Review Article

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Childbirth-related posttraumatic stress disorder and racial-ethnic disparities: a literature review

Transtorno de estresse pós traumático relacionado ao parto e disparidades etnico-raciais: uma revisão da literatura

Trastorno de estrés postraumático relacionado con el parto y las disparidades raciales y étnicas: revisión de la literatura

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ABSTRACT:

Childbirth-related post-traumatic stress disorder is a condition in which post-traumatic symptoms develop as a result of a traumatic birthing experience. The likelihood of developing childbirth-related PTSD is heavily dependent on subjective birthing experience, of which quality of interaction with healthcare providers has significant influence on. Racial-ethnic minority women face a particularly high risk of developing childbirth-related PTSD. The present review analyzes existing literature on racial-ethnic disparities in childbirth-related PTSD in order to provide a framework to discuss the impact of racial-ethnic background on subjective birthing experience, as well as its influence on the quality of interaction with healthcare providers. Literature findings indicate that racial-ethnic minority women often report poor quality of interaction with healthcare workers during childbirth, citing poor pain management, communication issues, verbal mistreatment that may include racially-insensitive commentary, and infringements upon autonomy. Certain stereotypes related to racial-ethnic minority women's pain tolerances, intelligence, and conduct may sway healthcare providers' decisions regarding pain medication management and joint patient-provider decision-making and communication. Despite the important negative implication of these factors, several steps can be taken to reduce their impact, such as culturally-sensitive prenatal treatment and trauma-informed intrapartum care.

Keywords: stress disorders, post-traumatic, ethnic and racial minorities, labor obstetric, childbirth-related PTSD, PTSD

RESUMO:

Transtorno de Estresse Pós-Traumático (TEPT) relacionado ao parto é uma condição na qual sintomas pós-traumáticos se desenvolvem como resultado de uma experiência traumática de parto. A probabilidade de desenvolver TEPT relacionado ao parto é fortemente dependente de uma experiência de parto subjetiva, na qual a qualidade da interação com os profissionais de saúde tem grande influência. Particularmente, mulheres de minorias étnico-raciais enfrentam um alto risco de desenvolvimento de TEPT relacionado ao parto. A presente revisão analisa a literatura existente sobre disparidades étnico-raciais, com o objetivo de fornecer uma estrutura para discutir o impacto do contexto étnico-racial na experiência subjetiva do parto, bem como a influência na qualidade da interação com profissionais de saúde. Achados literários indicam que mulheres de minorias étnico-raciais frequentemente relatam interações de baixa

qualidade com profissionais de saúde durante o parto, citando manejo inadequado da dor, problemas de comunicação, abusos verbais, que podem incluir comentários racistas, e violações da autonomia. Certos estereótipos relacionados à tolerância à dor, à inteligência e ao comportamento de mulheres de minorias étnico-raciais podem influenciar a decisão de profissionais de saúde quanto ao manejo medicamentoso da dor, bem como a tomada de decisão e a comunicação conjunta entre paciente e profissional. Apesar das importantes implicações negativas desses fatores, várias medidas podem ser tomadas para reduzir seu impacto, como um tratamento culturalmente sensível no pré-natal e prática informada sobre trauma no cuidado intraparto.

Palavras-chave: transtornos de estresse pós-traumáticos, minorias étnicas e raciais, trabalho de parto, TEPT

RESUMEN:
El trastorno de estrés postraumático (TEPT) en el postparto es una condición en la que se desarrollan síntomas postraumáticos debido a una experiencia traumática de parto. La probabilidad de desarrollar TEPT en el posparto depende en gran medida de la experiencia subjetiva del parto, en la cual la calidad de la interacción con los profesionales de la salud tiene una influencia significativa. Las mujeres en minorías raciales y étnicas enfrentan un riesgo particularmente alto de desarrollar TEPT en el posparto. La presente revisión analiza la literatura existente sobre las disparidades raciales y étnicas en el TEPT en el posparto con el fin de proporcionar discutir el impacto del origen racial y étnico en la experiencia subjetiva del parto, así como su influencia en la calidad de la interacción con los profesionales de la salud. Los hallazgos de la literatura indican que las mujeres de minorías raciales y étnicas a menudo reportan una mala calidad de interacción con los profesionales de la salud durante el parto, citando un manejo deficiente del dolor, problemas de comunicación, maltrato verbal que puede incluir comentarios racialmente insensibles y vulneraciones de la autonomía. Ciertos estereotipos relacionados con la tolerancia al dolor, la inteligencia y la conducta de las mujeres de minorías raciales y étnicas pueden influir en las decisiones de los profesionales de la salud con respecto al manejo analgésico,la toma de decisiones y, comunicación conjunta entre paciente y profesional de la salud. A pesar de la importante implicación negativa de estos factores, se pueden tomar varias medidas para reducir su impacto, como un tratamiento prenatal culturalmente informado y una atención intraparto que tenga en cuenta el trauma emocional secundario.

Palabras clave: trastornos por estrés pós-traumático, minorías étnicas y raciales, trabajo de parto, TEPT

Introduction

Post-traumatic stress disorder (PTSD) is a complex psychiatric condition that occurs in response to exposure to a traumatic event. It manifests in a diverse array of symptoms, such as the onset of intrusive thoughts, emotional reactivity, avoidant behavior, and cognitive changes [1]. Due to this relevant and abundant symptomatology, it can lead to chronic impairment and elevated risk of comorbid psychiatric illnesses, including susceptibility to suicide. Childbirth-related PTSD is a psychiatric condition that entails the development of PTSD symptoms following a traumatic birthing experience [2].

Technological advances in the twentieth century saw to the medicalization of the birthing process, shifting childbirth from a largely domestic and female-oriented process [3] to almost exclusively occurring in hospital settings and aided with drug, instrumental, and operative interventions [4]. While that approach has brought about important decreases in maternal mortality rate, [5], the perception of childbirth as a medical condition grants significant authority to healthcare providers, with the potential to violate the autonomy of women in active labor [6]. For instance, interventions such as recumbent positioning, induced labor, and cesarean sections have the potential to exacerbate general psychological distress if implemented in a coercive way[7]. Combined with the acute physical pain characteristic of childbirth, these factors contribute to an environment in which childbirth can be perceived as potentially traumatic.

Moreover, medicalized childbirth has the potential to be particularly traumatic for racial-ethnic minority women. The term “medical racism” is sometimes utilized to describe the biases and discrimination that may impact the quality of medical care received by racial-ethnic minority patients [8]. Similarly, the term “obstetric racism” refers to situations where gender-based and racial-ethnic discrimination intermingle and impact treatment decisions in the fields of pregnancy, labor, delivery, and postpartum care [9].

The present paper aims to review existing literature on childbirth-related PTSD symptoms in racial-ethnic minorities to discuss racial-ethnic disparities in symptom endorsement, risk factors, and outcomes.

Methods

A literature search was conducted on PubMed database and Google Scholar with the following terms: maternal trauma, childbirth trauma, childbirth posttraumatic stress disorder, obstetric racism, obstetric trauma, childbirth trauma, women of color, black women, latina women, and hispanic women. The inclusion criteria for article selection were articles written in English that involved women of childbearing age and focused on racial and ethnic disparities in obstetric care, psychosocial risk factors, or outcomes related to childbirth trauma. All study designs were included, such as observational, qualitative, review articles, literature reviews, and meta-analyses.

Childbirth Trauma

Childbirth-related PTSD annually impacts more than six million mothers worldwide [2]. Risk factors for developing childbirth-related PTSD include previous traumas, pre-existing psychiatric conditions, and emergency or unplanned interventions such as cesarean sections [10], as well as poor social support, poor coping skills, experiencing "threatened death" and "actual or threatened injury to the baby"[11], and contextual stressors such as food insecurity, everyday discrimination and violence to self or to loved ones [12]. However, subjective birthing experience is largely regarded as particularly detrimental among risk factors for childbirth-related PTSD development [2, 13 - 14]. Subjective birthing experience is dependent on several elements such as prepartum fear of childbirth, primiparity [15], and modus of birth [16].

Childbirth-related PTSD meets Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria when the birth experience fulfills the definition of a traumatic event by involving exposure to actual or perceived threat to life or physical integrity of the mother or the infant (criterion A), followed by the emergence of at least one intrusion symptom related to the event, accompanied by avoidance, negative mood or cognitive changes, and hyperarousal symptoms. These symptoms may seem as distressing recollections of the birth, avoidance of medical settings, guilt or emotional detachment, and hypervigilance or irritability. They must persist for more than a month and cause significant clinical distress or impairment while not being related to medical conditions or substances [1].

The quality of interaction with healthcare providers during labor has a significant influence upon the subjective birthing experience, and is a substantial determinant of the likelihood of subsequent PTSD development [17 - 18]. Healthcare providers engaging in positive communication,

prioritizing patient autonomy and joint decision-making with patients during the birthing process, are associated with actively reducing the risk of developing childbirth-related PTSD [15, 19]. In turn, perceived poor quality of interaction with healthcare providers during labor, characterized by communication issues, perceived discrimination, coercive language and behavior, and physical force [20 - 21], is associated with heightened likelihood of childbirth-related PTSD development [22].

Overall, existing data demonstrate that subjective birthing experience is one of the most important determinants of childbirth-related PTSD development [10]. When racial and ethnic minorities face reduced autonomy, discriminatory treatment in perinatal care, and inadequate communication during labor, their risk of trauma increases significantly. Understanding these dynamics requires analysis of how they develop across racial and ethnic groups.

Racial-Ethnic Aspects of Childbirth Trauma and PTSD Development
Racial-ethnic minority women are more likely to endorse PTSD symptoms following childbirth [23]. Black and Hispanic women in particular are more likely than White women to experience perceived racial-ethnic discrimination while hospitalized for childbirth [20]. These factors illustrate how childbirth trauma can be shaped by broader sociocultural and institutional dynamics. Examining how these mechanisms operate across ethnic groups is essential to understand how childbirth-related PTSD affects minority women and how symptom patterns emerge differently across populations, providing a foundation for future interventions that can effectively address these disparities.

Black women experience childbirth-related PTSD at a higher rate than all other racial-ethnic groups [24]. This population is also more at risk of lifetime violence, such as: discrimination, interpersonal violence, witnessing violence to others, sexual violence, being victim of assault, and presents with the highest levels of symptom severity for total PTSD symptoms and across all dimensions except for dysphoric arousal [12]. Latina women, when with high contextual stress class (i.e, food insecurity and everyday discrimination), had greater PTSD severity than black women but lower re-experiencing severity when under the same psychosocial stressor [12]. No relevant data was found about other minorities such as Asian Americans and Native Americans, indicating a need for more research on these underrepresented populations.

Quality of interaction with healthcare providers plays a crucial role in the subjective perception of one's birthing experience and, in turn, the development of childbirth-related PTSD. Racial-ethnic minority women frequently report a negative quality of interaction with healthcare providers during hospitalization for childbirth, citing an array of treatment decisions and disparities that are indications of potential obstetric racism [25, 26, 27, 28, 29].

There are significant racial-ethnic disparities in childbirth-related and postpartum pain management, with Black, Hispanic, and multiracial women being less likely to receive pain medication than White women [25, 26]. In a study involving semi-structured interviews with racial-ethnic minority women, a Black participant reported being repeatedly refused pain medication by a nurse following a cesarean section [27]. Nonetheless, an Asian participant in the same study reported being coerced into receiving an epidural due to repeated pressure from a nurse who claimed that she was not physically capable of handling the pain of childbirth [27].

Racial-ethnic minority women are often subjected to verbal and communicative mistreatment while in labor. Black women sometimes report being ignored and chastised by healthcare providers [17], such as being told that they were making too much noise while in pain [28], as well as feeling as though providers ignored their inquiries due to a perceived lack of intellect [27]. Similarly, Asian women hospitalized for childbirth reported receiving degrading commentary from healthcare providers and were labeled as disrespectful due to their lack of English proficiency [28]. There have also been reports from racial-ethnic minority women involving communication issues with healthcare providers and treatment decisions resembling microaggressions. Those include being presented with unrequested adoption papers following delivery and healthcare providers making assumptions regarding the paternity of children after delivery [27]. In a 2002 study on Somali women who had given birth in Canada, several participants reported healthcare providers explicitly condemning their religion and culture, such as referring to their native language as "disturbing" while they were hospitalized for childbirth [29].

Racial-ethnic minority women also report perceived infringements upon their autonomy during the birthing process, with Black women being more likely to cite being denied the authority to make medical decisions [17], and Asian women reporting instances of being told by healthcare providers

that their personal preferences would be discounted in determining the course of their care, such as whether an induction would be performed [27]. Indigenous birthing customs, such as burying the placenta and opting out of cesarean sections, are stigmatized by medicalized childbirth, denying indigenous women reproductive autonomy and the option of a culturally-adherent birth [30].

While the quality of interaction with one's healthcare providers during childbirth does indeed have a vast influence over subjective birthing experience, there are several other elements of medicalized childbirth that may be shaped by medicalized racism and in turn increase the likelihood of a traumatic birthing experience and PTSD symptom development. The maternal mortality rate (MMR), for example, is disproportionately skewed in terms of racial-ethnic background. Black women are at a significantly higher risk for maternal mortality than white women [31 - 32]; as of 2023, the MMR per 100,000 live births for black women was 50.3, compared to 14.5 for white women [33]. This disparity is not alleviated when Black women possess protective factors such as being married or engaging in early prenatal care, and is possibly due to medicalized racism affecting the quality of care black patients receive during labor [34]. Similarly, indigenous women have an inordinately high MMR, and are twice as likely to experience maternal death than white women [35 - 36]. Black women have reported that pre-existing awareness of racial-ethnic disparities in MMR is a contributing factor for anxiety surrounding the experience of childbirth [37]. Experiencing psychological distress during labor is associated with the birthing experience being viewed as traumatic, subsequently increasing the likelihood of childbirth-related PTSD development [38].

In addition, intense acute physical pain can be considered a traumatic event in and of itself [39] and an underestimation of birthing pain has also been associated with poor subjective birthing experience [40], which childbirth-related PTSD development relies heavily on. As previously mentioned, racial-ethnic minority women have sometimes been found to be administered pain medication at a lower rate than white women [25, 26], suggesting that they experience acute pain for longer durations and therefore are more likely to develop childbirth-related PTSD.

Discussion

Although medicalized childbirth creates a set of conditions for labor to become traumatic—what with the union of limited autonomy and acute physical pain—in a manner that is independent of racial and ethnic background and therefore impacts white women as well, the influence of obstetric racism in the medicalized birthing process has a significant negative impact on the quality of interaction with healthcare providers and subjective birthing experience of racial-ethnic minority women, and increases their risk of developing childbirth-related PTSD. Reports of poor quality of interaction with healthcare providers from racial-ethnic minority women tend to remain consistent in their subject matter, with frequent mention of withholding of pain medication [25, 26, 27], communicative issues and verbal mistreatment [17, 29], and violations of medical autonomy [17, 27, 30]. Although these are not exclusively experienced by racial-ethnic minorities, racial-ethnic minority women tend to report them at higher rates than white women [25], and often report perceiving their race or ethnicity as a definitive factor in the quality of care they received while hospitalized for childbirth [27]. These disparities and obstetric racism itself are likely explained by several sociological stereotypes present in healthcare systems that perpetuate specific ethnic-based beliefs about pain tolerance, maternal behavior, competence, and emotional expression.

For example, the root of the racial-ethnic discrepancies in pain medication management during and following hospitalization for childbirth [25 - 26] may lie in physiological racial-ethnic stereotypes surrounding the pain tolerance of minorities. Black individuals in particular have historically been stereotyped as having a collective biological capacity for pain that is inherently higher than that of White individuals [27]. There is evidence to support that these biases circulate within healthcare systems. Studies have found that healthcare providers and medical students frequently endorse racial stereotypes such as the notion that black individuals physically have thicker skin and less nerve sensitivity than white individuals [41], and are more likely to underrate the pain levels of racial-ethnic minority patients, particularly black patients [42 - 43]. Asian women, particularly South Asian within the context of medicalized childbirth in Great Britain, are stereotyped as and criticized by healthcare providers for having low pain tolerances and exhibiting excessive volume and attention-seeking behavior during labor in comparison to other racial-ethnic groups [28]. That a significant number of healthcare providers and medical students perceive Black patients as having higher thresholds for pain than white patients [41] and tend to underrate their pain levels [42 - 43] is a potential explanation as to why black patients receive pain medication less frequently in

childbirth than white patients [25 - 26]. Similarly, that healthcare providers view Asian patients as excessively loud and inconvenient to treat due to a perceived low tolerance for pain [28] may serve as a subjective justification for Asian patients being pressured into interventions such as epidurals and inductions [27].

Likewise, verbal mistreatment, communicative issues, and infringements of autonomy that racial-ethnic minority women are subjected to during childbirth on behalf of healthcare providers may also be due to underlying racial-ethnic stereotypes in the healthcare system. That racial-ethnic minority women report interactions in which they were provided unrequested adoption paperwork or where assumptions were made about their children's paternity [27] suggests that healthcare providers may internalize racial-ethnic stereotypes that perpetuate negative narratives surrounding minority women's interest in and ability to care for their children and sexual activity, and allow these internal biases to dictate their interactions with patients. Several participants from the same study [27] reported feeling as though their healthcare providers ignored their inquiries and personal preferences due to preconceived, racially-charged biases surrounding their intellect, aligning with both existing data that states that healthcare providers view racial-ethnic minorities as less intelligent than white individuals [44 - 45] and historical stereotypes portraying minorities as unintelligent [46]. Infringements upon reproductive autonomy such as indigenous birthing customs being invalidated and erased in medicalized childbirth settings [30] and insensitive commentary from healthcare providers on patients' religious and cultural backgrounds [28 - 29], are more unambiguously indicative of the presence of racial bias in healthcare settings, exhibiting providers minimizing the cultural importance of certain customs and explicitly engaging in racially-insensitive and xenophobic rhetoric.

Childbirth-related PTSD has broad post-birth consequences. It may have significant repercussions on the development of the mother-child relationship, having been associated with disruptions in maternal perception of attachment and bonding, as well as with delayed or failed lactogenesis [47]. These disturbances can adversely influence decisions regarding breastfeeding, limiting opportunities for early mother–infant connection, which is considered essential for healthy socioemotional development [48]. Breastfeeding issues have also been associated with adverse physical health outcomes for both the mother and infant, such as an increased risk of developing breast and ovarian cancer, infection [49],

and neonatal weight loss [50]. In addition, childbirth-related PTSD may contribute to reproductive avoidance behaviors, including decisions to delay or give up on later pregnancies, and is linked to an increased preference for medical interventions in future labor experiences [48].

Moreover, as avoidance is a core symptom of childbirth-related PTSD, it may negatively affect interactions with healthcare providers in the postnatal period. Women with childbirth-related trauma frequently report avoiding hospitals and memories of the birth, which can manifest as non-attendance to scheduled follow-up visits, reduced trust in healthcare professionals, and delays in seeking medical care [51, 52, 53]. It is important to note that avoidance behaviors can also occur in subclinical or partial PTSD presentations, suggesting that the lack of postpartum healthcare engagement may affect a more extensive population than those who meet full diagnostic criteria [54]. Racial-ethnic minority women in particular have reported that their postpartum healthcare avoidance was specifically associated with racially-charged traumatic birth experiences [27]. This suggests that obstetric racism may be a systemic factor responsible for racial-ethnic minorities having lower rates of attendance to postpartum care appointments than white individuals [35, 55].

Trauma-informed intrapartum care, which includes providing adequate analgesia, honoring patients' cultural preferences and needs, establishing clear expectations before labor begins, and developing birth plans in genuine partnership with patients in order to protect their sense of autonomy [56], is an important potential combatant of childbirth-related PTSD development. When these practices are combined with supportive postpartum interventions such as early therapy (within 96 hours of birth), trauma-focused therapies, psychological counseling, and mother-infant focused treatment [57 - 58], they can help reduce distress and lessen the unequal burden of childbirth-related PTSD experienced by racial-ethnic minority women.

Conclusion

Literature findings indicate that childbirth-related PTSD among racial and ethnic minority women seems, at least in part, related to the interaction between medicalized birth practices, unequal provider–patient communication, and historical sociocultural biases within healthcare settings. Although these structural determinants are difficult to change in the short term, clinical teams can work proactively by identifying women who may be particularly vulnerable through careful prenatal assessments

that consider racial, cultural, previous psychiatric diagnoses, and psychosocial stressors. Implementing trauma-informed intrapartum care that emphasizes patient preference and a communicative patient-provider relationship is equally important, and together these applications may decrease the likelihood of a traumatic birth and alleviate the racial-ethnic discrepancies in childbirth-related PTSD rates.

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