ISSN 1097-8003

Journal of Prenatal & Perinatal Psychology & Health

Published by the Association for Prenatal and Perinatal Psychology and Health (APPPAH)

Volume 39 Number 2
Fall 2025

Journal of Prenatal and Perinatal Psychology and Health

Official Journal of the Association for Prenatal and Perinatal Psychology and Health (APPPAH)

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Published by
APPPAH
63 Terracina Blvd
Redlands, CA 92373
www.birthpsychology.com

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Volume 39 Number 2 Fall 2025

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The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003
Vol. 39 No. 2 Fall 2025

Editorial

Christiana Rebelle, PhD, Editor-in-Chief

This issue of the *Journal of Prenatal and Perinatal Psychology and Health* (*JOPPPAH*) brings together diverse contributions that continue to challenge, deepen, and expand our understanding of birth, bonding, trauma, and healing across the reproductive spectrum. The articles presented here explore clinical, policy, and advocacy perspectives, all grounded in a shared commitment to improving maternal, infant, and family well-being. Beginning this issue, our mid-year issue is now fall instead of summer, allowing more time for peer review and production during the summer months.

We open with two case studies of 3.5-year-old children. Devecigil and Wade illustrate how experiential play therapy can serve as a bridge between a child's early imprints, especially those shaped by neonatal trauma, and a caregiver's relational patterns and expectations. The authors stress that aligning therapeutic strategies with parental objectives, while maintaining the authenticity of the child's emotional process, facilitates enduring positive outcomes in both family relationships and child development.

Next, Abdi et al. offer a qualitative study on the postpartum experiences of Black birthing people after stillbirth, which investigates risk factors for postpartum depression using Edinburgh Postpartum Depression Scale scores from a retrospective chart review. The study reveals that Black patients and those with a prior history of mental health diagnoses are disproportionately affected. The findings highlight the persistent racial disparities in maternal mental health and call for interventions beyond standard postpartum telehealth visits to address this inequity.

Burkhard et al. examine how state Medicaid policies affect maternal mental health screening practices among obstetric providers. Analyzing contracts from 40 states and the District of Columbia, the authors reveal a troubling lack of standardized support for providers to implement screening. The article calls for stronger incentives, such as mandated reporting and improved reimbursement, to ensure consistent and effective care.

Lykkegaard et al. present the final installment in their three-part series. The authors propose a novel approach to chronic disease and mental health conditions through the lens of subcellular psychobiology. Drawing from over a decade of practical applications, they demonstrate how kinesthetic and trauma-based regression techniques may provide therapeutic relief for conditions considered untreatable by conventional medicine.

This issue also features a conversation with Christy Turlington Burns. Reflecting on the founding and evolution of Every Mother Counts, Turlington Burns shares how personal and intergenerational experiences shaped her commitment to maternal health advocacy. Her vision for accessible, safe care for all birthing people has become a global movement, and this interview celebrates the organization's 15-year milestone.

In our book review of *Wild Mothering: Finding Power, Spirit, and Joy in Birth and Creative Motherhood* by Tami Lynn Kent, Cloutman describes the book as a compelling and practical resource. Rooted in the wisdom of feminine spirituality and body-based practices, Kent's work offers readers a multidimensional view of creative motherhood, healing, and personal empowerment.

This issue concludes with a call to action. Cupelin introduces the development and demands of a groundbreaking global advocacy document born from the Postnatal rEvolution Summit. Centering the postpartum year as a vital period in maternal and family health, the "Call to Action" outlines key recommendations to transform postpartum care through trauma-informed practice, policy reform, and sustained investment in community-based support.

On behalf of the editorial team, I want to extend our gratitude to the authors, reviewers, and volunteers whose time, thoughtfulness, and expertise bring each issue of *JOPPPAH* to life. We are also delighted to welcome Atul Mehra to *JOPPPAH*'s editorial board. As a Registered Psychotherapist, international speaker, and author specializing in anxiety, inner-child healing, and the subconscious impact of intrauterine experiences, his expertise and insights are immensely valuable to the journal.

As we continue to grow, we welcome new voices to help shape the future of this journal. If you are interested in joining the editorial board or serving as a peer reviewer, please email journal.editor@birthpsychology.com. Your contribution helps ensure that *JOPPPAH* remains a vital platform for research, theory, and practice in our field.

The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003
Vol. 39 No. 2 Fall 2025
https://doi.org/10.62858/apph250801

Integrating Play Therapy and Parental Objectives: Case Studies in Neonatal Trauma and Therapeutic Progress

Nilufer Devecigil, PhD, Jenny Wade, PhD

This article explores the dynamics between experiential play therapy (EPT) and the need to align therapeutic goals with parental expectations. Using two case studies of children 3.5 years old presenting with behavioral issues taken from a larger study, the article examines how play behaviors can be linked to early imprints, especially neonatal trauma, and caregivers' working models of relationships, highlighting the importance of understanding these connections to break the cycle of intergenerational transmission and foster healthier family dynamics. The cases illustrate how therapists can maintain the core principles of play therapy while addressing concrete parental goals, leading to sustainable improvements in the children's emotional and relational health.

Keywords: Experiential Play Therapy (EPT), neonatal trauma, therapeutic goals, parental expectations, intergenerational transmission

The early years are crucial for emotional and relational development, especially when trauma occurs during the pre- and perinatal period. Research

The authors have no conflict of interest. Nilüfer Devecigil, PhD (ORCID: 0000-0003-1772-4980), is a psychotherapist and certified Experiential Play Therapist (EPT) who provides EPT training in Türkiye and conducts seminars and workshops on attachment, mindfulness, and parenting for national and international organizations. She is certified in Trust-Based Relational Intervention (TBRI) and works with adoptive families using holistic approaches that emphasize nervous system attunement. Jenny Wade, PhD, is a professor at the California Institute of Integral Studies, San Francisco, a developmental psychologist, and a consultant specializing in the structuring of consciousness across the lifespan. She has authored numerous academic articles and books, including *Transcendent Sex* and *Changes of Mind*. Please send correspondence to ndevecigil@hotmail.com.

shows that adverse neonatal experiences, such as medical interventions or early separation, can have lasting effects on emotional regulation and behavior (Emerson, 2020; Perry & Szalavitz, 2017; Schore, 2015). Play therapy is effective for young children to express and resolve internal conflicts, particularly from preverbal trauma (Cochran et al., 2023; Norton & Norton, 2010a).

Among play therapy approaches, Experiential Play Therapy (EPT) offers a uniquely embodied, child-led model that emphasizes co-regulation, symbolic expression, and repair of early relational wounds. Rooted in Gestalt therapy and somatic psychology, EPT draws on the body's implicit memory systems and relational field to facilitate healing (Townsend et al., 2021). Establishing clinical objectives in EPT requires a nuanced approach, as this therapeutic model prioritizes emotional expression, self-discovery, and healing through play (Norton & Norton, 2010a, 2010b). Unlike directive approaches that emphasize symptom reduction and behavioral modification, EPT resists narrowly defined goals to focus on the child's internal world and natural developmental process (e.g., Kottman & Ashby, 2024).

Therapists trained in process-oriented models, e.g., EPT, often face the challenge of reconciling broad, growth-focused goals with caregivers' desire for measurable behavioral outcomes (DiFederico, 2021; Kestly, 2014). Rather than imposing structured interventions, EPT emphasizes therapeutic attunement and flexibility, allowing play to unfold in a manner responsive to each child's emotional needs. EPT incorporates the caregiver in sessions when therapeutically indicated but allows the child to determine if and when the caregiver is needed in the room, typically as a secure base rather than active agent, a trauma-sensitive approach that preserves the child-led nature of the therapy (Norton & Norton, 2010a, 2010b).

In EPT, formulation involves linking the caregiver's working models of relationships with the child's behavior and early imprints through play therapy. The *working model* describes the internalized beliefs and expectations about relationships caregivers develop based on their attachment histories (Medina et al., 2025), which significantly influence how they perceive and respond to their child's behaviors. For instance, parents who view the world as unpredictable or threatening may unknowingly project these fears onto their children, shaping how they interpret their child's distress or resistance. *Imprints* are the deeply ingrained patterns and emotional responses formed during early experiences, such as prenatal, birth, or early relational trauma (e.g., Emerson, 2020; Evertz,

2021). Children who experienced medical interventions at birth, prolonged separation from caregivers, or high maternal anxiety in utero often develop implicit, body-based memories of distress that manifest in play behaviors and relational difficulties (e.g., Perry & Szalavitz, 2017).

A structured parent consultation process bridges play therapy principles and parental expectations. Parents often enter therapy with goals related to observable behavior, such as reducing tantrums. However, in EPT, progress is often seen in symbolic shifts in play, increased emotional regulation, and changes in relational patterns rather than immediate symptom reduction (e.g., Schore, 2015). Thus, it is critical to help parents recognize play themes as reflections of the child's inner world rather than random actions. Highlighting these markers of progress reassures parents that therapeutic change is occurring. A key component of parent consultation is reframing problematic behaviors as manifestations of early imprints rather than oppositional or defiant conduct. Children with early trauma may display behaviors that seem resistant, avoidant, or overly dependent. Parents may interpret these behaviors through the lens of their own working models, assuming their child is "too sensitive" or "difficult." Therapists can reframe these behaviors as adaptive responses to past stressors, helping parents respond with empathy and co-regulation (Perry & Szalavitz, 2017). Educating parents about how their own anxieties and interpretations influence their child's behaviors is a goal of consultation to help them shift their interactions and foster a more attuned relational dynamic (Chow, 2024; Grummitt et al., 2022), thereby reducing the transgenerational transmission of dysfunctional family dynamics.

This article explores the integration of EPT with structured parent consultation to support both child-led healing and parental insight through two case studies from a larger qualitative study investigating early trauma imprints (Devecigil & Wade, 2024). In both cases—featuring 3.5-year-old children presenting with behavioral challenges—therapists used symbolic play to access neonatal imprints while also helping caregivers revise their working models and interpret behaviors through a trauma-informed lens. These case studies demonstrate that when EPT is coupled with intentional, developmentally attuned parental consultation, therapy can bridge the often divergent objectives of deep emotional processing and concrete behavioral change.

Such integrative work not only supports healing in the individual child but may also interrupt intergenerational cycles of trauma, fostering more secure relational templates within families (Chow, 2024; Siegel & Bryson, 2020).

Through this dual focus, the present study contributes to a growing literature advocating for trauma-informed, relationally integrated, and developmentally sensitive approaches to early childhood therapy.

Methods

These two cases were part of a larger qualitative study exploring prenatal precursors of colic through play therapy sessions and interviews with mothers and EPT therapists (Devecigil & Wade, 2024). The larger study comprised 23 mother-and-child pairs, including 11 boys and 12 girls aged 31-58 months. The children were not otherwise under therapeutic care; were not taking prescribed medications; had no known previous trauma, genetic conditions, or developmental delays; and were living with their biological mother. Children with and without a history of colic, born vaginally and via cesarean section, were included. The two case studies below were chosen from this sample to illustrate contrasting presentations and histories, yet similar clinical approach and efficacy.

After interviewing the mothers, children in the larger study were assigned to certified EPT therapists who employed a modified EPT format to access womb and birth experiences in a series of up to 12 weekly 40-minute sessions with each child, followed by a 10-minute consultation with the mother. During the initial session, the purpose of the play sessions was explained to the child. Subsequent sessions began with the therapist and child and/or the mother and ended with the mother alone. All sessions took place in the first author's Istanbul office, furnished with video-recording equipment and symbolic toys.

The study was conducted in accordance with the ethical standards of the American Psychological Association and approved by the Human Research Review Committee of the California Institute of Integral Studies in San Francisco.es

Case Analysis: Barbara, 3.5 years old

Barbara's mother brought her to therapy for persistent nail-biting, avoidance of meeting new people, difficulty socializing with peers, frequent unexplained crying, shouting, and tantrums. Barbara's clinginess and separation difficulty particularly troubled her mother. Barbara avoided familiar friends, behaving as if they were strangers. At school, she often stood aloof and

distant. At home, she persistently asked her mother to play with her, indicating stress about potential separation.

Caregiver's Working Model of Relationships

Barbara's mother had a highly anxious disposition shaped by her childhood of allergic asthma, bronchitis, verbal abuse from her alcoholic father, and psychiatric medication use. Her anxiety increased after the 2023 earthquake in Türkiye. Her background suggested a working model of the world as unpredictable and threatening, requiring constant vigilance and control (Medina et al., 2025). It was hypothesized that she might project her anxieties onto Barbara, fearing that Barbara might suffer similarly or that she might not be able to protect Barbara adequately, as evident when she described Barbara as shy, cautious, quick to give up, and anxious, mirroring her own traits. She thought Barbara's anxiety would lead to introversion and difficulty with everyday challenges.

Barbara's mother was particularly attuned to behaviors that triggered her own anxieties, such as Barbara's crying, nail-biting, and resistance to self-care tasks like brushing her hair, which she tended to interpret as signs of anxiety and a lack of resilience, reinforcing her own fears. Barbara likely internalized her mother's anxieties and beliefs about herself, leading to behaviors such as transition difficulties. She might have perceived herself as needing to be cautious and having anxiety, attributes reinforced by her mother's responses. Her behavior confirmed her mother's expectations, creating a cycle of reinforcement.

The primary goals for therapy were to reduce separation anxiety and nail-biting. Progress was tracked through changes in play themes and caregiver reports. Given Barbara's separation anxiety, she initially insisted on having her mother in the sessions, which proved therapeutically beneficial. Having the mother actively participate in play helped her understand Barbara's inner world, and the therapist modeled how to offer comfort and attunement. Parent consultations focused on Barbara's play themes and helping the mother recognize how her working model shaped her interpretations of Barbara's behavior (VanFleet, 2015).

Early Imprints and Their Impact on Behavior

Barbara was the result of a planned pregnancy and vaginal birth. During the pregnancy, Barbara's mother underwent more than eight ultrasounds. In Türkiye, frequent ultrasounds are often part of regular prenatal care to monitor the baby's development and address maternal anxiety. In the last months of her pregnancy, she experienced edema and nerve compression that rendered her hands unusable. Labor began at 42 weeks. At the last moment, the doctor suggested a water birth because he said Barbara was very active and needed to be slowed down. Upon arriving at the hospital, Barbara's mother was well dilated, and Barbara was born within three hours. Barbara was taken to the neonatal intensive care unit (NICU) for meconium aspiration and started on antibiotics. Seeing Barbara connected to many devices was very difficult for the parents. COVID-19 restrictions prevented them from visiting the NICU often. Three days later, they moved into a hospital room with Barbara, whose voice was hoarse from excessive crying.

A mother's anxiety during pregnancy can imprint a sense of hypervigilance and stress on the fetus (Glover et al., 2021), which may manifest as heightened sensitivity to stress and anxiety. Separation in the NICU was extremely distressing for Barbara, which likely contributed to her resistance to separation and difficulties with self-care tasks. Such events, coupled with the discomfort of NICU interventions, can create imprints of abandonment and physical pain (e.g., Chamberlain, 2014).

Initial Exploratory Session

The initial EPT session is exploratory and foundational, establishing trust between therapist and child, and creating a safe space where the child can begin to express their inner world through play (Kottman & Ashby, 2024). Themes that emerge during these initial sessions typically foreshadow the central issues that will be addressed throughout therapy (Norton & Norton, 2010b). Barbara touched the end of the tunnel toy while standing beside her mother, and the therapist mirrored her actions. Barbara asked the therapist, "Do you have a wound?" while pointing to an imaginary wound on her leg. She took out the toy doctor's kit, examined each item, and applied Band-Aids to herself and her mother. While playing with a dinosaur toy, she reassured her mother and the therapist, saying, "It doesn't bite" and "It didn't hurt." She then checked the therapist's and mother's heartbeats.

By asking the therapist about a wound and showing her imaginary pain, Barbara was likely expressing experiences from the NICU interventions. Children who have undergone medical trauma often use play to process their experiences and emotions (Frawley & Dillman Taylor, 2024). Barbara might have been attempting to reassure herself and others through self-soothing statements, reflecting her internal struggle with fear and pain (Kestly, 2014). Checking heartbeats suggests Barbara's need to ensure her caregivers' well-being, likely stemming from her NICU separation anxiety. Heightened sensitivity to others' emotional states is a common coping mechanism in children with early trauma (Lyons-Ruth et al., 2006).

Validating the Initial Formulation

The initial formulation was supported by analysis of sessions 2-4. In session 2, Barbara played with balls, brushed her mother's hair, and fed the therapist. She restrained her mother with toy handcuffs. She gave the therapist and her mother a baby doll to dress and prepare for school, asking the therapist to make the baby swim. In session 3, Barbara again handcuffed her mother, asked the therapist and her mother to rub toy guns and knives together, and engaged in roleplay being a bee "biting." In session 4, Barbara held her mother's hand tightly, and they built a tower together with Legos. They played house inside the tent, and Barbara initiated a game of scaring the therapist by hiding and peeking out from the tent, saying "boo." Barbara's play consistently revisited certain themes.

Theme: *Nurturing and Caregiving*. Barbara's play emphasized nurturing and caregiving activities, such as brushing her mother's hair and feeding the therapist, reflecting her need to reconstruct and make sense of the disrupted nurturing during her early life. Handcuffing her mother, perhaps, symbolized Barbara's feelings of helplessness and desire for control in caregiving situations. The tent and feeding games symbolized a safe space and nurturing, which were disrupted by early separation. Building a tower symbolized unity and growth, connected to her need for secure and nurturing relationships.

Theme: *Control and Helplessness*. Barbara struggled with vulnerability and the need for control. Handcuffing her mother, asking the therapist to make the baby swim, and giving dolls to the mother and therapist to prepare for school symbolized attempts to gain control over her environment, reflecting early helplessness in the face of medical intervention and separation. The

handcuffing, guns, and knives suggested an ongoing struggle with feelings of vulnerability and aggression. The creation of a home in the tent and the "boo" game symbolized attempts to establish control and security in her environment. Play allows children to experiment with power and work through traumatic experiences in a safe environment, regaining a sense of control (Frawley & Dillman Taylor, 2024).

The analysis of Barbara's sessions validated the initial formulation that her play behaviors were connected to early imprints and her mother's working model of relationships. Understanding these linkages enables a therapist to help parents comprehend the roots of their child's behaviors, thereby breaking the cycle of intergenerational transmission and fostering healthier family dynamics. It was important to explain to the mother that Barbara's resistance to self-care tasks might be related to invasive NICU procedures, imprints that can heighten sensitivity to touch, and discomfort with personal care activities. Similarly, Barbara's anxiety about getting ready for school and other transitions might be linked to neonatal separation. These explanations could help the mother understand that Barbara's resistance was a normal response to past experiences rather than willful defiance, which could reduce the mother's frustration and increase empathy.

It was important to help the mother understand how her belief that Barbara was shy and cautious might stem from her own childhood experiences (Chow, 2024). Assisting her to see Barbara's behaviors through a lens of sensory processing and early trauma could help her respond more supportively and reduce the cycle of negative expectations and behaviors. Helping parents become aware of their unconscious projections can free them to learn developmentally appropriate child-rearing practices.

Deepening Themes and Process Arc

Sessions 5-7: Deepening Themes of *Pain and Fear*. Barbara played in the sandbox (bulghur is used in place of sand), throwing sand at mother and therapist, and pretending she was swimming like a baby in the sandbox. She continued to play inside the tent, scaring the therapist with her mother by saying "boo," and role-playing insects like bees and flies. All of these pointed to attempts to process pain sensations from her NICU intervention. Her mother reported that Barbara had stayed at her grandmother's house for the first time without her.

Sessions 8 and 9: *Gradual Separation and Autonomy*. Barbara began incorporating nurturing and positive themes in her play, such as cooking and feeding her mother and the therapist. She brushed her mother's hair, indicating a shift towards healing. Barbara's use of doctor tools, pretending to have pain in her leg, and asking her mother to apply bandages, showed her processing of medical trauma alongside positive interactions. Her greatest milestone happened in session 9, when she entered the tent alone for the first time. Her mother, accustomed to always being included, asked if she should come inside. Barbara declined, choosing instead to play independently. Afterwards, her mother said she felt both proud and slightly left out, acknowledging her separation anxieties. The tent play also changed: instead of feeding her mother, Barbara now fed baby figures, signaling more emotional independence (Schore, 2015).

Session Conclusion: *Integration and Secure Attachment*. Barbara's final session showed full integration of earlier themes. She still played medical scenarios, but no longer needed her mother's constant presence. Her mother said Barbara was far more confident in separating from her in daily life and that nail-biting had decreased. Barbara's mother had also grown significantly, learning to trust Barbara's emotional process. She began offering nurturing integrations without fear of reinforcing dependency, understanding that temporary regression had been a necessary step in Barbara's healing process. The combination of play therapy and parent consultation allowed Barbara's therapy to be both child-led and parent-supported, reinforcing progress inside and outside the sessions (Siegel & Bryson, 2020).

Barbara's case highlights the importance of attuned parental involvement in play therapy. Having her mother participate early and then gradually step back allowed Barbara to experience safe attachment while building autonomy. By session 10, Barbara had built the internal capacity to separate with confidence. The mother's behavior evolved from struggling with frustration and misunderstanding Barbara's behaviors to recognizing them as expressions of early trauma and responding empathetically. Moreover, she gained insight into how her past influenced her perceptions of Barbara.

With the therapist's help, she told Barbara her birth story when they were at home and apologized for all the hardship that happened to her, which validated Barbara's experiences by acknowledging her early struggles and feelings (Siegel & Bryson, 2020). Storytelling helps children make sense of their past and integrate those experiences into their personal narrative, fostering

resilience (e.g., Schore, 2015). The mother's apology helped restore their disrupted bond, showing Barbara that her feelings were understood and valued. The mother also began to implement more supportive parenting practices, such as allowing Barbara to take her time with transitions and providing reassurance during moments of anxiety. She became more aware of her stress and its impact on Barbara, working to create a calmer, more nurturing home environment.

Case Analysis: Zayne, 3.5 years old

Zayne was brought to therapy primarily because of toileting issues, which had begun after toilet training, coinciding with the arrival of a babysitter who stayed for 10 months when the mother returned to work. He sometimes held his bowel movements for two days and held his urine all day at school. After the babysitter left, Zayne relaxed, but the issues resurfaced with the transition to school. Zayne also tended to put everything in his mouth and would often deliberately spill his drink while looking at his mother. He screamed when leaving the house, a behavior his mother attributed to once telling him to be quiet so as not to disturb the neighbors. Despite repeated warnings, he continued this behavior, which angered his mother. She believed Zayne might be seeking parental attention, and she often responded with anger and shouting, which she knew set a poor example. She noted that Zayne challenged her more when he sensed her frustration.

Transitions were particularly difficult for Zayne, and he experienced minor accidents almost daily, such as falls or bumps. When in pain or sick, he became clingier. He displayed aggression toward peers, hitting them frequently. The mother said her husband's parenting style tended to apply pressure and force, while she preferred repetition and explanation. Both parents were often frustrated in their interactions with Zayne.

Caregiver's Working Model of Relationships

Zayne's mother came from a conservative family, and her history suggested unresolved trauma and anxiety. Although she denied domestic violence during her upbringing, her body language indicated otherwise, including avoiding eye contact and a meaningless, inappropriate smile (e.g., Siegel & Bryson, 2020). She managed stress by avoiding tense situations and diverting her attention to other things, a strategy developed in childhood. Her reserve about her past suggested a history of unprocessed emotional difficulties.

Zayne likely internalized his mother's unresolved trauma, anxiety, and avoidance, manifesting them in key behaviors, such as withholding urine to avoid the stress of using the school bathroom (Fearon et al., 2019). His difficulty with transitions and clinginess also suggested internalized anxiety. Deliberately spilling drinks and screaming might be his way of seeking attention and validation from his mother, mirroring her own need for recognition, which might have been missing during her upbringing (e.g., Reyes et al., 2024). Zayne's aggression towards peers and almost daily accidents suggested that he internalized his mother's frustration and anger, which she might project during her interactions with him (Perry & Szalavitz, 2017). Zayne's need for control over his bodily functions might reflect internalization of his mother's control issues stemming from her past (Schore, 2015).

Imprints

Zayne was born vaginally after a difficult 18-hour labor, involving a vacuum and artificial contractions. He stayed in the NICU for six days for an infection caused by the prolonged labor. Born at 37 weeks, weighing 2.5 kg, his initial months showed delayed development, which later normalized. The NICU stay and painful birth likely imprinted feelings of physical discomfort and separation anxiety (Emerson, 2020). Additionally, Zayne's early feeding seemed to have left a significant imprint. His mother regretted starting him on solid foods at six months, noting that, although he ate, he was not aware of having food in his mouth, suggesting early sensory processing issues or dissociation from sensations, which could be linked to the traumatic birth and NICU experiences, perhaps connected to his putting objects in his mouth and deliberately spilling drinks.

Zayne's retention of stool and urine, coinciding with his mother's return to work, suggested an imprint from the traumatic labor and NICU separation, possibly exacerbated by early toilet training. The stress and discomfort associated with these transitions likely reinforced his anxiety and control issues (Assimamaw et al., 2024; Schore, 2015). His mother's observation that Zayne often challenged her more when she was frustrated highlighted the cyclical nature of their interactions, in which Zayne's behaviors might be attempts for control and attention in response to his mother's emotional state (Siegel & Bryson, 2020). Zayne's almost daily falls and bumps could be further manifestations of these early imprints, with his need for additional comfort

when in pain. His aggression towards peers might be expressions of unresolved trauma and a need for security, compounded by his mother's avoidance and difficulty providing consistent emotional support (Perry & Szalavitz, 2017).

Exploratory Session

In session 1, Zayne headed straight for the cars and said one of them had lost its electricity. He lay in the sandbox as if swimming, pushing his body against the edges. He then took the guns and handcuffs. He picked up a toy train, calling it a car with a toilet, which he showed his mother. He looked through toy binoculars and said another car had a toilet. He showed his mother the tent and crawled around the sandbox with a car, using regressed body movements. He asked, "Mom, this car's wheels don't turn, right?" before burying the car and turning it into a game, burying and revealing it. He put sand in his mouth and ears, then shot the therapist with a toy gun while obviously in a dissociated state. He fired two toy machine guns and entered the egg chair, calling it a toilet. He threw a baby doll and its cradle to the ground, then asked the therapist to spin him quickly in the egg chair. His feet stuck out slightly as he played a game about visibility. The therapist, suspecting from his body language that he needed to urinate and worried he might do so (since he said the chair was a toilet), reassured him there was no toilet there. He shot at his mother and said the car's wheels could not move. He opened a doctor's bag and took out a bandage. He had a hard time leaving the session.

Zayne's swimming and pushing against the walls of the sandbox could be interpreted as feeling confined or trapped, echoing his NICU experience (Emerson, 2020). The visibility games might symbolize his feelings of being seen or unseen by his mother and others, possibly related to the parents' frustration with him. The broken and powerless cars might symbolize feelings of inadequacy or a sense that something is inherently wrong with him, possibly mirroring his mother's anxieties about him (Homeyer & Sweeney, 2022).

Zayne's fascination with a toilet and aggressive actions towards mother and therapist with the guns might represent his internal conflict and anger regarding toilet training and control, or his perception of his mother's aggression towards him during toilet training (Frawley & Dillman Taylor, 2024). His dissociation indicated a coping mechanism to deal with overwhelming emotions, perhaps related to his NICU experiences, where medical procedures might have involved mouth and ear discomfort (Ogden, 2021). Calling the egg chair a toilet

and asking to be spun might reflect his need for control and release, as well as a desire to reenact and process his traumatic experiences in a safe environment (Cummings et al., 2017). The use of binoculars could be a metaphor for attempting to bring distant or hidden issues into focus, possibly reflecting his need to gain clarity on matters not immediately apparent or acknowledged (Homeyer & Sweeney, 2022).

Validating the Initial Formulation

In sessions 2-4, Zayne repeated many of the same behaviors, playing with cars, stating they did not work, burying and revealing them, and toying with handcuffs. He made baby noises and moved around on his knees. He spent a long time shooting a toy gun and pretending to kill the therapist. He approached his mother with a car, calling it a toilet, and ignored her offer to go to the bathroom. He used handcuffs and Legos to create scenarios of being trapped and rescued. He again exhibited difficulty leaving the session, showing anxiety and a need for control (Perry & Szalavitz, 2017). In sessions 3 and 4, Zayne repeated his regressed sandbox play and engagement with the car as a self-object, noting that the wheels were broken, covering it with sand, and calling it dirty and ugly. He used a monster toy to scare the therapist and pretended to cut and shoot the therapist and the mother. In session 4, Zayne said, "Mom gets angry," poured sand on the therapist's head, and pretended to hit and scare the therapist and mother with a monster toy, while assigning roles and directing the play.

Theme: *Control and Helplessness*. Zayne's play consistently involved themes of control and helplessness. His use of handcuffs and scenarios where he controlled or was controlled reflected his struggle with feeling trapped and a need to regain a sense of control, likely stemming from the NICU intervention and separation (Perry & Szalavitz, 2017). His car play symbolized feelings of inadequacy and being fundamentally flawed, mirroring his mother's anxieties.

Theme: *Aggression and Frustration*. Zayne's aggressive play signaled internalized anger and frustration, indicating his perception of his mother's aggression, his struggle to process these emotions, and probably reenacting being trapped and in pain in the NICU (Perry & Szalavitz, 2017). His dissociation was likely a coping mechanism to deal with overwhelming stress.

Theme: *Visibility and Recognition*. The visibility game symbolized Zayne's internal conflict about being seen and recognized, probably reflecting

his mother's avoidance and frustration (Chow, 2024). Zayne's regressed behaviors indicated his struggle with early developmental trauma in the NICU, subsequent sensory sensitivities, and a need for sensory comfort.

The initial formulation that Zayne's play behaviors were intertwined with his early imprints and his mother's working model was supported. Thus, it was important to explain to Zayne's mother that his resistance to using the toilet might be linked to painful and invasive procedures in the NICU, which can lead to heightened sensitivity to touch and discomfort with personal care activities (Castellino, 2004). Delving into what occurred during toilet training and helping the mother recognize her role in it was essential, especially helping her see that Zayne's resistance was a normal response to past experiences rather than willful defiance. Reframing Zayne's behavior could reduce her frustration and increase her empathy. Additionally, it was important to explain that Zayne's anxiety about school and other transitions might be linked to separation from his parents in the NICU. Increasing awareness of how her avoidance might influence Zayne was crucial in enabling her to discern the unconscious repetition of her past in the present and her distorted perceptions of Zayne, ultimately leading to the development of child-rearing methods that were developmentally appropriate.

Deepening Themes and Process Arc

Sessions 5-7: Deepening Themes of *Pain and Fear*. Zayne's play continued to display deep-seated feelings of pain, fear, and aggression. In Session 5, he played in the sandbox, often appearing dissociated, making baby noises, and using toy trains as cars. He engaged in nurturing behaviors, like making a dessert for his mother, while also pretending to shoot the therapist and mother. Crawling through the tunnel and using doctor tools suggested a re-enactment of his NICU experiences. In Session 6, Zayne threw sand at the therapist, repeated shooting toy guns, hit a doll, and asked if it was afraid. He role-played a doctor. He put sand in the pacifier and the baby doll's mouth. Session 7 continued Zayne's alternating between comforting and hurting dolls and directing the therapist to enact specific roles. He played with the egg chair and its role as a toilet.

Sessions 8 and 9: *Integrating Positive Sensations*. Zayne's play began to incorporate more positive and nurturing themes, although aggressive behaviors persisted. He alternated between gentle care and harming dolls. He asked his

mother and therapist to play roles that reinforced his feelings of control and validation. His play with the therapist, in which he pretended to be a lion, involved him putting protectors on his fingers and then having the therapist pretend to bite them, a sign that he was exploring boundaries and power dynamics in a safer way.

Sessions 10-12: *Mastery Themes and Final Integration*. Zayne expressed a desire to regress: "Mom, I want to be a baby." His play included themes of control and defiance, such as imprisoning the therapist and dismembering a doll. He alternately harmed and protected the doll. Some of his pretend play involved dirty underpants and a toilet. In sessions 11 and 12, mastery themes emerged more clearly. Zayne no longer relied on aggression but instead found ways to incorporate nurturing and problem-solving skills. By session 12, his toileting anxiety had significantly decreased.

Resolution of Therapy

Zayne's therapy will be concluded when he demonstrates consistent behaviors indicating resolution of his initial issues. His integration of nurturing and painful themes indicated a healthier processing of traumatic imprints. Improved emotional regulation and reduced aggression towards peers will be key signs of progress (Cochran et al., 2023). Zayne's mother's transformation was crucial to the success of therapy. She shifted from viewing Zayne's behaviors as defiance to recognizing them as expressions of trauma and responding more empathetically. She told Zayne his birth story at home and apologized for the hardship he had suffered, including apologizing for later struggles and wrongdoings during toilet training. She engaged in more nurturing parenting practices.

Discussion

These two cases illustrate the range and diversity of issues that can be successfully addressed using methods to validate the initial formulation linking a child's problematic behaviors to early imprints and the parents' working model of relationships. This approach addresses the need for play therapy to emerge dynamically while also meeting parents' objectives for concrete information. The examples demonstrate that the same principles are effective with different presenting problems, even when the trauma histories vary in type and severity.

Nevertheless, it is important to qualify the results. The study was delimited to an urban Turkish population, which affects generalizability since birth practices vary by culture, socioeconomic status, region, and so forth. The focus on children aged 2.5 to 4 years enhanced comparability but limited generalizability. Moreover, mothers' reasons for participating and maternal characteristics varied widely, adding more diversity to the sample. However, using only two case histories does not show the robustness of the findings from the larger study (Devecigil & Wade, 2024), which were consistent with the dynamics illustrated here.

By allowing play to develop naturally, therapists can observe and interpret the underlying issues driving the child's behavior. This method respects the child's readiness to explore and process their experiences, fostering the safety and trust essential for effective therapy (Kottman & Ashby, 2024). At the same time, the therapist's explanations help parents connect play behaviors and early experiences, providing the concrete information they seek and assurance that their goals of behavior change may be met. Providing insight to parents about their projections helps widen their window of tolerance regarding the child's expressiveness of historical dynamics outside the therapy session. Developing and sharing the working model of the caregivers' perceptions and relationship patterns helps them understand how their own early experiences affect their child's behavior as well as their interpretation of it. Without a clear formulation, therapy can lack direction, become scattered, and potentially extend for months without significant progress. A structured framework ensures that therapy remains focused and effective (Cochran et al., 2023; Derdikman Eiron, 2021).

Conclusion

These cases demonstrate that formulation is not a rigid script, but a flexible guide, and how the same therapeutic model can be adapted to diverse needs and varying levels of complexity. While the approach may not offer an immediate solution, it effectively addresses the root of the child's issues, leading to more sustainable, long-term improvements and helping parents break the cycle of intergenerational transmission of maladaptive behaviors. By creating space for preverbal trauma to emerge symbolically through play, EPT offers young children an embodied pathway toward integration and relational repair. Working simultaneously with the child's inner symbolic world and the caregiver's outer interpretive framework honors the intersubjective and

intergenerational nature of healing. It moves beyond symptom management toward a deeper reweaving of the parent-child relationship. Such integration holds particular relevance for neonatal and perinatal trauma, where early rupture often remains unspoken yet profoundly impactful. For practitioners working in early childhood mental health, these findings underscore the necessity of holding both child-led expression and parental transformation as coequal therapeutic goals. Future research should continue to explore how somatic, play-based modalities can interface with caregiver insight to support lasting, systemic healing within families.

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The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003
Vol. 39 No. 2 Fall 2025
https://doi.org/10.62858/apph250802

Postpartum Experiences of Black Birthing People After Stillbirth: A Qualitative Study

Hamdi Abdi, PhD, Ruth Arévalo, MPH, Joann O'Leary, PhD

Despite improvements in obstetric care, stillbirth rates in the United States remain disproportionately high among Black birthing individuals, who experience losses at more than twice the rate of non-Hispanic White and Hispanic counterparts. This qualitative study explores the postpartum experiences of Black birthing people following stillbirth, with a focus on social support, emotional responses, and healthcare quality. Thematic analysis of focus group discussions revealed five central themes: the multifaceted nature of social support, complex emotional reactions, interactions with healthcare professionals, the impact of racial concordance in care, and challenges with postpartum follow-up. Participants described inconsistent or absent support, feelings of isolation, and interactions with providers that often lacked empathy and cultural understanding. When racial concordance was present, it enhanced communication and trust, but was rarely available. These findings highlight significant gaps in grief-informed and identity-affirming care, as well as the broader systemic

The authors have no conflicts of interest. Hamdi Abdi, PhD, MPH (ORCID: 0000-0002-1191-0726), is a public health researcher specializing in evidence-based research and systematic review methodology. Her research interests include stillbirth, postpartum care after perinatal loss, and support for individuals during the postpartum period. Her professional and personal experiences inform her dedication to improving bereavement care and advancing justice in maternal health policy and practice. Ruth Arévalo, MPH, RN, BSN, is a public health professional focused on integrating public health principles into community engagement. Her work emphasizes community well-being and the use of narrative and storytelling as tools for connection and empowerment. Joann O'Leary, PhD, MPH, MS, IM-ER(IV), is a researcher, writer, and consultant specializing in prenatal mental health, infant loss and the pregnancy that follows, and issues affecting siblings. Send correspondence to abdi0152@umn.edu.

inequities that shape care experiences. By centering the voices of Black birthing individuals, this study provides critical insights into the unique challenges faced after stillbirth. It underscores the need for targeted interventions and policy reforms to improve care quality and outcomes. Addressing these gaps is essential to promoting equity and healing for this underserved population.

Keywords: Black birthing people, stillbirth, postpartum care, social support, grief, racial disparities, racial concordance, healthcare experiences

Stillbirth, the loss of a baby before or during birth, affects approximately 24,000 families in the United States each year (Centers for Disease Control and Prevention [CDC], 2025). Black birthing people disproportionately experience stillbirth, with a mortality rate more than twice that of non-Hispanic White or Hispanic women (11.2 per 1,000 live births compared to 5.0 and 5.1, respectively) (Pruitt et al., 2020). Despite advancements in obstetric care (Peahl & Howell, 2021), racial inequities in stillbirth rates have remained unchanged since 2005 (MacDorman & Kirmeyer, 2009).

Structural racism, deeply embedded within systems, policies, and institutions, significantly shapes health outcomes for Black communities (Braveman et al., 2022). Mechanisms such as residential segregation, unequal access to healthcare, and biased clinical care contribute to persistent racial disparities in maternal outcomes, including stillbirth (Braveman et al., 2022; Gee & Ford, 2011; Hailu et al., 2022; Williams & Mohammed, 2013). Many Black birthing people report feeling unheard, stereotyped, or dismissed in clinical encounters, further contributing to mistrust and disengagement from healthcare (Barnett et al., 2022; Mehra et al., 2020; Murphy et al., 2022; OjiNjideka Hemphill et al., 2023; Spurlock & Pickler, 2024).

Although Black birthing people face the highest risk of stillbirth, their voices and lived experiences remain largely absent from the research literature (Lisy et al., 2016). The aftermath of stillbirth is often marked by profound grief, social isolation, and disenfranchised mourning, which may be further compounded by intersecting factors such as medical mistrust, implicit bias, and structural racism commonly faced by Black birthing people (Berry et al., 2021; Doka, 1999; Gillis et al., 2020; Kelley & Trinidad, 2012; Persson et al., 2023).

However, most studies on stillbirth and postpartum care overlook racially minoritized perspectives, particularly those of Black birthing people.

Despite the recognized importance of postpartum care, attendance at postpartum visits (PPVs) remains suboptimal among many Black birthing people. Broadly, those who had a stillbirth are less likely to return for a PPV compared with those who had a live birth (Limenih et al., 2016). Existing research also suggests that participants who identify as Black are significantly less likely to attend a PPV compared with participants who identify as White (de Bocanegra et al., 2017). However, current literature has not explored how the experiences surrounding stillbirth, including grief, support, and quality of clinical care, may influence decisions about PPV attendance, particularly for Black birthing people.

To address these critical gaps, this study aimed to: (1) generate an in-depth qualitative understanding of social support, grief, and quality of care among Black birthing people who had a stillbirth and (2) explore whether these experiences may play a role in PPV attendance.

Methods

This qualitative study used a semi-structured interview guide with open-ended questions on grief, social support, and healthcare system factors, which were explored through focus group discussions (FGDs). The primary research question is: "What are Black birthing persons' experiences with social support, grief, and quality of care during the postpartum period following a stillbirth?" A secondary question is: "Do these experiences of social support, grief, and quality of care play a role in PPV attendance?"

A non-probability purposive sampling approach was used. Recruitment took place from November 2023 through April 2024 via national and local stillbirth-related organizations (e.g., Star Legacy Foundation, Return to Zero, Push Pregnancy), Black-led community organizations in the Twin Cities (e.g., Faith's Lodge, Chosen Vessels, Roots), and University of Minnesota-affiliated clinics. Flyers were distributed through social media, email listservs, clinic handouts, and in-person referrals. Interested individuals contacted the study team and participated in a 10–15-minute eligibility screening via Zoom. Eligible participants were invited to a 90–120-minute FGD, provided informed consent, and completed a brief demographic questionnaire. Each participant received a $75 electronic gift card in appreciation of their time.

Participants were eligible if they self-identified as African American or Black, were 18 years or older, and had experienced a *stillbirth*, defined as fetal death at 20 weeks' gestation or later (CDC, 2025), within the past five years in the United States. The five-year limit was set to minimize recall bias and account for evolving obstetric care practices (McCool & Simeone, 2002). Individuals were excluded if they identified as White or another racial or ethnic group, were currently pregnant, or if the referenced loss was a miscarriage or elective abortion.

Two virtual FGDs were conducted via Zoom to gather qualitative data. FGDs were chosen over individual interviews due to their ability to foster shared reflection and comfort among participants when discussing sensitive topics such as stillbirth and postpartum care (Wellings et al., 2000). Each FGD included four participants, lasted approximately two hours, and was facilitated by the lead researcher. The semi-structured interview guide was structured around key domains, with questions focused on social support, grief, and quality of care, all of which were examined within the context of the postpartum period. The guide also included questions about postpartum visit attendance as the primary outcome of interest. It was piloted with two eligible participants and refined based on their feedback. Discussions were recorded and transcribed using Otter.ai for subsequent analysis (Otter.ai).

Data were analyzed by two researchers, both of whom bring lived experiences as parents, including experiences with miscarriage, stillbirth, live birth, and cesarean delivery due to complications. Dr. Abdi identifies as a Black woman and member of the Somali diaspora. Arévalo is a mixed-race, non-binary MPH graduate, registered nurse, and staff member at a community OBGYN clinic. Their positionality informed a reflexive and empathetic approach to data analysis and interpretation. Transcripts were analyzed using Braun and Clarke's six-step thematic analysis approach (Braun & Clarke, 2006). Deductive codes aligned with the conceptual model were combined with inductive codes developed during transcript review. Coding and theme development were carried out through an iterative, consensus-based process, with regular meetings to review coded excerpts. Data were managed using Dedoose (Version 9.0.107), and participant pseudonyms and illustrative quotes were used in reporting findings (Dedoose). A synthesized version of the results was shared with all participants to enhance transparency and trust. To ensure rigor and trustworthiness, Lincoln and Guba's evaluative criteria were applied: credibility, dependability, confirmability, and transferability (Lincoln & Guba,

2007). Strategies included piloting the interview guide, dual coding by independent researchers, regular team debriefs, a clear study protocol, and purposive sampling methods to ensure relevance and depth.

This study was approved by the University of Minnesota Institutional Review Board, including consent procedures and all data collection instruments. All participants provided informed consent. The research was supported by two grants: the Graduate Student Research Development Grant ($2,000) from the Minnesota Population Center and the Health Equity Working Group Grant ($3,000).

Results

Eight African American participants who identified as cisgender women (mean age: 36) participated in the study. Most were married (n = 5), held an advanced degree (n = 4), and resided in the northeastern United States (n = 4). The average gestational age at loss was 29 weeks; most delivered singletons (n = 7), with one twin birth. One participant had a prior perinatal loss, and two had a previous live birth. An overview of the themes that emerged from the FGDs is presented in Table 1.

Table 1

Themes and Subthemes

Theme	Subtheme
1. Social Support/Support System	1.1 Sources of Support 1.2 Types of Social Support Received 1.3 Perceived Quality of Social Support 1.4 Lack of Support
2. Emotional Well-being/Grief Reactions	2.1 Emotional Responses 2.2 Behavioral Responses 2.3 Cognitive Responses
3. Interpersonal Interactions and Experiences with Healthcare Professionals	3.1 Positive Interactions 3.2 Negative Interactions
4. Racially Discordant and Concordant Care and Perceived Biases	4.1 Discordant 4.2 Concordant 4.3 Perceived Biases

Theme	Subtheme
5. Postpartum Follow-up Care and Beyond	5.1 Postpartum Visit Attendance 5.2 Type of Care 5.3 Navigating Subsequent Reproductive Care

Theme 1: Social Support

Participants described receiving varying forms of social support during and after their stillbirth experiences, which fell into three categories: emotional, informational, and instrumental. Support was primarily provided by healthcare professionals, especially nurses, and to a lesser extent by personal networks.

Emotional Support

Nurses were the most frequently cited source of emotional support, offering empathy, presence, and gestures that participants found deeply meaningful. Several participants described forming strong emotional bonds with their nursing teams. The mother of baby Giles shared "…one of them was like kind enough to, you know, give me a hug and kinda like tried to help me hold a [sic] piece together like what was happening" (Baby Giles), while Romiko's Mom remembered receiving "…a thinking of you card in the mail from a team of nurses who delivered my baby." Outside the hospital, nearly all participants emphasized the importance of peer support groups, which offered a space for honest expression and shared healing. Asiyah's mother expressed that "…when I tell you it has been, you know, very, very helpful for me just being in those groups and meeting other women who have experienced the same thing. …it's been an amazing journey."

Informational Support

Nurses were also the primary source of informational support, providing guidance during hospitalization and postpartum care, including lactation management.

> …I had a nurse who just yeah, she said cold cabbage. And so, I had my husband go buy cabbage. And sure enough, you know, again, two days after delivery, the milks [sic] started to come and so [I] had the cabbage prepared. (Mommy C3)

Most participants also received discharge packets from hospital social workers containing grief resources and local support group listings. Dee confirmed, “For me, I think that they, in that packet, like everyone mentioned, they give you just a free stuffed folder of stuff. There was a list of support groups, local support groups, and organizations.”

Only one participant reported receiving informational support from a family member; her brother helped her find a therapist after the loss.

Instrumental Support

Instrumental support included tangible actions such as memory-making activities or logistical help. Again, nurses played a central role in facilitating these efforts. “She [nurse] took pictures of me and my partner and mom. …they dressed him [son] up in little donated premature outfits. They did his handprints, and his feet prints for me” (Romiko’s Mom). Musa’s Mommy shared, “My midwife called my doula, and she also called my mom, and one of the nurses took me home.” From personal networks, one participant described a community-organized meal train: “I think my main social support came from the community that we’re in, you know, they organized meal trains. It was, it was so beautiful” (Mother to Asiyah).

Perceived Quality of Support and Lack of Support

Participants overwhelmingly praised the emotional and practical care provided by nurses, often describing them as “compassionate,” “spectacular,” and “sincere.” However, many expressed dissatisfaction with physicians, characterizing their presence as brief and emotionally detached. Baby Giles’ mother felt like “the doctors tried to distance themselves.” Several participants also reported a lack of meaningful support from family and friends, noting that relationships often became strained or distant: “Like I said, I’m not even one year, but there are some friendships that have already gone by the wayside. Because they don’t know how to handle someone who’s had something like this. And that’s hard, but it’s reality” (Mommy C3).

Theme 2: Emotional Well-being and Grief Reactions

Participants described complex grief reactions following stillbirth, encompassing emotional, behavioral, and cognitive dimensions. These

responses were organized into three subthemes: emotional, behavioral, and cognitive.

Emotional Responses

Emotional reactions were varied and intense, with sadness, guilt, and anger being most prominent. Over half of the participants reported persistent anger during the postpartum period. Bereaved parents shared, "I think my postpartum experience was really emotionally devastating, and I had various emotions, sadness, regret, guilt, and all that" (JD and KD). Musa's Mommy expressed, "I started seeing a therapist like maybe seven months later, because I knew that I was, I was getting worried because I was angry. I was angry all the time" (Musa's Mommy).

Behavioral Responses

Social withdrawal was widespread, as participants isolated themselves from family and friends. One participant noted, "I just cut people off because they were irritating me" (Sunshine). Another participant, Romiko's Mom, shared the profound impact of stillbirth: "I did the self-isolation. It took me a month to even announce to the world that my son was no longer here, that I wasn't pregnant..."

Simultaneously, nearly all participants actively sought support from others with similar experiences, often through support groups and targeted resources:

> …but I ended up doing my own deep dive, you know, kind of research on Google, trying to figure out like, what resources would be helpful to me since I have a baby, you know, it wasn't like I had a child that died. So that kind of took me to finding like Star Legacy and other different resources that were more focused on infant loss and miscarriage. (Baby Giles)

Other behavioral responses included self-care practices and deliberate avoidance of loss-related triggers.

Cognitive Responses

Though mentioned infrequently, one participant described how she often found herself spending a significant amount of time "ruminating" and reflecting on the loss. This rumination typically centered around thoughts of "how things could have been different" and dwelling on aspects that were "missed."

Theme 3: Interactions and Experiences with Healthcare Professionals

Participants' experiences with healthcare professionals during and after their stillbirth were divided into two subthemes: positive and negative interactions.

Positive Interactions

Many participants described receiving compassionate, collaborative care during labor and delivery. Supportive communication from nurses, midwives, doulas, and social workers was a key feature, often including emotional support, shared decision-making, and access to grief resources. Participant Dee shared that "the emergency room team and the labor and delivery team were very kind and they were so socially engaged and gentle with me…". Another participant detailed:

> You know, she [doula] told me what to expect, you know, like she told me what my choices were, as far as having a C-section or delivering, and since I had a doula, I knew I was gonna have a solid support system at the hospital. … The midwife that was at the hospital who was going to deliver me, like you know, we, you know, everything was just take a breath, you know, like this is going to be really, really difficult, but we're here to support you. (Musa's Mommy)

Participants appreciated being involved in care decisions and noted when professionals took time to support their families. For example, JD and KD affirmed, "The good thing about this [was] we were involved in decision making. I feel the family was adequately involved in decision making during the whole process…" Another participant shared her experience, stating:

> So, they did you know, there was a woman [social worker] you know, she did take her time to really go through how to she took her time with me to talk to me about how to help my kids cope with the grief. (Mother to Asiyah)

Negative Interactions

Conversely, participants also recounted distressing interactions across the continuum of care during pregnancy, labor, and postpartum. Nearly half

described unsupportive or dismissive communication, often feeling gaslit or unheard.

> My OBGYN who I felt like this accident could have been prevented, because there were some questions that I had asked her prior to the occurrence of his passing that I believe could have been lifesaving. And yeah, I wasn't listened to. (Mommy C3)

Some shared traumatic or retraumatizing encounters, including being congratulated on a baby who had died or being met with confusion during follow-up care. Dee explained, "I felt like more than just the labor and delivery and postpartum experience. My entire pregnancy and and just my interactions with OBGYN were incredibly traumatizing the entire time." She later described her interactions with nurse assistants during routine follow-up care.

> Every time I went back in the nurse assistants were asking so you had a pregnancy, you're pregnant, where's your, you had a baby, you have a baby, how many babies do you have? And it's just very it's just like retraumatizing every time. (Dee)

Similarly, another participant said, "I got a bunch of congratulations, but it wasn't a congratulations because I knew I was going to be going in pregnant believing [sic] without a baby…" (Romiko's Mom). Many participants also felt their care was rushed or impersonal, particularly after the delivery. One participant noted, "…but in regard to my health care provider, I think it was just like, this is what we do. And then bye, your here's your stuff, and that was it" (Mommy C3). Dee shared a similar sentiment, stating, "I felt like once he was delivered, I was just another person in the way… they [medical doctor and hospital staff] were just trying to figure out how to get me out of the unit."

Theme 4: Racially Discordant and Concordant Care, and Perceived Biases

Participants reflected on how race and perceived biases influenced their reproductive healthcare experiences. This theme is divided into two subthemes: 1) racially concordant and discordant care, and 2) perceived biases.

Discordant and Concordant Care

Half of the participants mentioned that the racial identity of their healthcare providers was a significant factor in their care experience. Several shared that

racially concordant providers, those who shared their racial or cultural background, were more likely to communicate in relatable, accessible ways. In contrast, discordance often created a disconnect.

> But I feel like medical professionals, who can see themselves in their patients, can figure out a way to paraphrase complex terms in a way that's relatable. And, I feel often times that I because I don't have medical professionals who can see themselves in me, I am not afforded the opportunity to have things broken down in a relatable, layman's term way. … And, that's where that disconnect with white medical professionals comes into play. (Dee)

Some participants actively sought out providers of color, particularly Black women, though they acknowledged these providers were often difficult to find:

> You know, there's sometimes there's something to that so I always attempted at the very least to try to find a woman doctor, African American tend to get harder. Not so much because they weren't around. … So and then always I would try to go to a woman of color next. (Baby Giles)

Others expressed fear of discrimination impacting the quality of their care: "Somehow I had fears that I would be maybe discriminated because of my race and all that, and I would not receive a good care after delivery and all that" (JD and KD).

Perceived Biases

Several participants described interactions they interpreted as biased or dismissive. One participant felt her birth options were presented in a way that discouraged genuine choice:

> When I got to the hospital, they laid out all of my options on the table, but I don't feel like the options were given to me. Like, what would you like to do? I feel like they were biased or like they were trying to persuade me to one option versus the other. (Romiko's Mom)

Others felt they were being gaslit or blamed, potentially due to their race, age, or appearance:

> …I was given so much like reassurance, if that makes sense. Like, it was like, you're okay. You're fine. Like gaslighting in a sense of making me

> feel like I don't know if it was because of my age or for whatever the reason, maybe hijab, not sure, color of the skin. I don't know that my ethnicity. (Mother to Asiyah)

Theme 5: Postpartum Follow-up Care and Beyond

This theme explored participants' experiences with postpartum follow-up care and their navigation of reproductive healthcare after stillbirth. Subthemes included: (1) postpartum visit attendance, (2) type of postpartum care received, and (3) navigating subsequent reproductive care.

Postpartum Visit Attendance

About half of the participants attended their PPV within the recommended timeframe, while others either skipped it or followed up later through other means.

Type of Postpartum Care Received

Participants primarily received clinical care focused on physical recovery, often prompted by postpartum complications. "I had a follow-up, I think six days, like within a week or two after I gave birth to my son, because I had excessive bleeding, and I was concerned about it…," remembered Romiko's Mom. The mother of Baby Giles "was in and out of the hospital for follow-up procedures for the full six weeks of [her] postpartum period." Some also received informational support, such as explanations of autopsy results or referrals to resources. "And then I ended up going back because I really needed the MFM to explain to me the autopsy report," participant we have coded as Baby Giles shared. Repeated stillbirths could mean more attention. "I was given additional resources because of the first [sic] and experiencing loss earlier with [sic] with your first pregnancy" (JD and KD).

Navigating Subsequent Reproductive Care

Several participants expressed a profound loss of trust in the healthcare system and hesitance to engage with OBGYN care in the future.

> …it still wreaks havoc on my medical care, like how I interact with, especially OBGYN, just because for other like menstrual care and things

like that, I just don't trust that they will believe when I tell them something, because they never showed that they believed me in the first place. (Dee)

…it's so hard to trust anyone after that, like even my OB now. Like we're always just going like it's so hard to like the whole the healthcare like it's just, it puts you in such like this terrible mindset where it's like these people don't know what they're talking about, like, like we don't even know what we're talking about like there's it's so hard to trust someone in the health care now… (Mother to Asiyah)

Some attempted to re-engage previous providers. In one case, a participant was denied continued care without explanation:

…but I did end up getting pregnant a few months later. And I tried to go back to that woman that I was getting my prenatal care from because I don't feel like any of it was her fault. Or you know, I feel like it was out of her control. She didn't do anything wrong, but that clinic was still very close and I still had that idea that positive idea of her being everyone's doctor and she kind of refused service from me. So that kind of all will always stick in my mind as well. And I'm like why she couldn't give me a medical reason. Why so that kind of hurt my feelings as well. (Romiko's Mom)

More than half opted to change providers and in some cases, their entire healthcare setup to regain a sense of control and safety. "It was a completely different company, a completely different location, a completely different city. I even got a new medical insurance…," shared Romiko's Mom. Mommy C3 was unsure of how to approach neducan care going forward: "So, for me all the medical like I don't even know if I'll see a doctor next time. Maybe I'll just do a midwife…" (Mommy C3).

Discussion

This qualitative study explored the postpartum care experiences of Black birthing people following stillbirth, with a focus on social support, grief, and quality of care, and examined whether these experiences influenced PPV attendance. Participants reported limited sources of postpartum support, with nurses and midwives often serving as the primary providers of emotional, informational, and practical support. These findings mirror prior research indicating that nurses play a critical role in compassionate care following stillbirth, particularly for Black birthing people (Fenstermacher & Hupcey,

2019). This theme also underscored that time with medical doctors was generally brief and usually occurred only when a medical diagnosis was involved. For the birthing parent, this often created the impression that doctors were detached and distant, and appeared to lack empathy for the situation. Support groups were described as a crucial outlet, providing emotional validation, reducing isolation, and fostering a sense of community. This aligns with previous studies noting that support groups help bereaved parents navigate grief by sharing experiences with others who understand perinatal loss (Cacciatore, 2007). A recent feasibility study also emphasized the importance of culturally specific online support groups for people of color, highlighting the need for tailored bereavement support (Gold et al., 2022).

Participants described a range of grief responses, including sadness, guilt, anger, and social withdrawal, which are well-documented in the broader stillbirth literature (Persson et al., 2023). Consistent with prior qualitative research involving Black birthing people, this study confirms that emotional and behavioral reactions to stillbirth are multifaceted and often intense (Evans et al., 2023; Kavanaugh & Hershberger, 2005; Van, 2001; Van & Meleis, 2003). While the study did not introduce new grief typologies, it adds depth to the limited body of literature specific to Black birthing people's emotional responses after stillbirth.

Participants generally reported positive interactions. This positivity often stemmed from the social support provided by the nursing staff, whether it was emotional, informational, or practical assistance. These findings also align with the limited qualitative research that indicates interactions with nursing staff are generally positive for Black birthing people who have experienced perinatal loss (Fenstermacher & Hupcey, 2019). However, negative encounters with other healthcare professionals were frequently described. Participants recounted experiences of being gaslighted, dismissed, or retraumatized, especially when medical staff congratulated them at follow-up visits without reviewing their charts. Findings from this study are consistent with other research that broadly examines the obstetric experiences of Black birthing people, though not specifically in the context of stillbirth. Previous studies suggest that many Black birthing people frequently encounter poor communication, feel overlooked with their concerns disregarded, and often report a lack of empathy from healthcare providers regarding their obstetric care (Barnett et al., 2022; Mehra et al., 2020; OjiNjideka Hemphill et al., 2023).

These findings suggest that Black birthing people who have experienced stillbirth encounter similar challenges in care.

Many participants emphasized the value of racially concordant providers and described how racially discordant care compromised communication, comfort, and cultural understanding. These findings align with a growing body of research showing that racial concordance improves trust, patient-provider communication, and perceived quality of care among Black patients (Shen et al., 2018) Participants in this study reported greater comfort and openness with racially concordant providers, confirming findings from earlier work indicating that such concordance fosters safer, more affirming care environments (Altman et al., 2020; Deichen Hansen et al., 2021). This study extends that literature by highlighting how the desire for racially concordant care is especially salient in the context of stillbirth.

While half of the participants attended a PPV, their primary motivation was medical necessity, typically due to complications during pregnancy. Emotional care was often absent from these visits, and prior negative experiences with the healthcare system eroded trust, prompting some to seek new providers. These findings are consistent with the literature, indicating that chronic health conditions increase the likelihood of PPV attendance in live birth populations (Bennett et al., 2014; Levine et al., 2016; Schwarz et al., 2017), suggesting this may extend to those experiencing stillbirth. However, participants did not explicitly link their experiences of social support, grief, or care quality to their decision to attend a PPV, limiting the ability to draw conclusions about these relationships. This highlights a gap in the existing literature, while prior studies have suggested that social support may influence PPV attendance (Cardona Cordero et al., 2021), no known studies have examined grief or quality of care as predictors of PPV following stillbirth.

Strengths and Limitations

This study has several notable strengths. It addresses a significant gap by centering the lived experiences of Black birthing people following stillbirth, a population that faces disproportionate risk yet remains underrepresented in the literature. Grounded in Black Feminist Thought, the study offers a culturally attuned lens that enhances its relevance and depth. A further strength is that participants were given a synthesized summary of the findings, promoting transparency and trust. However, the study also has limitations. The small

sample size and use of only two focus group discussions limited the ability to explore contextual diversity (e.g., geographic location, place of birth, socioeconomic status). All participants had sought support groups, which may have influenced their experiences and limited the variability in their responses. The inductive analytic approach, while appropriate, relies heavily on the researcher's interpretation, which may differ from that of other analyses.

Conclusion

This study contributes to a growing but still limited body of research exploring postpartum experiences of Black birthing people who have experienced stillbirth. It is among the first to qualitatively examine how social support, grief, and care quality may influence PPV attendance in this population. While no direct link was established, these findings underscore the importance of emotionally attuned, culturally responsive care and highlight the need for further research on systemic barriers to post-loss support and follow-up. Given the disproportionately high rates of stillbirth among Black birthing people, addressing existing gaps in the literature is crucial, particularly around key elements of care, such as care quality, that warrant further examination to better support this population.

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The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003 Vol. 39 No. 2 Fall 2025

The Role of Medicaid in Advancing Obstetric Provider Maternal Mental Health Screening and Treatment

Joy Burkhard, MBA, Madison Scott, JD, Caitlin Murphy, MPP, Kate Rope, Cindy Herrick, MA

Untreated maternal mental health (MMH) disorders significantly contribute to preterm births and maternal mortality, highlighting the essential role of obstetric providers in screening and treatment. This report examines state Medicaid agency (SMA) contracts with managed care organizations (MCOs) regarding the implementation of the American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines for MMH. Our analysis of contracts from 40 states and the District of Columbia (DC) reveals that only nine states require MCOs to address the role of obstetric providers in MMH screening, with varying approaches to reimbursement and quality measures. The findings suggest a critical need for enhanced policies that incentivize MMH screening among obstetric providers, as states with robust reporting and reimbursement mechanisms demonstrate higher screening rates. Recommendations include mandatory HEDIS reporting for MMH screening and adequate reimbursement rates to ensure effective implementation of ACOG guidelines, ultimately improving maternal and infant health outcomes.

The authors have no conflict of interest. Joy Burkhard, MBA, is the Founder and Executive Director of the Policy Center for Maternal Mental Health. Caitlin Murphy, MPP, DrPH(c) (ORCID: 0000-0001-9365-0691), is a Research Scientist in the Department of Health Policy and Management at the Milken Institute School of Public Health, George Washington University. Madison Scott, JD, and Kate Rope are contractors with the Policy Center. Cindy Herrick, MA, PMH-C, CPSS, serves as the Senior Editorial and Research Manager at the Policy Center. Please send correspondence to cindy.herrick@policycentermmh.org.

Keywords: maternal mental health, obstetric providers, Medicaid, maternal mortality, State Medicaid Agencies (SMAs), mental health screening, health outcomes

The prevalence and harms of untreated maternal mental health (MMH) disorders are well-documented. In the United States, MMH disorders are a leading cause of preterm birth and maternal mortality, with suicide accounting for nearly 20% of maternal deaths (Cox et al., 2016; Lindahl et al., 2005; Osterman et al., 2023). One in five women will experience an MMH disorder, such as prenatal or postpartum depression and anxiety; yet, research estimates that 50-70% of women go undiagnosed, and 75% of those diagnosed go untreated (Cox et al., 2016; Osterman et al., 2023). As the woman's primary provider during pregnancy and the postpartum period, obstetric providers, e.g., obstetricians and gynecologists (OBGYNs), midwives, and family practice providers who deliver babies, are uniquely positioned to provide screening, treatment, and referrals starting at the beginning of pregnancy through the full postpartum year.

Screening to detect these disorders has been recommended by bodies including the American College of Obstetrics and Gynecology (ACOG) in 2015 and the U.S. Preventive Services Task Force (USPSTF) in 2016 (ACOG, 2023; Policy Center, 2022; Siu & USPSTF, 2016). In 2023, ACOG expanded upon its recommendation for OBGYNs to screen for MMH disorders and released the first clinical practice guidelines (CPGs) for screening and treatment of these disorders (ACOG, 2023). The CPGs recommend screening using a standardized questionnaire, beginning at confirmation of pregnancy and continuing at various intervals throughout the perinatal period, followed by diagnosis and treatment. Also in 2023, the Health Resources and Services Administration's Alliance for Innovation in Maternal Health (AIM) released a patient safety bundle recommending perinatal mental health screening at prenatal and postpartum visits (AIM, 2023).

Though the development of ACOG's maternal mental health CPGs is monumental, research illustrates that care has not been routinely delivered in accordance with any CPGs in the United States for an average of 17 years. The implementation of CPGs in the United States requires substantial efforts by payers, including state Medicaid agencies, to address payment and incentives, as well as to measure whether services are being provided per the guidelines.

In 2019, two standardized measures were created by the National Committee for Quality Assurance (NCQA) to track rates of obstetric providers screening for MMH disorders: (1) Prenatal Depression Screening and Follow-Up (PND-E) and (2) Postpartum Depression Screening and Follow-Up (PDS-E) as a part of the Healthcare Effectiveness Data and Information Set (HEDIS) (NCQA, n.d.). These measures were adopted by some state Medicaid agencies, which required their managed care organizations (MCOs) to adopt these measures. Pennsylvania (PA) and California (CA) were among the early adopters. The Centers for Medicare and Medicaid (CMS) reviews measures to designate as mandatory or voluntary in *Core Sets* of measures that state Medicaid agencies (SMA) must consider. These measures were first included as voluntary measures in the Adult and Child Core Set maintained by the CMS in 2024 (Centers for Medicare & Medicaid Services; CMS, n.d.-a, n.d.-b).

Currently, Medicaid covers nearly 50% of all births in the United States (KFF, n.d.). SMAs are, therefore, well-positioned to address the essential and life-saving role that obstetric providers play in identifying and treating MMH disorders. In 40 states and the District of Columbia (DC), SMAs contract with health insurers known as MCOs to provide Medicaid enrollees with care. Nearly 80% of all mothers enrolled in Medicaid are enrolled in MCOs, making this the primary way that Medicaid mothers receive their care (Hinton & Raphael, 2025). These contractual arrangements outline the requirements for reporting, payment, and incentives.

State Medicaid Agencies and their contracted MCOs primarily reimburse their in-network obstetric providers through a bundled obstetric payment for maternity services (Lally, 2013). Expert bodies such as ACOG have suggested that this bundled payment is insufficient and may disincentivize OB providers from providing MMH screening and follow-up counseling (Health Care Payment Learning & Action Network, 2016). ACOG's policy statement, *Payment for OBGYNs,* specifically supports separate billing and payment for MMH screening and follow-up counseling provided by an obstetric provider:

> ACOG supports insurer billing policies that include: Separate billing and payment for ancillary and supportive services, including but not limited to the administration and interpretation of screening (eg, depression, health-related social needs, or social determinants of health), counseling services (eg, genetic, vaccine, nutrition), group prenatal care…and other services that were not accounted for in the development of the global maternity

> codes; Separate billing and payment for ongoing outpatient management and care coordination for postpartum conditions that require additional care, such as cardiac conditions, mental health conditions… (ACOG, 2024, para. 5)

Indeed, when ACOG first issued recommendations to screen for prenatal and postpartum depression, ACOG also shared applicable fee-for-service (FFS) CPT billing codes (96160, 96161, 96127, or 96146), indicating that insurers may or may not reimburse for these codes in addition to the bundled obstetric payment (ACOG, n.d.). State Medicaid agencies have several opportunities to implement ACOG's recommendations among their MCOs and the MCOs' in-network obstetric providers. This report examines the extent to which SMAs have been leveraging the following opportunities to implement ACOG's CPGs:

1. Requiring obstetric providers to provide prenatal and postpartum MMH screening
2. Separating obstetric providers' reimbursement for MMH screening and follow-up from a bundled rate
3. Requiring reporting of HEDIS MMH screening and follow-up measures

This report provides an overview of the Policy Center for Maternal Mental Health's (Policy Center) examination of SMAs' MCO contracts to understand the extent to which SMAs are addressing the role of obstetric providers, such as OBGYNs, midwives, and other practitioners, in screening and treating MMH disorders. Specifically, we assessed health plan contracts to determine if they 1) require obstetric providers to screen, 2) address obstetric reimbursement for MMH screening, or 3) require MCOs to report HEDIS® perinatal depression screening measures. The report also includes the HEDIS MMH screening rates for the top-performing states in order to investigate whether these three actions may be influencing screening rates.

Methods

This study included three parts: a review of: 1) Medicaid MCO contracts, 2) three SMA approaches to reimbursing obstetric providers for MMH screening and treatment, and 3) Medicaid HEDIS MMH screening rates, by state. In July 2024, the Policy Center identified and downloaded the boilerplate

MCO contracts for each of the 40 states and DC that take part in Medicaid managed care.

Each contract was searched for the following keywords: maternal, maternity, obstetric, obstetrician, gynecology, pregnancy, pregnant, prenatal, perinatal, postpartum, anxiety, depression, mental health, and screening. Contract language with these keywords was documented for analysis. When other documents were linked to or referred to in the contract, we also searched for this language. Thematic analysis was conducted to determine if the MCO contracts reference or require:

1. Obstetric providers provide MMH screening
2. Medicaid MCO report HEDIS (or HEDIS-like) MMH screening and follow-up measures
3. Obstetric provider reimbursement for MMH screening and follow-up separate from a bundled maternity payment

Our contractual scan only reviewed documents that were directly linked to the state MCO contracts. However, we chose three states to conduct a more comprehensive review of all relevant publicly available documents, including those not linked in the contracts (i.e., provider manuals, state policy guidance, and fee schedules). We selected states that, based on our initial review, appeared to be innovating in MMH screening reimbursement and are top-performing states regarding Medicaid HEDIS maternal depression screening rates: CA, NC, PA, WA, and WI, as per a data pull the Policy Center received from the NCQA in January 2024.

We aimed to address several questions for each state, including whether MMH screening billing codes are provided, the specific codes used, and their corresponding locations. Additionally, we investigated the reimbursement rates and whether there are limits on the number of MMH screenings. We also examined whether an evidence-based MMH screening tool is required and whether a higher reimbursement rate is available for positive screens to compensate providers for developing a follow-up plan. Lastly, we sought to determine if there is guidance for billing follow-up services, along with the relevant codes and rates.

Finally, we identified the states that were top-performing on the HEDIS MMH screening measures: *PND-E* and *PDS-E*. (These HEDIS specifications and data are not limited to screening by obstetric providers.) To identify these states, we analyzed data from the 2023 Quality Compass dataset, provided by

the NCQA in January 2024. We identified the top four performing states that had reported enough data to NCQA for rates to be reportable.

Findings

Obstetric Providers Required to Provide Prenatal and Postpartum MMH Screening

Four of the 41 contracts explicitly require obstetric providers to provide prenatal and postpartum MMH screening and treatment: AZ, CA, OR (only prenatal screening), and VA. Arizona's MCO contract (Arizona Health Care Cost Containment System, n.d.-b) requires maternity care providers to conduct screenings for perinatal and postpartum depression and anxiety at least once during pregnancy and during postpartum visits. Positive screenings must be followed up with appropriate counseling and referrals using validated tools. California's MCO contract (California Department of Health Care Services; DHCS, n.d.-a) mandates comprehensive risk assessments at the initial prenatal visit, once each trimester, and at the postpartum visit, in line with ACOG and CPSP standards. All identified risks must be documented and followed up with appropriate interventions.

Oregon's MCO contract (Oregon Health Authority, n.d.) requires maternal mental health screening at the initial prenatal exam, with a focus on prevention, early detection, and referral to behavioral health services as needed. Virginia's MCO contract (Commonwealth of Virginia Department of Medical Assistance Services, n.d.) stipulates that providers screen pregnant individuals for mental health concerns per ACOG standards and ensure referrals for follow-up services for those who screen positive.

Nine States Require Reporting of HEDIS MMH Screening and Follow-Up Measures

The prenatal and postpartum depression HEDIS measure specifications do not limit screening and follow-up to that performed by obstetric providers. However, the HEDIS measures are important indicators and can capture screening and follow-up by obstetric providers. Nine states currently require HEDIS MMH screening reporting. Among these nine states, five states include requirements for the HEDIS MMH screening measures in their MCO contracts (IN, MI, NH, NM, and WA), three states include these measures in their annual

External Quality Review (EQR) reports (CA, PA, and NV), and one state includes this in their State Medicaid Quality Strategy (WI). (Since some states change performance metrics throughout the contract period, it was also necessary to scan states' EQR and State Medicaid Quality strategy documents for the latest performance measures they require of their MCOs.) New Hampshire limits its focus to postpartum depression screening, and Indiana focuses only on prenatal screening.

Several states have established requirements for MCOs to report on HEDIS measures related to maternal mental health screenings. WA mandates MCOs to report on prenatal and *PDS-E* as part of their contract metrics (Washington State Health Care Authority, n.d.). WI's 2025 Medicaid Quality Strategy aims to improve birth outcomes and includes similar screening measures within its performance metrics (Wisconsin Department of Health Services, n.d.-c). PA requires MCOs to report all HEDIS measures as part of their Quality Assessment and Performance Improvement programs (Pennsylvania Department of Human Services, n.d.-b). Arizona's medical policy manual emphasizes the need for monitoring compliance with perinatal and postpartum depression screenings (Arizona Health Care Cost Containment System, n.d.-a). Indiana incentivizes MCOs based on their performance on the PND-E measure, providing financial rewards for achieving specified performance levels (Indiana Department of Health, n.d.).

Obstetric Provider Reimbursement for MMH Screening and Follow-Up Separate From a Bundled Rate

Two states' contracts explicitly address reimbursement to obstetric providers for MMH screening and treatment. Only NC and WI's contracts reference reimbursement to obstetric providers for maternal mental health care, and they refer to external documents with that detail.

Obstetric Providers Reimbursement Case Studies

Our study confirmed that most states include reimbursement details in separate policy documents, not their Medicaid-managed care contracts. These details may be found in provider manuals, state billing guides, fee schedules, or other documents.

Therefore, to understand the other methods that states use to document reimbursement expectations, we chose three states to conduct a more

comprehensive review of all relevant publicly available documents. CA, NC, PA, WA, and WI were selected because our initial review found that they appeared to be innovating in obstetric provider reimbursement for MMH, and because these states, except NC, were top-performing HEDIS MMH-screening states for Medicaid. Using all relevant, publicly available policy documents, we sought to answer several key questions about reimbursement.

The following are the summaries of the findings for each state:

California

CA provides billing codes for MMH screening in their Medicaid provider training document (DHCS, n.d.-c). Claims can be submitted twice a year per pregnant or postpartum individual—once during pregnancy and once postpartum. A pregnancy or postpartum diagnosis code is required on all claims, and Modifier HD is used for both positive and negative depression screenings. Positive screens are reimbursed at $37.25, while negative screens receive $17.14 (DHCS, n.d.-b). There is no mention of required evidence-based screening tools or guidance for billing follow-ups.

North Carolina

NC provides billing codes for MMH screening in NC Medicaid Policy IE-5 (North Carolina Department of Health, n.d.). Obstetric, family practice, and pediatric providers can be reimbursed for three brief emotional and behavioral assessments during the first year postpartum. If a problem is identified, beneficiaries should be referred to their primary care provider. Providers performing postpartum depression screening must bill diagnosis Z13.32 in combination with CPT code 96127 for a brief assessment, reimbursed at $4.49 per screen. Providers can bill for up to four MMH screenings postpartum; however, no further guidance is provided on follow-up billing or higher reimbursement for positive screens.

Pennsylvania

In PA, MCOs are required to reimburse obstetric providers for completing a comprehensive prenatal needs assessment form (ONAF). This includes screening for maternal depression and is part of the 2023 Maternity Quality Enhancement Program (MQEP). Reimbursement for the initial ONAF form began on January 1, 2023, and will continue through the 2024 program year at

the contracted rate during the final settlement, associated with the EOB code ONAF.

Quality measures influencing incentive payments include: Social Determinants of Health Screening, Timeliness of Prenatal Care, Postpartum Care, PND-E, Postpartum Depression Screening Follow-Up, and Prenatal Immunization Status. Scoring is based on achieving specific goals, with points awarded for meeting targets such as 77.27% for PND-E and 86.94% for Postpartum Depression Screening Follow-Up. PH-MCOs must track and report these measures to the Department for both the Maternity Care Bundle and the non-Maternity Care Bundle populations.

Washington

MMH screening billing codes are provided in the "Pregnancy-related services billing guide" for the period from October 1, 2024, to December 31, 2024, by YeWashington. HCA covers depression and anxiety screenings during pregnancy and postpartum using standardized tools. Screening must occur at the initial prenatal visit, as well as once during the second or third trimester, and once postpartum, as per ACOG recommendations. Providers may submit a limitation extension request for more frequent screenings.

Billing uses CPT codes 96127 or 96160, with modifiers U1 for negative screens and U2 for positive screens, reimbursed at $2.85 in 2024. Providers must document the screening tool used, the score obtained, and any referrals made in the client's record. There is no mention of higher reimbursement for positive screens or follow-up billing guidance. For identified issues, clients must be referred for further assessment and care.

Wisconsin

WI provides billing codes for Mental Health (MMH) screenings and follow-up counseling in their Medicaid provider handbook, applicable to obstetric providers during pregnancy, but not postpartum (Wisconsin Department of Health Services, n.d.-b). The WI MCO contract references the provider handbook for MMH screening details (Wisconsin Department of Health Services, n.d.-a).

The screening code (H0002) can be billed during pregnancy and up to 60 days postpartum, with no limit on the number of screenings. The mental health counseling code (H0004) has a limit of 16 units per member, with a maximum

of four units allowed per visit. Medicaid reimburses $35.35 per screening using code H0002 with modifiers HE (mental health) or HF (substance use). Follow-up counseling is reimbursed at $16.41 per unit, with a limit of 16 units per pregnancy. Providers are required to use an evidence-based screening tool, as specified in the handbook.

Medicaid HEDIS Prenatal and Postpartum Screening and Follow-up Rates by State

Our team analyzed the HEDIS MMH screening rates received by the NCQA's 2023 Quality Compass dataset. Among the states with enough data being reported, we identified four states as top-performing: PA, CA, WI, and WA.

Table 1

HEDIS Top 4 Performing States Among Medicaid Enrollees for Screening

State	PND-E Medicaid Prenatal Depression Screening Rate	PDS-E Medicaid Postpartum Depression Screening Rate
Pennsylvania	28.7	26.9
California	19.1	14.7
Wisconsin	13.4	11.1
Washington	2.2	0.3

Although these rates were not limited to screening by obstetric providers, it is likely that state Medicaid agencies with high rates, particularly for the prenatal measure (PND-E), have taken some action to address screening among obstetric providers with their MCOs. Our research found that one state includes these measures in its MCO contracts, two states include these measures in their annual EQR (CMS, n.d.-c) reports (CA and PA), and one state includes them in its State Medicaid Quality Strategy (WI) (CMS, n.d.-d).

Key Findings:

- Obstetric providers required to provide prenatal and postpartum MMH screening: Four states (AZ, CA, OR, VA) explicitly require obstetric providers to conduct MMH screenings during prenatal and postpartum visits.
- Reporting of HEDIS MMH Screening and Follow-up Measures: Nine states mandate the reporting of HEDIS MMH screening and follow-up measures.
- Obstetric provider reimbursement for MMH screening and follow-up separate from a bundled rate: Only two states (NC, WI) explicitly address reimbursement to obstetric providers for MMH screening and treatment in their contracts.
- Top-performing states for Medicaid HEDIS MMH screening rates, including PA, CA, WI, and WA, exhibit the highest rates of Medicaid prenatal and postpartum HEDIS screenings.

Discussion

We found that of the states we analyzed that took one of these three actions (requiring screening in contracts, reimbursement for MMH screening and follow-up, and addressing reporting of HEDIS measures), two states did not address obstetric providers and prenatal screening: NC only addresses reimbursement for postpartum depression, and NH requires HEDIS measure reporting for postpartum depression, not prenatal depression. This is unfortunate, given that the ACOG CPGs and prior screening recommendations address the importance of screening starting in pregnancy.

Further, our analysis illustrated that most state Medicaid agencies are not leveraging opportunities to address obstetric provider screening, billing, and reimbursement for MMH services, with only nine states taking action contractually in MCO contracts: AZ, CA, IN, MI, NV, OR, PA, VA, and WA. Specifically, we found that four states (AZ, CA, OR, VA) mandate maternal mental health screening during prenatal or postpartum care within MCO contracts. Case studies highlighted CA, NC, PA, WA, and WI as states working towards reimbursing obstetricians for maternal mental health screening separately from maternity care bundle rates. While NC and WA offer low reimbursement rates that may not encourage screening, CA and WI provide reimbursement rates of over $30 for screenings. PA requires MCOs and

obstetricians to report on screening through an Obstetric Needs Assessment Form and related quality improvement programs.

Additionally, nine states require their Medicaid MCOs to report HEDIS or similar screening and follow-up data, which may influence obstetricians ' screening practices, particularly for prenatal mental health. CA, PA, WA, and WI exhibit the highest rates of Medicaid prenatal and postpartum HEDIS screenings, with requirements for reporting and reimbursement for obstetricians in place.

As illustrated by the states with the best performance for Medicaid HEDIS perinatal depression screening rates, it is not enough to require screening by obstetric providers nor reimbursement to obstetric providers for screening through fee-for-service billing codes. States must also require reporting of screening rates, through HEDIS or HEDIS-like reporting, and reimburse obstetric providers a substantive rate for screening and follow-up care.

Limitations

This study aimed to provide a preliminary review of state Medicaid agency contracts in the 40 states and DC that work with MCOs' health plans, to gain insights into how states are addressing MMH through these Medicaid contracts. Future studies could include a 50-state review of payment mechanisms for maternal mental health, including fee-for-service states. Furthermore, claims data could be reviewed to determine how frequently obstetric providers submit claims for these services.

Finally, this study found that states with high Medicaid HEDIS screening rates are associated with state requirements that MCOs report these measures. Further, we suspect, as is the case with quality improvement initiatives, that the longer a state has required reporting, the better the results. However, it is still possible that states that have not required the reporting of these measures could also have high screening rates that are not being measured and reported. For example, New Jersey, a state that has required providers to screen for maternal depression for nearly two decades, reported that roughly a third of women indicate that they have been screened through the Pregnancy Risk Assessment Monitoring System (PRAMS) survey (New Jersey Department of Health, n.d.). A future study could examine this by comparing states' HEDIS rates and patient self-reported screening data as reported through PRAMS.

Recommendations

State Medicaid agencies should adopt the following strategies to improve maternal mental health detection and follow-up:

1. Require health plans and insurers to track and report HEDIS MMH performance measures to determine the frequency and utilization of screening and follow-up care, and incentivize plans and insurers to implement quality improvement plans. Achieving this through state quality programs yields the highest results. Medicaid agencies should also require that screenings align with ACOG guidelines, including, at a minimum, following the ACOG-recommended frequency. ACOG guidelines currently recommend that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits. HEDIS also requires a follow-up on a positive screen, so at least one follow-up encounter should be required.
2. Reimburse at an adequate rate for screening and follow-up. States with high screening rates incentivize screening through adequate reimbursement. For example, WI reimburses screening at a rate of over $30. CA reimburses negative and positive MMH screenings differently, with positive screens being reimbursed at over $30 to compensate obstetric providers for the creation of a treatment and follow-up plan (DHCS, n.d.-b).
3. Code and reimburse for MMH screening and follow-up on a fee-for-service basis. ACOG released CPT FFS billing codes (96160, 96161, 96127, or 96146) for reimbursement in addition to any bundled obstetric payment (ACOG, n.d.). Billing codes can also include, for example, behavioral health integration (BHI) codes (such as 99484) and collaborative care codes (CoCM) (such as 99492, 99493, and 99494), which align with broader trends to support integrated mental health care. Furthermore, screening, billing, and coding should differentiate positive and negative screens so claims data can be utilized for HEDIS measurement and reporting.

Conclusion

This report highlights the critical role of Medicaid in enhancing MMH screening and treatment through obstetric providers. Despite the well-

documented prevalence and severity of untreated MMH disorders, which significantly contribute to maternal mortality and adverse birth outcomes, our analysis reveals that only a limited number of states have integrated robust screening protocols and reimbursement policies within their Medicaid managed care frameworks.

The findings indicate that while four states mandate MMH screening during prenatal and postpartum visits, the majority of states have yet to implement comprehensive measures that support obstetric providers in delivering necessary care. Specifically, only two states explicitly address reimbursement for MMH screening and treatment outside of bundled payment structures, which may hinder providers' willingness to engage in these essential practices. Furthermore, the lack of consistent reporting on HEDIS MMH measures across states suggests a significant opportunity for improvement in tracking and enhancing screening rates.

The analysis of top-performing states reveals that the effective implementation of ACOG guidelines, combined with adequate reimbursement and required reporting, is correlated with higher screening rates. To address the substantial gap in maternal mental health care, state Medicaid agencies must adopt systematic strategies that include mandatory screening protocols, increased reimbursement rates for MMH services, and regular reporting of screening outcomes.

In conclusion, the integration of comprehensive maternal mental health strategies within Medicaid managed care systems is imperative to improve health outcomes for mothers and infants. By implementing these recommendations, state Medicaid agencies can play a pivotal role in ensuring that obstetric providers are equipped to identify and effectively treat MMH disorders, ultimately enhancing the health and well-being of families across the United States.

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The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003
Vol. 39 No. 2 Fall 2025
https://doi.org/10.62858/apph250803

Applying Subcellular Psychobiology Theory to Disease: Treatments for Dizziness, Asperger's, and Hearing Voices

Kirsten Lykkegaard, DVM, PhD, Mary Pellicer, MD, Grant McFetridge, PhD

The lack of effective treatments for chronic disease and mental disorders is a tragic and growing healthcare crisis. Despite tremendous efforts by generations of researchers and substantial investments, little progress has been made. For example, in the area of psychiatric disorders, this situation has deteriorated to the point where drug companies have essentially abandoned efforts to find pharmacological solutions due to so many years of costly failures (Hyman, 2013; Miller, 2010). In our view, the lack of progress in these areas is primarily caused by two key problems: an inability to identify the underlying causes of diseases of unknown etiology, and the spiraling costs and difficulties associated with developing effective pharmaceuticals.

In this paper, the last in a three-part series (Lykkegaard et al., 2024; Lykkegaard et al., 2025), we present a practical solution to these intractable problems. Based on subcellular psychobiology theory (Lykkegaard et al., 2025), we start with a step-by-step approach for finding the underlying intracellular causes of diseases of unknown etiology, utilizing kinesthetic markers and regression to key developmental traumas. With this, we then show how to design effective treatments using trauma therapy techniques.

Extraordinary claims require extraordinary proof, and the best proof is empirical. Hence, we give three practical examples of medical and mental

The Institute for the Study of Peak States was founded in Canada in 1998 by Grant McFetridge, PhD (ORCID: 0000-0002-8917-6613). This privately funded international research, training, and clinical institute focuses on understanding the psychobiology behind exceptional mental and physical wellness. Many talented volunteers did this work without funding as part of the research efforts of the Institute. Kirsten Lykkegaard, DVM, PhD (ORCID: 0000-0001-7602-1578), directs the fundamental research team, and Mary Pellicer, MD (ORCID: 0000-0002-5335-7957), directs the psychoimmunology applications team. We have published five textbooks so far; in particular, the *Subcellular Psychobiology Diagnosis Handbook* (2014) for trauma therapists covers diagnosis and treatment for several intracellular diseases. This paper is dedicated to our inspiring research colleague and close friend, Adam Waisel, MD (Israel), who died of a heart attack in 2006. Please address all correspondence to kirsten@peakstates.com and learn more at PeakStates.com.

disorders of unknown etiology currently considered incurable (dizziness, hearing voices (intrusive thoughts), and Asperger's syndrome). By using prenatal regression and primary cell modeling, we show how the symptoms arise from intracellular pathology and describe simple, fast, and effective trauma psychobiology treatments. This is not just an academic hypothesis; these treatments have been successfully used for over a decade with clients worldwide.

The Subcellular Psychobiology Theory and Disease

Illness or disease is usually assumed to be due to intercellular pathogens, problems with biological pathways identified by lab tests, or structural damage. However, many chronic diseases and mental disorders do not have any of these obvious causes and do not respond well to pharmaceutical treatments. The subcellular psychobiology theory (Lykkegaard et al., 2025) says this conundrum exists because there are unrecognized, more fundamental intracellular biological causes for both diseases of known and unknown etiology. A core principle of the theory is that a disease can only be present in a person because of specific damage or dysfunction in their primary cell(s), and that repairing this intracellular problem results in immediate elimination of symptoms. This means that the real vulnerability to disease is at the intracellular level, not in the more obvious level of easily observed intercellular pathology. We have unknowingly been like the man who dropped his keys in the dark but searches under the streetlight because the light is better there. The theory also says that our immune system is more powerful than we ever imagined, because our concept of what is normal is based on observing a system in internal conflict. Once an intracellular cause is removed, the organism quickly eliminates both symptoms and the corresponding pathology.

From a practical application standpoint, this core principle implies that any disease or disorder can be eliminated using a psychobiology approach (given that the client can successfully use the relevant trauma psychobiology techniques). This includes chronic diseases of unknown etiology, mental disorders, and the more familiar pathogen infections we go to the doctor for. Over the last 20 years, we have successfully applied it to over 50 diseases and disorders, primarily in the area of mental illness (McFetridge, 2014).

Intracellular Pathogens

If we look at psychological client issues for a moment, the majority are simply due to ordinary trauma (generational, biographical, associational, or a mix of the three). However, every serious psychiatric disorder of unknown etiology we have examined has, surprisingly, been directly or indirectly caused by an intracellular pathogen (bacterial, fungal, etc.) living in or on the primary cell (Lykkegaard et al., 2024). Symptoms arise from pathogens in three main ways: 1) direct damage to an intracellular structure (for example, the noxious foreign coating that inhibits mitochondrial gene expression in dizziness, or cell membrane damage that causes pain); 2) indirectly via psychoactive structures formed by the pathogen (for example, the glass tube in Asperger's syndrome); or 3) direct psychoactive interactions, usually via toxins. In this paper, we limit our discussion to disease treatments that do not require pathogen immunity. Fortunately, this still covers a tremendous range of diseases and disorders. We extend the theory to psycho-immunology in a later paper.

Treatment Design

The subcellular psychobiology theory allows researchers to choose a disease or disorder and then design an effective treatment using targeted trauma therapy. The iterative steps below give a simplified design guideline. We then illustrate this design process using three actual diseases of unknown etiology, describing the outcomes of each step and the resulting successful real-world treatments.

1. Find a unique experiential marker. The key to successful psychobiology treatment design is in first finding an experiential psychobiology subcellular marker for the disease or disorder (Lykkegaard et al., 2025). These are kinesthetic, visual, or emotional symptoms that occur in, on, or around the client's body and are a unique indicator of the disease. Markers exist because primary cell damage from the disorder is overlaid onto the client's normal perceptions of their body. Markers allow us to do an accurate differential diagnosis. They also give us a definitive endpoint for treatment; once the marker is fully gone, so is the disorder.
2. Identify the marker biology in the primary cell. This optional step uses the uncommon ability to observe the interior of the primary cell in order

to understand the intracellular biology of the marker. This step can offer unexpected ways to treat symptoms and may reveal unanticipated intracellular interactions that impact treatment safety or effectiveness.

3. Regress to find the moment when the marker sensation first appeared. This shows how and why the developing organism causes the marker to form, generally due to an interaction with a pathogen. This moment usually occurs before conception and takes place for both sperm and egg.
4. Design the treatment. There are several psychobiology treatment approaches, e.g., regression healing, a focus on specific trauma, or direct primary cell interactions. For regression, identify key emotions, sensations, imagery, phrase, kinesthetic, postural, and musical cues. For direct trauma healing, choose the trauma types needed (biographical, generational, body associations) and their associated key feelings. Additionally, for some disorders, one can develop a psychobiology technique to directly eliminate the marker and hence the disorder. The three approaches have tradeoffs between simplicity, time, emotional pain, and completeness in treatment.
5. Test for safety and efficacy (phase 1 and phase 2 clinical trials). This is a critical step because we are dealing with techniques that modify the interior of our cells, rather than just addressing a psychological issue. As in drug testing, if any problems are found, this leads to iteration of the treatment design until the issues no longer arise, or we develop procedures to avoid or address those issues. We also recommend observing the primary cell during phase 1 trials with subjects trained to do so, in order to watch for any unexpected intracellular problems. For more information on testing and safety, please refer to our previous paper (Lykkegaard et al., 2025).

We measure psychobiology treatment outcomes very differently from traditional medicine. As in engineering, we expect a complete, immediate, and permanent removal of symptoms. If we do not get this result, we stop to find out why. We then iterate to optimize the technique further. Since a given disease treatment is the same for everyone, practitioner training, client delivery, and outcome measurements are straightforward. We use a pay-for-results billing model—if the treatment does not work, or only works partially, there is no fee. We expect treatments to work for most clients.

Psychobiology treatment design is a team effort. It requires skills in prenatal regression, extensive experience with trauma therapy techniques, knowledge of intracellular biology, and, for many disorders, a solid medical background at the MD level. It also requires the willingness to repeatedly face rather horrific prenatal traumas, a high tolerance for repeated failure, and much iteration with colleagues. In our experience, a small, experienced research and development (R&D) team typically requires at least a person-month of time (excluding clinical trials) to develop a psychobiology treatment. However, some diseases can take years of effort to work out their underlying biology. Of course, once the difficult R&D is finished, the resulting client treatments are extremely simple.

Example: Treating Dizziness (Vertigo) with Psychobiology (ICD-10 codes R42, H81.0-3)

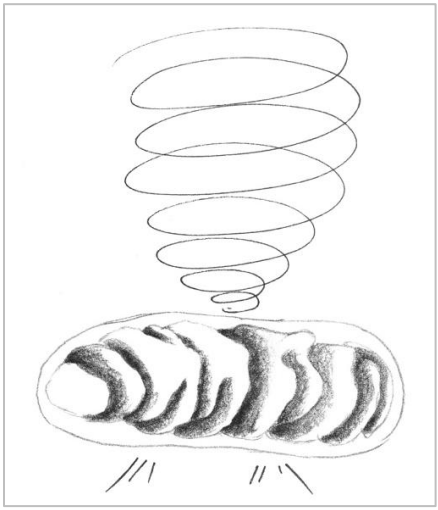
Dizziness, a term referring to the loss of the sense of balance and orientation, is one of the more common reasons adults see a healthcare provider (Wipperman, 2014). In this section, we address the specific form of dizziness known as vertigo, characterized by the sensation that the person or their surroundings are spinning (Della-Morte & Rundek, 2012).

The kinesthetic marker for vertigo is simply the sensation of spinning itself, akin to being caught in a tornado or vortex. If you are in the periphery, you spin. If you are in the center, your surroundings spin. People's awareness gets pulled into this vortex due to various triggers, such as excessive (alcohol) drinking, but it can also happen spontaneously.

The biological cause that we have observed in the primary cell is an actual whirlpool (vortex) in the cytoplasm. It is created by a damaged mitochondrion that continuously sucks cytosol into itself (Figure 1), creating a whirlpool or vortex of fluid. (A healthy mitochondrion will briefly suck in cytosol at its top, then squirt it out again from its bottom, as if it were breathing.) The client feels symptoms because they are experiencing themselves in the vortex of the cytosol. The source of the problem is a noxious foreign coating on an internal free-floating ring structure inside the mitochondrion. That ring structure is almost certainly mitochondrial DNA (Farge & Falkenberg, 2019), whose gene expression is inhibited by the foreign coating. This coating is deposited in an interaction with an intracellular fungal pathogen.

Figure 1

A Sketch of a Vortex Entering a Mitochondrion



Note. A sketch of a mitochondrion creating a vortex by continuously pulling in cytosol. This fluid is squirted out from several small openings in its bottom. (McFetridge, 2014)

Treatment is simple. We have the client kinesthetically go down to the bottom of the vortex cone. This brings them to what feels like the floor of a room (the interior of the affected mitochondrion). Once there, they put their awareness into something that feels damaged and injured on the floor. After about five minutes of accepting the discomfort, the damage dissolves, the mitochondrion is repaired, and the vortex stops. It is simple, fast, and effective. We then have clients search for more vortices to prevent symptom recurrence due to other unhealed mitochondria (Courteau, 2013). Alternatively, we can eliminate all vortices simultaneously by using a regression approach; however, the tradeoff is a slower and more complex technique.

Surprisingly, although there are various medical causes of vertigo, we have so far only observed this mitochondrial mechanism in our clients. In our clinical experience, even clients diagnosed with vestibular vertigo, such as benign paroxysmal positional vertigo (BPPV), have eliminated their dizziness through this process. We do not yet know if other common vestibular diseases with vertigo, such as Ménière's disease, vestibular migraine, or vestibular neuritis, would also respond to this treatment. As the etiology of each of these vestibular disorders is still being debated (Wipperman, 2014), the spinning sensation they

share might be due to mitochondrial vortices. A note of caution: In acute vertigo, it is essential to rule out causes that require urgent treatment, such as stroke (Tehrani et al., 2018).

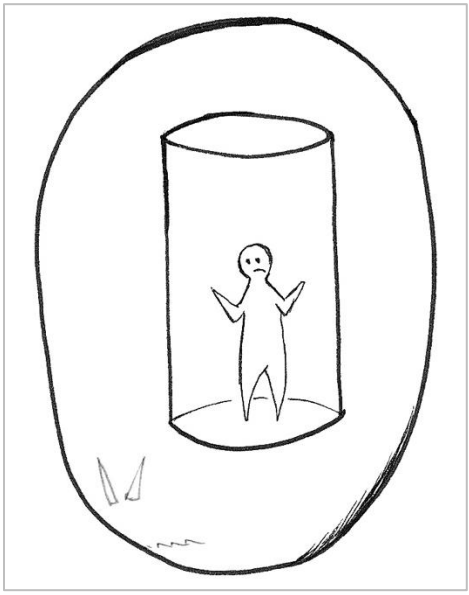
Example: Treating Asperger's Syndrome with Psychobiology (ICD-10 code F84.5)

People with Asperger's struggle to read social cues and have trouble recognizing other people's feelings, making social interactions difficult and exhausting. Among other symptoms, they may also develop an obsessive interest in a single subject and have problems with motor skills (Mirkovic & Gérardin, 2019). Asperger's is classified as a neurodevelopmental disorder that has no cure and is managed through support to address challenges (Motlani et al., 2022). In 2013, DSM-5 merged Asperger's into the autism spectrum disorder (ASD) (American Psychiatric Association, 2013), and the ICD-11 is doing likewise (World Health Organization, 2022). However, in our clinical experience treating clients, Asperger's and autism are completely separate disorders with very different subcellular biology and treatments. In this paper, we will only focus on the biology and treatment of Asperger's syndrome.

The kinesthetic marker was a surprise. People with Asperger's feel they are inside a closed tube of glass, and cannot kinesthetically sense anything in or through it (Figure 2). They think this is normal, as they are born with it. However, they can notice it by using a trick involving the small gap between the glass tube and their body, where they can sense things normally. Have them go through a doorway, or have someone bring a hand towards their body. If the doorway edge or hand suddenly appears in their kinesthetic awareness when it gets close enough, they have the marker. This is in contrast to people without Asperger's who will have a kinesthetic awareness of the doorway edge or hand from far away (no sudden appearance). Note that some people only have half the problem, either on their left or right sides, as if the tube had been cut vertically in half. These people compensate with their uncovered side, and aside from possible difficulty in playing some sports, do not typically exhibit Asperger's symptoms.

Figure 2

A Sketch of the Asperger's Syndrome Kinesthetic Marker



Note. A person with Asperger's syndrome is stuck inside what feels like a glass tube (sealed on all sides, including the top and bottom). The tube is a bacterial covering on a primary cell structure, whose presence is overlaid on the client's everyday perception. (McFetridge, 2014)

The biological cause that we have observed in the primary cell is a bacterial-induced covering on a key structure in the nucleus, which is acquired during an early sperm and egg developmental event. This bacterial covering in the primary cell is perceptually overlaid on the body, causing the affected person to feel emotionally and kinesthetically cut off from the entire outside world.

Treatment takes between 3 and 10 hours and eliminates both the glass tube marker and all Asperger's syndrome symptoms. Trauma healing at the originating event is used to eliminate the underlying damage that causes them to hang on to the bacterial covering. Alternatively, direct trauma healing on the marker can be used. Because the outside world is now accessible, the person will immediately have the full ability to read body language, interpret facial expressions, perceive the height of trees and the blue sky, as well as sense when people pass behind them (without looking or using their hearing). Notice that there is no need for training these abilities; they simply appear and must

therefore be intrinsic to human beings. We have been using this treatment successfully with clients since 2014 (McFetridge, 2014).

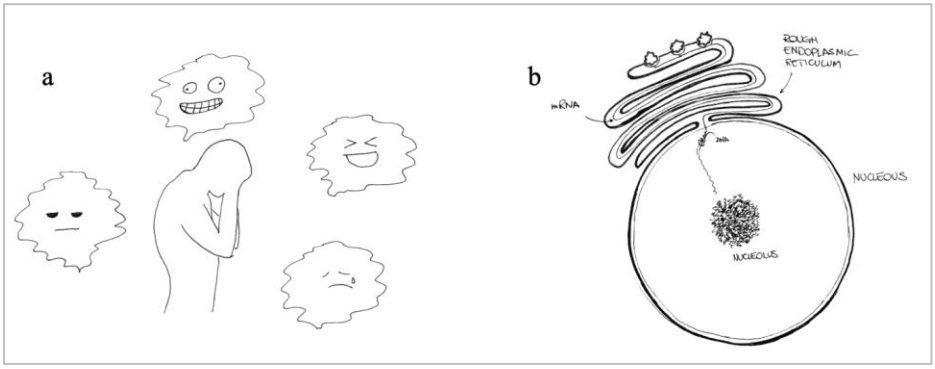
Example: Treating Hearing Voices (Intrusive Thoughts) with Psychobiology (ICD-10 codes R44.0, F42.2)

Surprisingly, mind chatter is a very common spectrum disorder. Intensity can range from mild background thoughts (as one might notice during meditation) to increasingly disruptive forms, variously called intrusive or obsessive thoughts, channeling, auditory hallucinations, or hearing voices. For example, intrusive thoughts are found in 94% of the general population (Radomsky et al., 2014). People generally mistake these voices for their own thoughts, but unlike regular thoughts, these voices do not shut off. In our clinical experience, some people shift from the mild to a more extreme form when an event in life is experienced as life-threatening. For example, it is not uncommon for women to experience unwanted postpartum intrusive thoughts triggered by the birth of their child (Fairbrother & Woody, 2008; Schene et al., 2017).

The kinesthetic marker is simple. Almost everyone can easily identify individual thoughts (or voices) located at fixed points in space (inside or outside their body), each with a specific and unchanging emotional tone (Figure 3a). The biological cause that we have observed in the primary cell for each voice is located inside a ribosome embedded in the rough endoplasmic reticulum (ER) (Figure 3b). People generally locate these *ribosomal voices* outside their body because most people's primary cell ER structure is superimposed onto the space around themselves (Lykkegaard et al., 2025).

Figure 3

A Sketch of Auditory Hallucinations in Space



Note. a) Voices are typically located in space around the client, and each voice has a specific emotional tone. A strong negative emotional tone (such as worry, contempt, or anger) will disturb a person more than a voice with a positive tone, but the biology is the same. b) A schematic of ribosomes stuck in the rough endoplasmic reticulum (ER) due to trauma. A typical person has about 15 ribosomes with voices in them scattered around the ER. (McFetridge, 2014)

Treatment for an individual voice is simple and takes less than 5 minutes. We dissolve the target ribosome using the body association technique (McFetridge, 2017), and the targeted voice disappears immediately. For many people who suffer from this problem, eliminating just the worst 1 to 3 voices is enough to change their lives. Other psychobiology treatment options exist. A slower, more complex treatment targets all the voice ribosomes simultaneously by using regression to the key event when these ribosomes first formed. This disorder is a good example of how an intracellular pathogen can be at the root of the problem. After years of work, we identified a widespread intracellular fungal infection that interacts with the ribosomes to create the voice. Thus, one can also eliminate all voices simultaneously (as well as several other problems that this fungus causes) by getting rid of this pathogen using psycho-immunology (McFetridge, 2017). These psychobiology treatments have had 16 years of successful use with over a thousand clients all over the world. For specific treatment steps, we refer you to our textbook, *Silence the Voices* (McFetridge, 2017).

Conclusion

In this paper, the last in a three-part series, we demonstrate the application of subcellular psychobiology theory in designing treatments for diseases and mental disorders. By giving practical, real-world treatment examples for three diseases of unknown etiology, we illustrated the design procedure and demonstrated that this approach works effectively. We now look forward to other researchers building on this approach and applying it to many other serious, currently untreatable diseases that so many people suffer from. In a future paper, we will extend the theory to psycho-immunology, which will broaden its usefulness even more for treating acute and chronic diseases.

To put this approach in perspective, psychobiology treatments have advantages and disadvantages when compared to medical procedures. There are no drug side effects or invasive surgeries. They can eliminate diseases and disorder symptoms that were previously untreatable. Treatment time is fast (ranging from 1 to 10 hours), and symptoms immediately and permanently disappear in the office. The treatments are simple, the same for everyone, do not require expensive equipment or drugs, and can be done by a single trauma therapist. However, there are also some drawbacks. Not every client is able or willing to feel their emotions or sensations, making the usual trauma techniques useless or only partially effective. Additionally, some disorders (like severe autism, Alzheimer's, coma, psychosis, or traumatic brain injury) leave the client unable to follow instructions. Although there are potential workarounds, treatment becomes far more difficult and time-consuming. Given this, one might envision a hybrid solution that utilizes psychobiology to identify any underlying pathogen, followed by the development of a corresponding pharmaceutical.

On a personal note, this series of papers marks the culmination of a 35-year odyssey to derive and refine the theory. Many talented and dedicated volunteers have donated their time and energy to test the theory's implications and the evolving treatments. Hundreds of therapists have taken our training and eliminated various previously untreatable diseases and disorders in thousands of people. We hope that you have been intrigued or inspired to consider this new approach to understanding health and treating disease.

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The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003 Vol. 39 No. 2 Fall 2025

Christy Turlington Burns and Every Mother Counts: Fifteen Years Advancing Maternal Health

Christiana Rebelle, PhD

In the fifteen years since Every Mother Counts (EMC) was founded, Christy Turlington Burns has become one of the most visible and influential advocates for maternal health, globally and in the United States. What began as a deeply personal experience has grown into an international movement with a mission to make the maternal health journey before, during, and after childbirth safe for everyone, everywhere. "I became a maternal health advocate the day I became a mother," Turlington Burns recalls. "That was the day I also became a statistic." After experiencing a postpartum hemorrhage following the birth of her first child, she discovered that hundreds of thousands of women around the world die each year from similar, preventable complications. Intergenerational awareness also fuels her advocacy, knowing firsthand how the death of a mother reverberates over time in families. She recounts, "My mother's paternal grandmother died in childbirth. Her husband and children never recovered from that loss."

Globally, more than 700 women die each day from complications related to pregnancy, childbirth, and the postpartum period, approximately one woman every two minutes (World Health Organization, WHO, 2025). In the United States, the maternal mortality rate is the highest among high-income countries, with approximately two deaths per day (Centers for Disease Control and Prevention [CDC], 2025). These outcomes disproportionately impact communities of color, especially Black and Indigenous women. A person is more likely to die from complications of pregnancy and childbirth than their mother was a generation ago, which underscores systemic failures in the United

Christiana Rebelle, PhD (ORCID: 0000-0002-2682-2120), is a consultant, writer, editor, and researcher whose work explores health beliefs, provider communication, and disparities in prenatal care. As Editor-in-Chief, Dr. Rebelle is committed to advancing health literacy and expanding *JOPPPAH*'s reach. She is honored to support Every Mother Counts and thanks Christy Turlington Burns for her enduring advocacy. To learn more, visit everymothercounts.org. Send correspondence to journal.editor@birthpsychology.com.

Note. Christy Turlington Burns talks to Naserian Oletiyo in the postnatal ward at the FAME hospital in Tanzania. (Sarah Waiswa, 2024)

States healthcare, despite its high spending (CDC, 2025). EMC is working to change this. As Turlington Burns points out, "Nearly all of these deaths are preventable."

In 2010, following the release of her documentary *No Woman, No Cry*, Turlington Burns launched Every Mother Counts. The organization was established to raise awareness, support community-led initiatives, and advocate for systems change to improve maternal health worldwide. Since then, EMC has invested over $48 million in advocacy, grantmaking, and awareness-raising programs, reaching more than 1.9 million women, families, and healthcare workers (EMC, 2025). "We aim to educate and engage the public so they can be part of the solution," she explains. "We aren't waiting for a cure. We know how to save these lives. It's so clear that women's lives are safer when the resources are there." This clarity of purpose drives EMC's approach, which centers on locally led efforts and prioritizes populations most affected by inequities in care, including Black and Indigenous women, women in rural areas, and displaced individuals. In 2024 alone, EMC supported 49 grantee partner organizations across nine core countries and 16 states. Notably, 96% of grantees in the United States are led by BIPOC women, and 100% serve communities that are uninsured, underinsured, or enrolled in Medicaid (EMC, 2025).

One of EMC's most visible awareness campaigns centers on distance running, an effort that symbolically mirrors the journeys many pregnant

individuals endure to reach care. “In many countries, pregnant women walk an average of 5k for basic care,” says Turlington Burns. “It’s not uncommon to travel 26 miles to reach emergency services, even while in labor.” Running has become a way for EMC supporters to fundraise and spotlight access issues. “Every time I go out for a run, I think about these women,” she says. “Some of whom I may never meet but know I can help.” To date, Team EMC runners have run thousands of miles, raising more than $8.5 million that directly fund maternal health programs (EMC, 2025).

As EMC marks its 15-year milestone, the organization has launched the Endurance Fund, a strategy designed to maintain stability in the face of political unrest, climate-related disasters, and shifting funding landscapes. The Endurance Fund ensures that EMC can continue to support partners on the frontlines, respond quickly to crises, and continue to tell the stories that move people to action. Despite political uncertainty and stalled progress in maternal health, EMC remains resolute. Their model, rooted in partnership, advocacy, and storytelling, demonstrates the power of sustained commitment. “I strongly believe that the life of every mother does count,” Turlington Burns says. “Maternal health is a universal issue that affects each of us. Women who are bringing life into the world deserve access to quality care, and every child deserves a healthy mother to love and protect them.”

The maternal health crisis is daunting, but EMC continues to work towards building a world where maternal health is considered a basic human right. Clinicians, researchers, educators, and policy leaders play a vital role in the next phase. “We want anyone who connects to this issue to join us,” says Turlington Burns. “Our long-term success depends on how deeply our community engages.” EMC offers many opportunities to get involved, ranging from supporting grantees and sharing stories to influencing policy and investing in the next generation of leaders. As Every Mother Counts enters its next chapter, the work ahead remains urgent, but not insurmountable. As the United Nations International Children’s Emergency Fund (UNICEF) notes, “Progress [on maternal health] is possible, but concerted action will be needed” (UNICEF, 2024, para. 3). EMC demonstrates how targeted, community-centered interventions, grounded in both passion and empirical data, can advance maternal health outcomes globally. Turlington Burns remains dedicated to the vision that started it all: “I will do what I am doing as long as the work is needed.”

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The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003 Vol. 39 No. 2 Fall 2025

Review of Wild Mothering: Finding Power, Spirit, and Joy in Birth and Creative Motherhood

By Tami Lynn Kent
Review by Stephanie Cloutman, RN

Tami Lynn Kent's *Wild Mothering: Finding Power, Spirit, and Joy in Birth and Creative Motherhood* (Atria Books/Beyond Words, 2024) presents a comprehensive exploration of motherhood through a feminine-centered spiritual framework, guiding readers toward healing and self-discovery. With her valuable understanding of the connections between a woman's creative essence and the female body, Kent offers a thought-provoking guide for individuals seeking connection to themselves and greater meaning and vitality on the path of motherhood. This book invites mothers to engage in the sacred rhythm of life, death, and rebirth—a dance of receiving and resting, creating and becoming—that nourishes and sustains the path of mothering. *Wild Mothering* is complete with personal and professional stories, alongside a variety of practices and exercises designed to support the well-being of mother, child, and family. It is a heartfelt invitation to embrace motherhood as a dynamic, sacred experience that offers profound opportunities to tap into one's unique potential.

Kent, a holistic healthcare practitioner, has dedicated her career to helping women rediscover their physical and emotional health through innovative practices that engage both the energetic and physical body, specifically the pelvic bowl. As Kent (2024) states, "My practice as a healer has taught me that a woman's creative essence provides her with infinite resources…Mothering and creativity complement one another, energizing rather than depleting as a way of wild mothering" (p. XXVII). She brings her decades of experience

Stephanie Cloutman, RN, BSN, CPN, CLC, is a pediatric nurse and shamanic practitioner who appreciates how the foundation built in early life influences development and future health and well-being. She is passionate about fostering optimal development and is dedicated to implementing high-nurture practices to support a strong foundation for babies and toddlers. Her shamanic work often guides individuals back to early experiences to address the root causes of current life challenges, facilitating understanding and transformation.

working with women to *Wild Mothering*, which reads like a blend of personal narrative, self-help, and spiritual guidance. The result is a book that serves as a soulful guide for mothers to reconnect with their instinctual nature throughout the motherhood journey, thereby nurturing not only their children but also themselves along the way.

The central theme of *Wild Mothering* revolves around what Kent refers to as the *wild feminine*. This concept is rooted in the idea that women can access their full potential and greater capacity to live life creatively and in alignment with what is most meaningful to them through the wisdom that arises from the body. Kent (2024) describes the wild feminine as the deep wellspring of creative energy housed within the female body, especially centered in the pelvic bowl. This ancient, cyclical force transcends societal roles, inviting women to reclaim their innate wisdom, bodily sovereignty, and connection to the natural rhythms of birth and life. Embracing the wild feminine allows mothering to become a sacred, embodied practice rooted in power, creativity, and renewal. However, mothers often encounter barriers in connecting with the wild feminine due to societal conditioning that suppresses their instincts in favor of conformity.

In the book, Kent presents a variety of practices aimed at helping mothers and women connect with the archetype of motherhood or the creative feminine, thereby reconnecting with their instincts and natural rhythms. The text encourages women to reject the notion that they must be perfect, self-sacrificing, or endlessly patient in their roles as mothers. Instead, Kent advocates for a more compassionate approach to motherhood—one that embraces the inherent messiness, complexity, and beauty of the human experience, and the many challenges and opportunities that arise during motherhood.

Kent's background as a physical therapist, coupled with advanced training in multiple bodywork modalities and energetic medicine practices, informs her perspective. With decades of experience working with women, she emphasizes not only the physical aspects of health, but also the energy patterns in the pelvic bowl. She has developed energy medicine practices to support women in healing and thriving. Kent argues that in our modern world, mothers have become disconnected from the natural rhythms of their bodies. By fostering a reconnection with the instinctual self through embodiment practices and engagement with the natural world, women can better align with their intuition and the nurturing energy of the feminine. The book advocated for a return to a

more intuitive, heart-centered approach to parenting, one that eschews rigid rules or external expectations in favor of the inherent wisdom that lies within each woman.

The personal stories Kent shares throughout the text —her own or those of the women she has worked with—offer real-world examples of how mothering can be a transformative experience. Kent skillfully weaves these anecdotes into her broader teachings, making the book feel like an intimate conversation with a wise friend who understands the struggles and triumphs of motherhood, as well as the value of self-compassion on this journey.

A most valuable offering of her work is the way Kent integrates practical advice into her narrative. From tips on nurturing a deep connection with the earth to exercises for cultivating emotional resilience, *Wild Mothering* offers actionable insights that mothers can implement in their daily lives. The book is peppered with prompts for reflection, rituals, and self-care practices designed to help women reconnect with their bodies and their inner wisdom. Whether through nature walks, journaling about one's experience as a mother, or simply taking time to pause and breathe deeply, Kent offers accessible methods for honoring the wild nature within.

Kent boldly confronts the societal pressures that mothers face. In a world where the ideal mother is often expected to be endlessly selfless, always loving, and perpetually calm, *Wild Mothering* offers a counter-narrative. Kent highlights the emotional labor that mothers do behind the scenes, the mental load, the constant juggling, and the invisible work that so often goes unrecognized. By encouraging women to embrace their imperfections and accept the ebbs and flows of motherhood, Kent challenges the pervasive myth of the "perfect mother."

The book also addresses how motherhood can often feel isolating, especially in the face of modern parenting culture, which tends to value achievement over emotional connection. Kent calls for a shift in this paradigm, advocating for a more community-oriented and nurturing approach that supports women in their motherhood journey, rather than expecting them to do it all alone. This aligns with the broader theme of *Wild Mothering*, which encourages women to lean into the collective energy of the feminine and to create a more supportive experience of mothering.

Wild Mothering is an empowering, heartfelt guide with ideas for going deeper and staying connected to your inner wisdom and natural rhythms. Tami Lynn Kent successfully blends practical advice and body-centered practices

with spiritual insight, guiding women to a more connected form of motherhood. Through its embrace of the wild feminine and its advocacy for emotional and spiritual well-being, *Wild Mothering* is a timely reminder that motherhood is not a one-size-fits-all experience. It is, instead, an organic, ever-evolving journey that, when approached with awareness and openness, can be deeply transformative for both mother and child.

Wild Mothering is a must-read for those seeking greater meaning and support to go deeper into their connection with motherhood and the feminine creative essence. It offers a roadmap for anyone looking to reconnect with their inner power, heal from depletion, or rediscover their creative vitality. While rooted in the experience of mothering, the themes extend well beyond biological motherhood to the archetypal aspect of *mother*, and the generative and nurturing aspects of the feminine so often embodied by people, mother or not. People who have connected with the creative, generative, and nurturing feminine essence within themselves, drawing from it to evolve and create in their lives and in the world, may also find great value in this book. At its core, this book is about reclaiming something sacred: one's inner power, intuition, and creative sovereignty. Kent's unique and pioneering voice is a vital contribution to the conversation around women's health and the well-being of women, especially of mothers.

Kent, T. L. (2024). *Wild mothering: Finding power, spirit, and joy in birth and a creative motherhood* (Reissue ed.). Atria Books/Beyond Words.

The Association for Prenatal and Perinatal Psychology and Health
Journal of Prenatal & Perinatal Psychology & Health
ISSN: 1097-8003 Vol. 39 No. 2 Fall 2025

Introducing the Postpartum Call to Action: A Landmark Publication by the Postnatal Support Network

Ekaterina Cuplin, PhD

The Postnatal Support Network is proud to announce the publication of the Postpartum Call to Action "Postpartum: A Critical Window in Women's Health," a landmark international advocacy document that centers the postpartum year as a crucial and too often neglected window in maternal, family, and societal health.

A Living Document Born from Collective Experience

This Call to Action emerged from the *Postnatal rEvolution Summit* (2024–2025), a series of global online and in-person events that brought together over speakers and participants from 25 countries. The Summit created a space for clinicians, researchers, midwives, doulas, mothers, activists, and policymakers to share their lived experiences and insights into postpartum care. Through months of post-Summit reflection, listening sessions, and iterative co-writing, the Call to Action evolved into a collaborative response to the urgent maternal health crisis. It weaves together personal testimonies, scientific research, and systemic analysis into one clear message: postpartum care must be reimagined as a comprehensive, continuous, and culturally safe standard of care.

Key Demands:

- Integrate physical and mental health care for at least one year postpartum

Ekaterina Cupelin, PhD (ORCID: 0009-0004-8873-1381), is a researcher, writer, doula, and postpartum care advocate whose work focuses on maternal health systems, matrescence, and the anthropology of care. She serves as Director and Head of Research at the Postnatal Support Network, based in the Netherlands, and is an Associate Editor at *JOPPPAH.* She is committed to advancing postpartum justice, supporting culturally grounded and trauma-informed care networks, and amplifying the voices of birthworkers and parents in policy and research. To learn more, visit postnatalsupportnetwork.com. Send correspondence to director@postnatalsupportnetwork.com.

- Train healthcare professionals in trauma-informed and culturally responsive support
- Recognize postpartum mental health as a public health priority
- Invest in parental leave policies and flexible work reintegration
- Build local community networks for postpartum support
- Designate research funding for postpartum outcomes and innovations

Why Now?

The urgency of addressing postpartum care cannot be overstated. Maternal deaths in the postpartum period remain unacceptably high, with suicide accounting for up to 26% of maternal deaths (Cresswell et al., 2025; WHO, 2025). Many physical complications remain unaddressed beyond birth (Vogel et al., 2024; Woolhouse, 2012). The invisibility of postpartum challenges in global policies have left mothers isolated and unsupported—emotionally, medically, and economically.

This Call to Action offers a clear path forward. It is both an urgent appeal and an invitation to participate in a global movement for change. To read the entire Call to Action or sign it as a supporter, visit: revolution.postnatalsupportnetwork.com/postpartum-call-to-action

For more information, contact Ekaterina Cupelin at director@postnatalsupportnetwork.com.

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We welcome submissions on a wide range of topics related to prenatal and perinatal psychology and health, including:

Psychological Factors across Conception, Pregnancy, Labor, Birth, and Postpartum: Investigating the psychological dimensions at each stage of the reproductive journey.

Maternal and Fetal Health: Exploring the influence of maternal health, lifestyle, and environmental factors on fetal development.

Childbirth and Perinatal Care: Examining various childbirth practices, models of perinatal care, and their impacts on maternal and infant well-being.

Parent-Child Bonding and Attachment: Studying the early relationship dynamics between parents and infants, including bonding and attachment.

Trauma and Stress during Pregnancy: Analyzing the psychological repercussions of traumatic events or chronic stress on both the pregnant individual and fetal development.

Interventions and Support: Evaluating interventions and support systems aimed at fostering positive mental health and well-being.

Developmental Outcomes: Researching the enduring effects of prenatal and perinatal experiences on child development, behavior, and overall health.

Reciprocal Interaction Mechanisms: Understanding the dynamics between the pregnant individual and unborn child and the birthing person and newborn.

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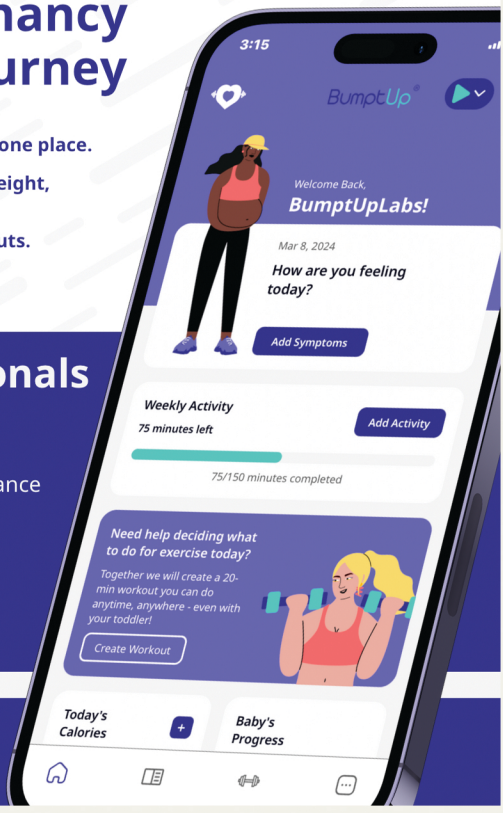

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