the 16 white mothers interviewed)

who had experienced the birth of one or more children as traumatic. Though it was not an inclusion criterion, all childbearing participants in this study identified as cisgender women and as mothers.

Purposive and quota sampling[3] were used to recruit a racially diverse sample.[1] Participants were recruited directly through social media ($N=28$) as well as personal and professional networks ($N=2$). Limited snowball sampling was used, with referrals capped at two. Participants completed a brief online screening survey to determine eligibility. See Table 1 for the sample's sociodemographic composition.

Following IRB approval, interviews were conducted in 2019–2020 by the first two authors over the phone due to the COVID-19 pandemic and with a trauma-informed approach.[40] All mothers discussed pre-pandemic birth experiences that took place in hospitals. Interviews lasted between one and 2 h, and participants were compensated 20 dollars.

Interviews were semi-structured, with questions about mothers' prenatal, childbirth, and postnatal experiences, as well as their interactions with their practitioners and the consequences of their traumatic childbirths. In addition, mothers were asked about how, in their view, aspects of their identity may have influenced their birth and treatment by practitioners. With participants' consent, interviews were audio-recorded, transcribed, and anonymized. All names in this paper are pseudonyms. Both authors took field notes during interviews and drafted interview summaries to facilitate later analysis. Interviews were conducted until theoretical saturation was reached.[41]

Data was analyzed using *Dedoose*, a qualitative software package, using qualitative content analysis (QCA). QCA is an inductive, dynamic form of analysis.[42] Initial open-coding revealed that mothers across the sample reported mistreatment by healthcare practitioners that drew directly upon intersecting gendered and racialized stereotypes about mothers. A focused coding scheme was developed to analyze these instances of obstetric racism, the specific stereotypes facilitating these instances, and mothers' reports of these experiences' impacts. While many mothers identified the mistreatment they received as evidence of racism or racist care, some did not; mothers' explicit recognition of obstetric racism or gendered and racialized stereotyping was not a requirement for their experiences to be analyzed within this conceptual framework.

TABLE 1 Sample characteristics. $N=30$.

Individual characteristics	*N*	%	Birth characteristics[c]	*N*	%
Race/ethnicity			Number of children		
Black[a]	11	37	1	12	40
Latina	12	40	2	10	33
Asian	7	23	3+	8	27
Highest level of education			Birth timing, years ago		
High school degree[b]	11	37	1–5 years	22	73
Bachelor's degree or more	19	63	6–10 years	2	7
Household income			>10 years	6	20
<60 k	9	30	Birth type		
60–100 k	2	7	Vaginal	12	40
101–200 k	6	20	Cesarean	18	60
>200 k	13	43	Labor type		
Employment status			Spontaneous	8	27
Full-time	19	63	Augmented	6	20
Part-time	2	7	Induced	16	53
Stay-at-home	7	23	Birth setting		
Student	2	7	Hospital	30	100
Maternal birthplace			Birth timing		
United States	25	83	Pre-term (<37 weeks)	8	27
Outside United States	5	17	Full-term	22	73

[a]One mother identified as both Black and Latina.

[b]Includes mothers with associates/vocational degrees. All mothers had a high school education.

[c]For mothers with more than one traumatic birth, characteristics of the most salient or recent traumatic birth are included here.

3 | RESULTS

Most mothers of color said that their race or ethnicity impacted the care they received. Mothers reported that practitioners' negative stereotyping shaped their experiences of traumatic birth, particularly because these stereotypes often contributed to practitioners' dismissal of mothers' needs, preferences, and sense of humanity during the birthing process. Almost two-thirds of mothers (4 Asian, 6 Black, 1 Multiracial, and 8 Latina) described instances where they felt stereotyped by their healthcare practitioners.

Mothers reported and described four primary intersecting racialized and gendered stereotypes their practitioners assigned to them: (1) uneducated (including unintelligent or uninformed); (2) negligent (including uncaring toward their child or themselves); (3) (in) tolerant to pain (including weak or tough); and (4) dramatic (including overreactive or unreasonably anxious). Below, we lay out how each of these four stereotypes rooted in obstetric racism manifested in mothers' traumatic birth experiences. We then discuss how the trauma that resulted from mothers' experiences of obstetric racism had three central consequences for mothers: long-term harm to mothers' mental health, decreased trust in healthcare, and a reduced desire to have future children.

3.1 | Mothers as uneducated

Mothers reported feeling stereotyped as uneducated, which included being treated as uninformed or unintelligent, not solely because of their gender but also because of their race. Historically constituted stereotypes within medical settings of women as less credible than men[43] often drive obstetric violence at large;[44] in addition, healthcare practitioners often hold specific biases that patients of color, particularly Black and Latinx patients, are less intelligent than white patients.[45] Indeed, mothers described feeling delegitimized when practitioners leveraged these racist stereotypes to dismiss mothers' concerns, questions, or preferences. Eight mothers (4 Black, 2 Latina, and 2 Asian) reported that their practitioners made assumptions about their intellect. One Black mother explained: "I definitely felt that because of my skin color, [my healthcare practitioners] just assumed that I did not know things. I was treated as if I knew nothing." Another Black mother reported: "I'm Black, and also we were poor at the time. I think that had a huge impact. I think that I just got lumped into a group and assumptions were made of my intellect, of my cognition, and so I feel like I was really dismissed." Both mothers felt dismissed due to practitioners' assumptions about their intellect; assumptions that mothers "knew nothing" about their care enabled practitioners to trivialize mothers' needs and perspectives. These racist dismissals led to feelings of belittlement and neglect, thus contributing to these mothers' traumatic birth experiences.

Mothers also reported that being stereotyped as uninformed helped drive practitioners' dismissal of their preferences around medical interventions.[46,47] One Asian mother recounted doctors telling her that she was going to be induced regardless of the result of her nonstress test or her own preferences. Undergirding this treatment was her physician's belief that she was not knowledgeable or capable of making informed decisions: "The doctor in the hospital was extremely condescending. [...] I just felt very disappointed and distressed at how things went down because I felt like I was there against my own will." Overall, mothers reported that practitioners' gendered and racialized stereotypes of them as uninformed or unintelligent enabled practitioners to write off mothers as capable decision-makers, which left them feeling invisible and often traumatized.

3.2 | Mothers as negligent

Mothers described feeling that they were stereotyped as negligent or "bad" mothers – a stereotype rooted in assumptions that mothers of color are "deviant" and "corrupt the reproduction process,"[48] whether through carelessness or irresponsible sexual behaviors.[49] For instance, politicians and media have labeled Black women as "promiscuous baby mamas" and "welfare queens" – in other words, as negligent mothers who have many children with different fathers in order to obtain social services.[49] This stereotype of promiscuity rests in racist ideas of mothers of color as sexually irresponsible individuals who fail to responsibly care for their children.[23,28]

Mothers felt that these stereotypes influenced practitioners' opinions about their capabilities to care for their children. In particular, mothers reported feeling disrespected when practitioners insinuated that mothers had ill intentions or were uncaring. One Black mother reported that this happened to her when she started to feel weak and unwell immediately following birth and therefore asked a nurse to take her newborn daughter off of her chest:

> [The nurse said], and I'll never forget, 'Don't you want to bond with your baby?' And I'm like, 'Of course, I want to bond with my baby, but like something's wrong.' And, and a couple of seconds later, I passed out. And

> it turned out that I was hemorrhaging. [...] She thought me asking someone to take my daughter was because I didn't want to bond with her, and that was really offensive.

Another Black mother reported that caseworkers were sent into her room with adoption paperwork, saying that she did not "show much interest" in her child. This occurred even though she had never mentioned a desire to put her baby up for adoption and had merely been limited in her mobility to perform certain caregiving tasks. Finally, a Latina mother reported that her doctor's view of her as promiscuous drove an incorrect view of her as an undependable mother who did not take full responsibility for her children:

> [The doctor] asked me how many fathers my children had. I told her they all had the same father, my husband, and she acted like she didn't believe me. She asked me if I knew what birth control was because, according to her, my kids were too close in age. She told me I was having kids to fill some type of void in my life.

By evoking stereotypes of promiscuity and negligence, practitioners undermined mothers as competent and caring. These stereotypes were core to mothers' traumatic birth experiences, as they left mothers feeling unseen and dehumanized.

3.3 | Mothers as pain (in) tolerant

Mothers also reported being subjected to racist stereotypes about their strength and pain tolerance during childbirth. In line with prior scholarship showing that Asian women can be cast as having a lower pain threshold,[30] an Asian mother described being stereotyped as "weak" and incapable of handling labor pain. She reported that her nurse kept pressing her to get an epidural because she wasn't "strong enough" to have the baby: "They were gonna give me an epidural whether I liked it or not." Ultimately, this mother felt coerced into accepting a medical intervention she did not request because of stereotypes related to her strength and pain tolerance.

On the other hand, four Black mothers reported that stereotypes about Black women's "physiological hardiness" contributed to the dismissal of their need for pain medications. These mothers' experiences were rooted in stereotypes of Black women as "medical superbodies" with higher pain tolerance; these stereotypes have been used for centuries to justify ruthless medical experimentation and have resulted in Black patients systematically receiving lesser quality pain care than white patients.[18,50,51] In this study, Black mothers reported being stereotyped as "superbodies" when practitioners ignored or dismissed their requests for assistance or pain relief. For instance, one Black mother reported that a nurse refused to give her Percocet (pain medication) following her cesarean birth, even after she repeatedly told the nurse that she was in pain:

> This is a Caucasian woman, and she's arguing with me that she doesn't have to give me my medicine; it's only if I need it. I'm like, 'Look, ma'am. You're late getting me this. I'm telling you I need this.' It kind of blew my mind, like, how am I still dealing with passive-aggressive racism in this day and age?

Aligned with research showing that Latina women, along with Black women, are undertreated for their pain in obstetric settings,[52] three Latina mothers shared that their pain was ignored by practitioners. One Latina mother described how "I said to [the nurse], 'Please, I need some help with this pain. I'm not coping well.' But it took a long time. I went through hours of neglect in my pain. It was traumatic." Overall, such implicit assumptions around mothers' obstetric hardiness – or weakness – contributed to mothers' trauma during their birth experiences.

3.4 | Mothers as dramatic

Mothers reported being stereotyped by their practitioners as overly dramatic, which included overreacting or being unreasonably anxious. These stereotypes are not only tied to gendered notions of women as "hysterical" within medical settings,[53] especially during labor,[11] but are also tied to racist notions of women of color as demanding and unreasonable[24] – for instance, that Asian women "make a fuss about nothing,"[30] that Latina women are "hot-tempered,"[54] and that Black women have excessive "rage."[24] Indeed, in this study, when mothers of color expressed discomfort or concern, they reported feeling perceived as too loud, demanding, or anxious. One Black mother reported:

> I was screaming because I was in pain, and my doula had said I could. I wasn't like cursing or anything. I was just yelling with the contraction. [The doctor] was like, 'Uh uh uh, you better stop all that. We're not going to

> have all that drama up in here.' [...] I did not feel like that was a professional response.

A Latina mother similarly felt labeled as dramatic, and as such, she felt her needs were dismissed:

> Most of the [healthcare team], I think they just felt like I was being dramatic. [That experience] was traumatic, not being heard at all. Feeling alone and defenseless and so vulnerable and so exposed. You know? Like, you're asking for help and no one is actually helping you.

Ignoring mothers' symptoms by labeling them as falsely exaggerated led to emergent situations, and the intense fear and pain associated with these situations was core to mothers' experiences of trauma. For instance, one Black mother reported experiencing heart palpitations and breathlessness 2 days following her delivery. Even though those were the symptoms of a pulmonary embolism – a life-threatening medical condition – she was dismissed by her nurse:

> I tried to report [my symptoms] to my nurse, and she told me that's just how all mothers feel after their births. [...] And then, day three, I told the nurse that it happened again. She said it was probably just anxiety. [...] Then, the doctor came in and told me the same exact thing. [...] Well, two hours later, I had to be put on oxygen [due to a pulmonary embolism], they had to give Lovenox and all those things. So no one believed that I was about to have something that some people die from.

This mother's physicians failed to take appropriate action and identify the source of her illness, likely because they assumed her symptoms fit within the "typical" associations of pregnant Black women as dramatic. Such stereotyping was central to mothers' traumatic birth experiences, as they led to the dismissal of mothers' needs and – at times – to life-threatening situations.

3.5 | Consequences of obstetric racism within traumatic childbirth experiences

Mothers described three main long-term consequences of their experiences of obstetric racism during their traumatic childbirths: (1) long-term harm to mental health; (2) lowered trust in healthcare; and (3) a reduced desire to have future children. These consequences did not correspond to one stereotype but rather to the holistic experience of being dehumanized and disrespected during childbirth.

First, mothers reported that their interactions with practitioners had long-term consequences for their mental health. Mothers reported that the trauma resulting from these interactions helped contribute to feelings of postpartum anxiety, depression, and symptoms of PTSD, including flashbacks and feelings of dread. One Asian mother shared: "When [my daughter] was about a year old, I had a total mental breakdown. So, I was definitely suffering from severe postpartum depression, anxiety, and PTSD for that entire time."

Second, mothers noted that their experiences led to an increased mistrust of the medical community as well as a decreased likelihood that they would visit a healthcare practitioner in the future. Mothers reported that being cast as hysterical, dramatic, or unintelligent during their traumatic birth experiences dissuaded them from seeking medical care. One Latina mother noted that her traumatic birth, which was shaped by racist stereotypes and dismissal of her pain, drove her to avoid seeking future medical care:

> As a result [of my traumatic birth], I think I have a worsening distrust of hospitals [...] like when I had to have my tonsils removed. I had so much trauma that I already went into it with the assumption that they weren't going to believe me, that they weren't going to provide proper pain management unless I like, f*ing begged for it.

Similarly, a Black mother explained that she feared visiting the doctor because of her concern that they would dismiss her needs:

> I definitely see how [the traumatic birth] impacted my ability to maintain my medical health because I have such a lack of trust with the medical community. How is it that I keep aligning myself with doctors who are really dismissive towards Black women, like extremely f*ing dismissive?

Third and finally, mothers reported how their traumatic birth experiences directly contributed to a lack of desire to have future children. A Latina mother explained that the experience "really made me sure that I'm just having this one [child]. It just traumatized me to that point that I will never put myself through that again." The lack of desire to undergo another birth intersected with mothers' reduced

trust in healthcare practitioners and a shared view that they should avoid hospitals to ensure their psychological and physical safety.

4 | DISCUSSION

This study advances two related streams of literature – one on traumatic childbirth and the other on obstetric racism. It reveals how obstetric racism can be a key component of traumatic childbirth experiences. Racist stereotyping led practitioners to ignore mothers' medical symptoms, requests for pain medication, and preferences regarding medical interventions, serving as a central mechanism of obstetric racism and the maltreatment core to mothers' trauma. As a result of these dismissals, mothers expressed feeling dehumanized, invisible, and disrespected. Mothers also reported long-term consequences of these experiences, including mental health impacts, mistrust of the medical community, and a decreased desire to have more children.

This study has notable limitations. First, the interview data used in this study may be subject to recall and social desirability biases. These qualitative data also do not provide information on how frequently experiences of obstetric racism contribute to or are a part of traumatic childbirth experiences. Second, the sample was limited socioeconomically, linguistically, and in terms of gender identity, as interviews were conducted with mostly middle- and upper-middle-class cis-gender English-speaking women. This and the sample size precluded an intersectional examination of how experiences of traumatic childbirth differed by racial or ethnic group or due to intersecting identities such as class, disability, gender identity, and/or sexuality. Indeed, a growing body of research documents the extensive discrimination and trauma faced by trans and nonbinary birthing people,[2,55] and this is a critical area for future research.

5 | RECOMMENDATIONS

Our findings argue for key changes in the field of reproductive health to help move the US healthcare system closer to aligning with principles of anti-racism, reproductive justice, and dignified care. Efforts must be made to address both systemic and interpersonal racism in the care of birthing parents, as our study suggests that racist stereotypes can help drive their traumatic birth experiences. As mothers of color themselves suggested, some of the necessary changes include increased access to doula services, increased racial/ethnic diversity among obstetric practitioners, and improvements to medical education curricula.

First, doula care has been shown to improve many perinatal outcomes – including rates of cesarean section, preterm birth, and infant mortality – as well as lowering maternal stress and enhancing mothers' self-efficacy during labor.[56,57] Unfortunately, birthing parents of color and low-income patients – including those in our study – can face critical barriers to accessing a doula.[58] Yet the experiences of mothers in our study suggest that increasing access to doulas could be particularly beneficial for preventing birth-related trauma for mothers of color.

Second, mothers in the study expressed a need for increased racial/ethnic diversity among care practitioners. Indeed, one Latina mother noted explicitly that much of her trauma stemmed from not feeling safe around her white practitioners and feeling like she had to "protect myself or I can't be fully who I am." Research suggests that when Black mothers are treated by Black doctors, maternal and infant morbidity and mortality rates decrease.[59] Patient-physician racial concordance increases patients' trust, satisfaction, use of services, and involvement in decision-making.[60] Systemic changes to increase the number of practitioners of color could benefit birthing patients by decreasing feelings of being misunderstood, unsafe, and uncared for.

Finally, changes to health professional education are necessary, such as adding more training on anti-racism and cultural humility to curricula. One Black mother shared that the entire healthcare system should be "educated on how institutional racism can be perpetuated" and other mothers spoke about the need for increased cultural competence training. Altogether, implementing these and the prior suggestions would help create a healthcare system far more responsive to birthing people's needs and prevent obstetric racism from occurring, therefore reducing traumatic birth's numerous individual and societal consequences.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Amelia Dmowska https://orcid.org/0000-0002-7592-7543

Priya Fielding-Singh https://orcid.org/0000-0001-7458-2937

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