Stratified Post-Reproduction: An Analysis of Black Women's Barriers to Postpartum Depression Treatment

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Stratified reproduction is defined as a systemic devaluation of one group's reproductive capacity over another's (Harris & Wolfe, 2014). This article seeks to analyze the effects of stratified reproduction on the experiences of Black women with postpartum depression. Beginning with a thorough analysis of postpartum depression, its prevalence, and its methods of treatment, the article then goes on to evaluate the existing research done on postpartum depression in Black women specifically. After analyzing evidence that indicates higher rates of mental illness among Black mothers, the article examines stratified reproduction, and a new term "stratified post-reproduction" is defined. In comparison, stratified post-reproduction, a term coined by the author, serves to elucidate the ways in which the prioritization of and concentration on white women's post-birth experiences by the medical community at large leads to a lower quality of treatment of non-White women and mothers of other marginalized groups (Primm et al., 2010). This creates a system that increases the rates of postpartum depression among Black women and keeps Black women from seeking post-birth care for this depression. The chapter concludes by offering community-based, feminist, and Black-centered approaches to treating and caring for Black mothers in the period directly after birth. It is important to center Black voices and experiences in conversations about systemic oppression, and thus the article cites research analyzing interviews done with Black mothers and focuses on research conducted by people of color and women.

Keywords

postpartum depression • race • Black • women • Black women • depression • mental health • intersectionality • PPD • postpartum • stratified reproduction

Introduction

In any exploration of a reproduction-related topic in the United States, it is imperative to mention the long and deeply harmful history of stratified reproduction. Simply put, stratified reproduction

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refers to a system wherein the reproductive capacity of a more politically and socially powerful group is valued at a higher level than that of different, less powerful groups. In the United States, this has historically entailed the devaluing and stifling of the reproduction of people of color, as well as those in low-income areas, while emphasizing and prioritizing the reproduction of wealthy White women (Harris & Wolfe, 2014). Efforts to enforce stratified reproduction have included mass sterilization and targeted distribution of birth control to incarcerated individuals, immigrants, and disabled people in order to lower their birth rates (Harris & Wolfe, 2014). Many parts of this system of stratified reproduction continue to be present today in the ways in which medical practitioners and government-controlled systems such as Medicaid operate (Albert et al., 2021; Moniz et al., 2017). Using these concepts of stratified reproduction and reproductive justice, this article seeks to specify the ways in which inequalities in birth prioritization affect post-birth experiences.

Stratified post-reproduction describes a system through which marginalized people are given unjust access to resources to properly care for themselves after birth. In many cases Black women specifically are not provided with education and screening to diagnose their postpartum depression (PPD). However, if they are diagnosed, they may not seek treatment as a result of medical-based trauma or racism. And further, if they do seek treatment, they are often treated poorly by a medical system rooted in racist practices (Moniz et al., 2017). Ultimately, this article will argue that due to the underlying causes of systemic medical racism and general stratified reproduction, Black women experience stratified post-reproduction. Starting with examining the relatively limited data on racial disparities in rates of diagnosis, I then look at rates of treatment-seeking among Black women, disparities in access to diagnoses, reasons for low treatment-seeking, and PPD treatment quality for Black women. I end with a review of alternative solutions that may help more adequately assess the specific needs of Black women with PPD.

PPD Definition and Rates of Diagnosis

Non-psychotic PPD refers to the type of depressive episodes that begin within six months of the delivery of a child and which, if untreated, can persist long term (Miller, 2002). The American Psychiatric Association describes PPD as "emotionally and physically debilitating" ("What is," n.d., Introductory section, para. 6) and characterizes it as lack of interest by mothers in previously enjoyed activities or in the baby itself, depressive thoughts, suicidal ideation, trouble sleeping or lack of energy, "feelings of being a bad mother," or "fear of harming the baby or oneself" ("What is," n.d., Symptoms section). PPD of some kind is relatively common, affecting about 10–20% of women in the United States within a six-month period after birth (Miller, 2002). This high rate of PPD indicates a need for attention and follow-up by medical providers on the health of mothers post-birth.

Although there is little research on racial/ethnic differences in rates of PPD, studies of specific regions have shown that racial minority populations are more likely to experience PPD. In one study based in New York City between 2004 and 2007, Liu and Tronick (2012) found that Asian and Pacific Islander women had the highest rates of PPD, followed by Hispanic and Black women, with White women having the lowest rates. This study concludes that in this instance sociodemographic factors account for higher rates of PPD among Black women. Another study in Wisconsin between 2016 and 2017 determined that "the odds of experiencing PPD were 2.2 times more likely among women who reported experiencing racial bias, compared to those who did not" and stated that "among the women who reported experiencing PPD, . . . , the odds of experiencing racial bias

were 6 times higher for non-Hispanic Black women than other racial/ethnic groups" (Shour et al., 2021, p. 26). According to Shour et al. (2021), "[The Wisconsin] study was consistent with previous results indicating that women – particularly women of color – experience both racial discrimination and PPD at higher rates than their White peers" (p. 28). Considering the higher rates of PPD among women of color, treatment options and follow-up appointments in these groups must be altered to cater to the specific needs of these women, and more research must be done to analyze the best way to offer treatment. Further studies in other areas of the United States are also necessary in order to be able to fully comprehend the extent of these disparities in PPD occurrence.

Despite the fact that these findings are concentrated on specific areas (Wisconsin and New York City) and within specific years (2004–2007 and 2016–2017), the trends found indicate that marginalized women are in fact more likely to experience PPD. There are also limitations to both of these studies because they use Pregnancy Risk Assessment Monitoring System data, which is largely amassed through self-reported information collected by health departments (Shulman et al., 2018). This may lead to false or under-reporting. Nevertheless, this cannot discount the value of this data because of both studies' thorough analyses of social determinants as they relate to PPD outcomes. The patterns in these two studies introduce the ways in which racism affects the mental health of Black women and specifically how systemic bias can lead to higher rates of PPD. Liu and Tronick (2012), as well as Shour et al. (2021), assert that more research is needed to fully determine if there is a causal relationship between anti-Black discrimination and higher rates of postpartum depression and, more broadly, all of the reasons behind these racial/ethnic disparities. Nevertheless, both studies make it clear that there is an emergent trend of research results showing higher rates of PPD among Black women.

PPD Options and Rates of Treatment

Though some trends indicate they have higher rates of PPD, Black women also have lower rates of treatment for PPD (Kozhimannil et al., 2011). Traditional treatment for PPD includes the prescription of antidepressant medication, usually selective serotonin reuptake inhibitors (SSRIs) (Miller, 2002). Therapies are also often considered in the treatment plan, including cognitive behavioral therapy, which seeks to confront negative and intrusive thought patterns, and interpersonal psychotherapy, which seeks to strengthen relationships between couples or between mother and baby (Miller, 2002). Despite the fact that these courses of treatment are largely effective in managing PPD and preventing the disorder from causing long-term health effects to mothers and their babies, Black women have a significantly lower rate of treatment-seeking than White women (Gjerdingen, 2003; Kozhimannil et al., 2011).

One article by Kozhimannil et al. (2011), entitled "Racial and Ethnic Disparities in Postpartum Depression Care Among Low-Income Women," studied the lack of access to PPD treatment for low-income women through an analysis of Medicaid program data for New Jersey women between 2004 and 2007. Among the 29,601 women in the study, around 13,000 women were White and 13,500 were Black. Though the results are geographically specific and cannot be directly applied nationally, the large sample size that was examined suggests that the trends found can be applied as a case study of the larger disparities in PPD care. The study found, for example, that there were "particularly low treatment initiation rates for black women" (Kozhimannil et al., 2011, p. 622). Specifically, low-income White women with PPD in the study had a 9% initiation of treatment

rate, whereas Black women had a rate of 4% (Kozhimannil et al., 2011). Follow-up care was also low for Black women at a rate of 54% in comparison to a rate of 64% for White women. Moreover, only 24% of Black women, versus 28% of White women, were offered continued care (Kozhimannil et al., 2011). Furthermore, Black women who did fill a prescription for antidepressants related to PPD treatment were much less likely to refill the prescription and continue taking the medication (Kozhimannil et al., 2011). This study serves as a microcosm, indicating that though Black women are affected by PPD and may need varied treatment, they are not receiving the help they need. This evidence indicates that disparities do exist between Black and White women in treatment-seeking, alongside rates of PPD in general. Examining why these disparities persist will aid in examining what can be done to provide adequate treatment to Black women dealing with PPD.

Access to Diagnosis and Information for Black Women with PPD

Before treatment-seeking and treatment-continuation rates can continue to be addressed, it is crucial to acknowledge that many Black women do not have the same access to adequate, specialized screening services and/or educational materials regarding PPD diagnosis as White women do (Tandon et al., 2011; Zittel-Palamara et al., 2008). First, there are historical and ongoing disparities in the access to hospitals and healthcare centers for Black communities (Yearby, 2018, pp. 1119, 1121). In "Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism," Yearby (2018) conducts a review of studies on racial segregation as it affects access to healthcare. They found that with an increase in the African American population of an area, there was an increase in closures and relocations of healthcare facilities, a reduction of hospital beds, and an increase in what is termed "physician flight," the movement of healthcare professionals to more affluent and white communities with the closures of facilities (Yearby, 2018, p. 1121). If Black women cannot access a place to receive healthcare, they are inherently restricted from accessing the mental health services or places for diagnosis of PPD that would have been included in those facilities.

Additionally, when they do have access to healthcare facilities, Black women require culturally and racially specific diagnosing processes by medical professionals that cater to how they experience PPD in unique ways that may differ from White women. As a result of Black women's distinctive social positioning, their experience as mothers with PPD may be different from that of other racial groups. Stratified post-reproduction is set up to support White women's reproductive capacity in the United States, so it is not surprising that post-birth care is also set up to tend to the needs of White women without seeking to address the specific experiences of other racial groups. In their article, "Stratified Reproduction, Family Planning Care and the Double Edge of History," Lisa Harris and Taida Wolfe (2014) write:

> Reproductive injustices persist, and are tied to particular women's social, political and economic marginalization and relative vulnerability in the face of dominant medical, legal, social and political structures. Achieving reproductive justice, and generating an unstratified experience of reproduction, requires grappling with the ways in which identity, social position and power intersect to produce reproductive experience and reproductive healthcare.
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> (p. 543)

In the medical field, then, it is imperative that the diagnosing and screening systems for PPD not be standardized across racial groups in such a way that experiences and histories are homogenized and the specific needs of Black women and other women of color are ignored.

In one qualitative study, "Postpartum Depression Among African-American Women," Linda Clark Amankwaa (2003) found six distinct themes that differentiate the experience of Black women with PPD from that of other groups: "stressing out," "feeling down," "losing it," "seeking help," "feeling better," and "dealing with it" (p. 301). This is among the first studies to conduct in-depth interviews to discern the experience of PPD from the point of view of Black women specifically. These six themes showed trends among the women of feeling as though they had to survive without help and under conditions of severe and long-lasting distress (Amankwaa, 2003). There were also patterns of self-talk in the women's experiences in which they labeled themselves as "weak" or fundamentally flawed for struggling with symptoms of PPD (Amankwaa, 2003, p. 305). This shame or embarrassment is described in the article as a product of the stereotype of the strong Black matriarch that can infiltrate Black women's conceptions of themselves (Amankwaa, 2003). Amankwaa (2003) found that "it seems that African American mothers are reluctant to expose any frailty, thus making it difficult for professionals to provide adequate diagnosis and treatment. Findings of this study may assist mental health clinicians to sensitively assess African-American women for PPD" (p. 314). These feelings are associated with systemic racism specific to the Black experience, which affected how the women in this study dealt with PPD. A medical professional without this kind of knowledge might not diagnose these women with PPD if they did not know what unique symptoms and experiences to look for.

These findings help to emphasize the importance of deconstructing our system of stratified post-reproduction. The devaluing of the post-birth process in Black women and the medical system's lack of understanding and research regarding the Black experience with PPD are continuations of the racism inherent in historically stratified reproduction in the United States. This example of stratified post-reproduction gives us one of many reasons why Black women are often not diagnosed with PPD and don't know that they have it. Clinicians may not diagnose PPD in Black women if they are not aware of their specific experiences with it and how the disorder might present itself.

Furthermore, a recent National Public Radio (NPR) article entitled "Black Mothers Get Less Treatment for Their Postpartum Depression" suggests that the language regarding PPD and mental illness in general may be contributing to lower rates of diagnoses in Black women (Feldman & Pattani, 2019). This piece introduces mental health specialist Alfiee Breland-Noble, an associate professor of psychiatry at Georgetown University Medical Center, and their work to understand the disparities in treatment for women of color. According to Breland-Noble, the resources currently set up to screen for PPD "were developed based on mostly white research participants" (Feldman & Pattani, 2019, Screening tools are not one-size-fits-all section, para. 2). However, Black women may have different ways of communicating their symptoms or even experiencing those symptoms that may not be caught by this kind of screening. For example, Breland-Noble states, "African Americans are less likely to use the term depression, but they may say they don't feel like themselves" (Feldman & Pattani, 2019, Screening tools are not one-size-fits-all section, para. 3). Additionally, the research detailed in the article demonstrates that Black women, along with members of other marginalized groups, are more likely to experience physical symptoms as outward demonstrations of their mental illnesses (Feldman & Pattani, 2019). The availability of information like this and the continued lack of support for screening for PPD in Black women suggest that

the system of stratified post-reproduction is still in many ways ingrained in the medical system in the United States. Changing diagnosis practices to include the symptoms and experiences of Black women, or at least seeking to acknowledge the ways in which current screening methods fall short, is imperative. Without these adjustments Black women will continue to seek treatment at lower rates because they are unaware that they have PPD.

It is crucial that primary care providers and physicians ensure that their patients, regardless of race, have access to education and adequate screening tools to assess their mental health in the postpartum period. A study by Tandon et al. (2011) analyzing "three screening tools to identify perinatal depression among low-income African American women" found that the women studied had high rates of PPD (28.4% of the sample) that could be better analyzed with more sensitive use of screening tools (p. 155). Though the use of un-modified screening tools may sometimes be useful to detect PPD, especially in non-Black women, Tandon et al. (2011) argue that "practitioners should consider using lower cutoff scores than those recommended by screening tool developers to most effectively identify low-income African American women in need of depression treatment" (p. 8). This would mean modifying the screening tools already available to make them even more likely to catch symptoms of PPD in Black women. These recommendations should be followed by healthcare workers to ensure that there are sensitive and appropriate diagnoses of PPD, especially in a population where it is so prevalent. The lowered sensitivity present currently in these tools does not adequately account for the differences in Black women's experiences with PPD.

Likewise, a survey of marginalized women in California by Declercq et al. (2022) indicates that just being asked by a physician about mental health and emotional states postpartum contributes to higher levels of treatment. Specifically, "being asked about depressive symptoms was very strongly related to receiving counseling. Women with depressive symptoms who reported being asked about their feelings of depression were almost 6 times more likely to report receiving counseling" (Declercq et al., 2022, p. 138). Providing access to postpartum mental health resources in healthcare settings is one way to encourage more women of color and marginalized women to seek further screening. It is clear that providers need to make adjustments to ensure more Black women are given sensitive and accurate diagnoses regarding their PPD.

Treatment-Seeking for Black Women with PPD

Beyond the struggles of Black women to be diagnosed with PPD, there are also difficulties in treatment-seeking that cause them to avoid counseling even if they know they are battling mental illness. These difficulties vary, demonstrating the ways that racism and stratified post-reproduction are pervasive in the entirety of the medical system. Many Black women do not seek medical support as a result of medical-based trauma (Markin & Coleman, 2021), stereotypes about Black women that infiltrate their self-perceptions and everyday lives (Amankwaa, 2003), and legitimate fear of having their children taken away by child welfare workers ("Child Welfare," 2021). These are just a few key factors among many that prevent Black women from seeking treatment, but they are worth examining in order to fight the system of stratified post-reproduction.

The issue of medical-based trauma for Black women is one that spans the entire history of the United States because of the ways in which racism is structurally embedded in the U.S. healthcare system (Hardeman et al., 2016). Black women have historically faced rape, forced sterilization, experimentation without consent, and various other violations by healthcare professionals

(Harris & Wolfe, 2014). Having learned of any these wrongdoings by supposed medical professionals or others, a Black woman might understandably feel uncomfortable or fearful about seeking medical care. Now, stories about medical racism often involve the experiences of Black women in childbirth. A paper for the American Psychological Association by Markin and Coleman (2021) asserts:

> Black women, as a cohort, are at risk of experiencing childbirth as a traumatic event and subsequently developing posttraumatic stress reactions, largely because of negative interactions and communications with medical professionals and systems during childbirth that are characterized by the simultaneous experience of both racism and sexism.
>
> (p. 2)

Black women are more likely than other groups to have serious complications in childbirth and leave with post-traumatic stress responses as a result of implicit and explicit biases by medical providers (Markin & Coleman, 2021). It is not hard to imagine why they might not feel comfortable leaving their newborn child at home and returning to the hospital, the site of their traumatic birth experience, only to be forced to deal with discrimination once again in a postpartum medical setting.

Beyond the hospital, there are also barriers to treatment in supportive community environments, such as support groups. According to a study by Chan et al. (2020), Black women face higher barriers to accessing community-based care. They conclude that "discriminatory processes and racial biases at the institutional, departmental, or provider level may account for the higher rate of hospital-based care for Black women compared with other groups of minority women" (Chan et al., 2020, p. 227). The study, which sampled close to one million women in California, found that physicians are most likely to refer Black women to psychiatric facilities or inpatient hospital care rather than community-oriented solutions (Chan et al., 2020). Community-based or outpatient care solutions normally provide an alternative to overly medicalized environments or separation from an infant (Chan et al., 2020). Chan et al. (2020) also assert that the reason for this discrepancy in solution recommendations between White and Black women is a result of structural racism and inequality. Alternatives to inpatient hospitalization could entail home visits with other people who have experienced PPD or services to manage mental health in general, such as breathing or meditation classes (Nguyen, 2017). As Chan et al. (2020) note, psychiatric hospitalization should be considered a last resort, especially since there are potentially negative health outcomes related to mother–child separation. However, the higher rates of inpatient hospitalization for Black women indicate that there may be barriers to accessing community-based solutions (Chan et al., 2020). In these cases, women may be discouraged, fearing that if they go to these institutions, they will be victims of further abuse, cause harm to themselves and their baby, or re-expose themselves to the place of their birthing trauma (Chan et al., 2020; Markin & Coleman, 2021). This once again demonstrates the lack of attention and value placed on Black women's experiences after birth, which can lead to treatment avoidance and potential worsening of PPD.

Besides trauma that may come from medical settings during birth or dealing with institutionalized racism on a daily basis, there is evidence to suggest that some Black women internalize the stereotypes held against them. They may be subject to negative thought patterns that can contribute to both their PPD and lack of treatment-seeking. A qualitative systematic review of PPD

help-seeking barriers by Dennis and Chung-Lee (2006) synthesizes different internal barriers for marginalized women as a result of external discrimination and abuse. Black women, who are often not trusted or believed when it comes to their own pain, may not believe they are worthy of seeking out the care they deserve (Morais et al., 2022). Some women of color may view their emotional issues as unimportant compared to their expected role as childcare providers and thus not communicate these problems (Dennis & Chung-Lee, 2006). Others may simply believe that they must be strong and deal with it instead of doing what they view as admitting weakness by discussing their symptoms with someone (Dennis & Chung-Lee, 2006).

Amankwaa's qualitative study (2003), mentioned in the previous section, further describes the existence of an internal dialogue experienced by Black women battling negative stereotypes. Just as it is important for medical professionals to understand Black experiences with these stereotypes, it is important to work toward dismantling these stereotypes altogether. These harmful images may stop women from seeking treatment as well as inhibiting the process of their diagnosis with PPD. In her study on African American women and PPD, Amankwaa (2003) notes that the perpetuation of the idea of the strong woman by family members and the idea of the idealized matriarch by the mainstream media sometimes causes Black women to associate asking for help with weakness. Within the group Amankwaa (2003) assessed she found that "the idea of being a 'Strong Black Woman' may have hindered some of the participants from getting the treatment that they needed. In other cases, it may have prevented mothers from accepting the diagnosis of depression as legitimate" (p. 310). These stereotypes that infiltrate all areas of public life in the United States stop women from seeking treatment even when they are given education to be able to self-diagnose or seek diagnosis (Amankwaa, 2003). Attention to these potential barriers to treatment is crucial in dismantling the system of stratified post-reproduction and placing more value on the lives and birth experiences of Black women.

Another key reason Black women do not seek out treatment for PPD is that they are afraid, often legitimately so, that they will be deemed unfit mothers and have their children taken away from them (Dennis & Chung-Lee, 2006). An article by the Child Welfare Information Gateway (2021) addresses the "racial disproportionality and disparity in child welfare" (p. 1). The review puts together several research projects that confirm that Black families are more likely to be suspected of mistreatment of children and more likely to be investigated by child protective services ("Child Welfare," 2021). It is estimated that while about 37% of all children are investigated by Child Protective Services, Black children are investigated at a rate of 53% (Kim et al., 2017). These investigation cases are also more likely to be confirmed, and Black children are more likely to be in and stay in foster care ("Child Welfare," 2021). Overall, the article states that while Black children make up "roughly 14 percent of the child population," they make up "23 percent of the foster care population" ("Child Welfare," 2021, p. 3). The reasons stated for these unequal rates are overwhelmingly related to structural and institutional racism and bias by caseworkers and reporters ("Child Welfare," 2021). Black women, being aware of these disproportionate rates, may become afraid that if they reveal any sign of trouble, they will be investigated. They are not wrong to worry. Black children are being removed from their families mostly due to systemic racism at high rates. Black mothers may feel that they are prioritizing the well-being and safety of their children by not disclosing their mental illness, rather than seeking treatment for themselves. This is another example of stratified post-reproduction because it demonstrates the ways in which state-sponsored discrimination (in this case with the child welfare service) works to devalue the post-birth experience for Black women. This prejudice may create barriers to their access to treatment and prevent them from

comfortably raising their kids. In a society that does not value the reproductive capacity of Black women, it is no surprise that their capacity as mothers is not valued postpartum.

Generally, Black women in the United States are subject to both higher rates of PPD and lower ability to access care. This perfectly represents the lack of attention and respect given to the rights of these women to care for themselves and their families before and after they give birth.

Poor Treatment Quality for Black Women with PPD

Nevertheless, there are Black women who despite all of these barriers to diagnosis and access to treatment find resources to help them recover from PPD. However, they may face another consequence of stratified post-reproduction: the treatments offered to Black women with PPD are often riddled with bias and a lack of culturally sensitive care. The history of psychotherapy in general has been dominated by White-centric views of psychological well-being. In *The International Handbook of Black Community Mental Health*, Joseph L. White (2020) writes about the model upon which modern psychology is built. White (2020) explains:

> The deficit model of psychology was the predominant lens/model in which white traditional "worldview" psychology interpreted and viewed Black people and our culture. The deficit model suggested that African-Americans were somehow deficient/inferior to whites with respect to intelligence, various abilities, family structure, and other factors.
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> (p. xxix)

This basis for psychological thinking was created by White men who carried deeply racist ideologies and held that Black people are abnormal and deficient. White (2020) advocates for a multicultural model of psychology, which, he says, "assume[s] that all cultures have strengths and limitations and rather than being viewed as deficient" (p. xxx). However, historically and currently this is not the method with which most counselors operate. Black women experiencing PPD, thus, often do not receive the specialized care they deserve. The treatment options that work for White women suffering from PPD may not work for Black women. In fact, the study by Shour et al. (2021) mentioned previously also indicates that there are measures for treatment and counseling of Black women with PPD that are underutilized but often more effective than those used for White women. Their study found that since Black women generally experience worse maternal mental health as a result of racial discrimination, "programs should be designed and implemented to decrease the frequency of racial prejudices and discrimination and to mitigate adverse maternal mental health effects within communities when such racial prejudices occur" (Shour et al, 2021, p. 28). These programs are not yet in place however, and Black women are not often approached by psychologists utilizing the "holistic approach" that this article recommends. Shour et al. (2021) assert:

> There is the need to invest in culturally sensitive interventions in the form of social support that could promote positive coping methods to deal with racial bias. The use of support systems and racial identity development may be an uplifting coping mechanism to reinforce positive psychological self image, especially in African American women experiencing PPD.
>
> (p. 28)

Black women benefit from counseling that includes prayer and spirituality at higher rates than White women, as well as treatment plans that

> [i]nclude leaning on the shoulders of and drawing strength from African American ancestors to sustain a positive self-image, relying on social support mechanisms, avoiding contact with certain situations, and directly challenging the source of the problem using pacific or de-escalation means.
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> (Shour et al., 2021, p. 30)

If the findings of these studies fail to be incorporated into treatment practices, more Black women suffering from PPD will be victims of discriminatory systems that center the White experience. These systems do not account for Black women's unique experiences dealing with the intersections of their identities and thus exemplify a challenge to receiving adequate treatment. White-centered programs further demonstrate how, even after birth, White maternal health is valued over Black maternal health. Methods of stratified post-reproduction – including the extension of stigma against Black mothers to the postpartum period – have created a system that does not typically do its job to support Black women. The odds are stacked against Black women in terms of diagnosis of PPD, treatment-seeking, and the lack of culturally sensitive treatment itself.

Discussion: Treatment Solutions that Address the Needs of Black Women with PPD

It is imperative to view the myriad problems in PPD healthcare in the context of possible solutions. These solutions promote the dismantling of oppressive systems that account for the higher rates of PPD among Black women, alongside the lower rates of treatment-seeking. Recently, more research has been conducted, especially by people of color, to find better counseling systems that can help lessen the barriers to getting much-needed mental health support.

One treatment recommendation is the feminist approach to postpartum care (Davis-Gage et al., 2010). This approach takes into account culturally specific experiences and the benefits of taking advantage of cultural and community centers and resources in counseling for PPD. The authors suggest that "a feminist counseling approach enables the clinician and the client to examine [systems of marginalization] collaboratively and to assess the effect of contextual and oppressive conditions on women's psychological health" (Davis-Gage et al., 2010, p. 125). The article entitled "Developmental Transition of Motherhood: Treating Postpartum Depression Using a Feminist Approach" describes this approach to treatment as focusing on the individual experience of each woman. It suggests a method of social support for "multiethnic women" that is reminiscent of White's multicultural model for therapy described earlier (Davis-Gage et al. 2021, p. 119; White, 2020). Though this is a relatively new concept introduced to the field of treatment for PPD, it is an approach that may help center Black women in their experiences and adapt to their specific needs.

Another list of recommendations for mental health providers was compiled by Keefe et al. (2016), based on first-person accounts of Black and Latina mothers who experienced PPD. The most commonly stated suggestions by these women were:

> For professionals to develop strong therapeutic alliances by (1) conveying knowledge and understanding of postpartum depression; (2) listening carefully to the mothers'

> concerns and empathizing with them; (3) offering validation and reassurance that the mothers' symptoms would improve; (4) providing emotional support; (5) building trusting relationships; and (6) establishing more services that are accessible, have flexible appointment times, and are parent- and child-friendly.
>
> (Keefe et al., 2016, p. 505)

> These women express a desire for stronger counseling relationships that revolve around the individual experience and listening. This may serve to counter stratified post-reproduction by centering and valuing marginalized women's experiences and incorporating them into support system models. Similarly, Watson et al. (2018) suggest that participating in CenteringPregnancy, a program that focuses on social support and group sessions, may aid in decreasing PPD in Black women. Results of their study analyzing the effectiveness of this program in Black women indicate that there is more success with this program over traditional forms of care for PPD (Watson et al., 2018). Pao et al. (2018) also found that, though social support does have a "strong positive association against PPD" (p. 111), Black populations have less access to it. These programs that are more community-based could help decrease the likelihood of bringing up post-traumatic stress due to difficult birthing experiences and medical trauma in general because they would likely be separate from overly medicalized settings. And if they included a strong focus on education, they could increase the availability of self- and professional diagnosis.

These suggestions demonstrate the need for future implementation of PPD treatment that is culturally sensitive and positively supports and caters to the needs of Black women. These recommendations seek to dismantle the current system of stratified post-reproduction that places more value on the White after-birth experience. They place emphasis on respecting Black women and their individuality in an effort to empower these mothers. It may finally allow them to seek the help that they deserve but have not always been granted access to. Hopefully in the future, these new procedures for care, among others, will allow us to rectify the significant disparities in the rates of Black women having PPD and seeking services to treat it.

Conclusion

Dismantling stratified post-reproduction is imperative to achieving equal access to resources to treat PPD. Black women experience higher rates of PPD compared to other racial groups and have lower rates of treatment-seeking. These disparities and others that have been enumerated in this article are due to the systemic mistreatment of Black women and structural racism. Physicians and psychology experts need to be made aware of these disparities and trained in the specific needs of Black women in the diagnosis and treatment of PPD. Moreover, new and better systems of social and community-based care should be implemented and advertised to Black women so that their post-reproductive health is supported.

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