Beyond Survival: Reimagining Black Maternal Mental Health

Through Trauma-Informed & Neurosomatic Care

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WHO AM I?

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Dr. Deilen Michelle Villegas, Ph.D., a Board-Certified Naturopathic & Lifestyle Medicine Practitioner, Clinical Mental Health Counselor, Trauma Specialist, and Certified Clinical Sexologist. I am the Founder and CEO of The Shamanic Goddess, LLC, an integrative wellness platform advancing trauma-informed, culturally responsive, and holistic care.

With over 19 years of experience across Internal Medicine, OB/GYN, Pediatrics, Oncology, and Behavioral Health, I specialize in neurosomatic healing, maternal & mental health, and health equity. I hold a Ph.D. in Natural Medicine, a Master's in Clinical Mental Health Counseling, a Master of Public Health in Global Health and I am a Traditional Midwife and Full Spectrum High-Risk Doula.

My work bridges neuroscience, public health, and ancestral healing practices to address systemic disparities and improve outcomes for underserved communities. As a published author and educator, I am committed to reshaping healthcare systems through advocacy, education, and transformative care models.

FOUNDER & INTEGRATIVE LIFESTYLE MEDICINE PRACITIONER
THE SHAMANIC GODDESS, LLC

COMPLEX TRAUMA SURVIVOR

PUBLIC HEALTH ADVOCATE

What You Will Takeaway

- Examine how trauma and chronic stress biologically impact Black maternal mental health outcomes.
- Critically assess the limitations of traditional maternal mental health care models.
- Understand the role of the nervous system in pregnancy, birth, and postpartum healing.
- Explore trauma-informed and neurosomatic approaches as scalable, integrative solutions.
- Identify actionable strategies to advance equitable, culturally responsive maternal care.

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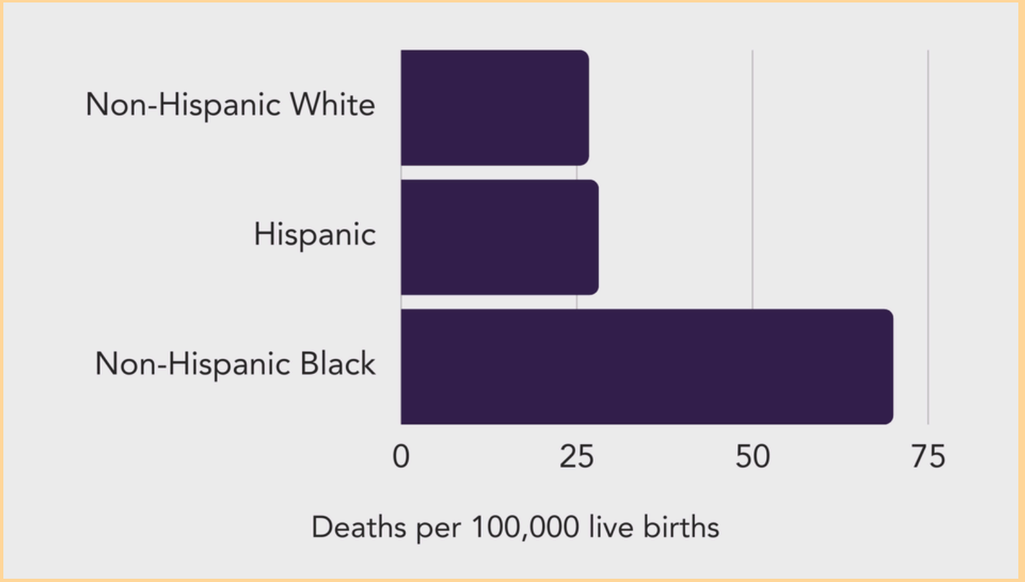
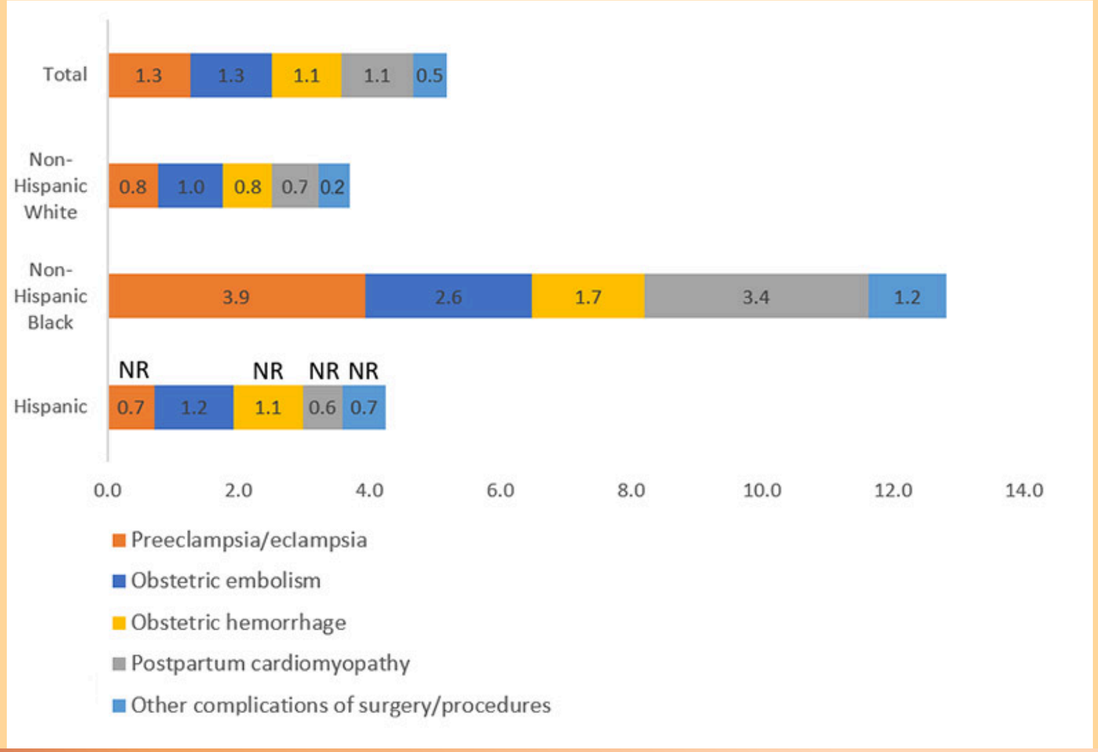
Why This Matters

- **Black women are 2–3x more** likely to die from pregnancy-related causes
- **Over 80% preventable**
- Mental health is underdiagnosed, undertreated, and dismissed
- **1 in 5 women globally** experience a perinatal mood or anxiety disorder (PMAD). (WHO, 2022)
- **Postpartum PTSD affects 3–6%** of birthing individuals, but up to **15–19% in high-risk or marginalized populations.**

This is not coincidence.
This is systemic.





BIOLOGICAL IMPACT OF TRAUMA

TRAUMA IS BIOLOGICAL

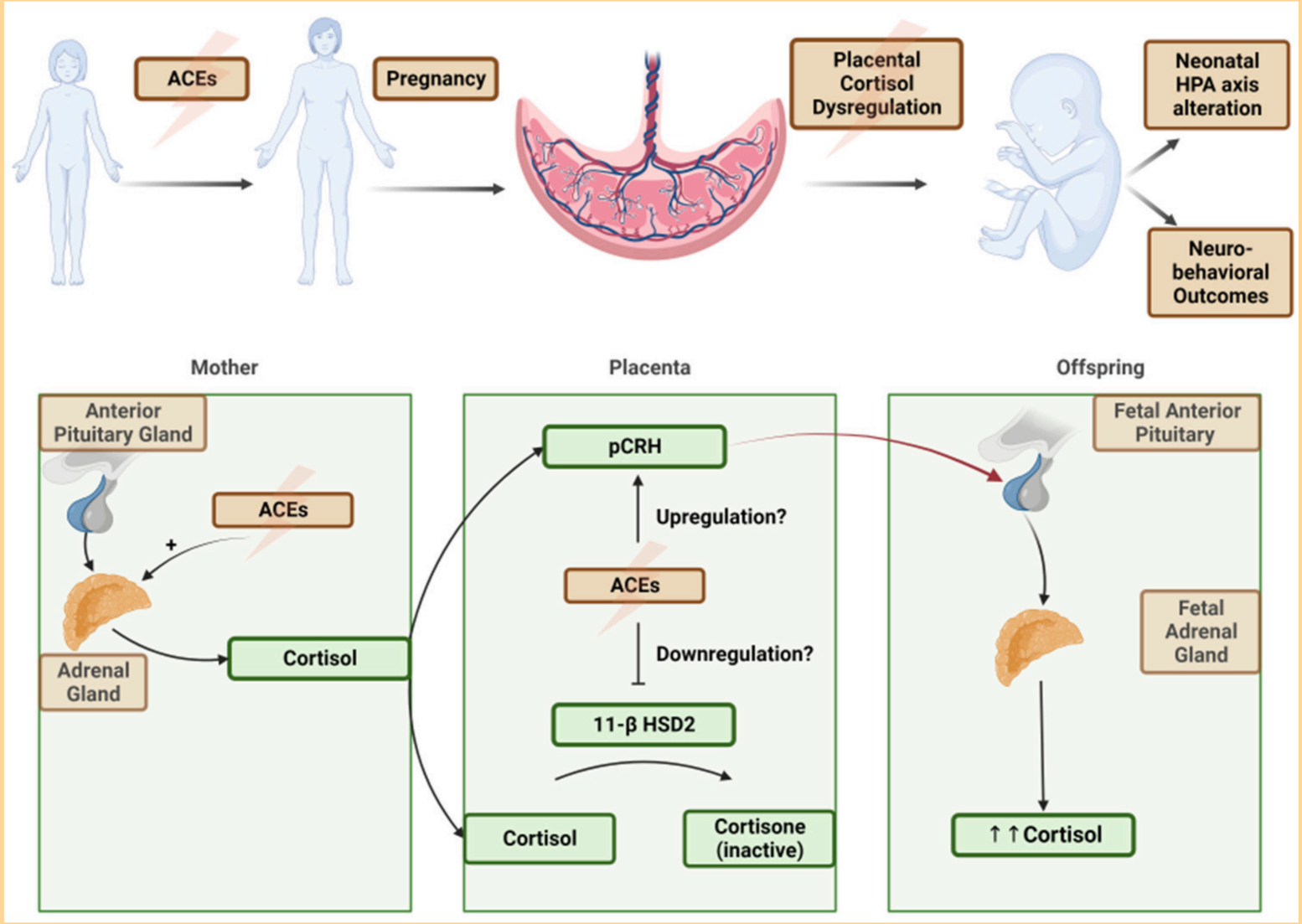
Trauma is not just psychological
It is **physiological**

- Chronic stress → elevated cortisol
- Impacts:
  - **Placenta function**
  - **Immune system**
  - **Hormonal balance**

MATERNAL HEALTH IMPACTS

Chronic stress increases risk of:
Preterm birth
Hypertension
Low birth weight
Postpartum depression

🗝️ **The body keeps the score, and pregnancy amplifies it.**

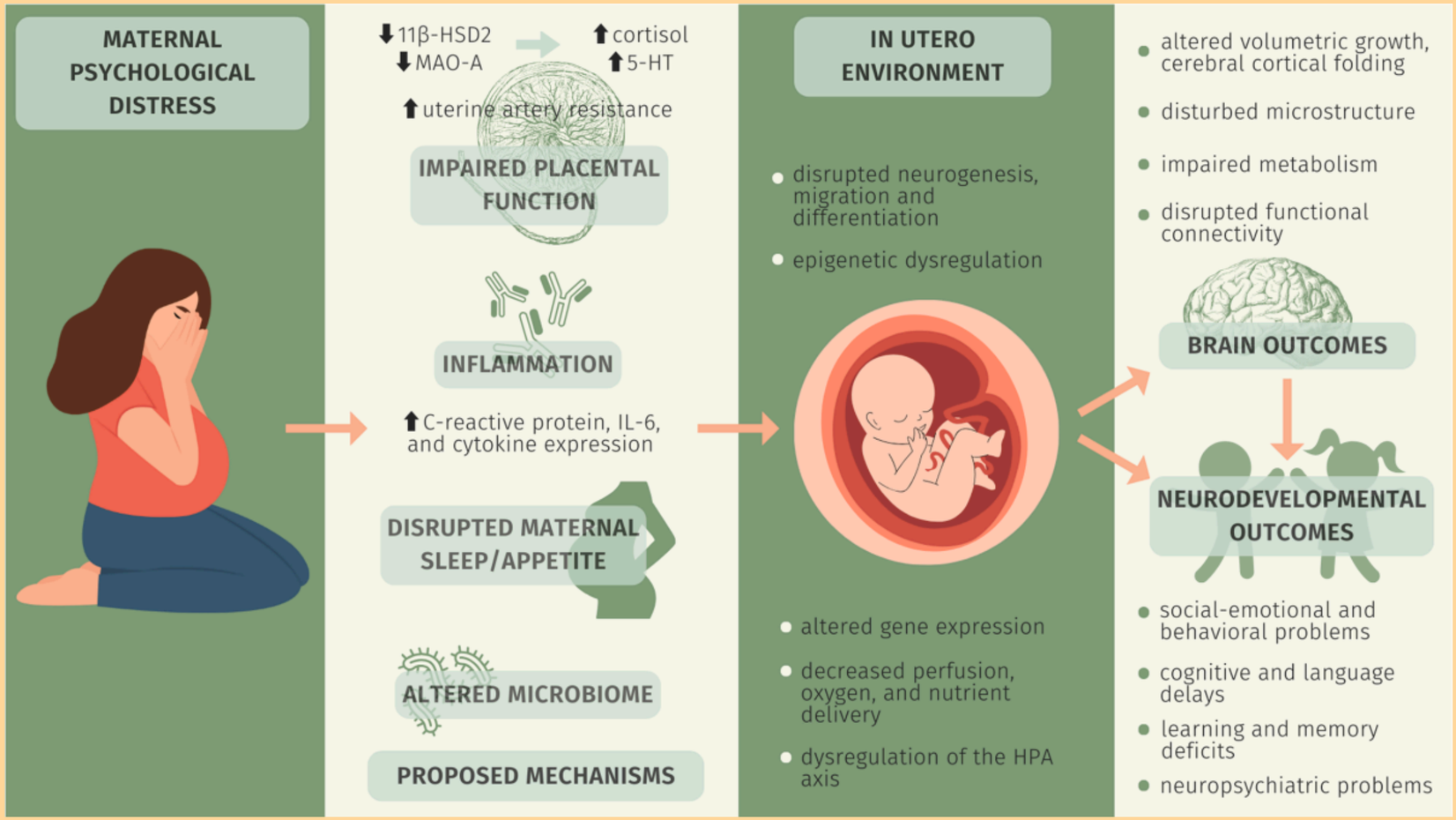


INTERGENERATIONAL EFFECTS

- Stress impacts fetal development
- Nervous system patterns begin in utero
- Trauma can be biologically transmitted

Long Term Consequences:

- Congenital heart defects/ cardiovascular diseases
- Increased risk for immune dysfunction
- Neurological impairments
- Mood disorders such as depression, anxiety, etc.
- Insulin resistance
- Obesity
- Addiction/ chemical dependence



PERINATAL MENTAL HEALTH

Symptoms of Perinatal Mental Health Conditions:

While 50-80% of women experience mild "baby blues" (short-term mood swings, crying) within the first two weeks, more severe symptoms that indicate a need for help include:

- Intense, overwhelming sadness or crying spells.
- Difficulty sleeping, even when the baby is sleeping, or sleeping too much.
- Fear of being left alone with the baby.
- Intrusive thoughts about harming oneself or the baby.
- Lack of joy or interest in activities.
- Feelings of worthlessness, shame, or guilt.

Causes and Risk Factors

Conditions can be caused by a combination of factors:

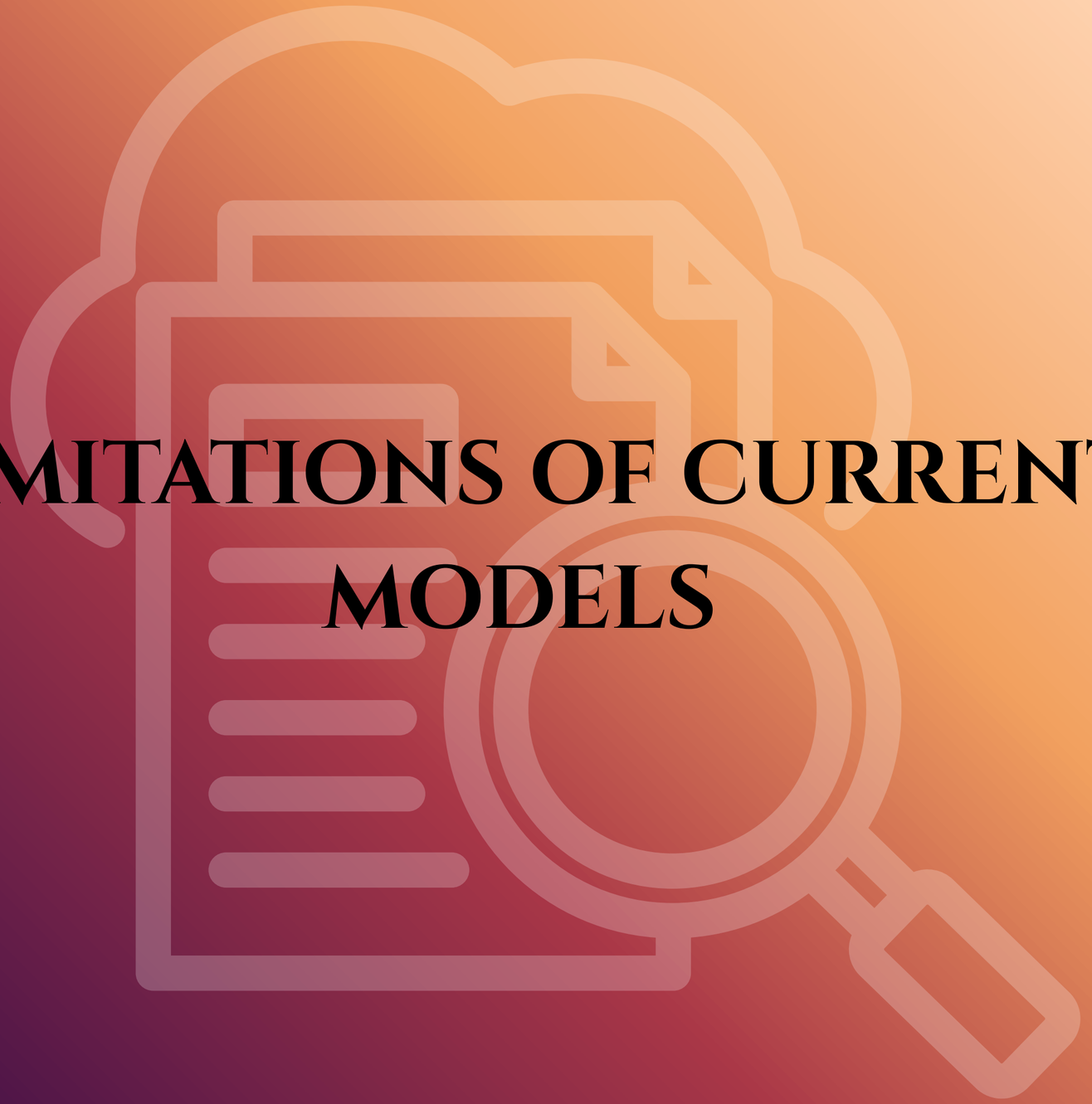
- **Biological:** Rapid hormonal shifts, chemical changes in the brain, and family history of mental health issues.
- **Psychological/Environmental:** High stress, poor social support, financial hardship, traumatic birth experiences, and history of abuse.
- **Other Factors:** NICU admission for the baby, breastfeeding difficulties, or unintended pregnancy.

Global Statistics

- Suicide is a leading cause of maternal mortality in developed countries.
- Black women are less likely to be screened and more likely to be misdiagnosed.

Maternal suicide and infanticide frequently occur after the traditional 6-week postpartum checkup, with the highest risk for suicide often between 6 and 12 months postpartum. While postpartum psychosis, a major risk factor for infanticide, usually begins within 2 weeks of birth, suicide risks peak much later. Up to 62% of pregnancy-related suicides occur 43 to 365 days after birth.

- **Highest Risk Period:** The risk of suicide is actually higher after the 6-week checkup, often peaking around 9 to 12 months postpartum.



LIMITATIONS OF CURRENT MODELS

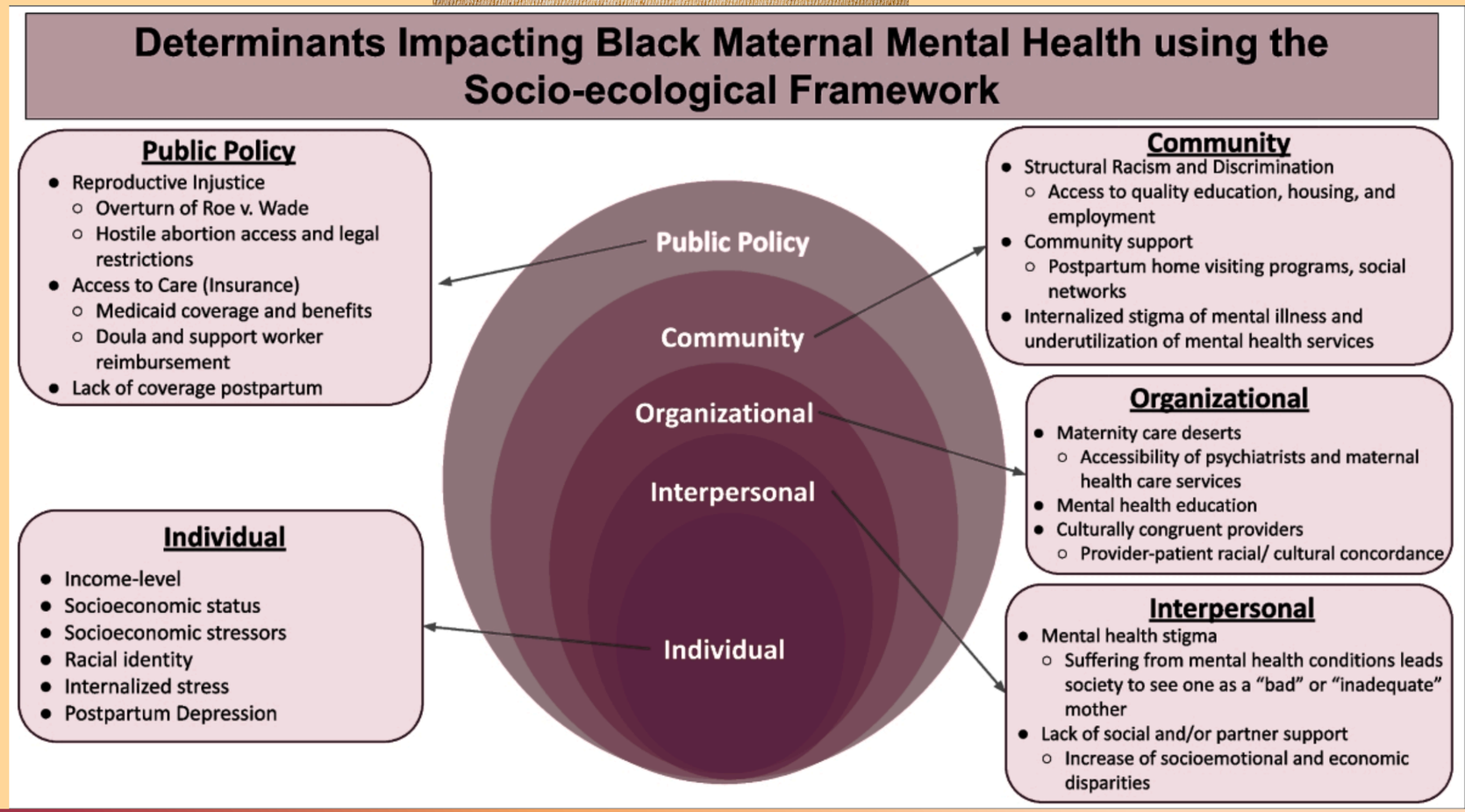
TRADITIONAL MODEL

Focuses on:

- Symptoms
- Diagnosis
- Medication

But often ignores:

- Lived experience
- Systemic stress
- Cultural context



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Maternal Mental Health Facts & Figures

1 in 7

The number of people who develop postpartum depression in the year after giving birth

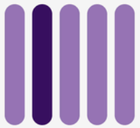
Up to 50%

The percentage of perinatal people with depressive symptoms who do not receive a clinical diagnosis, with even higher percentages of treatment gaps among those who are diagnosed

1/2

Half as likely

The rate at which Black and Latina women are likely to access maternal mental healthcare services as compared to white women, demonstrating the disproportionate maternal mental health burden placed on women of color



1 in 5

The estimated number of people who develop postpartum anxiety after giving birth

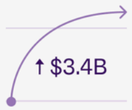
22x

22 times

The likelihood of having a psychiatric hospital admission following birth as compared to pre-pregnancy

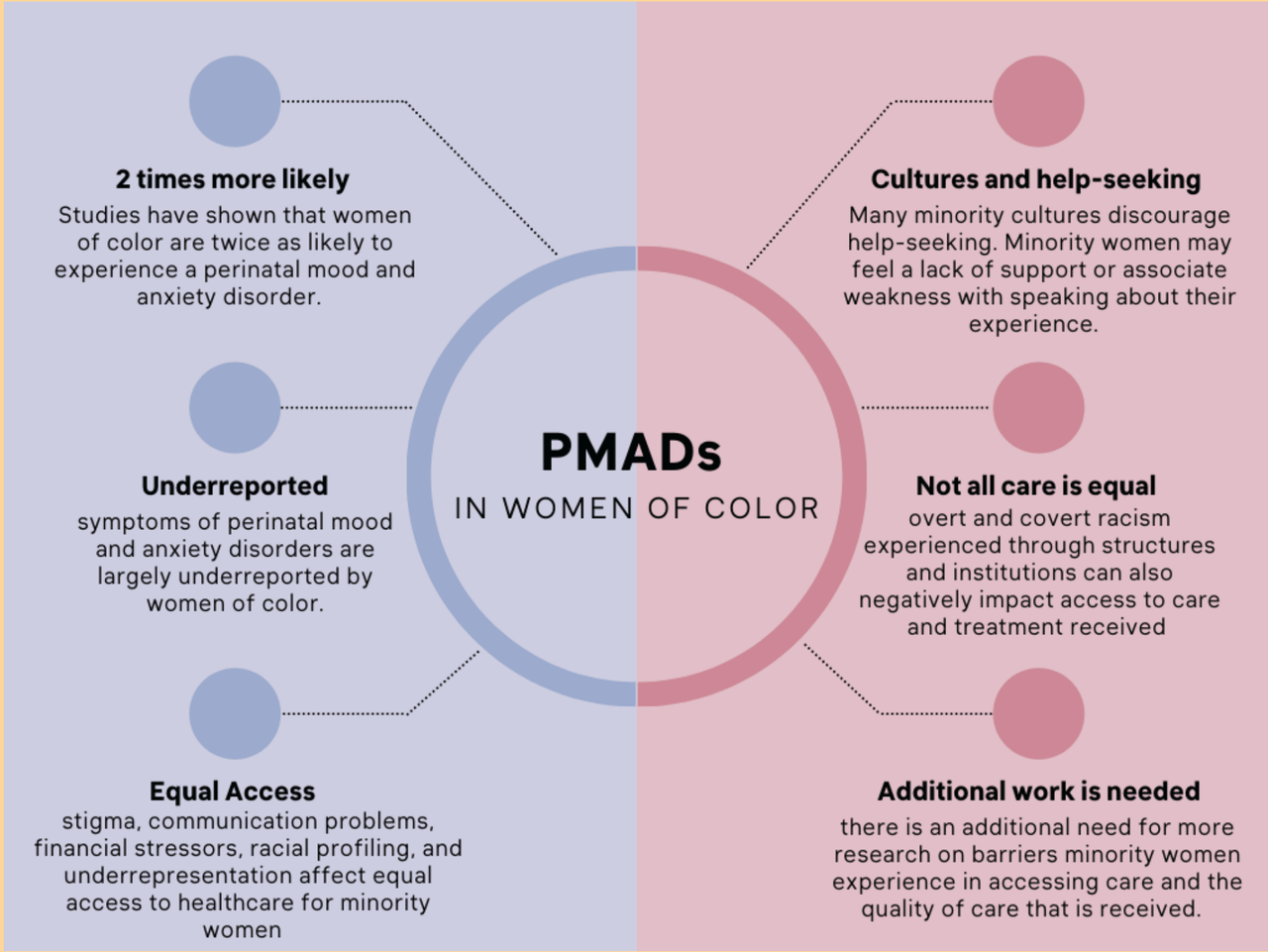
1 in 5

The number of perinatal deaths caused by suicide



$3.4 billion

The increase in societal health expenditures due to untreated PMADs over six years



Critical Gap

Current systems:

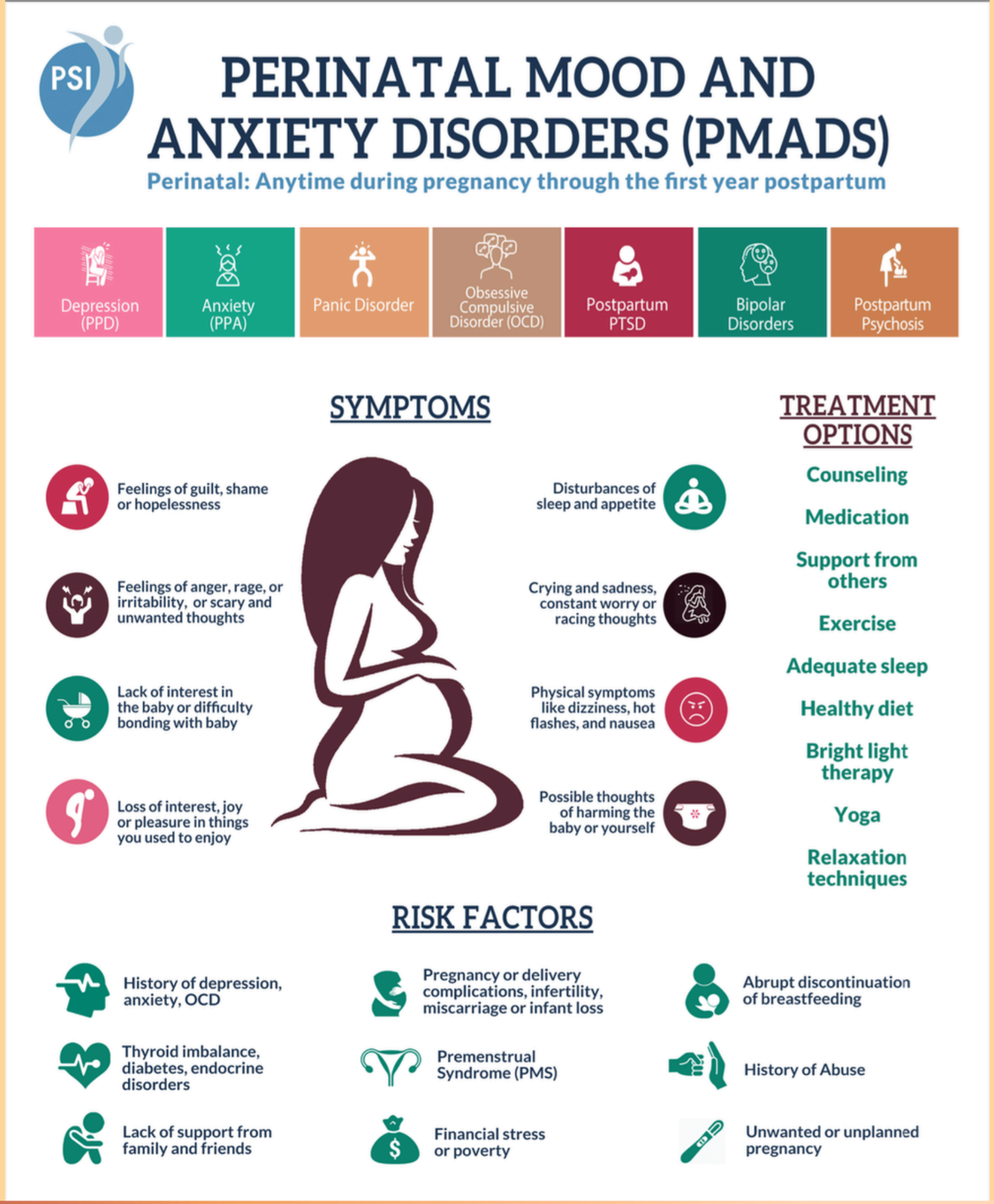
- Prioritize efficiency over connection
- Reward compliance over care
- Dismiss embodied knowledge

🗝️ **We are using models designed for compliance; not safety.**

PARADIGM SHIFT

Old Model:
➡️ **Symptom → Diagnosis → Treatment**

New Model:
➡️ **Safety → Regulation → Healing**



Postpartum Post-Traumatic Stress Disorder (PP-PTSD)

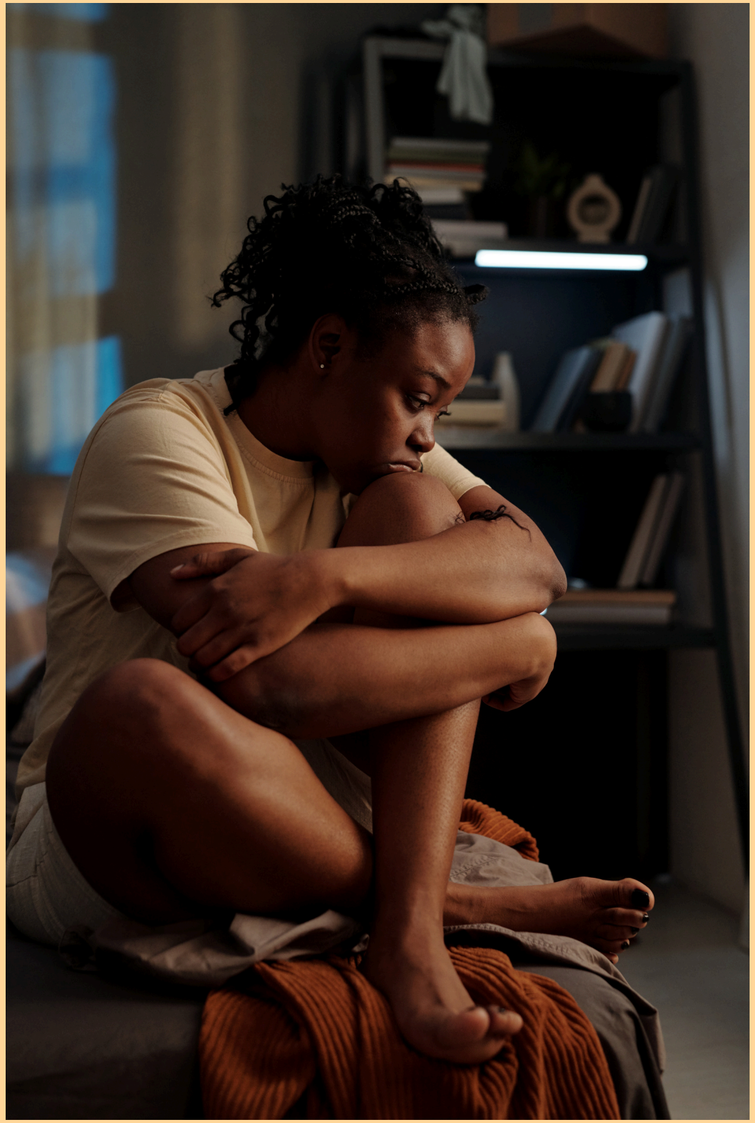
Postpartum PTSD is not rare, exaggerated, or a failure of coping.

It is a trauma response to perceived or actual threat, violation, or loss of safety during pregnancy, birth, or the immediate postpartum period.

Unlike postpartum depression, PP-PTSD is driven by fear, helplessness, and nervous system imprinting, not just mood disturbance.

Prevalence & Context

- An estimated 3–6% of birthing individuals develop PP-PTSD in the general population
- Rates increase to 15–25% in high-risk births (emergency interventions, NICU, prior trauma)
- Rates are significantly higher in Black, Indigenous, and marginalized birthing people
- PP-PTSD often goes undiagnosed because:
  - Symptoms are normalized as “new parent anxiety”
  - Focus remains on infant outcomes rather than maternal experience
  - Trauma screening is inconsistent in obstetric settings



Major causes of Postpartum PTSD

1. Loss of Control

Loss of control is one of the strongest predictors of birth-related PTSD.

This includes:

- Decisions made without informed consent
- Feeling rushed, silenced, or overruled
- Being physically restrained or immobilized
- Sudden changes in birth plan without explanation

Neurobiological impact:

- Activates the brain's threat circuitry
- Shifts the nervous system into survival mode
- Disrupts memory integration, leading to intrusive recall

Key clinical insight:

It is not what happened; it is how powerless the client felt while it happened.

2. Emergency C-Section

An emergency cesarean can be lifesaving, and still traumatic.

Why emergency C-sections are high-risk for trauma:

- Rapid escalation from "normal" to "crisis"
- Lack of time for emotional preparation
- Sensory overwhelm (lights, alarms, restraints)
- Dissociation due to fear and anesthesia
- Feeling cut open while conscious

Common trauma narratives:

- "My body failed."
- "I was out of control."
- "I didn't get to meet my baby the way I imagined."

Important distinction:

Planned ≠ emergency.
Consent ≠ coercion.
Speed ≠ safety in the nervous system.

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3. NICU Separation
Separation from a newborn during the critical bonding window is a profound attachment stressor.

Trauma mechanisms involved:

- Interrupted skin-to-skin contact
- Loss of early co-regulation
- Hypervigilance regarding infant survival
- Feelings of guilt, helplessness, and grief

Attachment implications:

- Parents may feel disconnected or “numb”
- Increased fear of infant death
- Difficulty trusting their own caregiving instincts

BIPOC disparities:

- Higher rates of NICU admission
- Less consistent family-centered NICU care
- Greater barriers to visitation due to work, transport, or policy enforcement

NICU trauma affects **both parent and infant nervous systems,** often simultaneously.

4. Perceived Betrayal
Perceived betrayal occurs when the people or systems expected to protect the client instead cause harm, dismiss concerns, or violate trust.

This may include:

- Pain being minimized or ignored
- Requests being dismissed
- Procedures performed without consent
- Feeling lied to or misled
- Being treated as a problem rather than a person

Why betrayal is uniquely traumatic:

- It shatters assumptions of safety
- It intensifies shame (“I should have known better”)
- It deepens mistrust of future care

Trauma is amplified when harm comes from a **trusted authority.**

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5. Medical Racism
Medical racism is not perceived; it is documented, systemic, and lethal.

Perinatal medical racism includes:

- Pain dismissal
- Stereotyping (e.g., “strong Black woman” myth)
- Delayed interventions
- Increased surveillance and suspicion
- Reduced autonomy in decision-making

Trauma impact:

- Chronic hypervigilance
- Fear of future medical care
- Heightened PTSD symptoms
- Compounded historical and intergenerational trauma

For many BIPOC clients, postpartum PTSD is not just about birth, it is about **surviving a system that has repeatedly shown itself to be unsafe.**

6. Forced Pregnancy and Delivery
Defined as being coerced into continuing a pregnancy or experiencing traumatic, non-consensual obstetric interventions.

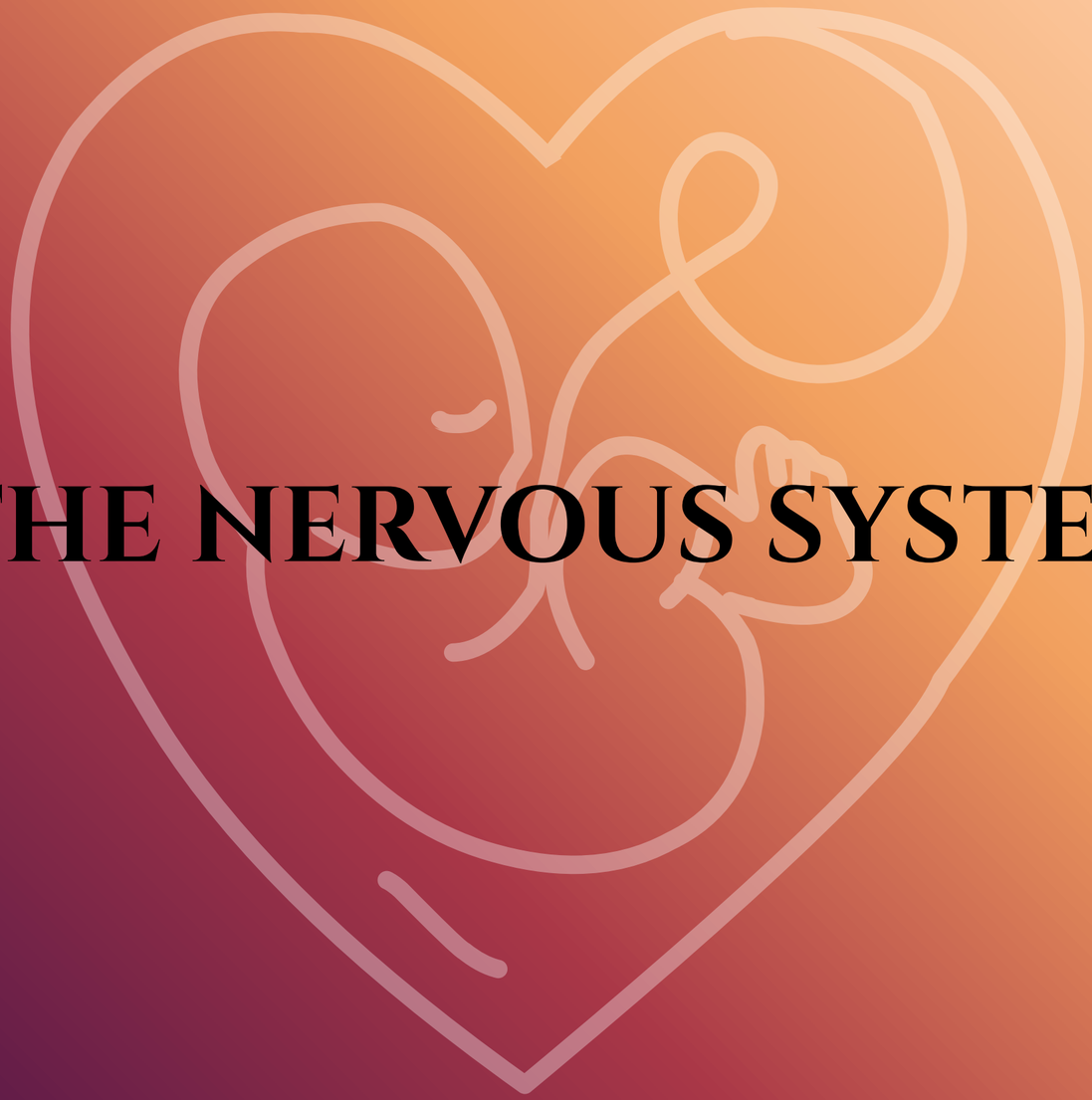
Key aspects includes:

- Traumatic labor and delivery
- Forced to carry pregnancy to term
- Laws preventing termination of unwanted pregnancy
- Lack of support or control during labor and delivery

Trauma impact:

- Chronic hypervigilance and anxiety
- Re-traumatization risk for victims of sexual violence and abuse
- Heightened PTSD symptoms
- Severe distress and bonding issues with the infant

Due to laws criminalizing miscarriages and terminations of pregnancies, we have seen an increase of cases of patients being seen in hospitals facing health complications due to self-managed terminations in attempt to terminate pregnancies resulting from incest, or sexual violence. Unfortunately, People of color who can become pregnant are disproportionately affected by this legislation in every respect. While also receiving inequitable access to proper prenatal care.



THE NERVOUS SYSTEM

The Missing Link

The body constantly asks:

Am I safe?

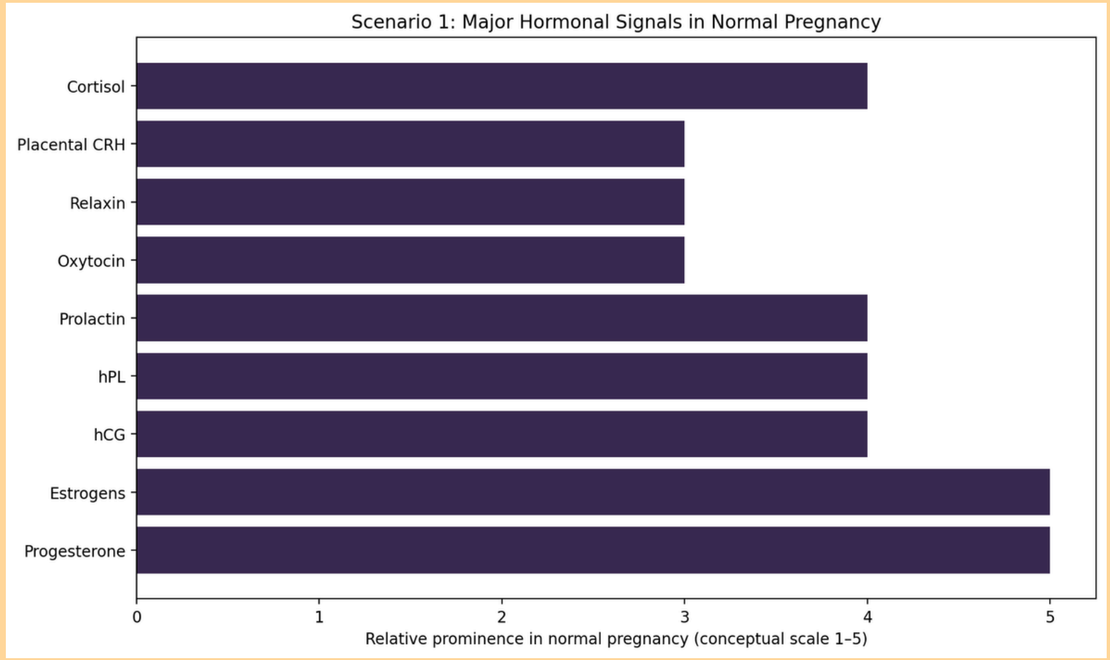
SURVIVAL STATES

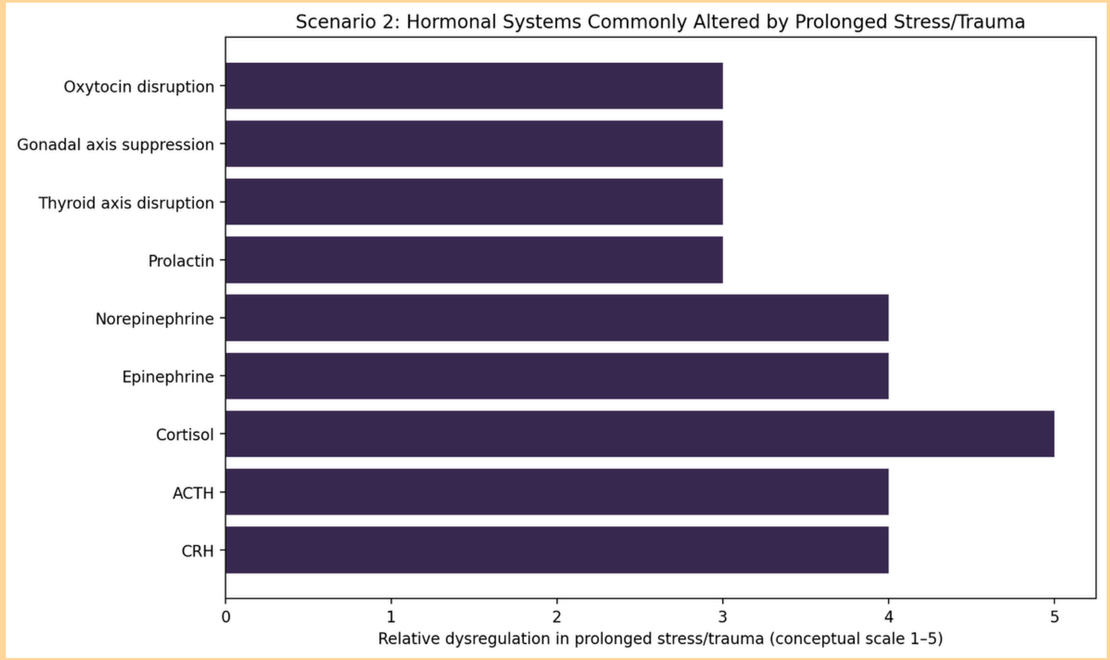
- Fight → anger, irritability
- Flight → anxiety, overwhelm
- Freeze → shutdown, dissociation

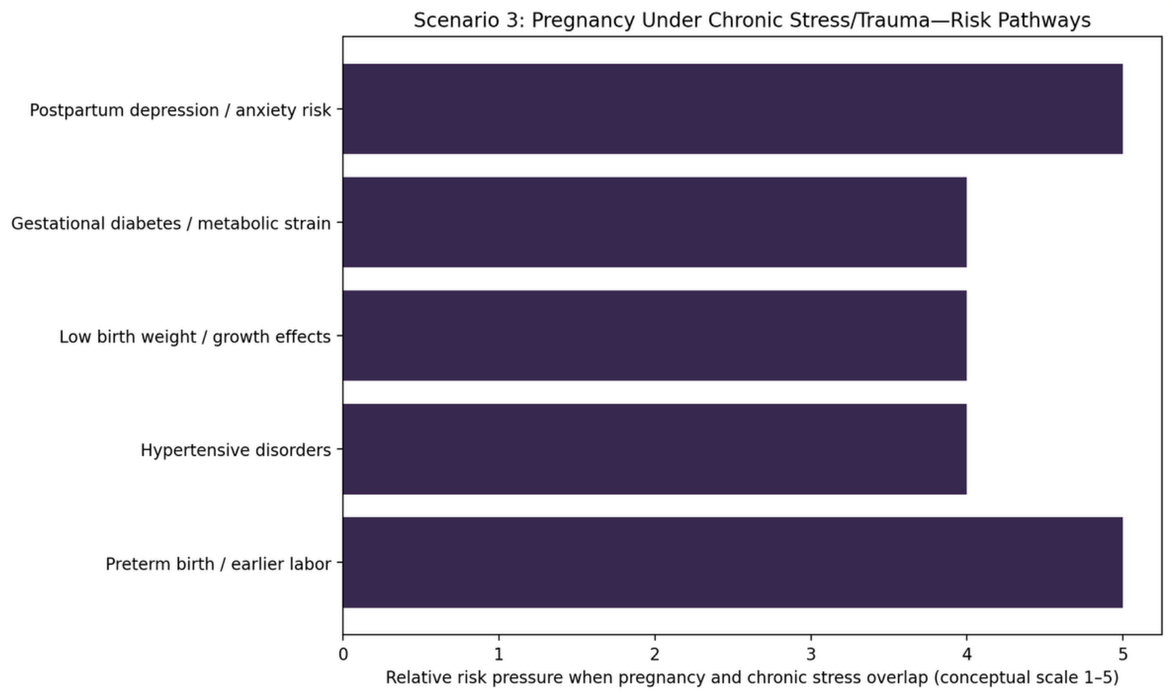
These are not disorders.
They are adaptive responses.

Pregnancy is already a high-demand endocrine state. When chronic stress and trauma dysregulate overlapping hormonal systems—especially cortisol, placental CRH, catecholamines, and metabolic pathways—the physiologic burden rises, increasing vulnerability to adverse maternal and fetal outcomes.

Understanding that Pregnancy is a total body stress test.







PREGNANCY & THE NERVOUS SYSTEM

- Pregnancy heightens sensitivity
- Birth is a neurological event
- Postpartum requires regulation for recovery

🗝️ **You cannot separate mental health from the nervous system.**

Normal pregnancy

- High progesterone, estrogen, hCG, hPL, prolactin
- Rising oxytocin, placental CRH, and cortisol
- Goal: sustain pregnancy, grow fetus, prepare for birth and lactation

Prolonged stress/trauma

- Increased CRH, ACTH, cortisol, epinephrine, norepinephrine
- Possible prolactin changes, oxytocin disruption, thyroid/reproductive axis disruption
- Goal of the body: survive threat, often at the expense of repair, rest, and regulation

Pregnancy + chronic stress/trauma

- Normal pregnancy hormone shifts are layered with stress-hormone dysregulation
- Greater strain on timing-of-birth pathways, blood pressure regulation, glucose control, inflammation, bonding/recovery systems
- Higher associated risk of preterm birth, fetal growth problems, hypertensive complications, and postpartum mental health burden

Biopsychosocial Influences in the Perinatal & Postpartum Period

1. Hormonal Shifts: Estrogen & Progesterone Withdrawal
After birth, estrogen and progesterone levels drop more rapidly than at any other time in the human lifespan, a neurological event, not just a reproductive one.

Clinical impact:

- Estrogen modulates serotonin, dopamine, and GABA.
- Sudden withdrawal increases vulnerability to:
  - Depression
  - Anxiety
  - Intrusive thoughts
  - Emotional lability
- Progesterone metabolites (like allopregnanolone) are key calming neurosteroids; their loss can destabilize mood and sleep.

Why this matters clinically:

- Symptoms are often misattributed to "coping issues" rather than neurochemical shock.
- BIPOC clients are less likely to receive hormone-informed psychoeducation and more likely to be labeled "noncompliant" or "overreactive."

Reframe for clients:
"Your nervous system is recalibrating after a massive biological shift. This isn't weakness, it's physiology."

2. Sleep Deprivation: A Neuropsychiatric Stressor
Sleep deprivation in the postpartum period is structural, not accidental, and it is one of the strongest predictors of perinatal mood disorders.

Neurobiological effects:

- Increases amygdala reactivity
- Reduces prefrontal cortex regulation
- Impairs memory consolidation
- Exacerbates trauma recall
- Mimics symptoms of anxiety, depression, and psychosis

Compounding factors:

- NICU stays
- Solo parenting
- Lack of extended family support
- Shift work and economic necessity
- Cultural expectations of maternal self-sacrifice

Clinical insight:
Sleep loss doesn't just worsen symptoms, it creates them.

Trauma-informed shift:
Instead of asking, "How are you coping?"
Ask, "How much uninterrupted sleep are you getting, and who helps protect it?"

...Continued...

3. Breastfeeding Challenges: When Nourishment Becomes a Stressor
Breastfeeding is often idealized as instinctive and bonding, yet for many clients it becomes a site of grief, shame, and bodily distress.

Common challenges:
- Pain, mastitis, nipple trauma
- Low supply or latch issues
- Pressure to exclusively breastfeed
- Lack of culturally competent lactation support
- Conflicting medical advice

Psychological impact:
- Body betrayal narratives ("My body failed again")
- Increased anxiety and hypervigilance
- Re-enactment of prior sexual or medical trauma
- Guilt when supplementation is needed

BIPOC disparities:
- Less access to IBCLCs
- Higher rates of coercive feeding advice
- Lower workplace protections for pumping
- Historical trauma tied to wet-nursing and reproductive exploitation

Clinical reframe:
Feeding is not a moral test.
Nourishment includes the caregiver's nervous system.

4. Financial Stress: Chronic Survival Activation
Economic strain is one of the most under-acknowledged drivers of perinatal distress, despite being one of the most powerful.

Stress pathways activated by financial insecurity:
- Chronic cortisol elevation
- Hypervigilance
- Sleep disruption
- Increased conflict in relationships
- Reduced access to care

Postpartum-specific stressors:
- Unpaid or inadequate maternity leave
- Medical bills from birth or NICU
- Loss of income
- Childcare costs
- Fear of employment retaliation

Structural inequity:
- BIPOC families are more likely to:
  - Experience wage gaps
  - Lack generational wealth
  - Be denied workplace accommodations
  - Rely on systems that surveil rather than support

Clinical implication:
You cannot treat anxiety without acknowledging economic threat.

...Continued...

5. Racism Exposure: A Nervous System Injury
Racism is not a "social issue" separate from health; it is a chronic traumatic stressor with measurable physiological consequences.

Perinatal racism includes:
- Pain dismissal
- Stereotyping
- Medical coercion
- Reduced informed consent
- Being talked over or ignored
- Fear of child welfare involvement

Neurobiological effects:
- Persistent sympathetic activation
- Increased inflammatory markers
- Accelerated biological aging (weathering)
- Heightened PTSD risk after birth

Clinical truth:
Many BIPOC clients are not anxious about birth; they are anxious about survival within systems that have already harmed them.

Trauma-informed care requires:
- Believing the client's lived experience
- Naming racism as a health determinant
- Avoiding minimization or neutrality

6. Intimate Partner Violence (IPV): Hidden but Pervasive
Pregnancy and postpartum are high-risk periods for the onset or escalation of IPV, yet disclosure remains low due to fear, dependency, and stigma.

Forms of IPV in the perinatal period:
- Physical violence
- Sexual coercion
- Emotional abuse
- Financial control
- Reproductive coercion
- Sabotage of medical care or recovery

Mental health consequences:
- Severe anxiety and depression
- PTSD
- Dissociation
- Impaired bonding
- Sexual pain and shutdown

Barriers to disclosure:
- Fear of losing housing or financial support
- Cultural norms around family privacy
- Immigration status
- Mistrust of systems
- Risk of child removal

Clinical responsibility:
Safety assessment is not optional, it is foundational.

THE S.A.F.E.R.™ FRAMEWORK

The S.A.F.E.R.™ Maternal Healing Framework

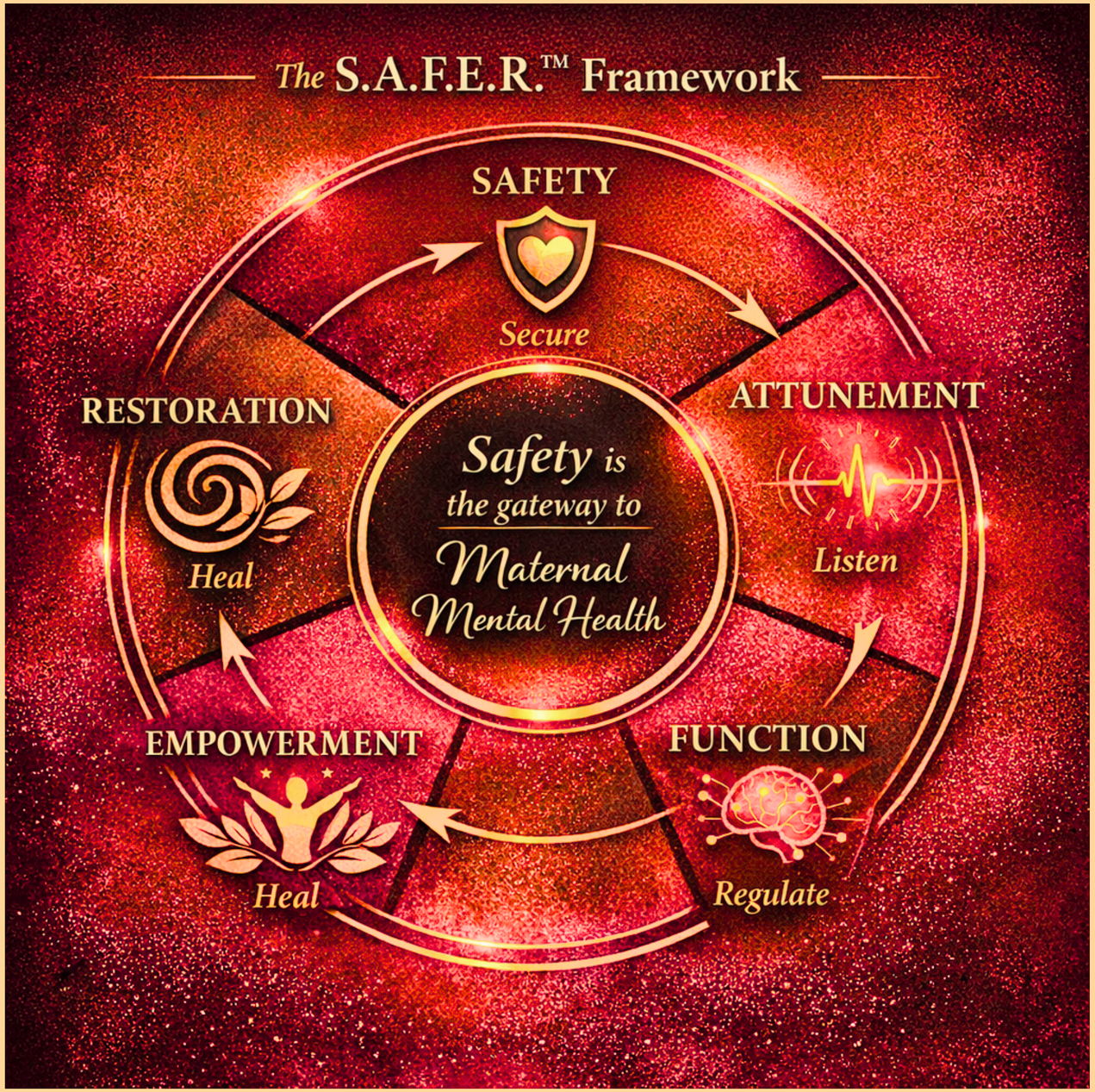
A Neurosomatic & Trauma-Informed Model

Safety • Attunement • Function • Empowerment • Restoration

🗝️ Safety is the gateway to maternal mental health.

WHY THIS FRAMEWORK

- Moves from reactive → proactive care
- Centers physiology + lived experience
- Scalable across:
  - Clinical
  - Community
  - Policy



"What we are witnessing in Black maternal mental health is not a lack of resilience... it is a lack of safety."

So instead of asking, "What's wrong with her?"

We begin asking, "What has her body adapted to survive?"

The S.A.F.E.R.™ Framework shifts maternal care from reactive symptom management → proactive nervous system support.

Because when the body feels safe...
Everything changes.

S – SAFETY (The Foundation)

Question: ***Does her body feel safe enough to receive care?***

- Nervous system state determines perception, trust, and engagement
- Chronic stress, racism, and medical trauma keep the body in survival mode
- Without safety, no intervention fully lands

Clinical Translation:

- Psychological safety is not enough → must include physiological safety
- Tone, touch, environment, and communication matter

“You cannot treat a body that is still trying to survive.”

A – ATTUNEMENT (The Missing Link)

Question: ***Are we actually listening to her body—or overriding it?***

- Black women's pain and intuition are historically dismissed
- Attunement = co-regulation + deep listening beyond symptoms
- The body speaks through sensation, not just words

Clinical Translation:

- Slow down assessments
- Validate lived experience
- Build relational trust

"Her body is not confused—the system is disconnected."

F – FUNCTION (Understanding the Body's Adaptation)

Question: ***What is the nervous system doing—and why?***

- Anxiety, shutdown, irritability = adaptive survival responses
- Trauma is not just psychological—it is biological
- Pregnancy amplifies underlying nervous system patterns

Clinical Translation:

- Shift from pathology → physiology
- Assess stress load, not just symptoms
- Recognize trauma patterns in prenatal/postpartum care

"What we label as dysfunction is often the body's intelligence trying to protect."

E – EMPOWERMENT (RESTORING AGENCY)

Question: ***Does she feel seen, heard, and in control of her care?***

- Disempowerment is a core driver of trauma
- Education without agency is not empowerment
- True care includes choice, voice, and autonomy

Clinical Translation:

- Shared decision-making
- Informed consent beyond paperwork
- Cultural respect and autonomy

“Healing begins the moment a woman realizes her voice matters in the room.”

R – Restoration (The Goal, Not the Afterthought)

Question: ***Are we helping her body return to regulation—or just survive the moment?***

- Regulation is the pathway to healing
- Rest, digestion, bonding, and recovery require parasympathetic activation
- Postpartum care must include nervous system recovery

Clinical Translation:

- Breathwork, somatic tools, co-regulation
- Community support + culturally rooted practices
- Long-term care beyond the 6-week check

“We don’t just need women to make it through birth—we need them to come back to themselves after it.”

EQUITY IN ACTION

Culturally responsive care means:

- Seeing the whole person
- Honoring lived experience
- Addressing systemic harm

OLD	NEW
Awareness	Action
Systems	Solutions
Survival	Healing
Inequity	Justice
Intervention	Prevention
Crisis Response	Restoration

Seeing the Whole Person

- **Physical health**
- **Mental health**
- **Emotional well-being**
- **Family and community context**
- **Social determinants of health**

Honoring Lived Experience

- **Validate patient concerns**
- **Recognize cultural wisdom**
- **Build trust**
- **Listen without judgment**
- **Promote shared decision-making**

Addressing Systemic Harm

- **Implicit bias**
- **Healthcare disparities**
- **Structural racism**
- **Access barriers**
- **Policy inequities**

"Equity is not treating everyone the same. Equity is ensuring everyone receives what they need to thrive."

Transforming Maternal Mental Health Systems

Trauma-Informed Care asks:
"*What happened?*"

Neurosomatic Care asks:
"*What does the body need?*"

Healing-Centered Care asks:
"*How do we restore safety, agency, and wellness?*"

OLD PARADIGM:
Awareness → Survival→ Crisis Response → Fragmented Care

↓ SHIFT ↓

NEW PARADIGM
Awareness→ Action→ Solutions→ Healing

Maternal health outcomes are not created in hospitals alone. They are created within ecosystems.

"Black women should not have to be extraordinary to receive ordinary care."

IMPLEMENTATION & SOLUTIONS

We must move from:

- Control → Collaboration
- Protocol → Presence
- Authority → Attunement

(CLINICAL ACTION)

Providers:

- Begin visits with regulation check-ins
- Ask: “What does your body need right now?”
- Normalize physiological responses

(COMMUNITY ACTION)

Birth Workers:

- Use co-regulation before education
- Create predictable, safe environments
- Integrate culturally rooted practices

(SYSTEMIC ACTION)

Policy & Public Health:

- Require trauma-informed training
- Extend postpartum care to 12 months
- Fund community-based programs

“When we build safer systems…

We don’t just change outcomes.

We change lives.”

“The question is not whether Black women can survive…

The question is—
Will we finally create systems where they don’t have to?”

Thank You!

For More Information on My Services, Courses, Trauma-Informed Trainings, and Presentations Connect With Me At:

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