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Artistic Expression of Medical Experiences of Mothers of Color: Perspectives using Art Therapy

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Artistic Expression of Medical Experiences of Mothers of Color: Perspectives using Art Therapy

A DISSERTATION

(submitted by)

Lauren E. Barrett

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

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DISSERTATION APPROVAL FORM

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Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

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Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

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I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

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STATEMENT BY AUTHOR

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Signed: Lauren E Barnett

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ABSTRACT

The purpose of this study was to qualitatively examine perspectives of mothers of color living in the US and their experiences in the healthcare system through art therapy. The study aimed to further identify personal narrative experiences of mothers of color navigating the healthcare system, promote individual voices, and acknowledge disparities impacting those within marginalized communities. The participants in this study included a total of eight identified mothers of color (non-White) living in the US. Participants took part in four weeks of consecutive art therapy sessions either in 60-minute group or individual virtual meetings. One art therapy directive was provided in each of the four weeks.

The eight themes and four subthemes included *Privilege and Disparity, Capitalism, Being Overlooked, Pressures Related to Reproductive Health (Subtheme A.), Fear and Protection, Mistrust (Subtheme B.) Advocacy (Subtheme C.), Resiliency, Generational Trauma (Subtheme D.), Loving Through the Unspoken, Holistic and Humanistic Care,* and *Art Therapy Responses*. The discussions were related to experiences with medical personnel, birthing stories, mothering identity, generational trauma, strengths, and interests in holistic healthcare interventions for mothers of color. All mothers spoke openly and engaged in the art therapy directives to better describe the perspectives of being a parent of color. The data included rich descriptions of nuanced parenting outlooks being women of color navigating the US healthcare systems.

Keywords: mothers of color, creative arts therapy, resiliency, strengths, disparities, healthcare

Author Identity Statement: This author identifies as a cisgender American woman and international South Korean adoptee.

CHAPTER 1

Introduction

Mothers of color living in the US are at higher risks of preterm birth, preventable maternal and infant mortality, undiagnosed postpartum depression symptoms, discrimination within the healthcare setting, and higher rates of cesarean sections as a mode of delivery (Arjunan et al., 2022; Collins et al., 2021; Destine et al., 2020; Goode & Bernardin, 2022; Keefe et al., 2021; Lett et al., 2023; Ogunwole et al., 2023; Reynolds, 2022; Sheikh et al., 2022). Medical racism impacting Black, Indigenous, People of Color (BIPOC) and people within marginalized communities leading to preventable fatalities and medical issues has been well documented (Arjunan et al., 2022; Berger & Miller, 2021; Campbell, 2021; Ogunwole et al., 2023; Reynolds, 2022; Smaw, 2021; Vilardaga et al., 2022). Mistrust within the medical system due to the US history of exploitation of BIPOC bodies and continual avoidance of formal acknowledgment of medical racism results in chronic disparities for people of color (Arjunan et al., 2022; Jackson, 2023; Williamson et al., 2019). As a result of an expanding body of literature on mothers of color and healthcare disparities, there have been increased inclusive programming focused on identity, the maternal BIPOC and people of color’s experiences, and recognition of disproportions (Hunte et al., 2022; Karbeah et al., 2022; Matthews et al., 2021; Sayyad et al., 2023) Better understanding the perspectives of Black birthing persons will work towards reducing infant and maternal inequities (Estriplet et al., 2022). There has also been a recognition of the value of providers of color, such as Black doulas and nurses, helping mothers to reduce birth complications (Sayyad et al., 2023). There is little formal research on the reproductive health experiences of Indo-Caribbean women and accessing basic healthcare services (Rozario, 2023). The research that has been conducted with Indo-Caribbean women have generalized their narratives to be traditional, conservative, and subservient, minimizing dimensional individual experiences and strengths (Hosein & Outar, 2012; Roopnarine, 2013).

The focus on US capitalism and insurance limitations within the healthcare setting continues to highlight the impact of structural inequities and lack of support for those within a lower socioeconomic standing (Campbell, 2021; Jackson, 2023; Ploplis, 2022; Sayyad et al., 2023). Basic healthcare needs and equitable healthcare options are also major concerns for mothers of color navigating the postpartum period (Keefe et al., 2021). It is imperative for BIPOC and people of color's voices to be heard in order to better understand the problems.

A 'mothers of color' lens is multicultural, multiethnic, and multiracial with varying outlooks on women's health in the US. While the research and mental health of all impacted persons are concerning and need to be formally addressed, the information discussed in this study primarily focused on Black and Brown health. The study's participants identified as Black, African American, Bi-racial (Black, Puerto Rican, and White), and Indo-Caribbean mothers of color.

Art therapy was created on the basis of humanism, individualism, and universal paradigms of human development (Talwar & Sajnani, 2022). The field uses the creative process and artistic expression to uncover internal knowledge and experience for therapeutic healing (Kramer & Gerity, 2001; Malchiodi, 2011; Rubin, 2011). "Art therapists are trained in art and psychological theory and can help clients integrate nonverbal cues and metaphors that are often expressed through the creative process" (American Art Therapy Association [AATA], 2022, para 1.). Art therapy can be applied to a variety of populations, including individual, group, or family approaches with psychodynamic, developmental, or humanistic orientations (Malchiodi, 2011). Originally, the field was described as two separate theoretical approaches, art as therapy and art psychotherapy, but has since expanded into a full comprehensive field with a clinical base (Gussak & Rosal, 2016). Art therapy is a growing practice and has continued to develop in academia, research, and as a profession (Art Therapy Credentials Board [ATCB], 2023).

More recently, art therapists have been encouraged to recognize the foundation of art therapy and revisit how the field can adapt its framework to support those within the global majority (Van Den Berg & Allen, 2022). As US political tensions between the Democratic and Republican parties have steadily grown over the past decade and inequities impacting those within marginalized communities have been identified, the use of a social justice theoretical framework within the context of art therapy as a healthcare profession has been proposed (Karcher, 2017; Potash, 2018; Talwar & Sajnani, 2022; Van Den Berg & Allen, 2022; Wright & Wright, 2022).

Karcher (2017) and Van Den Berg and Allen (2022) recognized the original principles of art therapy were tailored to the perspectives from White cisgender women's views. The researchers highlighted the responsibility of White creative arts therapists to rework outdated perspectives of art therapy foundations to avoid erasure of personal identities and inadvertent engagement in the cycle of harmful systemic oppression towards of those outside the dominant identity. This is problematic based on the sole principle it contradicts the field established on embodied paradigms of individualism, humanism, and self-expression (Talwar & Sajnani, 2022). This recognition of antiquated approaches to the field that covertly disregards people outside of the US dominant identity and passively subscribes to oppressive ideologies embedded within US hierarchies is controversial.

There was an open acknowledgement of how challenging these conversations centered on identity politics and injustices can be, and an encouragement to use a relational social justice approach was advised (Potash, 2018). Potash embraced the perspective that majority of people want to work towards a humanistic commonality away from supremacist ideations, but the road to better understanding nuanced privileges, expansive experiences, and collective identity trauma can quickly become delineated into a simplified, rigid binary model. The encouragement of relational social justice reworks a dual perspective and engages in the complex, interwoven relationship between parties attempting to be understood (2018).

While there have been limited studies conducted on art therapy for women with postpartum depression or maternal mental health needs, it has been suggested that this approach could be beneficial for those in the perinatal and postpartum periods (Burt et al., 2011; Harris et al., 2023; Qian et al., 2023). With the documented use of art therapy and intersectional identities in addition to researchers' proposals to re-examine foundational underpinnings using a social justice framework, a qualitive research semi-structured interview method with art therapy on perspectives of mothers of color is appropriate. The risk factors for mothers of color navigating the healthcare system, complexity of the perinatal and postpartum periods, and US experience of discrimination against personal identity also support the case for using creative expression in a research setting to better understand individual experiences.

Statement of the Purpose

Mothers of color living in the US are faced with a plethora of varying degrees of difficulty to meet their and their families' basic physical and emotional needs. The increased risk factors for preventable maternal and infant mortality, lack of support for adequate maternal and postpartum healthcare resources, and historical factors impacting current systemic injustices are the reasons to further understand perspectives of mothers of color navigating postpartum (Arjunan et al., 2022; Campbell, 2021; Destine et al., 2020; Jackson, 2023; Kemet et al., 2022; Reynolds, 2022). The need to revisit the humanistic principles of the creative arts therapy field for inclusive care, reexamination of foundations, and clinical impact on patients create more research opportunities for mothers and art therapy. Recommendations to utilize an individual narrative research framework for future implications also support the purpose for this qualitative study using art therapy.

At this time there does not appear to be research conducted with mothers of color living in the US and perspectives of the healthcare system through art therapy. Qualitative research has been conducted with mothers of color with supportive recommendations for narrative-based studies (Ogunwole et al., 2023; Wright et al., 2022), but there has not been a similar study incorporating the arts. This study poses the question, what are the perspectives of mothers of color in the healthcare setting within the context of the creative arts?

Researcher's Positionality

This researcher identifies as an American cisgender, international adoptee from South Korea living in the Pittsburgh, PA region. This researcher was adopted into a Caucasian American family in rural Upstate NY and is aware of the personal privileges that come from being associated and part of a White background. There is recognition of the historical harm the research community has committed towards BIPOC and attunement to not repeat these colonization cycles. This researcher is a parent to one child, was pregnant during the qualitative interviewing phase, and gave birth during the analysis phase of the study. Perspectives of being a mother of color and experiencing the medical system from various outlooks throughout the study may have presented different biases and expectations throughout the process. This researcher identifies as a supportive ally to the Black and Brown communities and does not assume similar experiences or perspectives within the mother of color spectrum in the US. Personal identity as an Asian American woman and as a Black or Brown woman have different risks, societal expectations, inequities, stereotypes, and assumptions. Asian American women living in the US do not experience the same level of maternal and fetal and/or infant risk as Black and Brown mothers or their children do.

This researcher also experienced birth trauma during delivery and has posited whether there were preventable action steps that could have produced a more typical birth experience. This perspective as a mother, woman outside of the dominant identity living in the US, and someone who has observed medical trauma provided a sensitive humanistic understanding between the researcher and participants. The information discussed was grounded within relevant peer-reviewed research and literature findings with a strong focus highlighting the participants’ narratives.

Chapter 2

Literature Review

The literature on mothers of color living in the US is a combination of medical research, essays on women's rights and health, and decades of information on US history. These perspectives provided an interwoven lens to what mothers of color living in the US are currently experiencing as they navigate the healthcare systems. The synergy between the compounded impact of history, unavoidable societal systems, and permeation of political influence creates an overwhelming web for mothers of color. These were the primary points of the comprehensive foundation supporting why it is important to further understand the experiences of mothers of color living in the US.

Professionals within the creative arts therapy field have been called to action to reexamine foundational perspectives and critique the ethical framework to make progressive equitable changes. There have been some studies conducted with mothers in the perinatal and postpartum period and art therapy, but race and ethnicity were not discussed in the participant data. It is unknown whether these studies included mothers of color. Specific studies on mothers of color and art therapy were not found. The creative arts therapy literature included information on the field, current concerns with future orientation related to equity and reflexivity of privileged creative arts therapists, perspectives using a relational social justice framework when speaking about controversial identity politics, and relevant arts-based research with mothers.

Disparities within the Medical System

Racism is a deeply rooted problem imbedded in American institutions and affects patients of color within the healthcare system (Berger & Miller, 2021; Reynolds, 2022). Birthing health concerns and disparities Black families experience within the medical system are well documented (Arjunan et al., 2022; Berger & Miller, 2021; Goode &

Bernardin, 2022; Lett et al., 2023; Matthews et al., 2021; Sheikh et al., 2022). "Nationally, Black mothers are nearly three times more likely to die in childbirth than non-Hispanic White mothers" (Destine et al., 2020, p. 605). Reynolds (2022) and Ogunwole et al. (2023) reported African American mothers are dying from preventable pregnancy-related concerns at a rate three to four times higher than non-Hispanic White women, and the death rate of Black babies is twice as high as White babies. Higher-income Black mothers and Black mothers in high-income countries are also at higher risk of neonatal death, stillbirth, preterm birth, and small-for-gestational age than wealthier White mothers or other mothers of other racial backgrounds (Sheikh et al., 2022).

Indo-Caribbean women searching for better reproductive healthcare opportunities within the US are then met with American healthcare inequities (Rozario, 2023). Latina mothers living in the US are faced with a variety of adversities, including anti-immigration policies, and have a higher risk of developing maternal postpartum depression. However, research has indicated they are less likely to be given a proper diagnosis (Pineros-Leano et al., 2021). Indigenous and Hispanic mothers have been victims of forced sterilization (removal of one's uterus without consent and/or knowledge) under US eugenics campaigns throughout the 20th century (Smaw, 2021). Though there have been documented legal evidence of these events, reconciliation with communities of color and retributive reparations have not happened. These examples have created an additional foundational layer of significant mistrust with the medical community (Smaw, 2021).

Medical disparities affecting people of color were recently highlighted during the COVID-19 pandemic resulting in high morbidity and mortality rates (Berger & Miller, 2021). Medical mistrust is an additional layer of the complexity that creates further disconnect between patients and providers (Williamson et al., 2019). This division is deeply ingrained over years of historical exploitation, lack of recognition, and multiple powerful systems (medical, criminal justice, educational) impacting the public with slow movement to change despite exhaustive efforts (Reynolds, 2021).

Even with extensive current research, the medical field has been slow to make corrective action and further address the detrimental systemic concerns that severely affect patients of color. Both Reynolds (2022) and Berger and Miller (2021) identified problems within the medical field and education programs. This included the lack of board action to make changes towards equitable healthcare, well-respected healthcare associations providing misinformation, and general avoidance of the topic of structural racism and historical implications in both systems.

Berger and Miller (2021) discussed how the leaders of the Association of American Medical Colleges (AAMC) have focused attention on the differences in culture versus racism as the main reason for health disparities. The result of this approach was the AAMC to instead concentrate on culture competence and become more culturally attuned to diverse backgrounds rather than recognize the awareness and effects of structural medical racism as the cause for health disparities. The researchers challenged this notion by reporting how this viewpoint not only softens the facts of history for organizational comfort but undermines the impact of medical racism supported by present research. They also identified how there is a notable ignorant viewpoint assuming interchangeable definitions between ethnicity, culture, and race within the medical field. This stance has been the general approach of these organizations and there has been an avoidance of directly addressing the impact of racism (Berger 2021). Despite revisions to the AAMC’s publications on diversity and inclusion over the years, there continued to be concerns over the presentation of what it means to be culturally competent.

Reynolds (2021) proposed specific suggestions regarding how the regulatory boards can combat medical racism. This included creating a more diverse membership of regulatory bodies to connect with communities of color, medical boards implementing a stricter disciplinary response to reduce bias and hold providers accountable, and educational programs overtly teaching the history of US medical racism to create a better understanding of people of color.

While the American Medical Association (AMA) has taken responsibility for medical racism by admitting to specific accounts, the general medical field has omitted record of racist occurrences and physicians have continued to denounce medical racism even exists despite countless publications (Reynolds, 2021). Specifically addressing the medical education system, “there is a long history of medical schools excluding and discriminating against Black students” (Reynolds, 2021, p. 34). Reynolds identified that while there were formal, accredited promotions of diversity from the Liaison Committee on Medical Education (LCME) in 2009, between 2002- 2017, there were decreased statistics of applicants of color, specifically Black women, despite an increase in Black men graduating from college.

These examples identify the overarching theme of powerful systems that affect the public and are grounded in comfortable ignorance and/or avoidance that promote the continuation of medical disparities. The researchers highlighted the intersections between power dynamics within reputable organizations, education, and subtle underlying messages that create the undertone of the system.

Historical Exploitation of Bodies of Color in Healthcare

The US has an extensive and violent history regarding where and how the medical field has obtained its span of knowledge about treatment, genetics, progressive diseases, reproductive health, and surgical techniques (Arjunan et al., 2022; Campbell, 2021;

Reynolds, 2022; Story, 2018). Examples of historical impacts against people of color include eugenics, “racial theories of disease,” the Tuskegee Medical Experiment, the Flexner Report, and the American Medical Associations’ exclusion of Black physicians (Reynolds, 2022, p. 41). Specific to women’s health and women’s rights, acknowledgement of the atrocious acts that were committed against women of color, specifically enslaved Black women, is important to understand when looking at reproductive health (Barclay, 2017). Outdated and harmful theories on differential biological makeup based on race has lead Black and Brown bodies to be presently vulnerable to overmedicalization, dismissal of appropriate treatment options, emotional trauma and burdens, and fatality (Campbell, 2021). It is also important to note that at a federal level, discrimination was not addressed until the 1960s (Ploplis, 2022).

Campbell (2021) wrote a detailed essay on the cruel medical history and exploitation of Black bodies within the healthcare system, while focusing on the interplay between obstetrics and racism. Enslaved Black women in the US could neither consent to nor refuse medical treatment at the hands of White male physicians. As a result, the field of gynecology prospered at the expense of Black women’s bodies and experimentation. Barclay added to the literature and discussed how Black women in slavery were seen as “good breeders” and a source of greater reproductive income for White owners (Barclay, 2017, p. 289). Campbell included how enslaved women’s duties included both the producers of children (who would also be considered legal property of slave owners) and production workers (2021). Women who bore more children were viewed as more profitable and provided incentives (low labor, labor-free days), but were also increasingly vulnerable to sexual abuse and exploitation (Barclay, 2017).

However, if an enslaved Black woman experienced infertility or gave birth to a child with congenital birth defects, they were framed within the racist hypersexualized model as deserving of or blamed for their “condition,” while White women were provided a “feeble” and “frail” association (Barclay, 2017, p. 255). Women who experienced infertility were viewed as disposable and consequentially were often abused and re-sold (Barclay, 2017). Traditional religious views were also used as a source of interpretation for women who experienced infertility or gave birth to children with disabilities. Furthermore, there was a stark contrast regarding how religious underpinnings were addressed between Black enslaved women (God punishing Black women as a result of their promiscuous behavior) versus White women (an unexpected sympathetic event under God) (Barclay, 2017). These historical perspectives speak to the intersections between sex, religion, race, and reproductive health. The level of dehumanization coupled with the racist, inaccurate theoretical notion that Black and Brown people are of an inferior genetic makeup created a foundation for exploitation with purpose. Additionally, there was no reprieve after death as grave robbers and medical institutions used Black bodies for continual experimentation (Campbell, 2021).

James Marion Sims (a White male physician who practiced between 1835 through 1877) created his performative reputation as a White savior within the medical field, supporter of women’s rights, and as a result is considered the “father of modern day gynecology” (Campbell, 2021 p. 55; Chan, 2023, p. 1). However, the realities behind his medical work were based on the violent, involuntary experimentation of enslaved Black women (Jackson, 2023; Smaw, 2021). To legitimize his status and promote public support, Sims presented his medical interventions as being received with gratitude and appreciation from his patients (Chan, 2023). He wrote an autobiography titled, “Story of My Life”, and depicted himself as a sentimental, revered practitioner engaging in selfless acts to strengthen the community (Campbell, 2021; Chan, 2023; Godley, 2021).

He developed the surgical procedure, *vesico-vaginal fistula* (tearing between the bladder and vaginal wall), and perfected his technique on enslaved Black women in his personal open medical theater (Campbell, 2021; Chan, 2023; Godley, 2021; Jackson, 2023; Smaw, 2022). "Betsey Harris, Anarcha Westcott (impregnated by her owner), and Lucy Zimmerman were identified as research subjects at his facility in Alabama" out of 11 women (Campbell, 2021, p. 55; Godley, 2021; Smaw, 2022). It is important to note Sims built this medical facility as an extension of his home and encouraged plantation owners to send him pregnant enslaved women to live there as subjects to practice his technique (Godley, 2021).

He experimented on these women at his facility between January 1846 through June 1849, did not use anesthesia though it was available, and operated on Anarcha Westcott thirty times (Godley, 2021). Campbell recalled in her essay how he invited medical professionals to join and watch him perform at his man-made home medical theater (2021). Once his technique was sufficient to his liking, he then performed on White women using anesthesia to mitigate their pain (Godley, 2021). These are disturbing cases of Black women's bodies being objectively displayed for the institutional gaze, violently abused, and the interventions being relabeled as appreciated, thankful efforts to uphold the White male savior trope.

A current racist assumption that continues to be problematic is the belief that Black people have a higher genetic pain tolerance, or lack thereof, than White people, and/or requests for pain medications are linked to drug-seeking behaviors (Vilardaga et al., 2022). Sims publicized this racist rhetoric and did not provide anesthesia to his subjects during surgery despite availability (Campbell, 2021). This insidious postulation is an example of how historical racism continues to presently affect people of color.

Ignorance has led Black and Brown patients to unnecessarily suffer and receive inadequate medical care that their counterparts do not have to bear.

Eugenics and Sterilization Abuse

While White slave owners were using Black women as reproductive profit throughout a significant part of US history, as the decades passed an opposing exploitive racist movement began occurring; the US history of population control sterilization of Black and Brown women. Researchers have warned of a strong need for practitioners in reproductive health to have grounded education in the heinous historical practices within the US in order to maintain consistent ethical approaches with patients of color and reduce risk of continuing structural medical racism (Arjunan et al., 2022). These areas include but are not limited to genetic testing, involuntary sterilization of women in marginalized communities, and the history of Black women within slavery (Arjunan et al., 2022; Barclay, 2017).

Forced sterilizations had been occurring in the US starting in the 1900s and were paid for by reputable organizations including the US Department of Human Services and Medicaid (Arjunan et al., 2022; Smaw, 2021). Investigations have discovered Black, Indigenous, and Hispanic women have been victims of eugenics campaigns in the US (Smaw, 2021). The foundation for this movement included the rise of the human genetics field and focus on “social fitness” strategies to curate a specific American society (Arjunan et al., 2022, p. 3). There are interconnections of racism, xenophobia, immigration, interracial marriage laws, and ability as overarching motivators for the eugenics movement (Arjunan et al., 2022; Smaw, 2021).

After the end of slavery, people of color began to obtain more individual human rights creating increased threat for White Americans. This resulted in radical changes including national eugenics campaigns to promote population control through governmental means (Smaw, 2021). “By World War II, over 60,000 individuals had undergone involuntary sterilization, and most of these individuals were poor people of color” (Smaw, 2021, p. 3). This procedure was so common with poor Black women including Fannie Lou Hamer, a Black female civil rights activist leader in the 1960s, it earned the nickname “Mississippi Appendectomy” (Rice & Young, 2021, p 186; Smaw, 2021). A lack of consent to this procedure, coercion, and blatant misrepresentation of what the procedure was going to entail all occurred during these sterilization abuse cases (Arjunan et al., 2022; Smaw, 2021).

A specific example to recognize the present-day traumatic impact the medical system has had on women of color that reflects this historical, oppressive dynamic is the case of Henrietta Lacks (JHMC, accessed September 9, 2023). Henrietta, a poor Black woman living in the US, received treatment at Johns Hopkins Hospital in 1951 after experiencing excessive uterine bleeding. After examination by well-known gynecologist, Dr. Howard Jones, they discovered a malignant tumor on her cervix. A sample of these cancer cells was collected during a biopsy and sent to Dr. George Grey’s lab for additional testing. Her cells, named “HeLa” after her initials, doubled every 20 to 24 hours whereas Dr. Grey’s other samples in this area would die. Her cells have since been used to achieve significant progression in the medical field and test different reactions to drugs, toxins, radiation, viruses, and vaccinations, including the most recent COVID-19 vaccine (JHMC, accessed September 9, 2023).

However, there are speculations of whether Henrietta consented to her specimen being retrieved and passed forward to medical organizations to be used for additional medical research and experimentation (Arjunan et al., 2022). There was not a formal process for consent during this time, let alone for low-income Black Americans. The researchers who have used her cells have won Nobel Prizes, biomedical companies have profited from the research, and her family has been fighting for medical justice since her passing (Arjunan et al., 2022; Shevelev & Shevelev, 2022). She and her family's experiences are one of modern-day obstruction of personal agency, use of Black and Brown bodies to support personal achievement and industrial profit, and maintain the continual conflict between BIPOC humanism and systems. Her story and thousands of others exemplify the need for informed consent, while providing a harsh reminder of the historical impacts the research and medical field have had on people of color.

Cesarean Sections and Black Mothers

Literature has reflected the medical decision to perform a cesarean section (c-section) as a mode of delivery is a serious surgical procedure (Hanson et al., 2022; Miller & Baker, 2022). While sometimes medically necessary, a c-section can place women and babies at unnecessary risks including fatality, infection, hemorrhaging, slower recovery time, delays in breastfeeding and skin-to-skin contact, and complications in future pregnancies (WHO, 2021). The World Health Organization (WHO) has indicated an uprising c-section trend from 1990 to 2018 with projections to increase by 2030 in high-income, middle-income, and low-income countries (Betran et al., 2021). The WHO has strongly recommended education and implementation of non-clinical interventions to mitigate the unnecessary use of c-sections. Betran et al. (2021) reported concerns with projected worldwide c-section use with overmedicalization and overuse resulting in increased mortality rates. With increasing number of c-sections, researchers have also acknowledged the interplay between historical overmedicalization of BIPOC and communities of color, integrated racist beliefs about Black bodies within the healthcare system, and higher rates of BIPOC chronic health conditions (Campbell, 2021; Jackson, 2023; Ploplis, 2022).

In the US, Black and Brown women are more likely than non-Hispanic White women to have poorer health outcomes, maternal and infant mortality rates, and discrimination from providers (Berger & Miller, 2021; Destine et al., 2020; Hanson et al., 2022; Ibrahim et al., 2022; Jackson, 2023; Miller & Baker, 2022). With the concerns of rising c-section trends, there is a dual risk for pregnant mothers of color. The literature has reflected current health disparities and the continual impact of historical oppression taking physical agency away from women of color. The overuse of c-sections should not be excluded in this same narrative.

Miller and Baker (2021) conducted a qualitative study with African American (AA) mothers living in the US who had had a c-section and subsequent birth in the past 12 years to better understand birthing experiences. These birthing modes included a successful vaginal birth after delivery (VBAC), failed VBAC, or repeat cesarean delivery (RCD). Twenty-five AA mothers were interviewed via recorded phone call and their transcriptions were analyzed to gather codes and themes. The researchers implemented the Sort and Sift, Think and Shift method to reduce researcher bias and highlight participant voices (2021).

The participants reported their team of providers had a significant influence on their birthing experiences (2021). The five main themes that arose in the data included provider beliefs and language, provider and facility type, provider identity, patient autonomy, and influence of race and racism. The mothers experienced projected opinions from the providers about VBACs and RCDs that affected their pregnancy and birth. Those who had preferred a RCD found communication between them and their provider to be respectful, while those who preferred a VBAC felt their providers were unsupportive and condescending. They reported their providers used “scare tactics” that removed their decision-making perspectives from the conversation (2021, p. 808).

While most of the participants worked with an OB/GYN provider and gave birth in a hospital setting, six participants partnered with midwives. The participants' preferred birth facilities included a hospital setting, home, or prenatal birthing center. The researchers found the participants who decided to connect with a midwife did so because of not liking the hospital setting, their relationships with previous OB/GYN provider, and an interest in seeking positive support for a VBAC. The participants also preferred a female provider and provider of AA background due to feeling more connected and comfortable.

The mothers who felt they had increased autonomy as a result of their patient-provider relationship in their birth experience had a more positive perspective regardless of the outcome. This response indicates the importance of the patient and provider connection during pregnancy and delivery. Finally, race and racism were identified as affecting their birth experiences. The participants reported providers speaking to them in a condescending manner and making assumptions about their health experiences based on their appearance, not their individual history. The researchers noted that while all the participants were aware of medical racism within the healthcare system, not all who experienced negative interactions attributed the cause to racism. These participants acknowledged the protective factors including having lighter skin, prior birthing information, support, and self-advocacy skills as a source of mitigation (2021).

This study highlighted the recommendations the WHO and other researchers have encouraged to create more equitable healthcare outcomes for mothers of color (Ibrahim et al., 2022; WHO, 2021). The information also echoes similar sentiments about the importance of patient and provider dynamics in the context of pregnancy, birth, and postpartum. Choosing to perform a c-section is an important decision and all factors should be thoroughly considered.

Mistrust and Mitigations of Risks

While receiving healthcare services, the relationship between the patient and provider is impactful and can help one feel more positive during their pregnancy and birth experiences (Hunte et al., 2022; Miller & Baker, 2022). The medical system places “unreasonable burdens” onto a mother by forcing them to be both an advocate for equitable healthcare and a patient during pregnancy and birth; a vulnerable experience (Campbell, 2021, p. 49). For mothers of color, having authentic, meaningful support during labor and postpartum can help reduce burdens such as stress, systemic racism, and infant and maternal mortality rates (Collins et al., 2021; Hunte et al., 2022; Karbeah et al., 2022; Lett et al., 2023; Matthews et al., 2021). Mistrust between the medical system and people within marginalized communities has been long documented (Smaw, 2021). Understanding the dynamic between marginalized communities and mistrusting the medical system is under-researched and yet affects the healthcare outcomes of people of color (Williamson et al., 2019). The following further identifies the present dynamic of mistrust and communities of color with specific changes that can be made to increase autonomy, safety, and support for mothers of color.

Williamson et al. (2019) used a quantitative research approach to examine the relationship between discrimination and medical mistrust, test the effects of mediated racial discrimination and medical mistrust, and better understand the antecedents. The results of the research included a correlation between medical mistrust and discrimination. The research also provided new information on the impact of mediated vicarious discrimination and mistrust. The researchers discovered the news and media stories related to discrimination but not healthcare impacted levels of mistrust within the medical system despite being separate perspectives. The researchers underpinned the power of public media exposure related to increased mistrust of the medical setting.

With acknowledgement of these factors contributing to disparities, movement towards reaching more equitable healthcare services for Black and Brown mothers has begun. Recent research has identified different progressive supportive services that can be incorporated into the healthcare setting during labor and delivery and postpartum for mothers of color. These services included partnership with a community support person (CSP) during labor and delivery and working with a perinatal support person (PSP) during pregnancy, delivery, and postpartum (Collins et al., 2021; Lett et al., 2023). Black midwives and doulas have also been identified as supportive persons for Black birthing people (Goode & Bernardin, 2022).

Lett et al. (2023) conducted a cross-sectional cohort study to determine whether the partnership with a community support person working with a mother during her labor and delivery and postpartum period reduced the experience of medical racism. What the researchers discovered was out of the 806 mothers of color, 720 (89.3%) had one CSP and there was a reduction of racist acts in all three domains they were examining. The incorporation of a CSP was found to increase protection for patients of color from further system racism and harm. Additionally, a CSP also increased patient advocacy to meet their needs during labor, delivery, and the postpartum period (Lett et al., 2023).

While there appears to be more recent acknowledgement of risks and historical impact on Black and Brown mothers, change towards equitable healthcare is slow. The seriousness of what has occurred within US history and outcomes related to mortality indicates the importance of research and continual support for change. This section identified the complex foundation with specific reasons why mothers of color need active support in maternal reproductive health. The following illustrates recent literature on maternal mental health for mothers of color and the effects of the postpartum period.

Mothers of Color: Maternal Mental Health

Mothers of color experience extensive concerns within the healthcare setting due to systemic racism, lack of culturally attuned supports, and preventable medical outcomes that impact their pregnancy, labor and delivery, and postpartum experiences (Collins et al., 2021; Destine et al., 2020; Estriplet et al., 2022; James et al., 2023; Goode & Bernardin, 2022; Howell et al., 2018; Hunte et al., 2022; Karbeah et al., 2022; Lett et al., 2023; Matthews et al., 2021). Postpartum healthcare for mothers is needed as a means of mental health support, treatment for health concerns related to pregnancy and/or postpartum, and authentic connection during this vulnerable time (Albanese et al., 2020). Increased rates of perinatal and postpartum depression (PPD) and/or higher infant mortality rates have been identified within Indigenous, Latino, Southeast Asian mothers living in New Zealand, and Black communities due to inequities, risk factors, and lack of racially sensitive care in healthcare systems (Conteh, 2022; De Graaff et al., 2023; Estriplet et al., 2022; Matthews et al., 2021; Owais et al., 2019; Pineros-Leano et al., 2021). Researchers reported Indigenous mothers are at higher risk of experiencing adverse outcomes during the perinatal period including anxiety, depression, and substance abuse, but due to a lack of research, the magnitude of risk is unknown (Owais et al., 2020). There is a growing body of research identifying adverse outcomes of the postpartum period and how healthcare systems can provide greater means of support for mothers and families (Albanese et al., 2020).

The following features the current research specific to mothers of color, postpartum depression, treatments, and barriers to receiving adequate care. It is important to recognize systemic racism and lack of research on mothers of color are the reasons for health disparities and some risks of adverse postpartum outcomes, and not genetic, physical racial differences or culture (Berger & Miller, 2021; Campbell, 2021; Reynolds, 2022). Furthermore, the mental health of mothers of color extends to numerous cultural, ethnic, and racial identities. This researcher reiterates that while the research and mental health of all impacted persons are concerning and need to be properly addressed, the information presented on maternal mental health care and disparities is primarily focused on Black and Brown mothers. The reasons are due to the current literature findings, acknowledgement of high-risk factors specific to Black and Brown mothers, and the primary participant demographic information within this research study. There is limited research on perinatal and postpartum experiences of Indo-Caribbean mothers (Roopnarine, 2013).

Postpartum Period

The postpartum period is a vulnerable and critical time for the healthcare of mothers to be prioritized particularly if they experienced additional medical concerns during pregnancy and/or birth (Ogunwole et al., 2023). During the postpartum period mothers are expected to return to their former psychological and physical functioning states, care for and bond with their child, and help their partner and other family members adjust to the changes (Demirel et al., 2018). The postpartum period can be taxing. Physical demands, emotional changes, social expectations, and environmental factors interplay with the mother's functioning during and after pregnancy (Incollingo Rodriguez et al., 2019). Mothers have been reported to hide their true feelings, symptoms, and stressors during this time due to emotional, social, and physical pressures (Demirel et al., 2018). These experiences can lead to greater risks and mental health needs. For mothers of color, these challenging postpartum needs are coupled with identified healthcare disparities and barriers to receiving adequate care.

Ogunwole et al. (2023) conducted a qualitative study to explore the experiences of Black women with cardiometabolic risks and the cultural, social, and historical factors that impact postpartum care within the first year. The researchers met with 18 women recruited from three early-home-visiting programs in Baltimore, MD and engaged in an in-depth interview process. They assessed the information and categorized the findings into six main themes that emerged from the data. These themes included (1) enduring influence of structural racism, (2) personally mediated racism in healthcare and beyond, (3) sociocultural beliefs about preventative healthcare, (4) barriers to postpartum care transitions, (5) facilitators of postpartum care transitions, and (6) postpartum health and healthcare needs, such as mental health and social support.

These results highlight a complex interplay between the healthcare system and mothers of color that conclusively affect their children. The researchers discovered that the participants were not fully aware of their need for postpartum care or how the collective experiences they had prior to their pregnancies affected their outlook on the healthcare setting and willingness to engage. They also noted pregnancy and childbirth as opportunities for these mothers to receive formal education on their needs, but it was overlooked. The healing and postpartum recovery was related to both mental and physical health, and the patient-provider relationship was impactful in the overall experience. Ogunwole et al. (2023) reported there was a need for primary care physician follow-up but often there was disruption between delivery to community care supports. Not receiving immediate postpartum follow-up can result in a lack of management of chronic diseases that could have been affected by pregnancy or oversight of high-risk concerns during postpartum.

The relationship between the patient and practitioner is impactful throughout pregnancy, delivery, and postpartum (Wright et al., 2022). New parents may turn to their providers for reassurance, information, and emotional support, making this relationship a crucial resource. As previously mentioned, there is a distinct interplay between systemic racism, history, and mothers of color. For reasons previously identified, women of color do not trust the medical system and are less likely to engage in therapeutic intervention or form a relationship with medical personnel (Bodnar-Deren et al., 2017; Williamson et al., 2019).

This barrier to treatment signifies a need for providers to be informed about maternal mental health symptoms and risks for mothers of color, possess education on the impact of structural oppression and history, and be knowledgeable about possible treatment options that are specifically helpful to women of color (Hunte et al., 2022; Matthews et al., 2021; Wright et al., 2022). Additional progressive interventions have been found to reduce racial disparities and provide protection to mothers during delivery (Lett et al., 2023). Doulas and midwives supporting mothers during labor and delivery and postpartum care have been increasing at hospitals (Lett et al., 2023).

Postpartum Depression (PPD) and Disparities

Postpartum depression (PPD) is a serious, global mental health condition that affects the general wellbeing of mothers and infants (American Psychiatric Association, 2013; Mersky & Janczewski, 2018). It is a mood disorder following birth with symptoms including disconnect, apathy, thoughts of harming oneself and/or their baby, and can range in severity (James et al., 2023). In the US, 29-44% of Black women experience PPD symptoms following delivery (James et al., 2021; 2023). Studies have shown that a woman’s mental health is at greatest lifetime risk following pregnancy (Seymour-Smith et al., 2017). This shift from suggestion to identification of the highest risk indicates a need to evaluate maternal mental health as women enter various stages of her reproductive health.

Generally, many societies assume the experience of motherhood to be positive, however the transition can be accompanied by intensive emotional and behavioral stressors (Closa-Monasterolo et al., 2017; Nnadozie & Nweke, 2017). A sudden, unanticipated change in a mother’s birth plan can also have a negative impact on her emotional wellbeing (Preis, Lobel, & Benyamini, 2019). A traumatic birth experience can impact bonding and attachment between mother and infant, leading to mental health diagnoses such as posttraumatic stress disorder (PTSD) (Hairston, Handelzalts, Assis, & Kovo, 2018).

Black mothers experience higher rates of postpartum depression symptoms and are less able and/or willing to receive medical care due to mistrust of hospital systems (Conteh, 2022; Keefe et al., 2021; Ogunwole et al., 2023). The reasons for perinatal mental health disparities are interrelated with persistent lack of adequate provider follow-up, lack of appropriate screening, access to healthcare services, and decisions to not engage in treatment (Conteh, 2022). Moreover, persistent structural oppression and medical inequalities continue to impact mothers of color and their children (Karbeah et al., 2022; Ogunwole et al., 2023; Owais et al., 2019).

Untreated PPD can result in serious outcomes including increased mental health needs for the parent, negative impact on childhood development, and greater distress within the family (Bell, Bloor, & Hewitt, 2019; Matinnia et al., 2018; Mersky & Janczewski, 2018). A mother’s sensitivity and response to her child is an important piece of development and if there are underlying unaddressed needs, it could affect the overall wellbeing of the mother and infant (Cordes et al., 2017; Prenoveau et al., 2017; Rotheram-Fuller et al., 2018).

While there is general acknowledgement of the high vulnerability and need for support during the postpartum period, resources for all mothers and families continue to be lacking in the US (Albanese et al., 2020). Furthermore, the development of depressive symptoms within the perinatal, postpartum, and early parenthood experiences are not well understood (Fredriksen et al., 2017). With the growing knowledge of gaps in healthcare for mothers of color, there has been an increase in progressive, inclusive programming during the postpartum period that will be further discussed.

Inclusive Perinatal Support Programs

Due to the risks and concerns within the current healthcare systems, there has been the recognition of need for pregnancy and postpartum supports focusing on inclusion and personal identity (Hunte et al., 2022; Karbeah et al., 2022; Sayyad et al., 2023). There has been a call for representation of nurses, doulas, midwives, and providers of color, and birthing centers centered around cultural identity (Hunte et al., 2022; Karbeah et al., 2022; Ploplis, 2022.; Sayyad et al., 2023). There are systemic and socioeconomic barriers that limit access to these resources including the impact of insurance coverage and insurance policies (Campell, 2021; Jackson, 2023; Ploplis, 2022). Midwife and doula services are less likely to be covered by insurance and Medicaid has complicated regulations related to reimbursement of specific services (Ploplis, 2022). Despite these concerns, there has been movement towards implementation of these programs.

Matthews et al. (2021) conducted a qualitative research study with 10 Black women advocates for Black birthing people including mental health practitioners, activists, and researchers. The purpose of the study was to identify specific strategies that organizations and healthcare systems can incorporate to reduce disparities and improve care of Black birthing people. The results included five avenues to take into consideration to reduce inequality, increase positive health outcomes, and decrease systemic harm. These included educating and training practitioners, investing in the Black mental health workforce, supporting Black women-led community-based organizations, engaging in community and traditional healing practices, and promoting integrated treatment care.

Matthews et al. (2021) reported there has been movement within national policies that align with these recommendations for Black healthcare. The increase in community mobilization works towards creation of federal, state, and local policies in favor of supporting equity. Black women-led reproductive health advocacy group examples include the recent formal recognition of Black Maternal Mental Health week and Black Maternal Health week by officials, policy holders, and communities. Matthews et al. also acknowledged the Kira Johnson Act; a bill that was created after Kira Johnson, a healthy Black mother who died giving birth to her second son. This act provides community-based resources to pregnant marginalized mothers of color struggling with substance misuse. Another example of community advocacy for mothers experiencing inequities is Moms4Housing; a Black women-led organization that garnered national support for families struggling with housing insecurities (Harper, 2021). While there is much work to be done, these examples provide evidence there is an increase in establishment of appropriate resources focused on mitigating inequities and disparities for mothers of color.

Though there have been medication management therapies and approaches to treat PPD, there are also barriers to consistent engagement, including transportation, childcare, and stigma (Mundorf et al., 2018). Mundorf et al. conducted a quantitative study to better understand whether early intervention perinatal social support groups could reduce the risk of PPD in lower-income women. Community health workers (CHW) partnered with participants through technology and home visits to form a positive relationship during the perinatal period.

The researchers found a moderate, statistically significant difference in 6-month PPD symptoms between those participants partnered with the CHW group and those who were not (Mundorf et al., 2018). They discovered the effects to be greatest for women without partners. The relationship with the CHW was moderately associated with PPD scores. They determined their intervention was the most successful with women who were single and able to form a general bond with the CHW.

Mundorf's et al. (2018) study concluded by recommending continued program outreach for women at risk for PPD. This intervention also provides another resource for women of color with PPD who may be mistrusting of engaging in treatment at a medical facility. The risk factors identified in their study included sociodemographic status, perception of pregnancy, and psychosocial variables. These risks will be discussed in the following subsection.

A healthy postpartum period for mothers of color includes culturally attuned medical professionals and resources to support mothers and families during this transition. These studies have shown that while there have been progressive, culturally standardized movements and federal recognition of change for Black and Brown mothers, there continue to be serious concerns in healthcare, research, and education to promote further developments.

Strengths of Mothers of Color

Strengths of mothers of color also presents in numerous ways due to the multi-faceted experiences of mothering identities in the US. The following provides information on what resiliencies can look like through lens facing differing layers of adversity, including acculturation and intergenerational historical traumas. While there is limited literature on Indo-Caribbean mothers, the existing information is focused on strengths and resiliency factors. Outdated, linear perspectives on the personal identities of women of Indo-Caribbean descent have been based on a traditional, subservient gendered image without acknowledging the impact generational immigration and complexity of individual humanism (Roopnarine, 2013; Rozario, 2023). Researchers have identified risk factors of mental health concerns (depression, severe isolation, intimate partner violence, and substance abuse) to include impact of generational immigration and cultural assimilation into the US, history of colonialization, familial stressors related to success, and racial discrimination (Ramdihal, 2023).

Roopnarine (2013) conducted a semi-structured qualitative research study with 30 immigrant Indo-Caribbean mothers living in Queens and Schenectady, NY to examine the complex, multiple perspectives of motherhood. The four themes that emerged within the analysis included the participants viewing motherhood as a lifechanging experience and blessing (1); maintaining a nurturing role while working to reduce similar struggles their mothers experienced (2); placing emphasis on structure, education, and respect to authorities coupled with disciplinary action as needed (3); and emphasis on continuing to support cultural values and religious beliefs related to their heritage (4). The perspectives of these participants were related to resiliency factors of attuning to their personal histories, families, and while actively parenting their children with dual identities. Taking an active stance against patriarchal gendered systems to create a more egalitarian household and denouncing a simplified, traditional framework were also noted in the qualitative data (2013).

There have been identified resiliency factors mothers of colors possess and ways of joining as a community to fight against systemic oppression, invalidation, and societal harm. Harper (2021) used the activist organization, Moms4Housing, as an example of Black women coming together and changing governmental policies for homeless women and families. The Moms4Housing organization was developed by three homeless Black mothers as a response to the housing crisis in Oakland, CA (Hahn, 2020). With the awareness of the ramifications and knowledge of the legal repercussions of homelessness, the mothers moved into vacant housing on Magnolia St. in Oakland, CA. They were evicted and arrested, and as a result, received local and national media attention supporting their cause. In response to the public, the mayor of Oakland transferred the ownership of the property to the Oakland Community Land Trust for mothers and families in need of housing (Harper, 2021).

Harper (2021) acknowledged Mothers4Housing as an example of mothers of color possessing the burden and awareness of systemic oppression and choosing to form a stronger alliance to challenge the policies working against homeless Black families. While this group of women were able to change the legal outcome, Harper recognized the underlying knowledge and preparation they had needed in order combat the structural powers in a successful way. This is not always an option for women in an underserved environment.

Oshin and Milan (2019) conducted a mixed methods study to analyze the associations with SBW (Strong Black Woman) attributes (strong, self-reliant) between mothers and their daughters of various racial and ethnic backgrounds. The purpose of the study was to better understand the influences of maternal socialization between mothers and daughters of different racial and ethnic groups. The researcher's discovered that while their original hypothesis was unfounded, they discovered Black mothers and daughters had more positive associations with SBW features than White or Latina mothers and daughters.

The researchers discussed these differences may be a result of historical and systemic experiences that the Black community has had to endure, versus their Latina or White counterparts. They acknowledged that the women who had been exposed to a degree of marginalization may align with these attributes due to their experiences. The researchers also posited whether these positive associations bolster innate, embodied self-efficacy and could be a resiliency factor as their daughters age.

James et al. (2023) conducted a secondary analysis study to identify clinical, racial, and sociodemographic factors connected to maternal functioning with 116 Black postpartum women living in the Southern US. Multivariate analyses indicated that Black racial identity ($p = 0.02$), PDS ($p < 0.0001$), maternal–infant attachment ($p < 0.0001$), and educational level ($p = 0.03$) were independently associated with maternal functioning. They adapted the BAM (Becoming a Mother) theory to include Black racial identity as a better framework for mothers of color (2023).

In this sample, James et al. (2023) discovered low postpartum depression symptoms indicating high levels of maternal functioning, high scores of MAI (scale to determine maternal-infant attachment) indicating high level of affectionate attachment between mother and baby, and those with a high school education/GED or less had higher levels of maternal functioning in contrast to those with post-secondary education. These findings were comparable to results of previous studies the researchers included in their analyses, and they also had different theories of reasoning behind these outcomes.

Due to the seemingly opposing results, they posited the influence of *Sojourner Syndrome* created by Dr. Mullings and named after formerly enslaved abolitionist and civil rights activist, Sojourner Truth (Mullings, 2005). This phenomenon describes the perseverance and resilience of Black women experiencing extreme levels of adversity, trauma, and discrimination (James et al., 2023; Mullings, 2005). The researchers also wondered about the influence of social identity of a SBW that was examined by Oshin and Milan (2019). These two studies both highlight the experiences of adversities or stressful transitions while noting the impact of internal identity and resiliency factors providing protection.

The strengths of mothers of color resembles a complex range of resiliency factors in the face of oppression, acculturation, racism, and the trauma of US history. Progressive research, programs, and consistent information about the history of women of color's health is a continual process towards humanistic and ethical healthcare outcomes. The following is information on creative arts therapy and how this approach interwoven with perspectives of mothers of color can be impactful in understanding narratives.

Creative Arts Therapy

It is difficult to conceptually define the arts and the impact they possess (Colella et al., 2022). Art therapy is a clinical mental health profession used to improve the wellbeing of individuals through nonverbal expression via the creative process of art making (AATA, 2017; Heckwolf et al., 2014; Malchiodi, 2011; Rubin, 2011). The use of the creative arts within a therapeutic setting embodies similar objectives as traditional therapeutic interventions with goals to reduce symptomology, increase self-esteem, resolve interpersonal conflict, and instill individual growth (Malchiodi, 2011). The difference being is engagement in art therapy enhances self-expression, identification of nuanced emotions, and provides an alternative method to processing therapeutic perspectives through creative means (AATA, 2017).

The push to further legitimize the field is continual. Researchers have noted the limited amount of studies with sufficient data has made it challenging to infer generalizations for further implications other than more research is needed (Harris et al., 2023; Qian et al., 2023; Snir et al., 2020; Uttley et al., 2015). The expanding research between art therapy and neuroscience has created a stronger approach grounded in both theory and science (King & Parada, 2021). These researchers (2021) have recommended future studies between science and the arts to be conducted to cement the need for the creative arts and expressive therapists in healthcare.

Art Therapy and the Perinatal Postpartum Periods

There were minimal empirical studies discovered through searching the EBSCO and PsychInfo databases using the terms “art therapy and postpartum depression,” “art therapy; creative arts; mothers of color; Black mothers,” “expressive therapies and postpartum depression, PPD,” and “art therapy and perinatal mood disorders.” However, the studies that were found reflected individual maternal perspectives about their infants, increased further awareness of the perinatal postpartum population through creative arts, and opportunities to solidify a stronger research-based foundation (Armstrong, 2013; Arroyo & Fowler, 2013; Colella et al., 2022; Harris et al., 2023; Lin et al., 2019; Or, 2010; Qian et al., 2023; Snir et al., 2020).

Researchers have also recognized the need for increased integrative mental health supports during the perinatal and postpartum periods to decrease risks and symptoms, and increase continuity of care to reduce systemic inequities (Lomonaco-Haycraft et al., 2019; Ogunwole et al., 2023). The creative arts therapies within a social justice framework could add valuable, suggestively cost effective (Uttley et al., 2015), non-pharmaceutical supports (Poulsen & Coto, 2018) for mothers of color navigating the healthcare systems.

Researchers conducted a meta-analysis of randomized controlled trials, including 2,815 eligible participants within 46 full-text articles, on the use of arts-based interventions with mothers who were pregnant or within one year postpartum (Qian et al., 2023). The inclusion criteria for the identified mothers included women over 18 years old, with no documentation of medical or mental health concerns, who engaged in an arts-based intervention (music, dance, and/or painting) during their pregnancy or postpartum period without limitations to frequency or setting. Exclusion criteria included women who experienced pregnancy-related loss or infertility, studies including integrative interventions with arts-based approaches, duplicated publications, and studies without sufficient information (Qian et al., 2023). Statistical meta-analysis using Review Manager 5.3 and Egger's tests were completed to reduce publication bias.

The researchers found this study to be one of few, if not the only, meta-analysis to examine the effects of arts-based interventions and perinatal and postpartum mental health (2023). They discovered arts-based interventions resulted in reduced symptoms of anxiety and depression for the participants. Arts-based interventions reportedly did not reduce stress levels and aligned with previous meta-analysis findings on patients with breast and gynecological cancers and art therapy (Qian et al., 2023). The researchers highlighted the positive outcomes between the engagement of arts-based interventions during the perinatal and postpartum periods, while positing the combined use of mindfulness techniques and evidenced-based practices for increased efficacy.

Another study examined visual arts-based interventions being used to promote positive parental mental health within the two-year postpartum period, or the "first 1,000 days" (Harris et al., 2023, p. 1). The researchers conducted an integrative review of current, eligible research studies involving art therapy and parents within a two-year postpartum period. While they discovered positive outcomes from the chosen studies, they also reported finding an overall lack of robust evidence highlighting the need for further efficacy in art therapy and perinatal postpartum research. The information they examined included 10 studies fitting within the eligibility criteria ([1] pregnant women and/or parents of infants under the age of two, [2] art therapy and visual arts-based interventions, [3] experiences, perspectives, and impacts on mental health and well-being, [4] any empirical studies using qualitative, quantitative, or mixed methods design, and [5] English with no date restrictions). The researchers analyzed the quantitative and qualitative information through a narrative analysis approach to determine codes and themes. Quantitative information was translated into a narrative format to be assessed with the qualitative data.

The analysis produced six themes with the first five related to psychosocial impacts and experience of interventions, and the sixth related to how certain strategies supported engagement. The themes were facilitation of *self-awareness*, *positivity and healing*, *the maternal bond*, *self-developmen*t, *wider opportunities and connections*, and *facilitated engagement*. The specifics of the themes reflected how arts-based interventions created a safe, non-judgmental space to build self-awareness and confidence. They also helped parents develop coping strategies, build intra- and interpersonal connections, and supported greater help-seeking behaviors. The researchers highlighted the importance of these interventions provided by trained, professional art therapists who have the skillset to manage psychological and emotional impacts of the creative therapeutic experience that other healthcare professionals might not be equipped to do. They also recommended the need for reliable evaluation methods when assessing art therapy interventions within a research setting to strengthen efficacy (Harris et al., 2023).

These studies provided perspectives on the use of art therapy with the perinatal and postpartum population with encouraging outlooks. Given art therapy offers an alternative, non-pharmaceutical method for coping, expressing, and further processing information, the incorporation of the creative arts may be useful in clinically and safely addressing aspects of the maternal experience that traditional therapy cannot. The reviewed studies suggest potential incorporation of the creative arts as a tool for supporting maternal mental health. However, the outcomes are largely theoretical. As such, while there were minimal extant studies on art therapy and the maternal population, and little or no studies with art therapy and mothers of color.

The Creative Arts and Relational Social Justice

Researchers have acknowledged the White identified female perspective as the foundational lens of the creative arts therapy field and the importance to jointly create progressive anti-oppressive practices (Van Den Berg & Allen, 2022). Van Den Berg and Allen (2022) openly critiqued the profession and invited White art therapists to engage in the supportive conversation of decolonizing the practice. They discussed the underpinnings of how art therapy is connected to sociopolitical dynamics and how the humanistic principles of the field reject neoliberalism, harmful White supremacist ideations, and exclusion. The researchers also recognized the difficult position art therapists possess while working within overbearing systems, such as healthcare, due to the exhausting efforts to remain true to the field while combating the structural confines (2022). This identified hierarchal dynamic is another reason to join in conversation to reduce isolation and inequities.

There has been recent research within the art therapy community addressing the need to look at the field through a social justice feminist framework (Talwar & Sajnani, 2022; Wright & Wright, 2022). A revamped, anti-oppressive creative arts therapy care approach for those within intersectional identities who have experienced historical oppression is strongly recommended (Goerdt et al., 2022; Karcher, 2017; Talwar & Sajnani, 2022). The perspectives of identities that are misrepresented, stereotyped, and affected by the shifting political powers are vulnerable to collective traumas, including physical harm, that affect the entirety of their wellbeing. These identities include but are not limited to people within the LGBTQ+ community, immigrants, communities of color, and those with physical disabilities (Karcher, 2017). Without a strong stance and recognition for art therapists to take a reflexive look at the field and their professional identities, those within marginalized communities engaged in art therapy are not receiving the therapeutic care, perspective, or supportive acknowledgement they deserve and need (Karcher, 2017; Van Den Berg & Allen, 2022).

However, it is also important to admit the method to better understand injustices, historical influence impacting non-dominant cultures and identities, and join together in education is a delicate, challenging and often messy process (Potash, 2018). Potash described the nuances of sociopolitical dynamics on either end of the spectrum that can get lost within a heated binary model. They encouraged a look at relational social justice theory as a framework to use when engaging in conversations supporting equitable change about injustices, human rights, and differing perspectives of identity, while positing how art therapy can reduce tensions and/or miscommunications in these conversations (2018).

Potash (2018) discussed the complexities of how people have responded to US political movements and challenges throughout the years. They wrote how the combination of impacted persons, a lack of perspective due to privilege being within the dominant culture (not because of purposeful intention), and strong reactivity continues the pattern of “false binaries” (2018, p. 203). This researcher provided examples of how different reactions towards sociopolitical movements, such as the 2016 US presidential election, can often be delineated into two ways creating a strong dichotomy of interpretation. “Naming and shaming” are two different responses that are often seen when attempting to speak amongst people within the dominant identity that can create different opposing responses (2018, p. 206). Potash identified how naming a continual problematic pattern or belief system can be a powerful stance to enact change, especially for those who are unaware of the impact, but shaming can often “backfire” creating more abuse and defensiveness (2018, p. 206). They posited that this approach leaves little room for a greater understanding, listening, or movement for those who want collectively work towards humanistic equality, and can purport the opposite cause. Simultaneously, it leaves those impacted by oppressive and political abuse to remain underrepresented, misheard, and stuck in the cycle of inequities.

Potash (2018) discussed how relational social justice integrates various psychological theories and practices to have challenging dialogues about human rights, identities, and political differences for humanistic change. Potash inquired about this approach with meaningful debatable conversations to "relinquish either-or dualism" (2018, p. 204). They quoted, "Opponents are not reduced to one-dimensional stereotypes but are viewed as multidimensional partners for solving problems and building community" (2018, p. 204). They inquired how the support of art therapists in this dialogue within a relational justice perspective can further enhance nuanced communication, authentic self-expression, and reduce defensiveness from either side. Potash encouraged the power of art therapists' perspective, use of creative artmaking, and the therapeutic experience to strengthen relationships and boost the collective goal of humanism (2018).

When considering research within the art therapy field and this study on mothers of color, there appears to be a lack of studies focusing on social justice, mothers of color, and art therapy. Given there has been greater acknowledgement for creative arts therapists to critique and redefine the foundations of the field through the lens of intersectionality and marginalized experiences, it opens new opportunities for the research field (Karcher, 2017; Talwar & Sajnani, 2022).

Separate from a literature perspective, it is also important to recognize the systemic barriers that reduce access to care, including art therapy resources, for people of color and those within marginalized settings. The interplay between insurance eligibility, a lack of insurance coverage for the expressive arts services (Pak, 2021 accessed

10/7/23), systemic barriers to equitable healthcare, and mistrust with providers can create greater barriers between the field and mothers of color (Ogunwole et al., 2023). Access to telehealth services and the use of art therapy with patients who have decreased ability to attend in-person sessions during COVID-19 has been studied (Story et al., 2023). Researchers have recommended the adaptive continual use of the creative arts approach and telehealth to reduce disparities.

Conclusion

Mothers of color have a complex interplay between history, systemic oppression, and navigating the postpartum period that needs to be better understood. There are significant concerns related to healthcare outcomes for mothers of color living in the US. The current literature recommendations include continuation of research for mothers of color, open acknowledgement of systemic issues leading to serious health disparities and limitations, and new inclusive treatment programs for mothers entering parenthood. The use of qualitative research promotes individual voices and identities to be heard within a research setting.

The incorporation of the creative arts provides a deeper perspective for mothers of color to express their understanding. Art therapy allows enhancement of what has already been identified as barriers and allows for a richer, more personalized platform to further speak about these narratives. The following research study is focused on gaining better knowledge of perspectives of mothers of color with the use of the creative arts to promote individual identity and motherhood.

CHAPTER 3

Methods

Purpose Statement

The purpose of the research topic was to explore perspectives of mothers of color regarding medical experiences who were either pregnant or within five years postpartum using an art therapy focus group and individual meetings.

Research Question

The research question was “What are the experiences of mothers of color living in the US and healthcare through art therapy?” This question was explored using a qualitative phenomenological paradigm and art therapy through a closed, virtual, four-week focus group and consecutive individual sessions with three additional participants.

Data Collection and Privacy

This study was approved by the IRB of Lesley University.

Participants

The study included a total of 8 persons of color (people who identify as both non-White and mothers) who were pregnant or within five years postpartum, and were over the age of 18 living in the U.S. There was a total of five group participants and three individual participants. All interactions with participants were through virtual meetings, phone contact, or emails due to COIVD-19. The two specific criteria taken into consideration when deciding on the number of participants were sufficiency and saturation of information (Seidman, 2013). The term “enough” is based on individual research as well as practical considerations such as time, money, and resources for the study (2013, p. 58). Initially, this researcher had planned on one focus group with five mothers of color, but at the conclusion of the group discovered a lack of data. The lack of data was a result of inconsistencies with group attendance. An addendum was created and included individual sessions with three additional participants using the same schedule, art therapy directives, and qualitative approach. The revised proposal was submitted to Lesley's IRB committee and approved.

Table 1.

Demographics

Participant ID	Age	Children/Age	Identified Race/Ethnicity
Sia (Group)	36	2 year old 3 year old	African American
Kai (Group)	39	12 weeks pregnant	Black
Tay (Group)	33	4 weeks old	Black
Bea (Group)	37	3 year old	Black
Kelly (Group)	28	12 weeks pregnant 3 year old 6 year old 7 year old	African American
Dana (Individual)	37	3 year old Unknown age of older child	Black
Dee (Individual)	32	7 months old	Biracial-White/German mother, Black/Puerto Rican father
Rita (Individual)	36	4 months 7 year old	Indo-Caribbean

Methods

Each participant was provided a gift card amount for $100 prior to the start of the study regardless of consistent participation. Recruitment included the researcher connecting with OB-GYN clinics, racially informed therapeutic organizations such as Pittsburgh, PA's Steel Smiling and Brown Mamas, local mother support groups, word-of-mouth from those connected to this researcher, and posting on social media. An IRB approved flyer was given to these organizations and social media platforms for more information on study participation.

An initial formal virtual discussion with potential participants on content of the study (purpose of the research, steps), individual rights, consents, and scheduling was held. During this virtual screening interview, the individuals were able to formally consent to their participation. Each participant was reminded of their personal rights to discontinue their involvement prior to each weekly engagement with the researcher. Times and dates were agreed upon via email and secure texting. The researcher had purchased gift cards and art supplies that included several white sheets of paper, markers, and colored pencils, and mailed individual packages to the participants’ residences. As a precaution, this researcher only sent materials and consent forms to the participants through mail due to COVID-19. The participants received the materials, confirmed with the researcher, and participated in the art directive via *Zoom* focus group and individual sessions.

A single virtual closed focus group with a 60-minute session per week via *Zoom* platform for four consecutive weeks was scheduled with consenting participants. One art therapy directive was conducted within the focus group once per week for four weeks. For the consenting three individual participants, four 60-minute sessions were scheduled for four consecutive weeks via *Zoom* platform.

This investigator had one state licensed co-facilitator conduct the art therapy directive portion of the meetings to reduce personal biases. The investigator conducted the verbal discussion portion of the focus group and left the setting immediately after the directive was completed. The licensed co-facilitator had knowledge of the expressive creative arts prior to the focus group and identified as a licensed dance movement therapist mother of color. This individual did not have a clinical or personal relationship with the research participants.

Table 2.

Virtual Session Schedule and Directives (Group and Individual)

Session 1.

- Art Therapy Directive: Using the materials of your choice, please draw an image of what you believe the medical system to look like if it were a person.
- Participants will be asked to engage in this directive for up to 20 minutes.
- An interview-style 40-minute discussion will follow the art directive to process the imagery, symbols, perspectives, and initial conversation about the medical system.

Session 2.

- Art Therapy Directive: Using the materials of your choice, please draw an image of you and your child(ren) in the medical setting.
- Participants will be asked to engage in this directive for up to 20 minutes.
- An interview-style 40-minute discussion will follow the art directive to process the imagery, symbols, perspectives, and what it is like for the mothers to be with their children in the medical setting.

Session 3.

- Art Therapy Directive: Using the materials of your choice, please draw an ideal hospital environment for you and your children.
- Participants will be asked to engage in this directive for up to 20 minutes.
- An interview-style 40-minute discussion will follow the art directive to process the imagery, symbols, perspectives, and conversation about the ideal medical system.

Session 4.

- Art Therapy Directive: Using the materials of your choice, please draw an image representing your strengths as a mother.
- Participants will be asked to engage in this directive for up to 20 minutes.
- An interview-style 40-minute discussion will follow the art directive to process the imagery, symbols, perspectives, and identified grounding strengths of the participants as mothers.

The focus group and individual sessions were recorded using an audio and video recording feature from the *Zoom* program. This audio recording was downloaded and stored in a password locked computer system. The researcher used a transcription program called *Otter.ai* to supplement the process. The researcher reviewed the program’s transcriptions and made grammatical revisions by listening to the audio recording to ensure the authenticity of the data. The researcher reviewed the revisions several times prior to sending the document to the participants. The participants’ identities were concealed using anonyms to organize the data. This researcher sent the transcribed data to the participants via email address encouraging feedback and transparent partnership.

Data Analysis

The data was initially thoroughly re-read by the researcher and then analyzed using both manual analysis and the software program MAXQDA 2022 version to determine codes and themes. The analytic process included several structured steps to provide adequate time between readings, physical space from the data, and continual immersion to determine outcomes. The data were coded through three separate cycles with at least one week in between coding sessions.

1. Week one included the researcher reading the full transcripts, listening to the recordings, and taking personal notes. Emotions, general themes, and responses emerged as the first layer of the analysis. The different roles, responsibilities, and initial perspectives were reported to create a basis for further development.
2. Week two included re-reading the transcriptions, color coding the different themes, taking notes within the MAXDQA system for each code, and reorganizing the initial notations. There was a focus on reviewing the words to investigate the emotions, what underpinnings of the words were, and what questions arose from the second coding process.
3. Week three included taking personal notes while reviewing the full transcriptions and written codes, rewording the themes, and reviewing

literature on qualitative analysis. The purpose of re-reading the literature was to ground and reflect on the concept of qualitative data while simultaneously identifying coded emotional themes, patterns, and the collective participant response.

CHAPTER 4

Results

The purpose of this qualitative research study on mothers of color living in the US using art therapy was to better understand first-hand perspectives of the postpartum period and medical system through art therapy. The data included voice-recorded transcriptions from both the focus group and individual sessions, and individual artwork from each art therapy directive. The artwork represented the creative responses from the group and individual members. Using four art therapy directives, the focus group and the three individuals had four one-hour long sessions totaling 16 hours of recorded data. Using a manual data analysis process and MAXQDA software, the transcriptions were thoroughly examined to identify codes and themes. The information was organized using the most collective, consistent themes throughout the sessions. Each participant was provided an anonym for identification and confidentiality.

The participants took individual pictures of their images and sent them back to the researcher via secure text and as a result, the images of the drawings were less clear. The substitution of a virtual platform in placement of meeting in-person was a precaution due to COVID-19. There was inconsistency in weekly group participation throughout the four sessions. More data from the individual participants (Dee, Dana, and Rita) than the group participants (Tay, Sia, Kelly, Bea, and Kai) was the result of this irregularity. The individual participants each received one hour per meeting, which provided space for more in-depth perspectives of the directives than given to the group members for the same allotted time. This difference was further discussed in the limitations section.

The following themes were organized by the strongest themes throughout the 16 sessions. There were comparable quotes on personal interactions with providers, complex emotional perspectives on mothering and the healthcare system, and hopes they had for the healthcare community. The eight themes and four subthemes (see Table 3.) included *Privilege and Disparity, Capitalism, Being Overlooked, Pressures Related to Reproductive Health (Subtheme A.), Fear and Protection, Mistrust (Subtheme B.) Advocacy (Subtheme C.), Resiliency, Generational Trauma (Subtheme D.), Loving Through the Unspoken*, *Holistic and Humanistic Care,* and *Art Therapy Responses*.

Table 3.

Themes and Subthemes

Theme	Subtheme
Privilege and Disparity	
Capitalism	
Being Overlooked	A. Pressures related to Reproductive Health
Fear and Protection	B. Mistrust C. Advocacy
Resiliency	D. Generational Trauma
Loving through the Unspoken	
Holistic and Humanistic Care	
Art Therapy Responses	

Each theme represented lived personal experiences, emotions, and responses as perspectives of mothers of color.

Privilege and Disparity

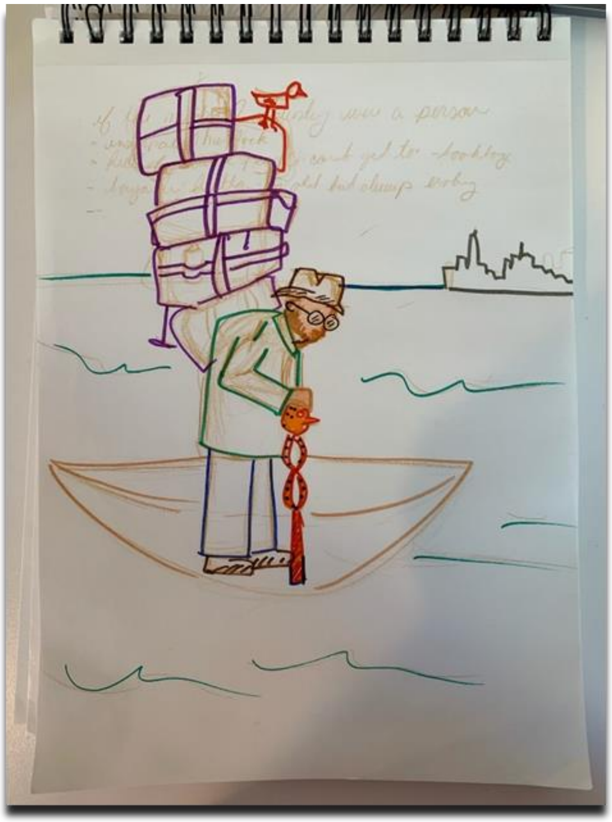
The concept of privilege was identified by the participants as experiencing more equitable treatment and/or possessing increased personal protection because of one's social class, available resources, and those being within the US dominant identity demographic. The concept of disparity was identified as being treated more negatively and/or harshly due to not being within the US dominant identity and/or not having adequate resources that would mitigate systemic oppression, neglect, and stereotyping. Privileges and disparities were expressed by the participants through verbal examples, artwork, and consistent responsive thematic statements about what they had encountered within the medical system.

Dana described her drawing of the medical system as an entity gatekeeping resources with barriers to limit personal access (see Figure 1). She reported she drew an older White male positioned in a boat in a body of water holding resources that were only available to those who had the abilities to retrieve them. This man was meant to represent the hospital system, the distance between he and the mainland symbolized privileges, and the valuables were described as medicines, quality care, and specializations. Dana said,

> There’s a lot of money and resources. But when you go to receive that, most people, unless you have a boat and can get out there, and you have the language, you have the wherewithal and you also maybe even look the part, right? Unless you have access to those to the, to the bridge that can get you there, most people don’t have access to all those resources.

Figure 1

Dana's image for art therapy directive one: please draw an image of what you believe the medical system to look like if it were a person.



Dee supported this notion about the medical system saying, "The system as a whole just made me think of like, the elite." Dee identified different examples of these resources related to the barriers Dana was describing. She reflected, "People are treated differently, because how they look." She also recognized her privileges as an individual with both health insurance and an identified-male spouse during her delivery. She said, "I was privileged to even have insurance and a husband that came in." Dee added, "I didn't realize how privileged I guess I was until this conversation of like, 'oh wait, I had health insurance. I had Eddie there.' Like, I had all these things to protect me, and to kind of keep me safe."

Dana also talked about how her personal privileges have shaped her experiences in the health setting. She reflected, “I think about a lot of the privileges that I have” which included being a “self-employed” worker, being “able-bodied,” having a supportive spouse, and family members working in the medical field who can provide a helpful healthcare perspective.

Rita supported these observed differences in interactions with medical providers by describing perspectives of being a woman of color and the invisible challenges she has faced. She posited whether she would be treated differently if she were a White woman.

> I felt like as a woman of color, I have to be even more careful, because I don't have the like flexibility for people to assume that I want to take care of my children and take care of myself, and not harm them.

This quote was in the context of speaking with a nurse following labor with her daughter and being hyper-attuned to how her interactions could be easily misrepresented. Rita talked about the hospital interactions and considerations she had to thoroughly examine before interacting with providers to prevent stereotyping, assumptions, or reactions that could affect her and her daughter’s medical needs.

Tay and Kelly added to Rita’s experiences regarding internal and external messaging when navigating interactions. The group had been speaking about the negative stereotyping they observed when attending appointments during their first pregnancy (provider pressures towards post-birth contraception) versus their second or third pregnancies (Sia: “Oh you don’t need to have no more kids. You don’t have help at home.”). Kelly reflected, “I feel like, whenever you have more than one child, the doctor will be like, ‘Oh, you need to slow down’.” When this researcher posited why providers may have responded to them in this manner Tay said, “I'm a woman of color, and that, I don't matter. I'm just gonna flat out say it. I don't matter.” Tay continued to state, “Everything else doesn't matter. Our babies don't matter. It's like, ‘Oh here we go with another one."

Dana also felt this external judgment, identified with this internalized response, and reflected her awareness of the generalized negative stereotypes society makes about Black or Brown women with children and their presumed family circumstances. She said,

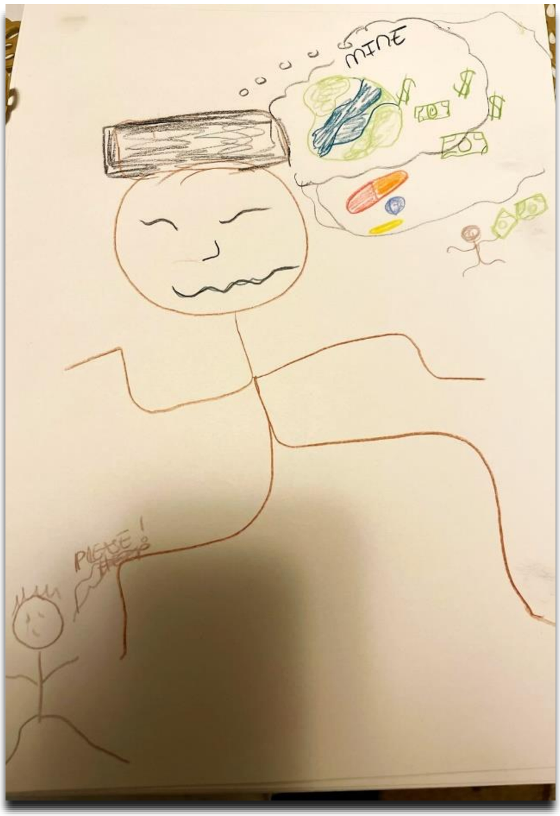
> I know, when you have more than lots of lots of kids, people will look at you like you’re just as a Black woman, especially like you just, you know, out here reproducing, people feel like, “Oh, you’re just on welfare,” you know, people see like baby daddies, which I don’t think anything’s wrong with that. But people look down on you.

Sia spoke about the power dynamic between the hospital system and people with less resources and personal privilege. She identified the strong focus the system has on profit instead of humanistic healthcare, and the limited options for low-income people of color. Sia expressed similar feelings as the other mothers in reference to combating the burden of the system.

> This man (see Figure 2) represents like general population of low-income people, maybe, Black Brown color people you know, they're down here like "please help" and he's just like stomping on them.

Figure 2

Sia's image for art therapy directive one: please draw an image of what you believe the medical system to look like if it were a person.



Outside of the adult reproductive healthcare perspective, Rita spoke about how she had noticed this power dynamic as an adolescent. She talked about how her providers' positions of privilege allowed them to feel it was okay to project comments about her body, weight, and attractiveness growing up. When asked why she felt these providers were comfortable making these statements, she responded with, "Positionality. Privilege. Unconscious bias about, like, our temperament." She spoke from the perspective of her mother, a first generation immigrant to the US, who felt it was okay to "subscribe to Whiteness" and how "She's just trying to keep her head down. She thinks that a preference to Whiteness is fine."

Both individual and group participants had similar stances on the observations of privilege and disparities within the healthcare setting. Two participants shared perspectives of their personal privileges that allotted them a different experience. Their descriptions, reasons, and emotional responses to disparities were comparable; projected judgments and providers generalizing their lived experiences based on demographic information. They identified feelings of internalized rejection, awareness of how society perpetuates negative stereotyping and how it affects their reactions, and questioning whether they would receive adequate support.

Capitalism

Capitalism emerged as another main theme throughout the sessions when reflecting on what the medical system represented, what the participants wanted to change about the system, and what they felt the focus of their care was. Capitalism was defined by the participants as the healthcare system being framed as business services for income, revenue, and profit rather than central to humanistic healthcare. This theme arose as an area participants wanted to change about the healthcare system due to the concerning paradox between human experience and profit.

The individuals talked about the limitations of insurance coverage and specializations, profit objective, and how problematic this focus was. Dee included a “wallet” of “money” on the figure for the first directive, and reported this is the person who would give you a “$20,000 bill” following a healthcare appointment.

Two group members also reported this recurrent observation. Sia said, “That's how I envisioned the healthcare system as a whole, just like very corrupt, not really out here to cure us, but just to make some money off of these pills and their profit.” Tay made similar remarks and said, “I'm just another number and a push through for them. So, they're going to bill my insurance, and they're going to get their money, and they're going to keep it pushing.” Dana also added to Tay and Sia’s observations and said, “It's just like another industry, another profession that's rooted in capitalism.”

Dee recalled the memory following her child’s birth and receiving a phone call requesting payment for the delivery service. She reported noticing a dismissive tone and the primary focus became the monetary value of the hospital stay versus giving birth. “I wouldn't say dehumanizing, but it was like minimizing your experience,” she said. This similar devalued feeling continued following her postpartum discharge home. She said, “No doctors called, checked up, said ‘Oh, how are you doing?’ Like, the bill people called, the bill people wanted their money.” She expressed the undertone of the priorities was on financial gain for services instead of supportive continuity of care postpartum outreach.

Rita created a similar symbolic representation to reflect her perspectives of the medical system. When asked about what her drawing represented, she said, “Profit dehumanization. Profit dehumanization. Disregard.” She talked about the effect this message has on those with financial hardship and said, “We don't humanize the fact that this person doesn't have the resources to pay whatever it is that we're asking them to pay.” She described how the capitalistic power dynamic within the healthcare system not only highlights the disparities in economic statuses and the assumption all people can afford healthcare, but simultaneously rejects the impact.

Additionally, Rita spoke about the different supports offered to those with financial privilege. She said, “Doulas are wonderful, but you have to pay out of pocket for it.” Dana reflected on the same dynamic between limitations on insurance coverage and healthcare recommendations. She discussed how specific out-of-pocket health recommendations aren’t equally accessible because, “it costs a lot of money to be able to have certain tests done.” These perspectives identified the intersectional connection between equitable care, insurance coverages, and personal financial wellbeing that collectively affect appropriate treatment outcomes.

The concentration on capitalism within the healthcare setting was present in multiple conversations with the mothers and fueled further distrust. There was a strong response towards the prioritized focus of gaining personal profit instead of equitable healthcare regardless of background or circumstances. The responses to these dynamics were anger, frustration, resentment, and feeling dehumanized.

Being Overlooked

The definition of "*Being Overlooked*" meant feeling undervalued, othered, and disregarded as a person. The participants discussed their reactions to healthcare interactions and how they viewed the medical system as a detached entity. The participants felt unheard, overlooked, and dismissed when receiving medical treatment from certain providers. These experiences directly resulted in the mothers needing to become advocates for their families due to the risk of not being taken seriously and problems being overlooked.

Dee posited whether the figure representing the healthcare system in her drawing would hear her concerns (see Figure 3).

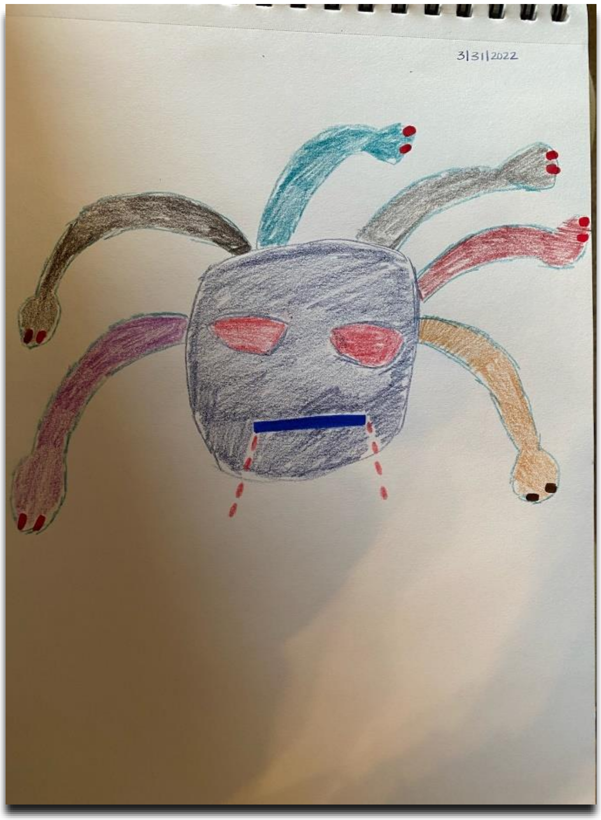
Figure 3

Dee's image for art therapy directive one: please draw an image of what you believe the medical system to look like if it were a person.

She described the figure as a cold, distant "blank" man with tentacles. She highlighted the theme of feeling overlooked by stating, "Is this thing really listening to me or are they already thinking of something else?" Rita had a similar response to Dee and reflected on how her drawing represented the system as "faceless," "unfeeling," and with "no personality" (see Figure 4). Both of their descriptions of the medical system included a figure with outer extremities embodying a feeling of detachment towards human experiences.

Figure 4

Rita's image for art therapy directive one: please draw an image of what you believe the medical system to look like if it were a person.



By using a single body connected to surrounding attachments, Rita's drawing possessed a similar visual representation as Dee. When asked what emotions arose for Rita when she looked at her drawing she stated, "Anger, dissociation, emptiness." She reported each head represented a different doctor she had worked with, and while she may have felt more connected to one or the other, they all came from the same medical structure.

Tay spoke about a similar experience between her and a nurse (see Figure 5) following an unexpected miscarriage. Tay stated, "She like literally walked in the room and like, slapped my foot and was like, 'Oh, it's okay, it happens all the time." She reflected how hurt, overlooked, devalued, and disregarded she felt during this sudden traumatic loss in the healthcare setting. She said because of this interaction she felt she "didn't matter." Tay added, "So glad that this is so nonchalant to you while I'm sitting here bawling my eyes out. But okay," and wondered whether this nurse would have responded to her this way if she were someone else.

Figure 5

Tay's image for art therapy directive one: please draw an image of what you believe the medical system to look like if it were a person.

This was not the first experience for Tay when interacting with providers. Tay spoke about how she was treated regarding jaundice concerns after the birth of her daughter. Tay voiced to the providers her other children had a similar skin coloration as newborns and it was normal for their family. The providers took an initial blood sample and received healthy numbers but continued to take additional blood samples without communicating with her or the reasons. Tay had to intervene in the moment to prevent further intervention.

Tay said she had to raise her voice to be heard and advocate to stop the blood draws. “There's nothing wrong with my baby and you keep pricking her almost like you're looking for something to be wrong,” Tay reported. She reiterated, “You can't just expect me to go with it without explaining it to me.” She identified being overlooked as a newly postpartum mother and stated that if the follow-up intervention was truly needed, they did not effectively communicate the reasons to her. This interaction left her feeling judgment from the providers. She reported wondering they were viewing her as an “unfit mother” because of her reaction and covertly questioning her intelligence.

Kai reported, “As a single parent, there is always pressure to make the best choice." When speaking about navigating the healthcare system and not being taken seriously, she stated she had felt like the other participants. She said, “I never feel like anyone is listening to what I have to say.” She spoke about how her relationship with God has helped guide her in decisions as a mother and not feel as isolated in her experiences. Kai did not submit a response drawing.

Rita acknowledged how she has met valuable medical workers who she believed prioritized her care. Rita expressed appreciation for a specific provider she felt connected to, but also recognized her role within a greater system.

> What really helped me feel safe was that she, she remembered things about my case. She would ask me how I was doing and then genuinely care and not because, you know, the doctors are supposed to do.

Rita said while she felt supported by this provider she was also aware they were a part of a larger system. She said, “I still think that at the end of the day, she's a part of the larger medicinal system.” Her subsequent appointments with a different fertility doctor reflected this notion. She talked about her in vitro fertilization (IVF) experiences and reported feeling overlooked by the team of doctors when she expressed concerns she had an ectopic pregnancy.

The doctor responded to her concerns with, “You sound totally fine, there's nothing wrong with you.” Rita did have an ectopic pregnancy and needed immediate medical care for her safety. She said if she had continued to blindly listen to this provider’s response, she would have died.

Participant Dana recalled a similar story about a friend, who she identified as a “bigger Black woman,” and advocated to receive treatment for stomach pain at three different locations before being taken seriously. Her friend was consistently dismissed by the providers leading up to the third hospital. The third physician immediately sent her into surgery because the concern had turned into an emergency. Dana posited about how her friend’s identity as a larger framed Black woman impacted her ability to be heard by providers. Being overlooked not only added to her unwanted experiences navigating the healthcare system in an emergency, but also could have been a cause of preventable fatality.

An impressive portion of the discussions were related to the participants’ experiences of being overlooked and having real symptoms dismissed by providers. There were two identified examples regarding preventable outcomes due to being unheard and not taken seriously. The effects of these interactions left the mothers feeling defeated, fearful of another occurrence, angry, and without means to closure.

Subtheme A: Pressures Related to Reproductive Health

The subtheme of *Being Overlooked* was *Pressures Related to Reproductive Health*. With the addition of observed negative stereotyping, the participants voiced feeling both external expectation and pressures to make specific decisions about their reproductive health. The following are details supporting this subtheme. The mothers shared how the awareness of negative stereotyping could have been at the root of these discussions. They also stated the lack of open communication from providers did not provide reassurances. Communication with the mothers was reportedly indirect and uninformative, and left the participants feeling dismissed, overrun, and negatively judged based on their identities. These were the factors defining this subtheme.

Kelly said her delivery and bodily choice between a cesarean section or natural delivery was overlooked. She said, “I feel like even giving birth is complete in and out,” and the communication leading up to the birth was not consistent. She added, “They're not giving Black women a chance to give, you know, give birth to our children naturally.” Kelly reflected how she gave her body four years to heal and wanted a conversation about a VBAC, but felt her autonomy and decision making abilities were not considered.

In a similar circumstance during labor and delivery, Tay experienced high anxiety following her daughter’s five-week premature delivery and her mental health needs were not addressed. She said she felt consistently “rushed” and disconnected from the medical team. Tay stated the providers communicated the risks during delivery, but “Everything else was dismissed.” She agreed with the other participants’ similar statements and said, “It’s whatever they want, not you.” She also reflected feeling detached from her healthcare team and that her perspectives, emotional wellbeing, and autonomy were also not taken into consideration.

Kelly added, “They're judgmental. That's the feeling.” and “I feel like doctors are judgmental, especially when you tell them how many children you have.” Sia echoed this notion and said she felt pressured to “get on birth control or get your tubes tied” and was encouraged to get a “hysterectomy”. She reported she was having reproductive “issues” and the providers exclaimed, “you got four already, it should be easy for you to get a hysterectomy.” She said after her first baby, the follow-up she received had been related to, “anything to stop you from reproducing”. She spoke about feeling stereotyped by her providers when they learned she had three children. Sia discussed how she received projected stereotypes assuming as a mother of color she did not have household help and was a single parent, when she did have a supportive partner.

The communication experiences the participants had with their OBGYN providers felt dismissive, detached, and rushed. The group members identified a strong sense of judgment from the providers about their choices related to birth, family expansion, and general support. This subtheme did not emerge for the individual participants. There was a clear disconnection, misrepresentation, and/or lack of information from providers that resulted in the mothers feeling pressured and stripped of their decision-making abilities.

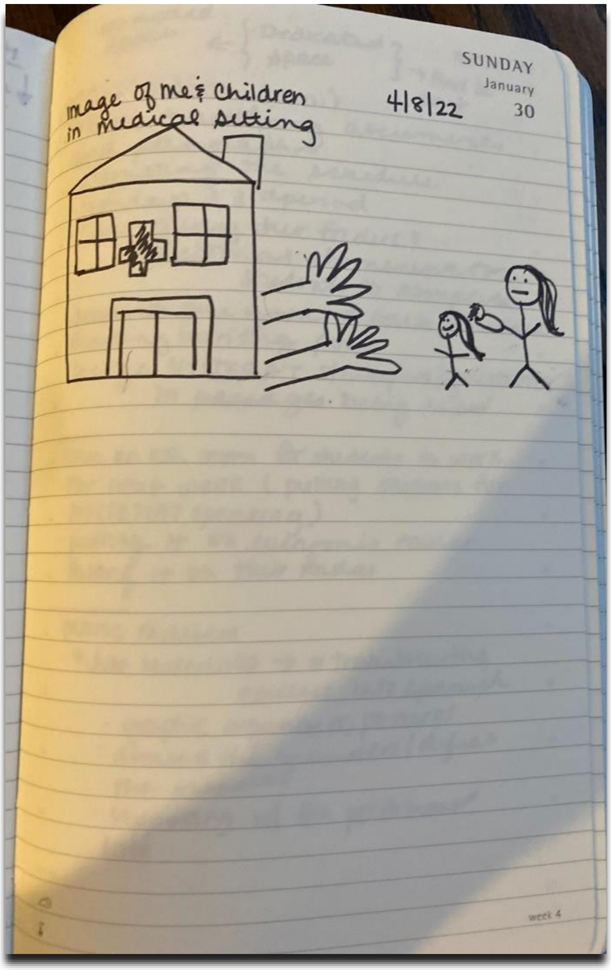
Fear and Protection

Experiencing *Fear and Protection* was identified as having a sense of impending worry and alarm needing to defend. These fears were related to concerns of not being heard in interactions that could affect their children, harm coming to their families, or their children being taken away due to reactive misunderstandings. Others were associated with the US historical knowledge and stereotypes towards people of color. One mother’s fears were related to worries being a new parent. Protective approaches to cope with the fears included personal religious beliefs, supportive joining as women of color, and the need to voice concerns to embody awareness.

Rita reflected her fears as she described her drawing (see Figure 6) representing the medical system “reaching out to take your children away” and “intentionally or unintentionally, potentially, inflicting harm on your children.” She identified her own experiences in the medical setting and feeling vulnerable. She said, “As a child, I don't feel like I was protected enough in those spaces.” She reported all her family members experienced some form of medical racism while receiving care.

Figure 6

Rita’s image for art therapy directive two: please draw an image of you and your child(ren) in the medical setting.



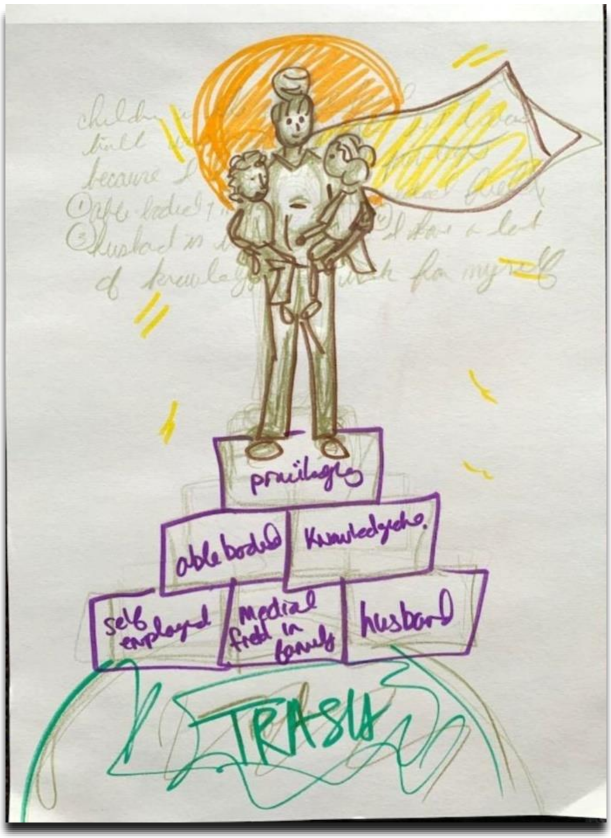
She spoke about what it has been like for her to take her children to the doctor’s office and feel the need to protect them from misdiagnoses, prepare multiple questions or be knowledgeable about recommendations, and revisit the fears she has had of her children being taken from her. She reported, “If the pediatrician sees something or suspects neglect or abuse of some kind, they can take, the hands could take the baby away, too." She highlighted the deeper, underlying fear of unexpectedly losing her children at these appointments.

When asked what her emotional response to the image was, she answered, "Anxiety, uncertainty, a little bit of fear." She also said she felt "there is no protection," indicating her need to advocate for her children as a parent through "assertive" and "aggressive" communication.

Dana described a similar feeling as a mother of color needing to protect her children reflected in her drawing. She said she created an image of her holding her children on top of a "trash system" (see Figure 7).

Figure 7

Dana's image for art therapy directive two: please draw an image of you and your child(ren) in the medical setting.



She reported strong intolerance towards providers harming herself or her children. She described this notion through building blocks of protection to keep her children safe. Dana recalled two instances where she had to medically advocate for appropriate care for both her and her son. She acknowledged the relationship her children will have with the system as they age, but current role as their parent is to protect them. Dana cited the importance of getting her children appropriate treatment for their present and long-term wellbeing.

Dee’s fears and need to protect were more closely related to becoming a new parent versus concerns related to the medical system. She reflected on the initial fear and anxiety she had immediately after delivering her baby including intrusive thoughts about her baby’s physical health and whether she was breathing. Dee spoke about how she did not initially identify as an anxious person but noticed a significant increase in anxiety once she became a mother. Her experiences represented a change in perspective because of the greater awareness of her role and the intensity of the unknowns. She reflected on her position as a new parent and stated, "Wow, my body changes, my mental change, just like having to protect this baby and kind of like put myself aside like...Wow. It's so powerful.”

Dee also gave voice to the stories she had heard from other mothers of color and their medical experiences. She reported hearing traumatic birth stories, fears from Black mothers about the quality of care due to the higher risks of preventable fatalities, and whether providers would believe their needs. “I keep thinking about the people that like the doctors don't believe them. Like not believing the pain or not like…that's what was always scary to me.” While she had not had fears or anxieties about her personal prenatal or postpartum care, she highlighted the general concerns women of color have because of statistical risks and racial discrimination.

Bea’s fears were related to the concerns with mandated vaccinations and being afraid of the unknown outcomes. She described what it was like as a mother to learn of the mandatory expectations for students to get vaccinated during the COVID-19 pandemic, and not knowing what could happen as a result. “That's something serious for a mother, you know. You don't want to give your child or doing anything to harm them, just because somebody else told you.” Bea described what it was like to have her decision not taken into consideration in these circumstances. She drew this example for the directive (see Figure 8).

Figure 8

Bea’s image for art therapy directive two: please draw an image of you and your child(ren) in the medical setting.

Bea included God in her image as a protective figure to support her family. She spoke about her religious beliefs helping her to feel safe when faced with medical uncertainty or difficult discussions with providers.

> I drew the sign and God just shining over us and the nurse to the right, health care providers and, you know, people who, you know, trained and went to school and do know, you know, things that I don't know, that keep my child safe and heavy, protected in here.

When asked about strengths and protective factors as mothers of color, Bea spoke about the need to support other women who may be going through something similar. She said mothers of color can challenge adversities by, “Sticking together, being heard, and definitely speaking out.”

The mothers discussed differing perspectives of how they have faced fear and protection as parents. These experiences included fear of the system, lack of control over responses or reactions, awareness of Black US history, and worries while becoming a new parent. The identified protective factors were personal and group advocacy, increased preemptive awareness of risks influencing their actions, and individual religious beliefs.

Subtheme B: Mistrust

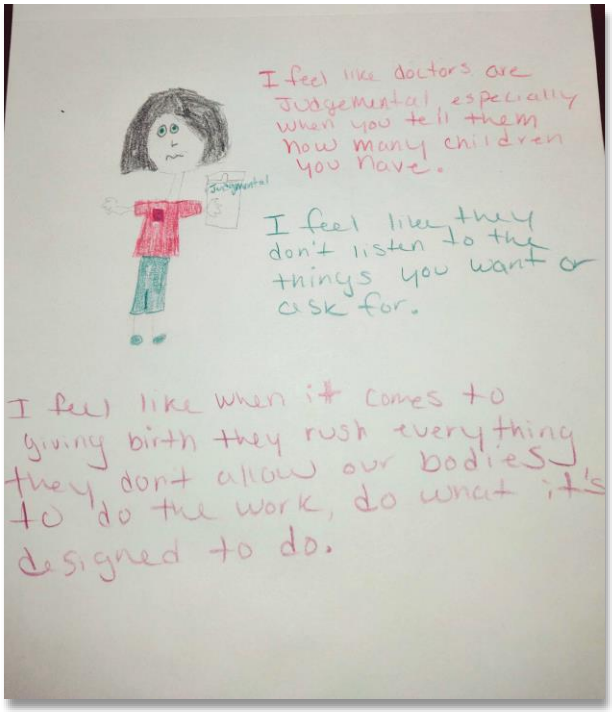
Mistrust was a subtheme that emerged in *Fear and Protection.* This subtheme was described as questioning the intention of others and feeling emotionally unsafe. The participants responded with avoidance of medical interactions or having strong emotional reactivity. Several participants identified questioning motives behind recommendations and whether they were in the best interest of their wellbeing and/or their child’s. Negative stereotyping and harmful assumption based on demographic background was considered by the participants. The mothers discussed chronic suspicion about ulterior intentions that created additional exhaustion and increased stress, and from an outside privileged perspective, seemingly harmless situations.

Tay reported an incident when she went to the hospital for stomach pain and the providers wanted to test her for sexually transmitted diseases after they had recently tested her during her pregnancy. She reported questioning the motives, confusion over why a STD test would be recommended, and wondering, “Why are you testing me again? I’m married. I’ve only had one partner for the last eight years.” She then added, “Because I don't matter to you.” When inquiring to the group about reasons this mother was treated this way, Kelly reported “We're just another statistic.” She said, “It's frustrating. I'm human just like you are, we all bleed. Our blood is all the same color.”

With similar confusion regarding medical tests, during pregnancy Kelly recalled her providers wanting to examine her unborn child for intellectual disabilities. She had not been informed about this testing in her previous prenatal visits and was not given a consistent reason why testing was being recommended. She stated she was told this was a new protocol in perinatal care, but there was an element of mistrust in this answer. She reported the doctors said, "I feel like you know, your child should be tested for disabilities.’ That's the part I don't really agree on.” She said she had been pregnant with three other children, and this was the first instance she had providers wanting to examine her unborn baby’s cognitive abilities during pregnancy. Her image (see Figure 9) reflected how she has been treated by the medical system.

Figure 9

Kelly's image for art therapy directive one: please draw an image of what you believe the medical system to look like if it were a person.



I feel like doctors are Judgemental especially when you tell them how many children you have.

I feel like they don't listen to the things you want or ask for.

I feel like when it comes to giving birth they rush everything they dont allow our bodies to do the work, do what it's designed to do.

Both interactions were unanticipated interventions challenging their body autonomy, and the reasonings behind the recommendations remained unclear or inconsistent. The lack of clarity or understanding behind the medical recommendations led to increased mistrust between the participants and providers.

The three individual session participants spoke of mistrust they felt towards the medical system. Rita reflected on what it was like to receive a questionnaire about potential PPD symptoms following her delivery. She stated her immediate response was, "Why are you asking me this? It's routine. Is it routine?" She talked about feeling fearful and guarded when faced with an unexpected request, regardless of whether it was policy. "I'm afraid to go to medical systems outside of my therapist, to get any additional help" she said. Regardless of whether providing a PPD questionnaire was protocol, the response was an immediate, mistrusting reaction from this participant due to her knowledge of the system and previous interactions.

Dee spoke about the tiered system of power and questioning the intentions of the highest-ranked people. She stated within the context of insurance and financial gain, “There's other motives behind the scenes.” She acknowledged the hard work she has seen from nurses and providers at the entry level but wondered about the motives and treatment of staff from the top hierarchy. When speaking about the figure in her drawing (see Figure 3) she said, “It's anxiety provoking for me to see, like this authority figure kind of like, creeping up.” Dee also added her mother told her at a young age, "Don't trust doctors, and don't go," based on her experiences. This statement created her foundation for these perspectives.

Dana spoke about the history of the US medical setting and communities of color leading to chronic years of mistrust. She underpinned the present-day mistrust between the Black community and medical system due to historical harmful acts and continual mistreatment. These insights validated the perspectives of the other participants’ experiences and acknowledged the deeper-rooted dynamics between the system and people of color. Dana reported she symbolized communities of color and traditional practices as the walking stick the figure was leaning on (see Figure 1).

> Black women and women, well, women, have not been in places of power to be able to control their own safety that people have suffered the most, and had the least access to this, all these resources, like most likely not even getting to the water.

Dana further discussed how her drawing represented the system relying on traditional practices and people of color through pressure and appropriation. She described how she felt the medical system has lost focus of using and respecting traditional, holistic practices. She made statements about the shift towards taking parts of traditions for what suits the dominant system to produce short-term one-sided benefits. She reflected how “that can be harmful...when you take things out of context.”

When asked about what potential long-term effects of these patterns could be she said, “How many people have died from the decisions that people have made? Whenever they're using practices out of context, or inappropriately?” Dana spoke about overall mistrust of the system’s reactive quick-fix approaches to healthcare and not having the best intentions for individual treatment.

Mistrust was a consistent theme that emerged for the mothers when speaking about their interactions between providers, voicing historic related events, and positing the greater dynamics. There were more questions than answers about why specific interventions were endorsed and wondering whether their identities influenced these recommendations. There were also overarching assessments about how the medical system gains its information, what it has appropriated from other cultures, and how a short-sighted reactive approach to treatment can be harmful for those needing help.

Subtheme C: Advocacy

Advocacy was the second subtheme that emerged from *Fear and Protection*. Advocacy was defined by the participants as engaging in assertive means to obtain appropriate information, intervention, and stand against oppressive practices. There were similarities regarding how healthcare advocacy emerged for both their individual care and families.

Tay spoke about her motivation to advocate for Black and Brown people who are unheard and overlooked in the system. She said, “There's no voices within our healthcare system for us, like, my field of study is social work, integrated healthcare.” She added that her perseverance and willingness to support others were motivation to receive higher education. She said, “I started my master's degree in this so I can be that voice. Because I can't, I just can't anymore.”

When asked what the participants would want providers to know about mothers of color, there were various responses related to strengths. Tay reflected,

> We're not dumb. And we don't have to follow everything that they tell us. We can question them whenever we don't feel something is right without it turning into something being combative. Also, we're not all the same.

Sia stated, “What I would want a provider to know is that we're very intelligent, we're special. We're very special and we deserve respect. We deserve a voice.”

Bea also added the importance of viewing people of color as individuals and not stereotypes. She said, “What works for one child does not always work for the other you know, and they do group us.” She added, “And when you try to defend yourself or speak on the information that you do have, it's like it's brushed off.”

Rita reflected on her role to “advocate” for her daughter “all the time” and felt the need to “fight until I get the answers that I'm looking for” in a “fight response mode.” To be taken more seriously, she addressed the additional pressures of speaking and dressing in a specific manner when facing White providers. The act of advocating for her children was not solely against medical providers, but also with her extended family members. This participant recalled having to speak out against judgmental or critical statements her family had made towards her oldest daughter’s identity. Advocating appeared in multiple areas for Rita’s experiences as a mother of color.

Dana talked about similar perspectives needing to ensure her children are taken care of. In reference to her drawing she stated, “I'm wearing a cape. I feel like I need to be like, I have to do above average amount of stuff in order to exist in this way.” She spoke about the amount of work it has taken her to reach a position of privilege (previously mentioned in first theme) to be able to support her family. She reflected on a mishandled interaction during an appointment her husband took her son to that resulted in an inappropriate and unnecessary response to his medical needs. She discussed that while her spouse has the same intentions, their levels of awareness or need to advocate are different. She stated, “I found that if I'm not there advocating on their behalf, they can experience harm. And they have. So yeah, it's a lot of work.”

Dee reflected on advocating for medication following her delivery. She recalled a nurse who began questioning whether she truly needed pain medications after having her baby. She said she had to assert herself to maintain the appropriate pain medication regime and felt frustrated stating, “Pain is real.” She said she did not want to take medication but needed to because she had just given birth. She wondered, “Oh you think I’m just popping pills?” and spoke about questioning a provider’s intentions and possible stereotyping.

Kai echoed Dee’s stance needing to persistently advocate to meet basic needs when speaking with providers. She stated, “You almost have to convince the doctors that you are in need, in need of something." She responded to what it is like getting connected with different services and wrote, “It seems it's always to be a fight." Kai reiterated the exhaustion of striving to meet basic standards and to be taken seriously.

Kai also described the act of learning how to advocate for her family through experience. She spoke of collecting more information after each appointment and using this compounded knowledge to build on for the next interaction. She said, “I have more awareness of what I should be expecting from the doctor and the correct information to ask for.” Bea added to this dialogue and said, “As you grow up, you realize that you have to go the extra mile to get the information.” Both participants identified with the experience of independently advocating and learning how they need to prepare for appointments. Bea also reported she had to learn how to ask for help and give herself permission to do so. She said this behavior was depicted in her drawing with her children and the medical system (see Figure 6). She talked about the importance of advocating and supporting other mothers by saying, “Gotta stick together I think, as moms and women.”

These perspectives all share commonalities in experiencing high pressures of increased awareness of their identities, setting firm limits, and advocating for standardized care. There were strong similarities in feeling both frustrated and recognizing the importance of advocacy as a parent.

Resiliency

Resiliency was a consistent theme that emerged throughout the discussions with all participants. Resiliency was identified as persevering through adversities related to personal identity and being open to processing multifaceted emotional responses. They spoke of their determination for the betterment of their children regardless of the difficulty. There seemed to be a dynamic between traumatic experiences, influences in parenting identity, and the need to persist. All the participants identified with different forms of resiliency in the context of parenthood.

Bea reflected on her pregnancy and the need to find strength in personal resilience. She was the only participant who spoke about the challenges isolation and inner strength while pregnant. She said, “Back to being pregnant and stuff is a very lonely journey. And is something I don't think people understand.” She reflected on the loneliness by stating, “I have four children, all four was lonely.” She discussed the specifics of why it was isolated, including the decisions being solely on the mother to make healthy choices for the child.

Bea described the seclusion of postpartum, not feeling understood by others, and having to be the person to make majority of the sacrifices for the baby. She identified her faith as a source of comfort and support. “This is you and Him alone, you still alone in this world, but you have faith and you have somewhere else to go, then you're safe.”

Rita shared her perspectives on how her trauma has shaped her parenting style and resiliency. She identified the relationship between trauma and resiliency and how her definition of motherhood was intertwined. She said, “Motherhood is just like another form of resiliency for me.” Rita described how this dynamic has been translated into a source of strength to combat her personal traumas.

Kelly had similar perspectives as Rita regarding how her trauma and current family situation forced her into becoming a resilient parent. She spoke at length about the impact of her new co-parenting dynamic (recently divorced) and the involvement with the court system. Kelly talked about how “stressed” she was while trying to be a “happy mom” for her children.

When asked which emotions were associated with her drawing (see Figure 10), she answered “not giving up.” She spoke about what it means to be resilient during trying times. Kelly discussed feeling strongly about remaining supportive for her children while allowing herself to experience vulnerability. She said, “I just always tell myself that I can't give up because I do have my, you know, my children depending on me through my life.”

Figure 10

Kelly's image for art therapy directive four: please draw an image representing your strengths as a mother.

Kelly spoke about what was included in her drawing (Figure 10) and the image she chose to portray. The image was of her crying with her children holding "the weight of the world."

> And I do have a sun right here because I know in the end, you know, my tunnel was going to be bright, you know? Because I don't give up and different things like that and these are just little quotes, I told myself, "You will be okay." Sunlight at the end of my tunnel, some are my days where like I said, I'm human, I feel like my walls are closing in. And I feel overwhelmed. And then like I said, I told myself, "I got this, I can't give up."

Dana had a different perspective on maternal strengths and resiliency factors. She spoke about her awareness of what it is like having Black children and the delicacy of how to approach the topic of race. Dana reflected on her resiliency as a mother of color. She said the hope for her children has been to acknowledge historical racism and thoughtfully translate the experiences of the Black community to have awareness, but not embody victimization. Her approach was grounded in presenting the concept of racial identity from a place of strength not helplessness. She said,

> We don't have conversations super-duper, super-duper deep conversations about race right now, because all you hear about race is like, "Those Black people need help." And I'm like, that's not the conversation we're telling. I'm not telling my kids that. They're fine. They're not walking around, like “something's wrong with me.”

She had inquired about how to both acknowledge racial identity without oppressing their individuality. She asked, “And how we are trying to make space for them to live in recognition of that, but also outside of that?” Reflecting on this concept while focusing on what was best for her children was a form of Dana’s resiliency. Her perspectives emphasized that while racism exists she was also wondering how to protect their developing identities from harmful narratives.

Dee’s reflections embraced a different aspect of resiliency. She spoke about the need to pause and remind herself about what she is doing as a mother. She used the directive to actively question what her strengths were. She spoke at length about her multiple responsibilities and how it is easy to forget how she shows her love. She said, “I guess I don't slow down and think about, like, ‘Oh, what am I doing?’ Like, ‘What are strengths that I'm doing on a daily basis?" Her immediate response to the directive was, “I guess reminding myself I'm a good mom.”

When speaking about her current schedule she said, “Realizing like, ‘Oh, I am doing a lot.’ And not even realizing, or like, I guess...Not, not explicitly.” Her responsibilities included a full-time clinical position, seeing therapy clients, participating in a full-time PhD program, and balancing active parenting. She reflected on the challenges she has had with external pressures of meeting expectations as a working woman and mother. This included, “I feel like as a mom, we have to do it all.” Her experiences reflected the resiliency of engaging in her multiple roles while being an attuned, caring parent and challenging deep-rooted societal pressures.

The mothers all identified with different forms of resiliency that underpinned the complexities of being a mother of color. The experiences and emotions represented the individual nature of how they have coped with challenges while maintaining love for their children.

Generational Traumas

When speaking about strengths of mothers of color, the participants discussed how generational trauma has had a profound impact on their parenting and cycles within families. They described their perspectives through the intersection of individual and mothering lenses. Generational trauma was defined by the mothers as chronic patterns of pressures and expectations within specific roles, and/or emotional and physical abuse throughout family generations. The effects of the untreated trauma were identified by the participants’ statements about their experiences and what they have noticed as parents. There was a collective motivation to combat familial generational trauma to create different future opportunities.

Dee spoke from the stance as a working parent aware of the generational expectations for mothers. She talked about the external intergenerational pressures mothers involuntarily receive from society and family members. She said,

> Like stop this intergenerational expectation for moms to “do it all.” And I know better, but I fall back into the trap. Because my mom did it all. I'm doing it all.

Dee identified that regardless of witnessing her mother “do it all” and being aware of the cycle, she has noticed herself internalizing the same pressures. She spoke about reframing her role as a working mother as a “balance” and “strength” instead of a “weakness.” This personal approach about how Dee wanted to process generational pressures sounded empowering as a new working mother. Her perspective acknowledged the embedded modern-day pressures mothers possess.

Rita expressed a different outlook on generational trauma by speaking on the impact of her own experiences and interest in making changes. Her image represented “links” between herself, family, and personal observations (see Figure 11). She said, “I want to prioritize breaking generational trauma.” She drew a “break” in one of the links to represent changing the parenting approach and ending the cycle of trauma.

Figure 11

Rita's image for art therapy directive four: please draw an image representing your strengths as a mother.

Rita also associated the blue link to also represent her late father, who had passed the year prior. She had spoken about her grief throughout the meetings and chose to include him because he had tried to parent differently than how he was raised. She said, "And I feel like even though he inflicted some of that trauma on me in many ways, he tried to circumvent the trauma that he experienced as a child." She explained how she would like to change the cycle of trauma in her family through attunement and awareness. She said, "I'm so hyper aware of my own experiences as a child. I just don't want to repeat those things with my own kids."

Kelly also talked about the influence generational trauma has had on her decisions and outlook as a mother. Like Rita, she discussed wanting to end trauma cycles for her family. When speaking about how to protect her children and teach them what a healthy dynamic looks like, she said,

> Generational curse? And it's almost like, I see my mom go through it, you know, with her husband. And to me I thought it was love, different things like that. So, me being in a situation I was the same similar situation, me thinking that, okay, that's love. But in reality, it's not. I don't want my children to think that that's love.

She talked about how she has made a difficult yet compassionate effort to change this cycle. She said, "I feel like I kind of broke that. I feel like I broke that curse within myself, for my children."

Dana talked about the historical context of generational trauma and how to protect them from the collective dynamic versus the immediate interfamilial experiences. She described her thoughts specifically on Black generational trauma and parenting. "I'm trying to let go right now and let them do their own thing, you know, because, um, because I think that there's a lot of ancestral and generational like trauma and responsibility as little Black children." She discussed two recent events with her son and two separate families that highlighted the need for her to recognize Black generational trauma, even at his young age.

She recalled two situations where her son's friend accused him of "stealing" a toy in the friend's home that resulted in the parents becoming involved. Dana reflected observing the different responses towards her son versus her daughter, and the deeper meaner related to implicit racial biases. She reflected on the use of the word "steal" and the negative connotations that were used with her son but not her daughter. "What? Why are you using that word with my son, my Black son? I've never heard anybody say that about my daughter, and she's super stingy.”

She spoke about the concern behind White families making accusations related to racism towards Black males. "He took this from me’ is fine. But stealing is...a crime. And you're associating that with my three-year-old son.” Dana reflected on grounding her parenting approach in the use of “intentional language.” She explained how she and her spouse have made a thoughtful effort to consider, “How we are intentional about the language that we use, and the ancestral context for that language, and the like, and the generational...like, oppressive nature of America that our children exist in.”

All perspectives reveal an awareness of what has occurred within their families and/or through a historical lens. This level of attunement has helped to create a central focus to make changes and process what it has meant. The overall hope was to support and protect their children in ways they or others within their families or communities may not have been supported.

Loving through the Unspoken

Loving through the Unspoken was defined by participants as invisible parenting approaches, decisions, and reflective care in each interaction. These acts were not easily seen and were an embodiment of thoughtful choices to protect and support. The mothers shared differing viewpoints of how they express their love.

Rita discussed how she has multiple love languages for her children. She said, “Those are two love languages, of constantly thinking about the future, and the past and the present all at the same time.” This action of continual wonderment and attunement to her children’s wellbeing represented the depth of her love. She talked about the experience of making thoughtful, knowledgeable choices based on her awareness. Rita continued to say,

> I know one day I will have conversations with them about the things that I've tried to do and like have very cerebral open conversations because we are a family that talks about feelings. And I think that when they're when they're old enough, I'll be happy to explain it.

For Rita, the weight of waiting until her children understand the range of consideration she has in their upbringing sounded challenging. She spoke about the experience of complex decision making without the ability to verbalize the reasons. She said, “It's like this constant cognitive battle in my head to show my love. Okay, like I love them, I give them hugs and I give them kisses and all of that other stuff, but it's also, like I don't think they'll understand my way of showing love until a little later when I can contextualize and explain it to them.”

Kelly also spoke about the deeper experience she engages in before making choices affecting her family. She discussed what it is like demonstrating vulnerabilities to her children and how internally challenging it is. She explained how she would like to show her children it is safe to ask for help. Kelly reflected on the amount of exhaustion she experienced in order to express vulnerabilities and recognize the importance of reworking these associations. She said,

> Patience. Love. And I will tell them that it's okay to cry, it's okay to be sad, it's okay to be you know, upset different things like that. And it's okay to talk about things to people, it's okay to ask for help.

Similar to Rita, Kelly acknowledged the complexity of processing her decisions before externally enacting. Her decision to allow herself to be vulnerable was focused on role-modeling asking for help.

Dana had a different approach showing her children unspoken love. She encouraged her children to authentically be themselves. She described herself as, “I think

I'm fun. I think I'm a fun parent. And I'm interested in them. Like, I actually want to know what they're doing and talk to them and play with them." She reflected how she shows love through play, unconditional support, and being genuinely interested in who they are as people to support individual identities.

Figure 12

Dana's image for art therapy directive four: please draw an image representing your strengths as a mother.

Dana reflected how she promotes the art of play, creativity, and exploration to show support (see Figure 12). She said, "I think that I take them on adventures a lot. And we go, we play, we spend a lot of time outside. And we listen to music, and we dance together." Additional examples of loving her children through the unspoken included the consideration of specific details. She said, "I really pay attention to all those little details about the things that they want to sleep with, you know, and the things that they notice. And try to encourage their curiosity."

Dana followed up her explanation by saying, "That's how we love on them. That's how we take care of them. Just kind of recognizing how they're growing up as a little Black children in a White city. And even with my child's hair, like, ugh, I can't even...I just makes me want to not be here in the city or in any White space." Similar to resiliency, she began to speak about the need for awareness as a source of protection against microaggressions and racism living in a predominately White community. She said,

> But the way in which we have to protect our children, how they interact with other people, is, has to be just so much...so, it's just has to be intentional. So that my child doesn't feel like something's wrong with her skin, or something's wrong with her hair, or that something something's wrong with her in general, just because she is living a different experience in this world.

Dee spoke about how she has created her identity as a working mother to role-model balance for her daughter. She talked about how she has had to internally weigh her ideas of what it means to be a working mother form her identity and set an example. The unspoken love she was showing to her daughter was actively setting a standard by being present in both roles as a working parent.

Figure 13

Dee’s image for art therapy directive four: please draw an image representing your strengths as a mother.

Dee discussed the challenging pressures to find inner strength in what she believes is best for her family instead of what society’s definition of a mother is. She described her drawing (see Figure 13) as an example of balancing both worlds. Dee said, “There's light. I'm attentive to her. You know, she's close to me. And so part of me too, is like I modeled for her what, you know, multitasking, take care of you. I can, you know, attune to you, but also get work done.”

All mothers shared their perspectives of different ways they expressed unconditional love and support to their children. While they described differential approaches, the underpinned tone of intention was authentic care, investment in thoughtful decisions for their futures, and deep consideration of how their choices will affect them as adults.

Holistic and Humanistic Care

Each participant spoke about wanting a hospital environment to be focused on the patients, nature, and humanism in both intervention and appearance. The collective discussion was related to the importance of humanistic care in medicine. Holistic and humanistic care was defined as approaching the whole individual (emotional, physical, and personal identity) when considering medical needs, interventions, and partnership.

Dana highlighted the importance of holistic healthcare through the art therapy directive (see Figure 14).

Figure 14

Dana's image for art therapy directive four: please draw an image representing your strengths as a mother.

“But mostly when I think of an ideal hospital environment it is relaxing, and it's rooted in nature,” stated Dana. She also said, “I think that that is what the ideal hospital environment is. It's just like, based in a deep awareness of yourself and, and how nature can support that awareness.”

She spoke about the different approaches to ailments using natural, organic means instead of sole pharmaceutical options. Dana also acknowledged in the meetings how Black people are at risk of their personal safety in remote outdoor settings. She described specific instances where people of color have been racially harassed, assaulted, or murdered in isolated wooded areas. This participant spoke of how the image dually represents feeling both physically and emotionally safe in a holistic healthcare space and within nature as a person of color.

Rita reiterated this outlook by saying, “It would be a system that I think could see me as a person first, as opposed to... only seeking to care to cure the problem or treat the problem.” As a support to what Rita was describing, Dee talked about her interest in a more “inviting” holistic appearance when considering the hospital design. She identified wanting to use warmer tones and nature (see Figure 16), wider spaces, windows, and creating an overall welcoming feel than that of an industrial building. Bea reported a similar interest in relation to the outer appearance (see Figure 15) and said, “A playground out here. You know, they're just walking and playing with their ball and family and just love and colors and happiness here.” The physical representation of the building was symbolic for both participants.

Figure 15

Bea's image for art therapy directive three: please draw an ideal hospital environment for you and your children.

Both Sia and Tay reflected the same interests when considering an ideal hospital setting. Sia reflected on her drawing and said, "It's just like a happy environment, very comforting." Tay added, "I feel like a hospital should be a place of healing of your whole self" and "It should be a place of like no judgment. And then I have bright beautiful colors everywhere." The participants' ideal hospital setting was centered around humanism and unconditionally supporting families. They spoke of what it would be like for them and their children to enter this environment instead of a building representing industrial profit and/or oppression.

Dee made the same request for an ideal hospital (see Figure 16). She stated, "And there's a park here for the kids and make them feel more comfortable. The nurses, different shades of color here of people and kids." Her perspectives of an ideal setting were grounded within racial concordance and safety.

Figure 16

Dee's image for art therapy directive three: please draw an ideal hospital environment for you and your children.

Rita acknowledged that while holistic care would be her primary choice, there are strong criticisms and judgments towards holistic healthcare approaches. She said,

> Wellness and holistic care are kind of at the top. And these are things that I think are missing from our medical system, because they're often seen as like junk science, or not being relevant to our care systems and processes.

Her thoughts reflected the deeper bias the general medical field may have towards wellness interventions that differ from the traditional medical model.

All participants' representations and interests in an ideal hospital setting were related to a comforting, compassionate, and thoughtful environment that reflected holistic approaches. They also hoped for an ideal setting focusing on those receiving healthcare support instead of industrial profit. They identified the importance of possessing a welcoming space for their families and community members.

Art Therapy Responses

The participants’ perspectives on engaging in the art therapy directives included seeing the approach as an open outlet for personal creativity, space to reflect and engage on individual identities, and fully express themselves. When asked what the experience of participating in the art therapy directives were, the participants responded positively.

Kelly reflected, “It felt good to be able to draw it out and express the things that's on our mind, because we're never heard.” In the final meeting Kelly discussed her perspectives in the expressive arts. She said,

> I feel like it helped me a lot because, like I said, it felt good to be able to write things down on paper and just to look at, okay, this is my story…part of my story. And it feels good to look at a drawing, I let it out on a piece of paper. So, I feel like this was a good experience for me.

She also added that, “It feels good to just be able to see color again because, I want to say it's been actually forever since I've actually drew a picture on a piece of paper, or even used crayon.” Dana reflected a similar stance about how it felt re-engaging in art after a long period. She said, “I enjoyed sketching and being reminded that I can draw, or I enjoy it anyway. Like, there was just like, ‘Oh, I haven't actually done this in a while."

Sia experienced a similar response as Kelly and said, “I think my feelings, but I'm not able to express them.” In the third session directive Sia stated, “I enjoyed it” when asked about the art therapy engagement. Tay discussed how it felt good to be able to express herself and not dismiss her own feelings. She said she talks with her spouse about her experiences in the healthcare field, but it can lead to questioning her reactions. She said based on his responses, she wonders whether she overreacts but stated, “I just feel like, you know, we're dismissed. And then, it's nice to put almost like a face to it to the name of the medical system.” Bea reflected on how she became anxious when she heard the directive and wished she had more time. She stated, “I kind of got anxious” and reported fears of “messing up.”

Dee stated she felt good about being able to engage with the topic of an ideal healthcare setting through artistic expression. She said, “It's a peaceful image...I think it grounds me.” She also reflected on how the engagement in the second art directive helped her to process her labor and delivery experience. She said, “And that art... helped understand that because I think…I think back and I was telling you like, oh my gosh, it was so scary. And then, ‘wow, but we did it!’ Like ‘we were okay’ and she came out so quick.”

Rita reflected on how she typically processes her experiences cognitively. The directives helped her to externalize her thoughts and look at the various contributing factors. She said, “The art therapy is just like a completely different entry point into my own reflection, like I'm very often so heady, and stuck in my thoughts and going round and round and round, but the art was a nice way to put it on paper and peel back the layers.” To finalize her art therapy experience in the study Rita stated, “For lack of a better word, it was just a nice way to capture my thinking.”

The participants shared their perspectives of what it was like to engage in the discussion with the art therapy directives. They spoke about the re-engagement with art materials and expression, the ability to encapsulate their experiences, and using it as an outlet to be heard.

The participants joined in both group and indivi dual settings to discuss what the perspectives of navigating healthcare being mothers of color living in the US through art therapy. Each person engaged in the directives, discussion, and shared their observations. The artwork depicted images to support their stances and express what it has been like to be parents within the medical system.

CHAPTER FIVE

Discussion

The purpose of this qualitative research study was to better understand the perspectives of mothers of color living in the US and medical system using art therapy. This study aimed to examine similar perspectives that Wright et al. (2022), Kemet et al. (2022), and Ogunwole et al. (2023) researched with Black mothers and pregnancy in healthcare. The study also built on Roopnarine’s (2013) qualitative research on Indo-Caribbean mothers and their mothering experiences, and Albanese et al.’s (2020) information on mothers during the postpartum period where the researchers recognized diversity as a limitation in their findings.

The participants engaged in four art therapy directives to provide further insight into their emotions, relationships, intersectional identities, and awareness navigating the healthcare system. The addition of art therapy directives provided a deeper reflection into the participants’ knowledge and emotional experiences. Presently, it appears there is no comparable research study on medical experiences of mothers of color living in the US using art therapy. The following discussion will connect the current literature findings with the research study.

The eight themes and four subthemes included *Privilege and Disparity, Capitalism, Being Overlooked, Pressures Related to Reproductive Health (Subtheme A), Fear and Protection, Mistrust (Subtheme B) Advocacy (Subtheme C), Resiliency, Generational Trauma (Subtheme D), Loving Through the Unspoken, Holistic and Humanistic Care,* and *Art Therapy Responses*. The following describes how this study’s findings connect to the current literature on mothers of color living in the US, the healthcare system, and art therapy.

Privilege and Disparity

Recognizing privileges and experiencing disparities within the healthcare setting was a common perspective. Barriers to equitable healthcare resources and the impact of systemic disparities were identified by previous researchers. Estriplet et al.'s (2022) qualitative findings included participants’ attention to practitioners working with Black birthing people to consider the influence on maternal health from a social and structural perspective instead of limiting their scope to individual symptoms. Berger and Miller (2021) thoroughly discussed the intersection between health disparities, structural racism, and classism. To consider realistic changes, there was encouragement to those within administrative healthcare and educational positions to shift the blame from individuals to the system. Berger and Miller also stated the lack of persistent use of a social justice framework within policy decision-making, changes in healthcare, and education administration initiatives stalls needed improvement towards equity (2021).

The participants of this study identified the outcomes of these systemic interactions and described the dynamics as elitism, capitalism, racism, and general disconnect between human experiences. This has left people of color to feel dehumanized, undervalued, and unsafe within these settings. These perspectives are also directly related to the literature on systemic racism and the impact of organizational healthcare decisions written by Reynolds (2022) and Jackson (2023). Reynolds linked the lack of understanding and acknowledgement of structural racism by the health regulatory boards to perpetuate continual cycles of disparity. This researcher identified the trickle-down effect of the interplaying systems (economic, education and medical) that continue the sequence of oppression. Jackson specifically recognized the interplay between historical contexts, policies, and present-day assumptions about Black women with chronic conditions and/or perinatal and/or postpartum distresses (2023).

Ogunwole et al. (2023) examined the predisposing factors that affect utilization of healthcare options for mothers of color during the postpartum period. The researchers acknowledged the effect of disparities and systemic oppression affecting the ability for mothers of color to access appropriate healthcare resources. Transportation concerns, financial flexibilities, housing stability, job expectations, and lack of childcare were included in these qualitative findings. These researchers also acknowledged the disproportionate upheaval caused by COVID-19. Keefe et al. (2021) also shared how emotionally difficult it is for mothers of color living in low-income situations to leave their homes without proper transportation resources. The present study's findings added to the information related to barriers to equitable access. The barriers identified by the participants included transportation, speaking a non-dominant language, a lack of insurance, and individual financial circumstances. Kemet et al. (2022) reflected additional barriers that were created by the insurance companies that contribute to lack of access to healthcare resources.

This study's participants also shared internal emotional experiences related to racism and harmful stereotyping when speaking with providers of a different racial background. Their examples included individual recollections of what their family members have endured in the healthcare setting. Researchers have recognized the importance of racial and gender concordance, or comfortability with similar appearances between patients and providers (Estriplet et al., 2022; Hunte et al., 2022; Ogunwole et al., 2023; Sayyad et al., 2023). Estriplet et al. (2022) identified that cultural and racial congruence helped providers to examine additional areas of the patient's experiences that inform appropriate intervention and diagnoses. Hunte et al. (2022) noted the importance of patient-provider concordance to instate trust. Similarly, Estriplet et al.'s (2022) and Kemet et al.'s (2022) qualitative research themes also reflected the significance of a similar patient-provider identity strengthening trust. Ogunwole et al. (2023) discovered Black mothers reported seeking Black practitioners to reduce code switching (changing tone of voices and approach when speaking with White providers in order to legitimize their stance) and engaging in stereotype shielding, and as a result, experiencing a sense of relief.

These participants shared the hypervigilant attunement regarding how they were being perceived and how they could attempt to control the environments to reduce the risk of discrimination. This notion supports the research on stereotype threat theory, specifically in healthcare, that Wright et al. (2022) included in their qualitative findings. It is an act of increasing environmental control and preparing for stereotyping through shielding themselves preemptively before an interaction (2022). This theory will be interwoven throughout other parts of this study's themes and discussions.

The participants shared comparable emotional responses through their artwork. Two participants drew a similar character representing the healthcare system using tentacles and multiple outer extremities to define how they felt. These perspectives represented how the medical system was experienced at both an individual and organizational level. Howell et al. (2018) described the impact of both institutional bias and implicit bias in healthcare. Howell described the dynamic between the two can lead to health disparities and racism in a wide spectrum of interactions resulting in poor outcomes (2018).

Capitalism

Acknowledging the impact of capitalism at the root of the healthcare system and recognizing it as another structure dedicated to profit over people was identified by all the participants. There was a strong association the participants had between the hospital settings and the focus on profit over humanistic support. Jackson (2023) noted those within low-income situations are not able to access private healthcare, which results in increased barriers to treatment. While there have been more recent governmental changes to postpartum supports covered by Medicaid, they have not been enacted at a federal level creating gaps between states (Jackson, 2023). The mothers openly stated they believe they do not matter and the hospitals' attentions were on billing insurance claims and supporting the pharmaceutical companies.

Ogunwole et al. (2023) discovered similar qualitative statements when asking Black mothers about their healthcare experience and participants felt like they were "just another number" (p. 13). Kemet et al.'s (2022) qualitative research with Black mothers speaking about mental health also reported concerns the participants had with mental health providers varying quality of care depending on their insurance. They also felt mental health professionals were more focused on personal financial income than therapeutic care (2022).

In this study, a participant had received a call from the billing personnel immediately following birth requesting payment for her delivery (leaving her feeling frustrated about the priorities) and another discussed the impact of limitations the insurance companies create regarding specific testing or recommendations. Supportive research recommendations for mothers of color included doulas, midwives, Black-owned culturally sensitive birthing centers, and Black in-home nurses (Estriplet et al., 2022; Hunte et al., 2022; Karbeah et al., 2022; Sayyad et al., 2023). In this study, the subject of doulas arose with the acknowledgement that doula care can be an invaluable, supportive resource for mothers but is often an out-of-pocket cost. Sayyad et al. (2023) recognized the financial issues for doulas caring for patients, specifically Black doulas, and the benefits of Medicaid coverage would support both mothers and doulas of color.

Estriplet's et al., (2022) qualitative findings on strategies to support mothers of color during the postpartum period also included the use of doulas and in-home nurses. However, there was again the recognition that doulas services are not typically covered under insurances and insured in-home nursing visits are minimal (2022). Inequities within the insurance industry were also identified by the participants.

Research has reflected midwife-lead birthing centers as a risk-reducing environment for birthing people that legally falls under Medicaid coverage (Ploplis, 2022). However, Medicaid reimbursement is only applicable under a specific license which depends on adherence by the states (2022). This information provides evidence supporting the participants' responses to the healthcare system not prioritizing people or legitimate needs, the gaps in the system, and instead focusing on profit and commercial insurance.

Being Overlooked

The participants all described similar accounts of being unheard and overlooked by providers within the healthcare setting at varying degrees of macro and microaggressions. Each interaction left the participants feeling devalued, unsafe, and frustrated they were not being taken seriously or treated equally. These perspectives follow the qualitative findings of Sayyad et al.'s (2023) research on mothers of color in the US. The research reflected Black doulas witnessing Black mothers not being given the same amount of information about treatment or allotted the same thoughtful interactions (eye contact, medical information, follow-up questions, compassionate emotional support) in comparison to White mothers meeting with the same providers. These observations also included doctors and staff not speaking to Black birthing mothers during their labor and delivery, not listening, and not following through with complaints (Sayyad et al., 2023).

The theme of feeling unheard both as women of color and mothers arose in this study's discussion. The participants stated when they had attempted to voice concerns with their pregnancy, interest in partnering in care, express emotions following a miscarriage, and report postpartum pain they were dismissed. Ogunwole et al. (2023) and Wright et al. (2022) also found Black and Brown mothers' statements not being taken seriously, specifically with pain management related to labor and delivery. Ogunwole et al. (2023) discovered the same qualitative perspectives from Black birthing mothers experiencing an intensive level of excruciating discomfort and advocating for medication. They discussed the impact of how reported negative racial stereotypes affected the provider's responses (providers assuming patients were drug-seeking). This information aligned with research on Black women with breast cancer and prejudices, history, and lack of equitable pain management follow-up (Campbell, 2021; Vilardaga et al., 2022).

Another participant acknowledged how mothers are already under an immense amount of societal pressure and the additional stress of not being heard in the healthcare setting increases difficulty to properly care for her children. Miller and Baker (2022) interviewed mothers of color regarding their delivery experiences. They found similar stances of not being taken seriously, listened to when making decisions, and/or being talked down assuming they could not comprehend the information. The participants in Miller and Baker's study expressed feeling patronized when speaking with medical staff and reported when there was dialogue, communication was presented in a condescending manner. Researchers Miller and Baker (2022), Ogunwole et al. (2023), Sayyad et al. (2023), and Wright et al. (2022) documented these perspectives of providers speaking down to patients of color in a superior manner and assuming Black patients had little formal education.

Subtheme A: Pressures Related to Reproductive Health

The subtheme within *Being Overlooked* was specific to *Pressures Related to Reproductive Health*. The participants experienced pressures and expectations related to reproductive health decisions and their labor and delivery options. Communication surrounding their reproductive health with the participants and providers was not conducted in a supportive manner. This resulted in feelings of frustration, exhaustion, and helplessness. Wright et al. (2022) discovered parallel perspectives with their participants related to open communication and birth.

Miller and Baker's (2022) qualitative research also possessed similar stories about Black mothers and secondary birth plans following a cesarean section. All participants voiced their providers had a significant impact on their birth decisions. For those who wanted to try for a vaginal birth after a c-section (VBAC), there was pushback and encouragement for a subsequent c-section. A previous study found racial disparities regarding c-section rates with Asian and Black women at a higher risk to have a c-section than White women (Hanson et al., 2022). The researchers posited that this correlation was related maternal age (higher risk of a c-section with age), maternal educational background (women with lower educational statuses were at higher risk), and maternal BMI (women with a higher BMI were at higher risk). Hanson et al. (2022) and Jackson (2023) noted systemic oppression and inequities underpin several of these factors and affect general health outcomes that can result in a higher risk of c-sections.

One participant in this study discussed wanting to have a VBAC instead of another c-section, but felt her autonomy and choice were not taken into consideration. This perspective aligned with the lack of autonomy experienced in Miller and Baker’s (2022) research when participants wanted a VBAC instead of a c-section. Their participants reported they experienced pressure from their provider to have another c-section and were treated differently as a result. This study’s participant felt her birth was rushed, her voice as a Black woman was not heard, and communication was not clear surrounding the reasons for her providers wanting to perform another c-section.

The mothers in this study also felt judged and treated differently by their providers when speaking about their family expansion and after voicing how many children they have. The responses were related to having a hysterectomy or starting birth control. A participant in Wright et al.’s study reported a comparable experience with a White male provider assuming she had no formal education and multiple children based on her race (2022). Researchers have also noted negative stereotyping in hospitals leads to hurtful and dismissive interactions between patients and workers (Sayyad et al., 2023).

Fear and Protection

Good mothering ideology is often centered around the perspectives and expectations of a White middle-class woman (Randles, 2021). Randles reflected how this creates an unrealistic standard for mothers outside of this demographic of how to protect, properly care for, and support their children. Randles theorized this as “inventive mothering”; the innovative efforts of mothers of color ensuring their children’s needs are met and protected from the intersections related to their identities (p. 35). Though information on socioeconomic status was not gathered for the purpose of this study, it is important to distinguish that regardless of financial income there are disparities that non-Hispanic White mothers do not need to carry.

These mothers spoke about their deeper fears connected to the wellbeing of their families and general mothering worries. Fears were specifically related to mistrusting providers and the system, whether their parenting choices were going to harm their children, and new parenting anxieties about first time parenting. The perspective on new parenting stressors was identified in Albanese et al.'s (2020) qualitative theme related to adaptation to the learning and adjustment to their baby’s needs and emotional regulation. Another specific fear for these participants was unexpected miscommunication with a provider and having their children taken away during a medical appointment. Racial stereotyping in White spaces was identified as underlying causes for this fear by the participant. This exact fear was also reflected in Keefe et al.’s (2021) previous qualitative research on mothers of color.

Research has indicated evidence and validation of these perspectives due to negative stereotyping towards Black women, a lack of listening and dismissal of their concern, and history (Ashley, 2014; Capp, 2022; Sayyad et al., 2023). There is an increased mental burden to thoroughly consider verbiage and presentation to be taken seriously with limited access to medical professional knowledge. This forces mothers of color to make independent decisions with increased odds of making a mistake that could then be penalized or reinforce biased treatment from providers. Mothers of color have had to engage in preemptive stereotype shielding as a way to protect themselves from misunderstandings, which includes code switching and preparing themselves with information to increase the likelihood of being heard (Wright et al., 2022).

Another fear was how to proactively advocate for their children’s needs to prevent physical harm. There was the open recognition from the participants that the healthcare system does not hesitate to perform risky interventions nor consider the repercussions towards people of color. This awareness informed the participants’ increased fear and need to protect. One participant shared her attunement to the long relationship her children are going to have with the medical system, and how to prepare them for this dynamic. She discussed how she has supported them by maintaining her “building blocks” of protection. These blocks included personal privileges (able-bodied, family ties in healthcare, insurance) and education on medical needs.

The implementation of mandated vaccinations for school attendance was a topic that created additional fears navigating COVID-19 and highlighted the complex interplay between distrust with the medical system and people of color. This dynamic was not only connected to the stress of COVID-19 but history of mistrust with providers and knowledge of experimental abuse with Black and Brown bodies (Campbell, 2021; Jackson, 2023; Reynolds, 2022; Williamson et al., 2019). These perspectives were related to pressures as a mother, personal responsibility, and power dynamics between organizations and the public.

Protection was identified as religious beliefs and faith to cope with the unknowns. Participants talked about praying and connecting with God in order to reduce feelings of isolation and sadness. Ogunwole et al. (2023) identified the use of prayer and faith as a replacement for mental health supports due to stigma and hesitation to engage in treatment. Bodnar-Deren et al. (2017) also discovered Black mothers navigating PPD turning to religious supports instead of pharmaceutical options more often than White mothers with PPD.

Subtheme B: Mistrust

The participants all spoke of mistrusting the medical system for various reasons. These reasons included the history between Black and Brown communities and the field, capitalism, and previous poor treatment. They discussed feeling uncertain about why specific recommendations were offered and wondering whether they were in their best interests. This level of mistrust between mothers of color and perinatal care is consistent with the previous literature and with similar reasoning (Kemet et al., 2022; Sayyad et al., 2023). In Miller and Baker’s (2022) research, mothers of color also identified feeling paranoid about minute interactions and observations questioning whether they were microaggressions. Williamson et al. (2019) found support to their hypothesis that medical mistrust was a combination of both vicarious racial trauma and personal experiences.

Capp (2022) similarly found the same theme of mistrust in their qualitative research with healthcare providers and their perspectives on Black mothers and infant mortality in Milwaukee. Providers reported the patients not being believed in the hospital setting during labor and delivery and experiencing a lack of body autonomy. Previous research has also found Black mothers distrusted mental health providers due to their belief providers were more focused on their financial wellbeing and engaging profit-based behaviors (prescribing medications) than quality therapeutic care (Kemet et al., 2022).

As previous studies have recognized, these mothers discussed feeling emotionally unsafe in these settings and felt unable to authentically express themselves. Previous qualitative research on Black mothers and perinatal care have identified similar themes of being dismissed when reporting concerns to White providers (Ogunwole et al., 2023). There was the additional pressure to be hypervigilant due to the statistical risks of harm towards Black mothers during pregnancy, delivery, and postpartum (Ogunwole et al., 2023; Sayyad et al., 2023; Wright et al., 2022). The participants’ reactions were either avoidance or experiencing a stronger emotional response than necessary. The outcome of both reactions have negative stereotyping associations including being idle, not caring about their medical care, and/or being “an angry Black woman” (Ashley, 2014; Ogunwole et al., 2023).

This study’s examples of mistrust were also related to concerns with overmedicalization. The reasons for this fear were due to their providers’ lack of communication and reasoning behind interventions. Two separate stories included one participant being tested for sexually transmitted diseases when seeking care for stomach pain. She reported being confused when she had recently been tested during her pregnancy, and not understanding the reasons why they were testing her when her complaint was stomach pain. Another participant discussed providers wanting to examine her unborn baby for intellectual disabilities reportedly as policy protocol. She stated she was confused because they had not tested her three other children in utero, nor explained the reasons why this was necessary. Overmedicalization, experimentation, and loss of physical autonomy for Black and Brown women in the medical community has been previously mentioned and well documented (Campbell, 2021; Capp, 2022; Godley, 2021; Jackson, 2023; Ploplis, 2022).

Subtheme C: Advocacy

The participants shared what advocacy meant as mothers of color. The mothers spoke about advocating for basic standards in their family's care, including physical and emotional safety, and the resulting amount of exhaustion and frustration. For these participants, advocacy had emerged through proactively gathering information before an appointment, mentally preparing to assert themselves, and preparing to "fight" for answers if necessary. As previously mentioned, code switching and stereotype shielding were methods of coping with the system in order to increase the likelihood of being heard (Wright et al., 2022).

Advocacy was a qualitative theme with pregnant Black mothers in healthcare settings in Kemet et al. (2022) and Wright et al.'s (2022) research. Wright et al.'s participant advocacy recommendations included encouraging women of color to do preemptive research before an appointment, to not hesitate to find another provider if they were feeling unsafe, and encouragement to dismantle how medical conversations were conducted. These recommendations were also reflected in the participants' discussions.

The mothers all identified the need to be prepared to insistently convince the doctors of their positionality. As previously mentioned, advocating for pain medication or voicing physical concern were common examples that have been researched (Ogunwole et al., 2023). The assumptions are rooted in racist historical beliefs Black and Brown people do not experiencing pain to the same degree as White people (Campbell, 2021; Vilardaga et al., 2022)

Advocacy was also identified as joining together as mothers of color to support one another. The participants reported connection and comradery reduced the feelings of isolation and disconnect. Kemet et al. (2022) found varying qualitative degrees of advocacy for mothers of color and noted recommendations on how to advocate for better healthcare supports. The mothers in Kemet et al.'s research reported the Black providers need to internally promote increased access to mental health services in their field for people of color. They identified the gaps in the system and the knowledge Black mental health providers possess to challenge these inequities.

Resiliency

The participants shared how they have coped with different experiences of adversity, trauma, and challenges. These experiences included navigating parenting and pregnancy, understanding their racial identities, and how mothering has been linked to further processing generational trauma. Their reflections underpinned the power of motherhood as both a source of strength and vulnerability. The theoretical framework of "Sojourner Syndrome" is important to note when speaking about Black and Brown mothers' resiliencies within an intersectional identity (Mullings, 2005; Oshin & Milan, 2019). For mothers of color, these overlapping identities include the interplay between sex, race, and class, and have a foundational impact on their experiences.

Personal resiliencies have a complex meaning for mothers of color due to the assumption Black and Brown women have a higher tolerance for difficulty and can do it all. Hunte et al. (2022) reflected this notion subsequently creates additional pressures and isolation in motherhood. Oshin and Milan (2019) asserted that Black mothers under the “strong Black woman” (SBW) trope can be both empowering and harmful within the same statement. This highlights the contradictory identities involuntarily placed onto mothers of color. The concept of a SBW was researched to better understand how this notion can be used as a source of parenting strength while also recognizing the historical origins and criticisms (2019).

Ogunwole et al. (2023) discussed how resiliency in mothers of color has been a result of countering oppression when faced with imbedded racist ideologies, but noted this level of resilience is not without concerns. Experiencing significant stressors can be connected to health disparities and create greater barriers in utilizing healthcare resources. Through self-identification of a SBW, there is a notion to do it all and avoid additional supports (Ogunwole et al., 2023). Chronic stress, hypertension, diabetes, obesity, heart conditions, and weathering were discussed in Jackson’s (2023) literature on medical conditions and Black mothers. Weathering is a term coined by public health researcher, Dr. Arline Geronimus, referring to the chronic physical and mental impact of racism (Davies, accessed 10/14/2023). Jackson acknowledged Black mothers are met with higher rates of these health concerns than White mothers due to long-term stressors of systemic oppression. Researchers also noted the mental health stigma within the Black community may heighten the caution to engage in services and further embody the SBW identity.

Several of the mothers openly talked about loneliness and pressure with pregnancy and parenthood. Keefe et al. (2021) reported isolation was a similar theme identified in their research study on mothers of color living in low-income areas. A participant spoke about the difficulty in engaging in vulnerability due to her fixed associations in asking for help as a single parent. Embracing religion and personal faith were seen as sources of connection during these times. Like these participants, Ogunwole et al.'s (2023) participant statements' reflected the use of pray and faith as outlets in place of mental health supports.

Maxwell et al. (2019) documented how personal strengths and resiliencies were also a consistent theme in articles on mothers of color managing the challenges of PPD. The research reported the strengths included the mothers centering on their individual outlooks and attuning focus to their children. Those mothers shared how they continued to persevere for their families (2019). Those findings were comparable to the discussions from the participants in this study.

Subtheme D: Generational Trauma

When speaking of strengths, the mothers of this study acknowledged their awareness of familial generational trauma and their motivation to make changes. They discussed the emotional difficulty of processing their own experiences due to discomfort with vulnerability. In the context of intergenerational immigration, this was a significant resiliency factor for mothers of Indo-Caribbean descent when actively parenting their children differently from their mothers (Rooparine, 2013). It is also critical to consider the impact of transgenerational trauma in various communities who have experienced significant, long-term chronic oppression and abuse throughout history (Parry, 2021). Researchers have examined case studies of those more susceptible to transgenerational trauma including descendants of American Civil War veterans, Holocaust survivors, and African Americans. There are various and conflicting detailed perspectives of how the effects of slavery have presently manifested within communities of color. However, Parry (2021) reported the recognition of continuation of trauma and the impact it has had on people of color. Some of the participants may have unknowingly been challenging more generational oppressive factors than realized.

The perspectives of this theme included how society views mothers with the unrealistic pressures placed on their shoulders, the effects of generational historical trauma onto children of color, and how the mothers have chosen to role-modeled healthy dynamics. This notion was specific to the qualitative themes found in Roopnarine's research on Indo-Caribbean mothers (2013). One participant shared her awareness of the burden Black children carry from decades of generational trauma and her goal to protect them. As a result of this awareness, she and her spouse have taken a collective stance paying attention to interactions other people project onto their children and using intentional language. She also believed in being cognizant of the language's origin to not inflict harm.

Common general statements and semantics in the US have historical linguistic context connected to racism and oppression (May, 2023). Anthropological and sociopolitical linguist analyses have uncovered concerns regarding "language ideologies", meaning the beliefs, feelings, and structure of language that underpin economic and sociopolitical interests of individual speakers (May, 2023, p. 655). This participant was actively breaking generational traumas by combating language exposure of the embedded racist ideologies.

Loving Through the Unspoken

This theme emerged when recognizing strengths of mothers of color. The participants shared collective experiences regarding unconditional love and support, sacrifices, and reflexive parenting styles. The mothers all discussed varying love languages in both overt and covert ways. Researchers have reported the concept of love has been labeled as an all-encompassing connection with few studies that have examined the complexities of what it means to love (Nadan et al., 2022). Nadan et al. highlighted that while loving a child is a central part of development, there can be cultural and contextual variation in how this love is expressed. Their thematic qualitative findings with Ultra-Orthodox Israeli parents and parental love included three different ways of what love means to them (responsibility, the nature of love or lack thereof, and religious aspects). This notion may apply to this study due to the cultural, ethnic, and racial differences of the participants.

The internal consideration of past, present, and future experiences and demonstration of emotional vulnerability were examples of how the participants expressed their mothering love. There was also mention of intentional parenting related to genuine interest in their children’s individuality in addition to proactive decision-making stemming from the theme *Fear and Protection.* Role-modeling multiple ways of showing love in parenting was discussed.

The participants’ perspectives on love aligned with Natividade et al.'s (2022) research on the five schemas of love including parental love. This qualitative research explored perspectives of 537 Brazilian adults and expression of love. Their prototypes concerning parental love included Care, Giving, Protection, Support, Responsibility, Education, Patience, Unconditional, and Transcendental loves. The mothers spoke of each prototype except for the specific identification of Education. However, the concept could be included when considering their children’s future experiences and awareness of treatment in community settings. These efforts highlight how a mother’s love is a complex web of interpersonal experiences and different ways to show their children how they care.

Holistic and Humanistic Care

The participants discussed how they would ideally want to change the medical systems to focus on humanistic and holistic care. The reasons mentioned included disavowing a profit-based system, belief in healing and recognizing a full identity, and safety in the healthcare setting. The examples reflected what the participants wanted to change in healthcare.

The images of an ideal healthcare setting included incorporation of nature, holistic medicinal intervention, family-friendly additives, and a warmer undertone instead of an institutionalized environment. The mothers also included racial concordance with providers to feel more connected. They spoke of how the entirety can create a different sense of belonging and support. Ogunwole et al. (2023) proposed specific suggestions for healthcare systems focused on a humanistic, equitable, and safer environment. These recommendations aligned with this study’s participants. The participants discussed a spectrum of macro and micro progressive ideas to refocus care towards the individual rather profit.

Some examples of Ogunwole et al.’s (2023) recommendations included hospitals and healthcare systems to take a look at community investments such as transportation resources, childcare at the clinic, flexible working hours, clinical efficacy through group-based care, joint mother-baby visits, in-home referrals, telemedicine options, and partnerships with community-based organizations focused on equity. Internal recommendations included initiating a racial discrimination patient safety reporting system, antiracist training as a mandatory requirement, regulators creating billing codes as appropriate diagnostic responses to racial trauma, reorganization of collaborative services to increase continuity of care, and partnering with faith-based organizations.

Specific to postpartum, they recommended hospitals partner with community doulas, midwives, and other postpartum care workers to support the transition to the home.

Ogunwole et al. (2023) echoed and built upon the patient-centered engagement framework for postpartum mothers and mothers of color through systemic innovation created by McCloskey et al. (2021). The initiative called *Bridging the Chasm between Pregnancy and Health over the Life Course: A National Agenda for Research and Action*, invited patients, providers, policymakers, healthcare leaders, and systems innovators to a two-day conference to create a National Agenda for Research and Education. The researchers also identified similar solutions with research-based foundations to promote change in women's health, specific to those within marginalized communities.

Hunte et al. (2022) reiterated the need for healthcare settings to come from a place of holistic, humanistic support when working with mothers of color due to the myriad of factors affecting their health and safety. The need for required education on antiracist practices, changes in structural operations to reduce disparities, mental health care focusing on the impact of vicarious trauma for Black mothers and children, and open acknowledgement of implicit and explicit biases affecting patient-provider relationships were also identified recommendations.

Additional researchers have purported the benefit of partnering with doulas, in-home nurses, midwives, and Black birthing centers attuned to the holistic, cultural, and individual experiences of mothers of color to be reasonable solutions to reduce inequities (Capp, 2022; Collins et al., 2021; Destine et al., 2020; Estriplet et al., 2022; Goode & Bernardin, 2022; Howell et al., 2018; Karbeah et al., 2022; Lett et al., 2023). The researchers have engaged in studies to better understand the impact of these services and how they directly combat the identified concerns with the healthcare systems. The current information provides a growing body of evidence to support the need for humanistic and holistic interventions for mothers of color navigating pregnancy and postpartum. These recommendations are directly linked to the perspectives of the participants engaged in this study.

Art Therapy Responses

The participants had varying reactions to the art therapy directives. They described feeling positive about the opportunity to creatively self-express and use the art to allow themselves to be honest. They also noted some performance anxiety. The participants reflected how the art process reminded them of artistic outlets and that they had not recently engaged in any artistic practice. Goerdt et al. (2022) conducted a monthly arts-based research (ABR) antiracism virtual circle with six participants as a response to tensions and civil unrest following the US 2020 election. The purpose of the circle was to provide a safe, creative outlet for BIPOC art therapists and graduate students needing a space to connect in solidarity. They also wanted to stand against oppressive factors and claim a space during a political time that challenged their personal identities. The outcomes of the monthly virtual groups included shared experiences of oppression, safety within White spaces, connection and empowerment through art sharing, emotional support, and motivation to make changes outside the circle meetings.

Their perspectives highlighted the value of joining together in a group format using a social justice creative therapeutic approach to tackle intersectional experiences of those living in the US. The participants of this current study felt similarly as the participants in the virtual BIPOC circle. They acknowledged the empowerment of engaging in open arts with a central directive related to personal identities and navigating an overpowering system. The participants of this study reflected how it felt positive to allow themselves to be present as mothers without invalidating or denying realities.

A similar ABR response group focused on art therapy within a social justice framework was conducted following the 2020 US election (Chen et al., 2022). Four participants of various backgrounds with an art therapy degree engaged in a three-session responsive art making experience to better understand the current political circumstances in congruence to their identities. They reflected the importance of joining together in an open space, allowing reflexive processing, and experiencing the discomfort of personal privileges and humility. The participants of this study also discussed what it was like hearing one another's experiences and finding comfort as a group of mothers of color (2022).

The participants also shared appreciation for the space to be heard within the context of their identities and capture emotions through the art. These notions aligned with Karcher's (2017) and Van Den Berg and Allen's (2022) research encouraging the field of art therapy to take a critical look at the foundational underpinnings and approaches to tailor therapeutic engagements for those outside of the US dominant identity.

Literature Findings

Current literature implications for researchers and providers working with mothers of color and the medical system included a wide spectrum of internal and external changes. This is not a representation of suggestions from this research study. Quotes from this study are linked to current literature findings but qualitative research is unable to provide specific literature recommendations. Researchers have previously defined a multitude of interventions needed in order to create a safer, more equitable and accessible system for those in marginalized communities (Estriplet et al., 2022; Matthews et al., 2021; McCloskey et al., 2021; Ogunwole et al., 2023). Below is a table of information including this study's participants' direct quotes to support the previous research.

Table 4.

Literature Findings

Themes	Participant Statements	Recommendations
Privilege and Disparity	*"The system as a whole just made me think of like, the elite."*-Dee	▪ Support for community-lead perinatal and postpartum health services model to reduce inequities (Collins et al., 2021; Karbeah et al., 2022; McCloskey et al., 2021). ▪ Physician and provider trustworthiness and accountability in Cultural Competency trainings, teachings, and organization information (Berger & Miller, 2021). ▪ Open organizational acknowledgement of systemic racism and effects of patient-provider interactions (Ogunwole et al., 2023; Reynolds, 2022). ▪ Education and training related to patient-centered anti-racist care with recognition of historical influences (Capp, 2022; Matthews et al., 2021; McCloskey et al., 2021; Ogunwole et al., 2023; Reynolds, 2022). ▪ Regulatory boards taking a firm stance to openly acknowledge the impact of systemic racism and make changes by leading by example [Dynamically "do as I say" and "do as I do"] (Reynolds, 2022).
Capitalism	*"The healthcare system as a whole just like very corrupt, not really out here to cure us, but just to make some money off of these pills and their profit."*-Sia	▪ Investments and allocation for funds to support childcare in the clinic, childcare respite programs, transportation services that do not create additional barriers (Ogunwole et al., 2023). ▪ Joint mother-baby visits, mother-baby group programming, and telemedicine options (Ogunwole et al., 2023). ▪ Donor relations, grant writing, philanthropic funding, marketing to increase awareness/funding opportunities (McCloskey et al., 2021). ▪ Connections with established community organizations for frameworks, research, and programming support such as Black Mamas Matter Alliance (BMMA, 2023).
Being Overlooked	"*Why? Why don't you believe what I'm saying?"*-Dana	▪ Systems implementing racial discrimination patient safety reporting procedure (Ogunwole et al., 2023). ▪ Active acknowledgement and discussion related to cultural norms, language, and perspectives of being a patient within the hospital setting during intake (Ogunwole et al., 2023).

Pressures to Reproductive Health	*"They're not giving Black women a chance to give birth to our children naturally, it's always a c-section."*-Kelly	▪ Access to doula services to provide increased support during labor and delivery without the burden of out-of-pocket cost (Collins et al., 2021; Destine et al., 2020).
Fear and Protection	*"Let me do the best that I can to protect her. Protect, both of them really."*-Rita	▪ Educational framework in medical schools/trainings related to health and social policy, institutional system activity, clinical encounters, and epistemic knowledge about health disparities (Berger & Miller, 2021). ▪ Doulas, perinatal mental health supports, patient provider concordance can reduce harmful stereotyping, miscommunications, and mitigate risks (Collins et al., 2021; Estriplet et al., 2022; Wright et al., 2022).
Mistrust	"*It's whatever they want, not what you want."*-Tay	▪ Doulas, perinatal mental health supports, patient provider concordance can reduce harmful stereotyping, miscommunications, and mitigate risks (Collins et al., 2021; Estriplet et al., 2022; Wright et al., 2022). ▪ Hiring and supporting nurses, midwives, providers of color for increased safety in healthcare interactions (Estriplet et al., 2022; Goode & Bernardin, 2022; Matthews et al., 2021). ▪ Encouragement for patients to attend doula and birthing classes with central to Critical Race Theory to promote individual awareness of rights in healthcare settings (Wright et al., 2022).
Advocacy	*"You almost have to convince the doctors that you are in need of something."*-Kai	▪ Insurance coverage, specifically Medicaid, for doulas, in-home nurses, and postpartum mental health supports (Destine et al., 2020; Ploplis, 2022.; Sayyad et al., 2023).
Resiliency	*"I drew the sign of God just shining over us."*-Bea	▪ Partnership with faith-based organizations and/or encouragements to spiritual religious communities for increased identity support for specific persons (Ogunwole et al., 2023).
Holistic and Humanistic Care	*"I feel like a hospital should be a place of healing of your whole self."*-Tay	▪ Promoting integrated healthcare, investing in Black women led birthing centers, educating and training providers on cultural humility with the recognition of provider accountability (Berger & Miller, 2021; Estriplet et al., 2022; Matthews et al., 2021). ▪ Need for holistic screening tools to include personal identity and cultural factors when assessing for PPD and mothers of color (James et al., 2021).

Art and Expressive Therapies	*"It felt good to be able to draw it out and express the things that's on our minds, because we're never heard."*-Kelly	▪ There is a need revamp the creative arts field with the perspective of an intersectional, anti-oppressive lens to support those within marginalized communities (Chen et al., 2022; Talwar & Sajnani, 2022; T. Wright & Wright, 2022). ▪ Research has encouraged additional studies on the effects of AT and ET with vulnerable populations for psychoanalytic treatment and as a source of integrative health resources within medical settings (King & Parada, 2021; Oren et al., 2019). ▪ Adaptation and use of telehealth with the creative arts has proven to be a helpful therapeutic resource to reach those who have difficulty accessing in-person health services (Story et al., 2023).

The recommendations for safe and equitable healthcare options were interconnected with multiple facets of the system. Researchers have reported recognition of the historical implications in the healthcare system and voicing the impact on macro and micro effects on patients is imperative (Berger & Miller, 2021; Reynolds, 2022). Without the foundational framework of US history, the evidence-based long-term effects of policies for people outside of the cis-gendered White heterosexual middle to upper class demographic will continue to be misunderstood. Higher rates of maternal and infant mortality, chronic health concerns, traumatic experiences, and general mistrust of the healthcare system for people of color are the outcomes of not acknowledging the greater interplays.

The recommendations from these researchers (Table 4) directly reflects the support for adaptive ethical approaches for mothers of color and perinatal/postpartum care, including the field of art therapy (Van Den Berg & Allen, 2022). Suggestions related to staff and provider education stem from preceding research on the healthcare systems and educational hierarchy discussed by Berger and Miller (2021) and Reynolds (2022). Reynolds (2022) supported the need for leadership and providers to be held liable for wrong doings related neglect grounded in racism regardless of micro-subtleties. Also recommended by Reynolds was the implementation of appropriate administrative follow-up as a response to healthcare neglect and open recognition of provider accountability in Cultural Competency education and organizational expectations (2022).

Suggestions for increased community relationships and policy changes to increase access and develop new resources were also identified (McCloskey et al., 2021; Ogunwole et al., 2023). There was a consistent theme related to reducing obstetric risk through partnership with doulas, midwives, and community support persons (CSP) (Collins et al., 2021; Destine et al., 2020; Goode & Bernardin, 2022; Lett et al., 2023; Matthews et al., 2021; Ogunwole et al., 2023; Sayyad et al., 2023). These researchers also recommended integrative relationships for mothers of color with the addition of Medicaid insurance coverage for postpartum care services up to 12 months.

Recognition of the importance of culturally attuned perinatal and postpartum mental health support was also noted (Estriplet et al., 2022; Kemet et al., 2022; Ogunwole et al., 2023; Wright et al., 2022). The researchers stated importance of continuity of care and consistent communication between providers within different departments (Ogunwole et al., 2023). Ogunwole et al. (2023) supported this expectation to mitigate additional burdens especially during vulnerable periods such as pregnancy and postpartum.

Research on postpartum, perinatal health, and mothers of color has been increasing and adding to the body of literature. Previous studies have recommended research centralized within personal narratives and voices of patients of color with the purpose of autonomy and the use of direct examples to promote new proposals (McCloskey et al., 2021). James et al. (2021) suggested research on the complexity of mothers of colors’ identities separate from low-income Black mothers with limited resources using Medicaid. The purpose of this recommendation was to challenge the assumption Black mothers live the same experience.

This study followed this recommendation and was not specifically focused on the interplay between race and socioeconomic standings, but the general experiences and perspectives of mothers of color. This study's information attempted to add to the literature of mothers of colors' identities, challenge stereotyping, and encourage a narrative-based research approach.

Limitations

This study is not without limitations. The experiences of mothers of color living in the US is a complex perspective and cannot be captured within one study. Several noted limitations include the amount of saturation engagement, lack of diversity within the participant group, lack of demographic information that would provide additional outlooks on experiences (educational background, career history, religious and/or spiritual beliefs, sexual orientation, gender identity, income, insurance information), and inability to meet in-person due to COVID-19. Research on mothers of color specific, but not limited to, Hispanic/Latinx, Middle Eastern, Asian (Pacific Islander, East), and Indigenous (American, Alaskan) communities, mothers of bi or multi-racial identities, refugee mothers, first or second-generation immigrant mothers, and mothers who are differently physically or cognitively-abled living in the US were limitations within this research study. These perspectives would have provided a greater depth for mothers of color. While one participant actively spoke about experiences having a second-generation immigrant mother and another participant identified perspectives from her White mother, qualitative questions and research information was not focused on these specific parts of their identities.

Another limitation to this study included a lack of information on sexual identity, orientation, and partnerships. Motherhood for those within, but not limited to, same-sex, trans, polyamorous, and open relationships and/or partnerships would provide additional information on experiences related to reproductive health, fertility treatments, and navigating the healthcare system. Another missing perspective was mothers of color in interracial relationships or partnerships.

The study originally was based on a focus-group setting but had modifications made because of inconsistent engagement within the group. The result of the inconsistencies and use of the group format included disproportionate perspectives between the group participants versus the individual participants, and lack of experiential depth of the group members due to allotted meeting time. However, the group members did report feeling a sense of joining and community that the individual members did not have. This supports Ogunwole et al.'s (2023) qualitative findings regarding the inquiry about maternal therapy groups to support mothers of color during pregnancy and postpartum.

The sample population was recruited through flyers and referrals within a Women’s Behavioral Health program in Pittsburgh, PA, social media, word-of-mouth from participants, and people known to this researcher. A wider connection may have resulted in participation mothers of color of various backgrounds throughout the US versus a specific part of the country. Specific information on their children, spouses, or partners was not identified within this research but could provide additional information. These limitations would be recommended for future research opportunities with mothers of color in the US.

Clinical Implications and Future Research

The perspectives of mothers of color living in the US and healthcare are a complex web of internal and external factors that provide value to one's experiences. The participants of this study engaged in thoughtful, emotional, and creative ways of self-expression to provide new information on what it means to be a mother of color navigating the healthcare system. The reflections pose different observations and questions related to how the healthcare system can continue to increase safety, emotional wellbeing, and connection for their patients.

The use of semi-structured qualitative methods with arts-based interventions supports the need for information about art therapy and the maternal population. Future studies with mothers of color and the creative arts are encouraged as a response to what previous research has identified as gaps (Harris et al., 2023; Qian et al., 2023). Additional research using a narrative framework and focus on personal autonomy may help elevate voices leading to treatments and recommendations. Providers, staff members, and other facilitators who work with mothers of color could benefit from learning more about these non-dominant perspectives.

Conclusion

The experiences of mothers of color living in the US are complex and nuanced. They provide valuable perspectives to challenge systemic oppression affecting families of multiple backgrounds. The intersections between the medical and educational systems with mothering identities impacts general wellbeing during the perinatal and postpartum period. The effects of the healthcare systems are overwhelming for mothers navigating the dynamics, and a greater burden for those within marginalized communities. There is a need to collectively redefine what the creative arts field represents as a therapeutic support to multiple populations of differing experiences, and how the arts can support people within intersectional identities. The newer progressive connection between neuroscience and art therapy is an encouraging outlook to continue to legitimize the field within a scientific framework. The artistic expressions and discussions on navigating the healthcare systems using art therapy highlighted the strengths, impact of generational traumas, and importance of resiliency factors. These humanistic perspectives offer value and holistic depth when understanding the healthcare experiences of mothers of color living in the US.

APPENDIX A

Recruitment Flyer

PAID VIRTUAL RESEARCH OPPORTUNITY

MOTHERS OF COLOR

Expressive Arts

Vocalize Experiences

$100 GIFTCARD

PLEASE EMAIL, TEXT, or CALL: LAUREN BARRETT PhD(c)- 585-698-5161, Lbarrett9@lesley.edu

Participation in a four-week research study on personal experiences of being a mother of color in the U.S. using Art Therapy via Zoom. Must be over 18 years old, identify as a person of color who is either pregnant or within five years of birth.

APPENDIX B

Interview Questions

Session One: Art Therapy Directive: Using the materials of your choice, please draw an image of what you believe the medical system to look like if it were a person.

When you look at your creation, what do you notice?
What was it like for each of you to engage in this directive?
What do you know of the medical system and people of color?
Do you have any specific experiences regarding treatment with your baby?
How have you interacted with this system?
What emotions arise when you enter a hospital or a doctor's appointment?
Would you like to add anything else?

Session Two: Art Therapy Directive: Using the materials of your choice, please draw an image of you and your child(ren) in the medical setting.

When you look at your creation, what do you notice?
What was it like for each of you to engage in this directive?
What have your experiences being a mother of color in the medical setting been like?
What was your pregnancy and postpartum care like?
What have the interactions been like between you, your children, and medical personnel?
How have your perspectives of the medical system changed since you became a parent?
Would you like to add anything else?

Session Three Art Therapy Directive: Using the materials of your choice, please draw an ideal hospital environment for you and your children.

When you look at your creation, what do you notice?
What was it like for each of you to engage in this directive?
What would you like to add or change for mothers of color and providers?
How do you think providers could increase their awareness to racial disparities, implicit biases, or color-blind approach?
What would you like providers to know about mothers of color?
Would you like to add anything else?

Session Four Art Therapy Directive: Using the materials of your choice, please draw an image representing your strengths as a mother.

When you look at your creation, what do you notice?
What was it like for each of you to engage in this directive?
What do you believe the strengths of being a mother of color are?
How has being a mother of color had an impact on you?
What would you like to say to your children if they choose to have children someday?
What was it like for you to participate in a group specific to mothers of color?
What do you think of the support of the Expressive Therapies for mothers of color?
Would you like to add anything else?

APPENDIX C

Consent Form

Lesley University
29 Everett St., Cambridge, MA 02138

Informed Consent

You are invited to participate in the research project titled "Artistic Expression of Medical Experiences of Mothers of Color: Art Therapy Focus Group." This research study is focused on understanding the experiences of mothers of color who are pregnant or within five years of giving birth living in the US and the medical community using art therapy. The question, "what are the personal experiences of mothers of color in the medical system using art therapy?" will be explored using a virtual four-week focus group using art therapy directives with semi-structured interviews. This researcher may publish this dissertation research in the future. The published information would include photographs of the artwork and outcomes of the study. Personal identities will remain confidential.

This is an agreement to participate in a four-week focus group study using *Zoom* technology with up to 12 participants who identify as mothers of color living in the U.S. who are either pregnant or within five years of giving birth. Your participation will entail an initial screening interview on the content of the study (purpose of the research, steps), individual rights, consents, and scheduling. You will be reminded of your personal rights to discontinue involvement in the study prior to the art therapy directive and following each interaction with the researcher. A $100 gift card will be sent to you upon agreement of participation, before the study begins, and will not be revoked if you choose to end your participation in this study.

A consecutive four-week focus group, semi-structured interviewing, and art therapy directives will be held using *Zoom* platform to better understand experiences of mothers of color and the medical system. Various art supplies and materials will be offered to the participants' home settings for the directive. A pre-stamped envelope will be included to have the artwork sent back to the researcher. The structure is as follows:

- Co-facilitator to conduct 20-minute art therapy directive. This researcher will facilitate 40-minute focus group related to being a mother of color in the medical system. The co-facilitator will observe the group discussion and will not have access to personal information. This structure will occur once per week for four weeks.

The sessions will be voice-recorded and transcribed for analysis. Artwork will be sent to researcher via picture text and/or pre-stamped envelope for analysis. The transcribed data will be analyzed using MAXQDA software on a personal password protected computer system only the researcher has access to. The artwork and transcribed data will be analyzed for codes and themes to determine the experiences of the participants. This researcher will send transcriptions to each participant via email to ensure the information is captured correctly. The researcher will connect with each participant via email or *Zoom* (based on participant preference) to review the collected data (transcripts and artwork) to ensure accuracy in representation.

In addition

- You are free to choose not to participate in the research and to discontinue your participation in the research at any time without facing negative consequences.
- Identifying details will be kept confidential by the researcher. Data collected will be coded with a pseudonym, the participant's identity will never be revealed by the researcher, and only the researcher will have access to the data collected.
- Any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- Participation in this research poses minimal risk. New perspectives as a mother of color may arise due to participation that may cause discomfort or stress. Additionally, hearing other mothers of colors' experiences may create unsettling emotions or memories that had not been recognized.
- This researcher identifies as a woman of color and mother.
- If any problem in connection to the research arises, you can contact the researcher Lauren Barrett (585-698-5161) and by email at lbarret9@lesley.edu or Lesley University sponsoring faculty Dr. Michele Forinash, DA at michele.forinash@lesley.edu.
- The researcher may present and publish the outcomes of this study (artwork included) for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.).
- If the findings of this study are published, each participant's identity will remain confidential and data will not be distributed.
- If you need additional therapeutic support, listed below are resources specific to people of color:
    - https://www.inclusivetherapists.com/
    - https://www.instagram.com/latinxtherapy/
    - https://www.asianmhc.org/
    - https://providers.therapyforblackgirls.com/
    - https://www.blackmentalhealth.com/
- This researcher will provide local therapeutic supports via email based on the individual's home setting for safety purposes.

I am 18 years of age or older. My consent to participate has been given of my own free will and that I understand all that is stated above. I will receive a copy of this consent form.

Participant's signature	Date	Researcher's signature	Date

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairpersons at irb@lesley.edu

29 Everett St., Cambridge, MA 02138

CONSENT TO USE AND/OR DISPLAY ART

CONSENT BETWEEN: ______________________ and ________________________________
Researcher's Name **Artist/Participant's Name**

I, ____, agree to allow ____________________

Artist/participant's name **Researcher's Name**

to use and/or display and/or photograph my artwork, for the following purpose(s):

☐ Reproduction and/or inclusion within the research currently being completed by the expressive arts therapy doctoral student.

☐ Reproduction, publication, and/or presentation of my artwork at a professional conference, dissertation, in a journal article, or academic setting.

☐ Reproduction, presentation, and/or inclusion within academic assignments including but not limited to a doctoral work, currently being completed by the expressive arts therapy doctoral student.

It is my understanding that neither my name, nor any identifying information will be revealed in any presentation or display of my artwork, unless waived below.

This consent to use or display my artwork may be revoked by me by informing the researcher. I also understand I'll receive a copy of this consent form for my personal records.

Signed ____Date ____________
I agree to keep your artwork safe, whether an original or reproduction, to the best of my ability and to notify you immediately of any loss or damage while your art is in my possession.

Signed ____ Date ___________
Researcher's Signature

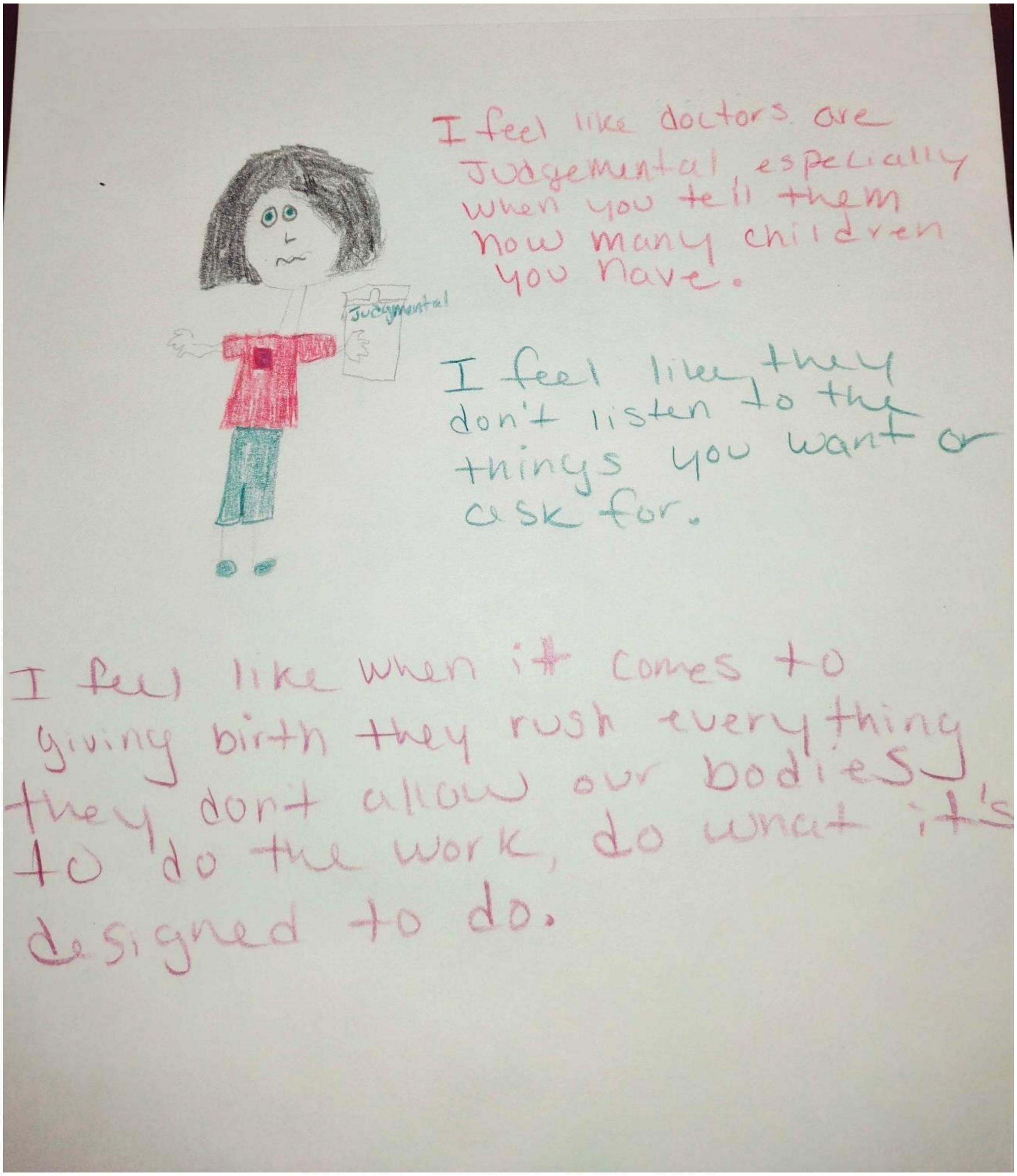
Lauren Barrett, PhD Candidate
(advisor)
585-698-5161
Lbarret9@lesley.edu

Dr. Michele Forinash, DA

29 Everett St.
Cambridge, MA 02138
Michele.forinash@lesley.edu
617.349.8166—office

APPENDIX D
Art Therapy Responses

Kelly Group Session One

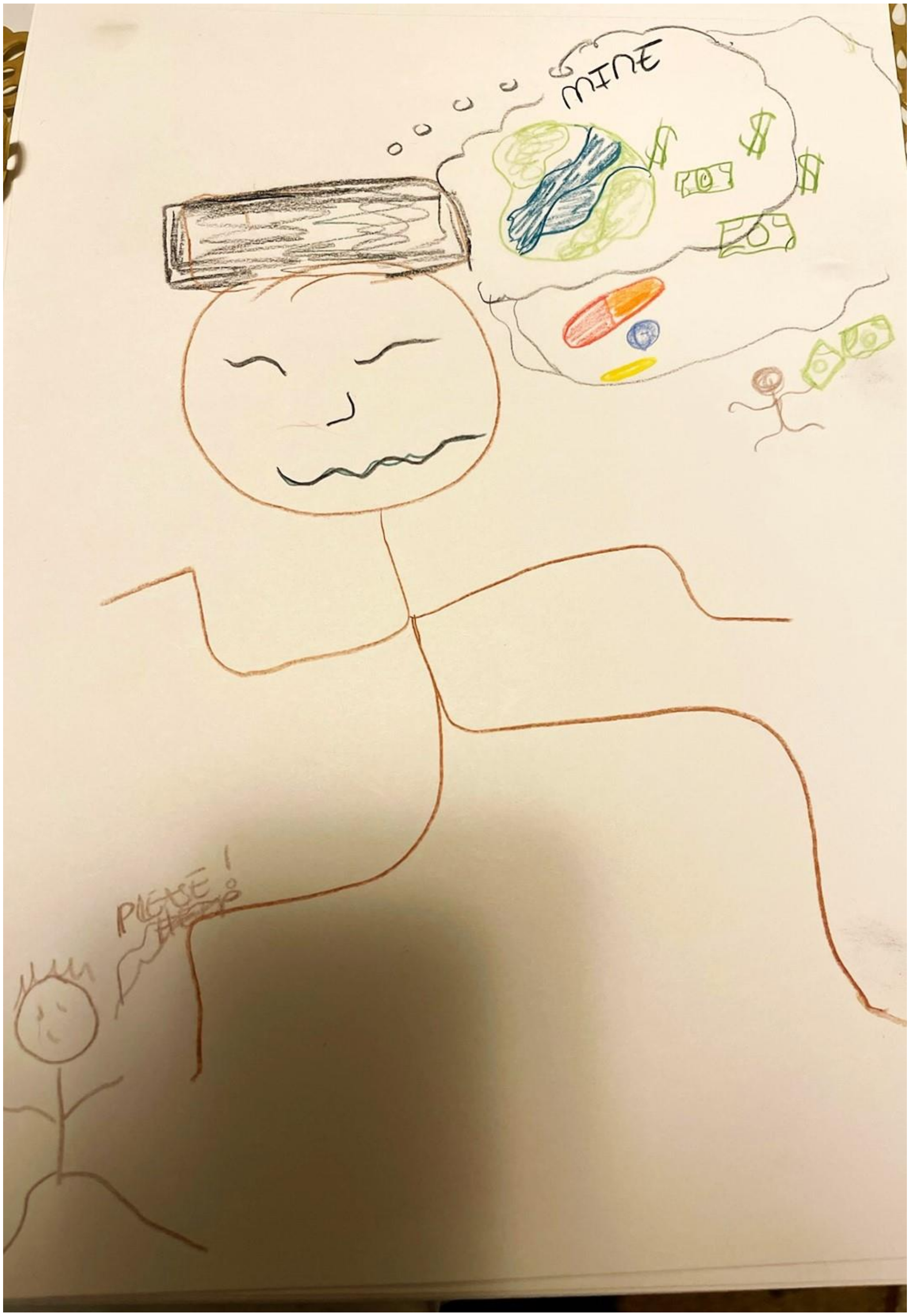


I feel like doctors are Judgemental especially when you tell them how many children you have.

I feel like they don't listen to the things you want or ask for.

I feel like when it comes to giving birth they rush everything they don't allow our bodies to do the work, do what it's designed to do.

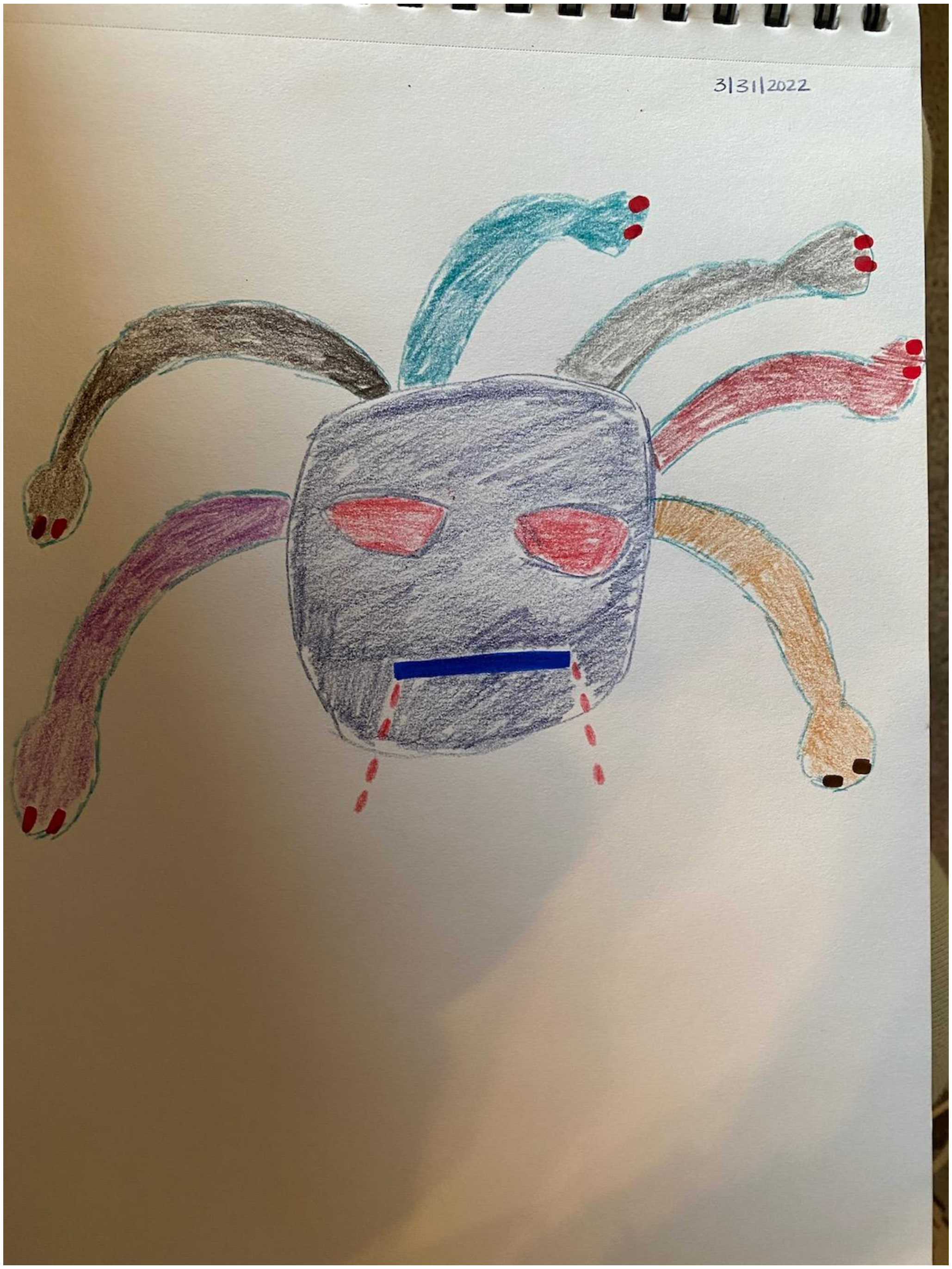
Sia Group Session One



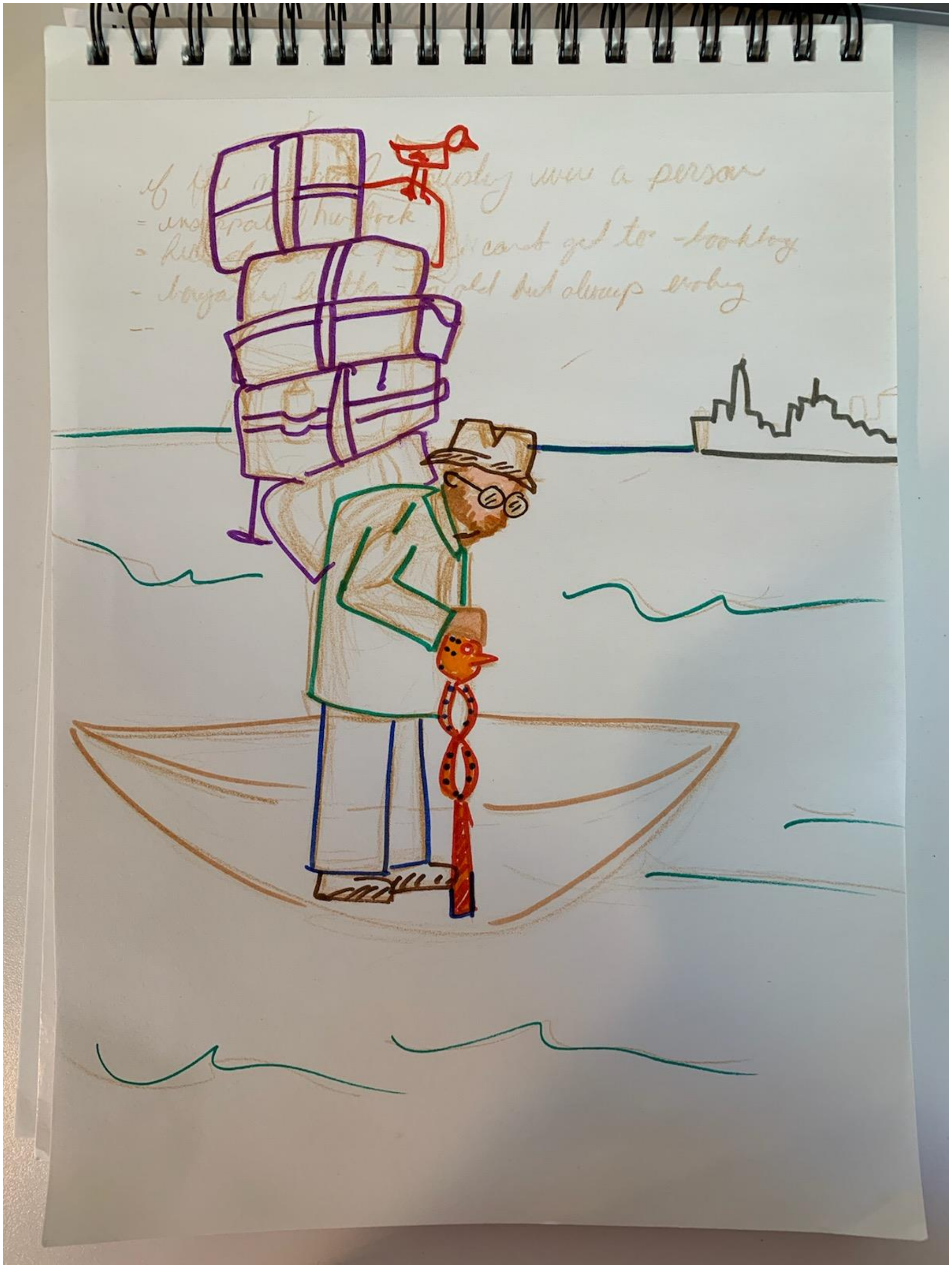
Tay Group Session One

Dee Individual Session One

Rita Individual Session One

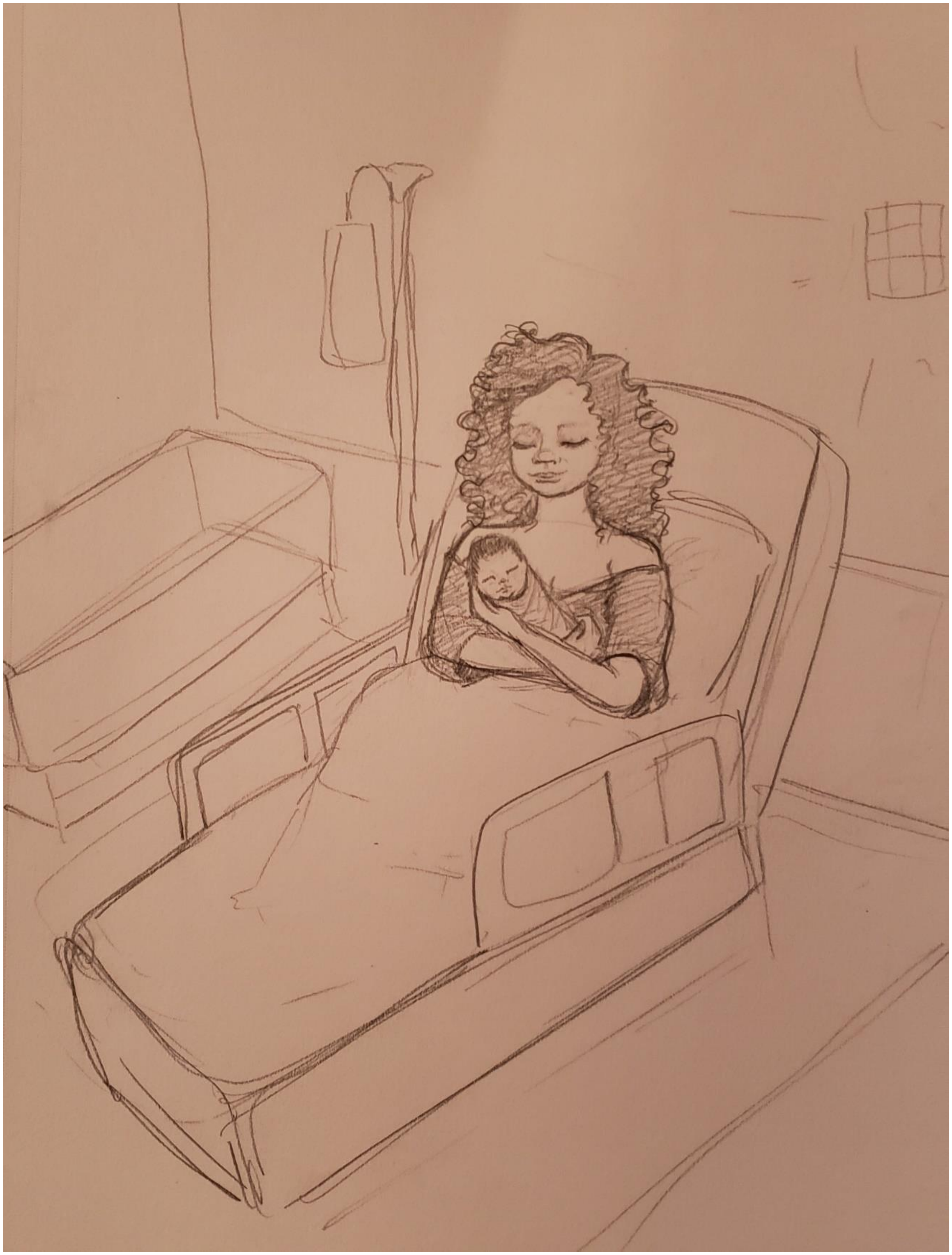


Dana Individual Session One

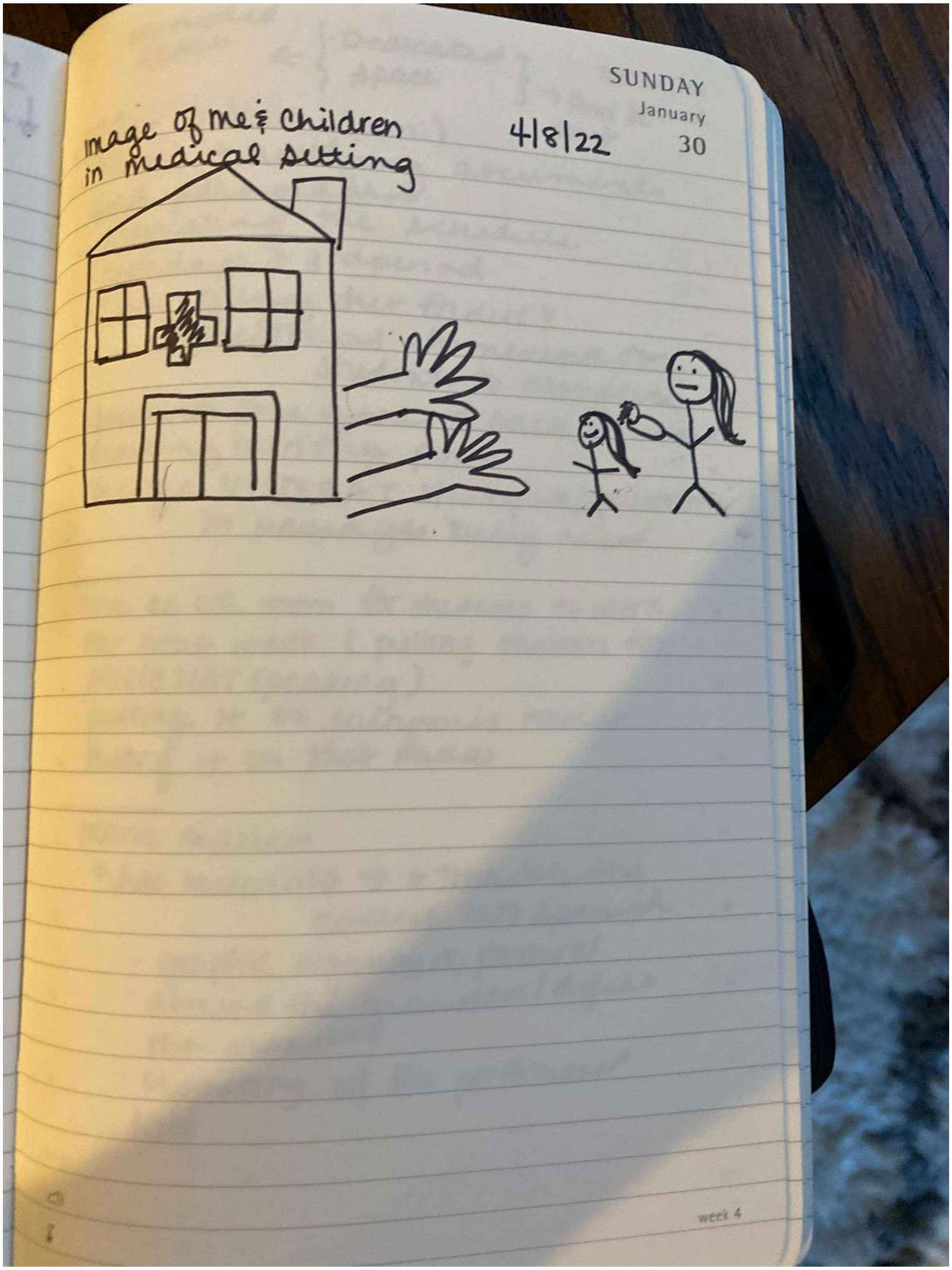


Bea Group Session Two

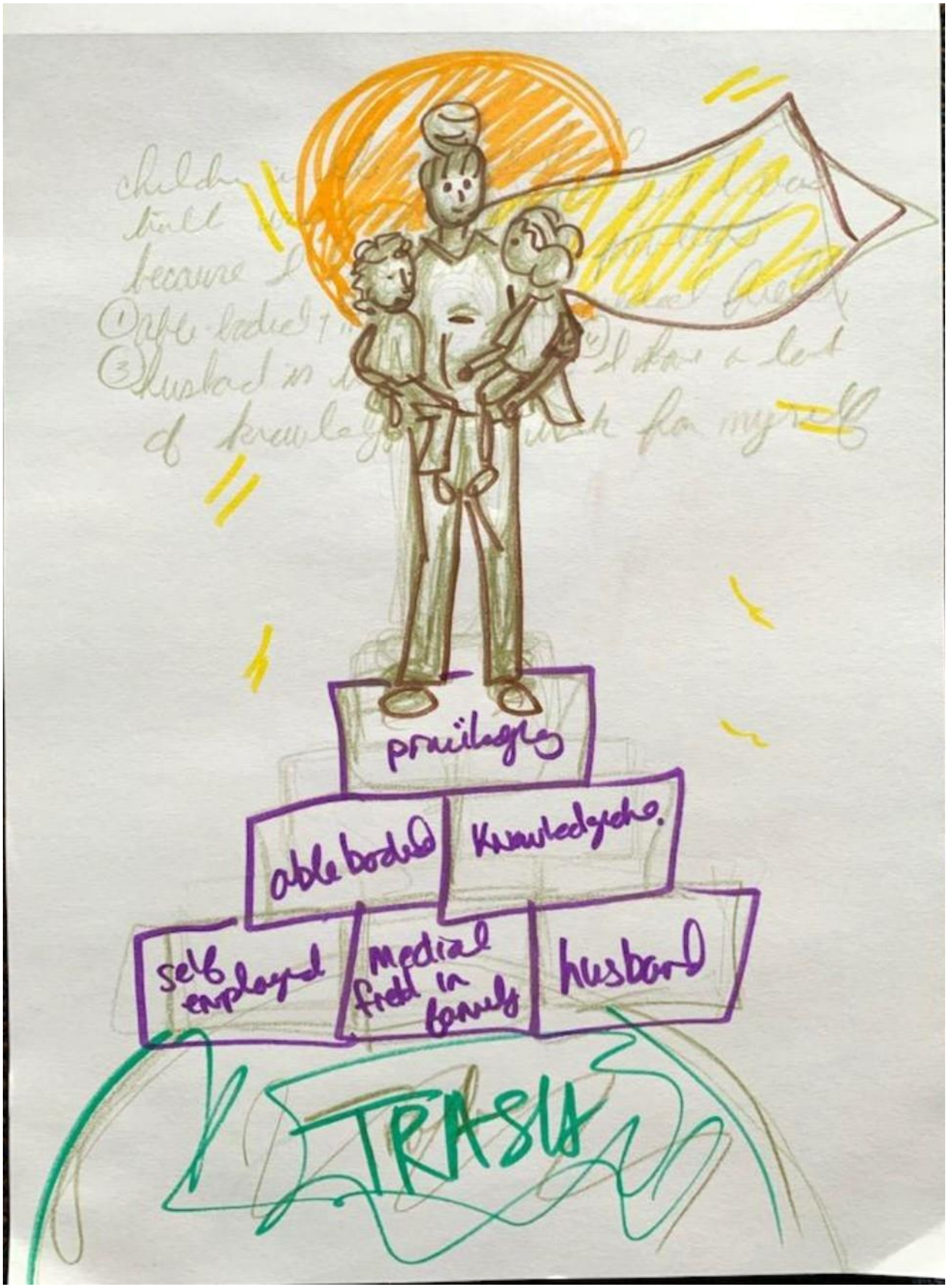
Dee Individual Session Two



Rita Individual Session Two

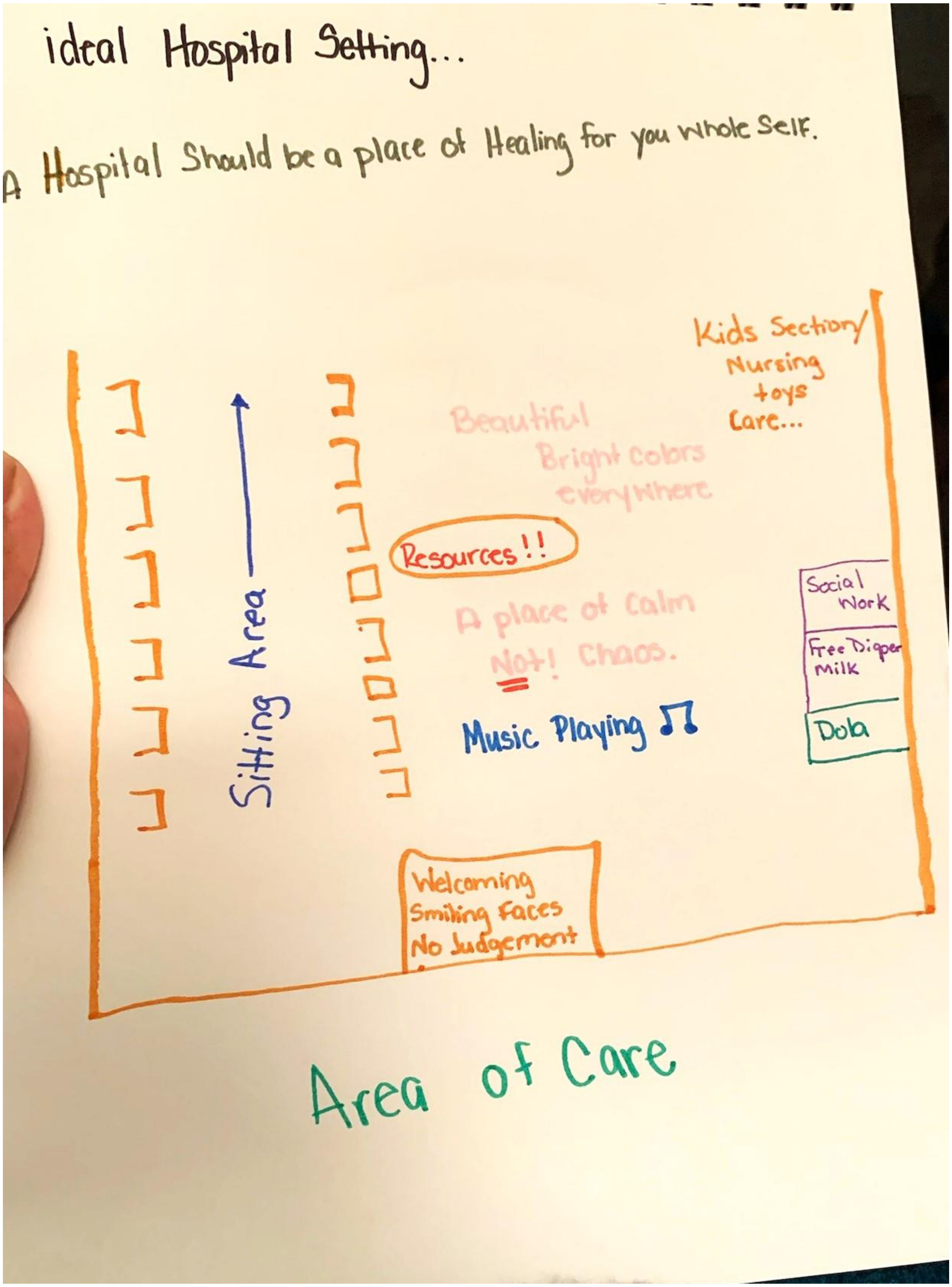


Dana Individual Session Two



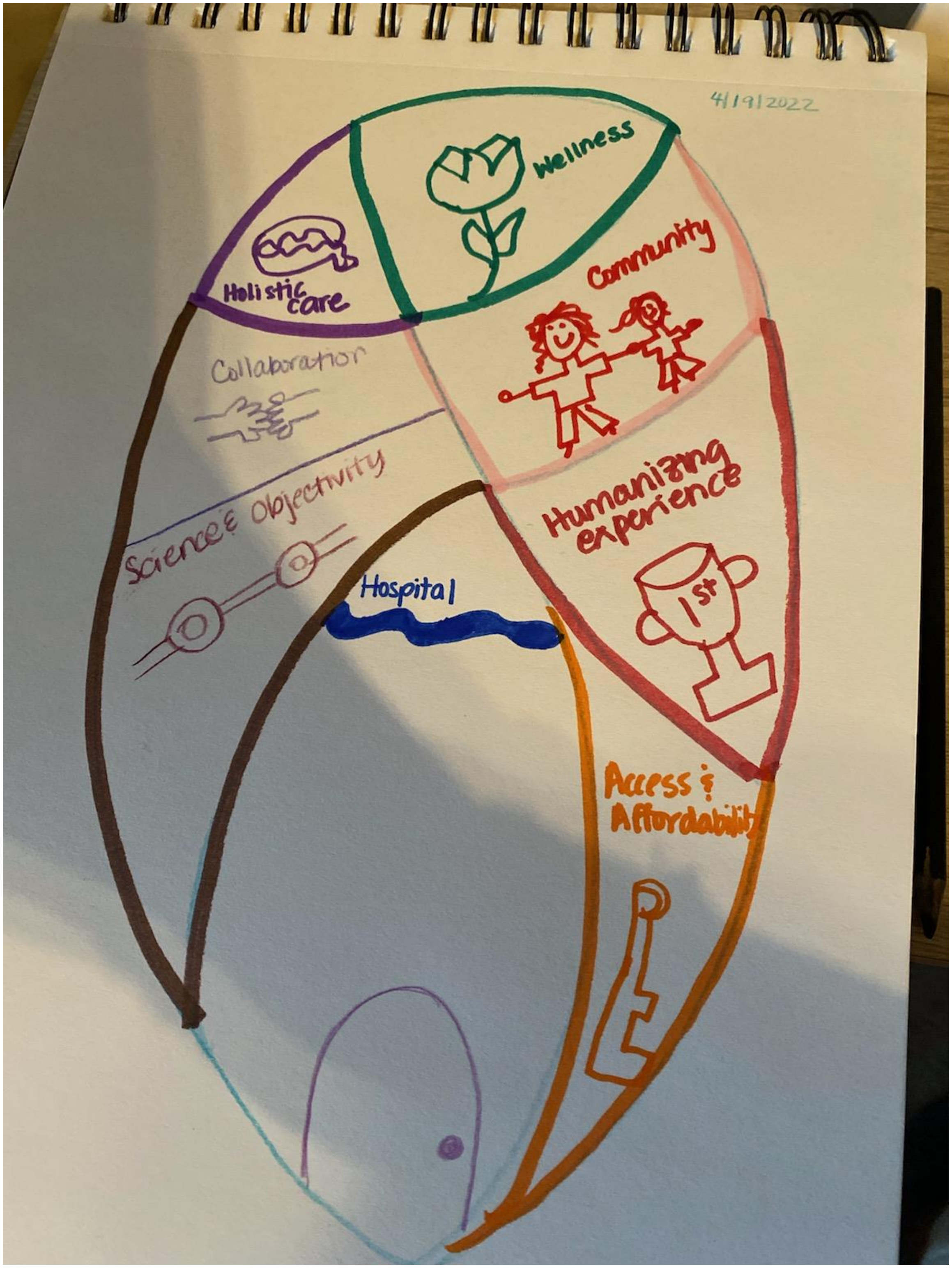
Bea Group Session Three

Tay Group Session Three



Dee Individual Session Three

Rita Individual Session Three



Dana Individual Session Three

Kelly Group Session Four

Dee Individual Session Four

Rita Individual Session Four

Dana Individual Session Four

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