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MATERNAL MENTAL HEALTH AND KEETOOWAH WOMEN: PAST, PRESENT AND FUTURE

by

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Dedication

This study is dedicated to all the indigenous mamas who have used their incredible strength, heart, souls, and culture to stare colonization and imperialism in the face with endless resilience. And to the Keetoowah women specifically, because without your willingness to share your stories and welcome me into your community, this would not have been a possibility.

Remember your birth, how your mother struggled
to give you form and breath. You are evidence of
her life, and her mother's, and hers. -Joy Harjo (1983)

Abstract

American Indian/Native American (AI/NA) women experience postpartum depression (PPD) at a disproportionate rate compared to the rest of the United States population. Despite this known prevalence, little research exists exploring essential factors related to postpartum depression among them. Specifically, the experiences of AI/NA women during the postpartum period pertaining to their culture, birthing and mothering expectations, self-sufficiency, and transportation barriers, and trauma (personal and historical). This dissertation research uses the theory of becoming a mother, historical trauma framework, and reproductive justice framework as they all relate to both personal and historical trauma of AI/NA women and offer an innovative approach to informing future interventions. Becoming a mother (BAM) entails the transition to motherhood, including preparation during pregnancy, birthing, and evolution of identity formation. Many BAM behaviors are tied to PPD development, which warrants research attention. Beyond that, the historical context of marginalization of indigenous motherhood through practices such as forced sterilization and abortion, as well as the erasure of cultural mothering practices warrants the use of reproductive justice and historical trauma frameworks. This dissertation explores Keetoowah mother's postpartum experiences using story inquiry to guide interviews with recent mothers within the United Keetoowah Band of Cherokee Indians in Oklahoma (Keetoowah or UKB). Additionally, the project explores participant's perspectives on unique risk and protective factors relating to postpartum mental health, including culture, personal and historical trauma, and self-sufficiency barriers. The overarching goal of the proposed project is to gather pilot data to inform future quantitative inquiry regarding unique risk and protective factors for the development of postpartum depression among AI/NA women. The findings of this story inquiry include shared stories discussing the past, present, and future. Within the past, mothering was revered, and there were many traditional beliefs centered around a mother's womb and the power it had to alter the outer world. During the present story, mothers expressed concern for lack of culturally responsive perinatal care providers, community stigma towards discussing mental health issues, and the need for more interventions provided by those who share their cultural values and spirituality. The story the mothers saw for the future included ways to increase cultural socialization, culturally responsive perinatal and mental health care, and an increase in services that would better support mothers during the perinatal process, including increased access to transportation and culturally relevant mental health interventions. These pilot data serve as a theoretical basis for the future development of community-based participatory interventions that are culturally sensitive and wanted by tribal members. Implications for social work include increasing social work focus on recruiting and retaining AI/NA students to practice within their communities, increasing specialization in maternal mental health, and addressing social work practices that have been historically harmful to AI/NA peoples. Implications for research include further investigations of unique AI/NA experiences of BAM, community-based intervention research, and research surveying the link between racism, historical trauma, and maternal mental health outcomes.

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Chapter 1. Introduction

Problem Statement

Postpartum depression (PPD) is a major depressive disorder which is clinically defined by the Diagnostic and Statistical Manual of Mental Disorders as depressive symptoms following birth of a child which include apathy, lack of interest in a new baby, anxiety about the baby and lack of bonding, feelings of being a bad mother, feeling hopeless, worthless, and sad (American Psychological Association, 2013). PPD symptoms also can include a preoccupation with the infant's feeding and health that extends into beliefs that no other caregiver is safe to care for the infant (Wisner et al., 2013). Anxiety about potentially harming the baby, either intentionally or unintentionally, also can afflict mothers with PPD, in addition to suicidal thoughts (Edhborg, Nasreen, & Kabir, 2011; Letourneau et al., 2012; Wisner, Moses-Kolko, & Sit, 2010). Currently, the leading cause of maternal death within a year after the birth of a child is suicide (Doe et al., 2017). PPD also reduces social engagement for the mother as it diminishes energy and interest in socialization (Evans, Donelle, & Hume-Loveland, 2012). Likewise, healthcare expenditures for women with PPD can be 90% more than for non-depressed women (Dagher, McGovern, Dowd, & Gjerdingen, 2012).

Parenting impacts resulting from PPD symptoms include reduced sensitivity to infant needs (Letourneau et al., 2012), lower responsiveness to infant/child, potential physical or emotional neglect, and less strength in the parental role (Smith-Nielsen et al., 2016). The presence of postpartum depression can impact bonding with the infant and the effects of weak bonding can be seen into middle childhood by the child (Smith-Nielsen, et al., 2016). Impacts on the mother's ability to bond with the child have lasting effects on the infant, which includes socio-emotional issues such as reduced self-esteem, anxiousness, and increased fearfulness (Letourneau et al., 2012). Physical and cognitive development can be impacted as well (Beck,

1998; Y. Liu et al., 2017), as feeding and sleeping patterns may be disrupted for the infant (Beck, 1998; Letourneau et al., 2012), motor and intellectual development may be delayed (Smith-Neilsen et al., 2016; Surkan, Kawachi, Ryan, Berkman, &Vieira, 2008), and the risks of health issues such as asthma, failure to thrive, and hyperactivity are increased (Edhborg et al., 2011). Similarly, infants in homes with caregivers who experience postpartum mental health disorders may be more likely to have reduced safety measures, such as car seats and outlet covers (Letourneau et al., 2012).

Lasting influences of PPD are not limited to only the maternal-child interactions, but also have an impact on familial relations, societal relations, and economic outcomes for families (Beck, 1998; Reck et al., 2008; VanderKruik et al., 2017). Families experience increased stress when the mother has PPD, and relationship attachment and dissatisfaction increase with PPD symptoms (Epifanio, Genna, De Luca, Roccella, & La Grutta, 2015). Additionally, marital or relational issues between the mother and the partner may arise; as a result, postpartum mental health disorders can lead to diminished partner intimacy (Edhborg et al., 2011), and increased partner agitation (Letourneau et al., 2012). Furthermore, partners of those who experience PPD are more likely to go on to develop depression themselves (Garfield et al., 2014).

One contributing factor to developing PPD is the experiences a mother has as she becomes a mother. The becoming a mother (BAM) theory, explains the many concepts and dimensions of the transition into motherhood. This transition can be shaped by a multitude of personal and societal factors; cultural context also contributes to how women become mothers, that ultimately affects maternal mental health.

Even though PPD affects mothers of all ethnicities and socioeconomic backgrounds, there are populations that are disproportionately affected. American Indian/Native American

(AI/NA) mothers have much higher rates of PPD, and research investigating unique epidemiological reasons for this exists but is not exhaustive (Baker et al., 2005). The way that AI/NA mothers experience the role transition to motherhood, or BAM, is one possible experience related to the development of PPD for this population.

Another potential unique risk factor for PPD among AI/NA women, which influences the experience of BAM, is historical trauma. Historical trauma is when a historically traumatic event is experienced by a mass of people and its effects proliferate into the community, with consequences can be traced intergenerationally (Kirmayer, Gone, & Moses, 2014). Although historical trauma has not been studied concerning PPD, there is research that explores historical trauma and its relation to other mental and social health issues. For instance, historical trauma contributes to increased risk for substance abuse (Lowe, Liang, Henson, & Riggs, 2016), increased risk for experience with intimate partner violence (IPV) (Evans-Campbell, Lindhorst, Huang, & Walters, 2006), and increase in somatic expressions of PPD among AI/NA women (Evagorou, Arvaniti, & Samakouri, 2016). Also, historical contexts of reproductive justice have influenced BAM for AI/NA mothers and may contribute to their uniquely high rates of PPD. That said, individual tribal cultures and histories may impact the BAM experience, and therefore, evaluating a more homogenous AI/NA cultural group may give insight into the specific intersections of historical trauma and reproductive justice as they relate to BAM.

Tribal Specific Problem Statement

The Keetoowah, traditionally known as Giduwah and contemporarily known as the United Keetoowah Band (or UKB) tribe, is the eighth-largest tribe located in Oklahoma. There are currently 14,300 members of the UKB. Located in Tahlequah, Oklahoma, a town with a population of 15,753 people, 30% of whom are American Indian/Native American, the

Keetoowah have a tribal headquarters that includes an elder center, childcare center, and cultural museum.

The Keetoowah relocated from areas in the southern United States, near present-day Georgia, after much of their land was taken in treaties, and they were forcibly moved during the Trail of Tears (Perdue, 1999; Reed, 2016). Keetoowah youth, like many other AI/NA people, were also forced into attending boarding schools by the United States government, which disallowed use of traditional language and cultural practices, separated children from their families at a young age, and were rife with physical, sexual, and emotional abuse (Bombay, Matheson, & Anisman, 2014). Boarding schools were a part of forced assimilation, a practice in which the U.S. government attempted to force AI/NA people into adopting western settler culture to lessen the tensions arising from forced relocation and land encroachment (Bombay et al., 2014). Relocation, boarding schools, and other culturally oppressive practices throughout history that are continuing now, have a lasting impact on the holistic well-being of the Keetoowah people weakening their cultural ties and adding ambiguities such as the feeling of not knowing their culture and being unclear about where they fit in culturally (Bombay et al., 2014; Lowe et al., 2016).

Due to the historical contexts described previously, it is reasonable to expect Keetoowah mothers to have a higher risk of developing PPD than white mothers in the United States. Although Oklahoma participates in the Center for Disease Control's Pregnancy Risk Assessment Monitoring System (PRAMS), it does not currently include PRAMS' mental health questions in its questionnaires. As such, it is difficult to ascertain the prevalence of PPD in Oklahoma, and more specifically, for members of the Keetoowah tribe. However, qualitative research using story theory with Keetoowah youth (Kelly & Lowe, 2012) suggests that tribal members may

indeed be at higher risk for mental health concerns than non-tribal members. In this study, youth wrote about their life stressors and how they manage stress (Kelley & Lowe, 2012). The stressors the youth explained could be like stressors Keetoowah mothers face. For example, youth expressed that the "burden of expectations from others" to adhere to cultural traditions and expectations cause them stress (Kelley & Lowe, 2012). Women have also expressed that cultural expectations can act as a burden when they are becoming mothers, and indicate cultural expectations can intensify PPD (Maxwell, Robinson, & Rogers, 2018). Further, 31.5% of AI/NA people within the same county as the UKB headquarters live below the poverty level (U.S. Census Bureau, 2017), and socioeconomic status is a risk factor for developing PPD. Given all these things, Keetoowah mothers may be at an increased risk of PPD, and the experiences of BAM among them, as influenced by historical trauma and denial of reproductive rights, may influence their maternal mental health experiences.

Significance

Few qualitative or mixed-methods studies seek to investigate culturally specific experiences of postpartum mental health. Amankwaa (2003) addressed cultural differences in expressions of postnatal mental health issues among African American mothers. Similarly, qualitative studies evaluated how Asian-Indian mothers respond to postpartum mental health issues (Goyal, Park, & McNiesh, 2015), Chinese women's postpartum psychosocial experiences (Jin, Mori, & Sakajo, 2016) and transcultural differences in postpartum depression response (Oates et al., 2004). Further studies have investigated cross-cultural birthing and anti-authoritative approaches to birthing and postnatal care (Davis-Floyd & Sargent, 1997). However, of the qualitative studies that do investigate cultural differences of postpartum depression, none address specifically AI/NA mothers of particular tribes. Since AI/NA people have very diverse

experiences, historical backgrounds, historical traumas, and cultural values, it is essential to evaluate their maternal mental health experiences in more homogenous groups (Struthers & Lowe, 2003).

Uncovering these experiences of Keetoowah women as they become mothers may influence future interventions and preventative measures. As such, gaining knowledge regarding Keetoowah mothers' BAM experiences has the potential to promote effective, culturally appropriate prevention and intervention strategies. Identifying unique risk factors through qualitative stories can help identify barriers to postpartum depression services as well as the ways existing interventions may not be culturally responsive or effective. Evaluating the experiences of one tribe may be limited in generalizability to other tribes, but may also provide a unique insight into AI/NA mothers' experiences and provide a foundation for future research with more diversity of tribes. The knowledge gained from studying Keetoowah mothers' postpartum experiences may advance not only maternal mental health in AI/NA communities, but also child educational, social, and mental health outcomes. If AI/NA mothers have better postpartum mental health outcomes, there are many potential positive outcomes. For instance, better postpartum mental health outcomes can influence children's social, emotional, and educational outcomes positively (Beck, 2002; Letourneau et al., 2012; Liu et al., 2017; Smith-Nielsen et al., 2016). Ultimately, addressing the postpartum mental health of AI/NA mothers has the potential to reduce further historical trauma as it will provide AI/NA mothers and their children with the best possible outcomes.

Additionally, any culturally informed preventions developed as a result of this research would support the sustained use of scientifically informed postpartum interventions for this population. Foremost, understanding of traditional pregnancy, birthing, and child-rearing

practices is needed to build a foundation to research on culturally informed interventions. Due to colonization and pressure to adhere to Western birthing practices, fewer native women of child-bearing age are aware of traditional birthing practices or engage in it far less than previous generations (MacDonald & Steenbeek, 2015). There is a current resurgence to reclaim traditional birthing practices in other tribes (Secwepemc, Innuit), with excellent preliminary outcomes for mothers and children (Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012). Members of the UKB have unique experiences regarding removal (Trail of Tears) and have shared geographic history as well as contemporary issues such as land and resource access, transportation issues, and rural living; all reasons why it is essential to focus on one geographical location.

Due to this, this qualitative social work research evaluating multiple dimensions of the participants and population intends to inform further quantitative inquiry regarding trauma-informed culturally specific innovative interventions aimed at reducing adverse maternal mental health outcomes for AI/NA women.

Rationale and Innovation

Trauma history, access to services, family well-being, and existing mental health issues impact PPD severity as well as prevalence (Abrams & Curran, 2007; Desmarais, Pritchard, Lowder, & Janssen, 2014; Valentine, Rodriguez, Lapeyrouse, & Zhang, 2011; Zvara, Meltzer-Brody, Mills-Koonce, & Cox, 2017). Due to the unique nature of the social work perspective, which often operates from a biopsychosocial approach and moves away from a more medicalized technocratic approach (using just psychopharmacology or cognitive behavioral therapy developed with white Western populations), Abrams and Curran (2007) have called for a social work approach to PPD research and practice. Relatively, nursing practices have aimed at providing culturally responsive care informed by historical trauma, to increase positive outcomes

among patients (Struthers & Lowe, 2003). This social work approach would include trauma-informed, culturally responsive interventions. Applying a social work lens to PPD research is necessary as it involves a person-in-environment perspective, that creates a more holistic understanding of the etiology of PPD (Abrams & Curran, 2007).

To this date, there are no trauma-informed, culturally specific interventions for PPD among AI/NA mothers. Given the significance of historical and personal trauma within AI/NA communities, this perspective offers an innovative approach. Also, research indicates that the postpartum experience differs among cultures (Halbreich & Karkun, 2006; Maxwell et al., 2018). For instance, in a qualitative synthesis, Dennis et al. (2007) discovered that the postpartum diet differed among cultures as some foods are viewed as healing, and others may hinder the progress of mother and baby. Hygiene and warmth practices also vary among cultures as some (such as in Mexico) believe the mother should not bathe at all postpartum for fear of becoming cold and allowing evil in, while others (such as the Hmong culture) believe warm baths help the mother to shed toxins.

Breastfeeding and infant care practices also have stark contrasts across cultures. In some cultures, such as in Nepal and India, the mother is not the primary care figure for the first few days of the infant's life. Instead, the paternal grandmother, aunties, or midwives take over primary care while the mother rests. As for breastfeeding, Hindu women may have family members wash and massage their breasts to promote milk production.

In contrast, Jewish culture prohibits the use of mechanical breast pumps on the Sabbath. In South Asian and Hindu cultures, breastfeeding is delayed a few days as colostrum, the first thick milk a mother makes is perceived to be indigestible. Additional postpartum practices that differ by culture involve the use of placental tissue after birth, as some bury it, some crush it up

and eat it, others scatter it is culturally representative places. Massage by family members among women in India and Hawaiian women postpartum also exists to rid the mother of negative thoughts and tensions (Dennis et al., 2007). These vast differences in postpartum care rituals indicate the necessity of understanding how cultural practices, or the stifling thereof, may impact PPD development amount AI/NA women.

Due to the high prevalence of PPD among AI/NA populations, this study sought to begin to fill the gap in the literature regarding PPD as it relates to becoming a mother among a specific AI/NA tribe. Exploratory research is required to begin informing culturally appropriate trauma-informed prevention programs and interventions for AI/NA mothers. AI/NA mothers experience PPD at a much higher rate than other ethnic groups and experience a unique combination of risk factors, including historical trauma. BAM is a psychosocial risk factor that has not been explored with this population, so this study is needed to lay foundational work to culturally appropriate interventions. Even though AI/NA mothers are classified in the same ethnic group, there are vast differences between AI/NA tribes and their culture, and therefore, studying one specific tribe is essential to begin foundational work.

Consequently, the importance of this study lies in gaining knowledge regarding Keetoowah mothers' pregnancy and postpartum experiences and the potential to influence effective, culturally appropriate prevention and intervention strategies. At this point, the fact that historical trauma prompts health and mental health disparities for AI/NA people is well documented (Adelson, 2005). Still, the relationship among historical trauma, loss of cultural birthing and mothering practices, and maternal mental health have not been explored. Using story theory, which is a decolonizing research approach, this study intends to create a story narrative with shared plots and high points to report the lived experiences of Keetoowah

mothers. Also, story inquiry acts as a reflective awareness tool for participants. It seeks to allow participants to add their voice to the collective understanding of birthing and mothering within the Keetoowah tribe. As such, this study aimed to answer a multitude of questions that are presented here.

The following chapters will first outline the theoretical approaches used in this work. Then, an overview of relevant literature relating to becoming a mother, postpartum depression, historical trauma, and cultural differences in becoming a mother is provided. The methodology of the study, including a decolonizing research approach and story inquiry method, are outlined in Chapter 3. Also, I address my positionality as a researcher to the population as well as my reflections upon entering a researcher relationship with the Keetoowah people. Following that, the results are reported in Chapter 4. Discussion, implications, limitations, and concluding thoughts of this study are presented in Chapter 5.

Chapter 2: Overview of Important Literature

This chapter includes a complete overview of the theoretical foundation for this dissertation, as well as a review of the pertinent literature. First, the theoretical foundation is explained, that consists of the theory of becoming a mother (BAM), historical trauma, and reproductive justice frameworks. Then, cultural differences of BAM in the global population, as well as the potential unique cultural differences of BAM for Keetoowah mothers, are explored. Following that, I introduce the explanation of the relationship between BAM and maternal mental health, mainly focusing on postpartum depression (PPD). Finally, I consider the gaps in the literature and provide a rationale for the research questions guiding this study.

Theoretical Foundation

This dissertation relies on three main relating theoretical frameworks. First, the theory of becoming a mother (BAM), which relates to the various facets a mother faces during her role transition to mother, helps to operationalize how this study examines BAM. Secondly, the study uses historical trauma framework, as it pertains particularly to AI/NA mothers and how historic contexts might influence BAM. Third, and finally, the reproductive justice framework helps examine both the historical contexts as well as the current experiences of BAM for AI/NA mothers.

Theory of Becoming a Mother

One thing all mothers with PPD have in common is their new transition to the role of mother. Becoming a mother encompasses physical, emotional, and social changes for a mother (Evans et al., 2012). Changes in sleep patterns, different lifestyle and recreational choices, shifting dynamics in personal relationships, and the new identity as a mother are all complex changes prompted by the birth of a child (Epifanio et al., 2015). Physical changes prompted by

birthing, such as cesarean scars or weight gain, may not only prompt pain but also negatively affect a mother's self-esteem. Emotional changes, influenced by disruptions or changes in hormonal patterns, can prompt crying or feelings of inadequacy (Henshaw, Fried, Teeters, & Siskind, 2014). New mothers also experience transformation in their social lives as they are often limited to staying indoors or constricted to baby-friendly establishments, that increases social isolation (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Knudson-Martin & Silverstein, 2009).

Furthermore, newborns change familial dynamics, and this transition can be stressful. Even in instances where it is not the first child, a mother with a newborn must adapt either to the new existence of a child or to the introduction of another child into the family system. The theory addressing the transition to this unique new role and of relevance to this research is the theory of Becoming a Mother (BAM).

Many constructs within BAM describe the transition to the maternal role. For example, motherhood beliefs are strongly tied to the expectations of society to be a "good" mother (Keefe, Brownstein-Evans, & Polmanteer, 2018). Cultural norms of society construct expectations of motherhood; these pressures are internalized by mothers and reflected in their beliefs about their capacity as a mother (Tardy, 2000). Motherhood beliefs are also perceptions of the attainment of the new role of "mother" (Mercer, 1981; Rubin, 1967). Multiple stages comprise classical role acquisition. These stages include the anticipatory stage (wherein an individual begins to socially and psychologically adjust to the new role), the formal stage (when an individual recognizes formal expectations of a role and begins to adhere to them), the informal stage (wherein an individual starts to incorporate their unique approaches to the role outside of expected societal norms, and finally, the impersonal stage (when the individual takes these novel approaches and

casts them back onto societal norms and creates their role performance) (Thorton & Nardi, 1975). In the likeness of classical role acquisition, the Maternal Role Attainment Theory introduced by Rubin (1967) explained the different role attainment stages a mother progressively goes through as she is pregnant and becomes a mother. These stages involve the development of maternal identity, constituting a mother's self-concept, her self-esteem, childbearing attitudes, flexibility as a mother, and perceptions of pregnancy and birthing (Mercer, 1981; Rubin, 1967). Further, the stage at which a mother assumes the maternal identity is defined by the existence or lack of a "sense of harmony, confidence, satisfaction in maternal role, and attachment to the infant" a mother has (Mercer, 2004). Mercer also described stages more specific to BAM that include the commitment to and preparation stage (pregnancy), the acquaintance and learning stage that allows the mother to engage in physical restoration, the movement towards new normal, and finally, the transition to mother as self (Mercer, 2004).

This dissertation relies on Mercer's (2001) BAM theory, that expands from Rubin's Maternal Role Attainment Theory (1967). More discernably, Mercer's BAM framework explains multiple stages, which occur in fluctuation, of becoming a mother. Although not linear, BAM first encompasses preparation for motherhood during pregnancy (Mercer, 2004). BAM then describes attachment to the infant during pregnancy and the birthing process. This process involves knowledge of motherhood passed down from parents and the attachment to the infant through the care of the pregnant body. Also, this aspect of BAM consists of the birthing process, whether the birthing process lived up to the mother's expectations, and whether they feel happy when they contemplate the birth (Mercer, 2004; Preis & Benyamini, 2017). BAM then moves into maternal self-efficacy, or how much the mother perceives her competence of being a mother to her infant.

Maternal self-efficacy and maternal self-esteem evolve and are tied to infant response, family response, and her alignment of preconceived assumptions of motherhood to how she sees herself as a mother. The familial context of maternal identity is how the mother fits into the family, now as a mother, both with her parents but also with her partner. This identity contributes to the mother's overall maternal identity. For example, is she now a partner and mother? Solely a mother? A daughter and mother? How these family dynamics develop to contribute to her own maternal identity. Additionally, whether or not a mother returns to work and maintains some form of her previous identity or stays home with the infant and has an identity aligned solely with motherhood is a part of BAM (Mercer, 2004). Beyond this, BAM entails motherhood engagement, the "active, involved, and mutual process of preparation for motherhood by caring for themselves and their infants" (Mercer, 2004, p. 230). Motherhood engagement also involves "promoting the child's well-being" by learning to care for their infant, settling into a "new normal" of socializing themselves and their babies, and beginning to experience love for their child (Mercer, 2004, p. 230).

Using Mercer's theoretical framework (1981) and the outlined BAM stages (2004), this study operationalizes beliefs towards becoming a mother (BAM) as a facet of maternal role attainment and includes beliefs about maternal competency, commitment to motherhood, maternal self-confidence, flexibility in the maternal role, security in maternal identity, attitudes towards childrearing, and maternal role strain. Furthermore, as part of the transition to mother as self, grief is associated with the transition to motherhood as the mother acquires new identities (Rubin, 1967), this study also includes concepts surrounding grief of the loss of identity as these relate to the motherhood role.

Historical Trauma Framework

Historical trauma is the generational impact of historically perpetuated grievances and traumatic experiences on a particular group (Evans-Campbell, 2008a). Historical trauma is cumulative, a shared experience, and can be passed down through generations; it includes bereavement of lost culture, land, and connection (Mohatt, Thompson, Thai, & Tebes, 2014; Yellow Horse Brave Heart, Chase, Elkins, & Altschul, 2011). Furthermore, historical trauma is also a "reaction to violent experience(s)" (Derezotes, 2014, p.5) and can be stored within memories, passed through stories and interpersonal violence, and can influence chronic stress within a community (Evans-Campbell, 2008a). Correspondingly, navigating unresolved grief is a process that is reactionary to continued cultural devastation, including the destruction of burial grounds and customs (Yellow Horse Brave Heart et al., 2011). Biological factors such as genetics and disease; psychological factors such as personalities and belief systems; sociological factors such as culture, religion, and equality; and spiritual factors, including the meaning of life and purpose, are all related elements of historical trauma (Derezotes, 2014). Measures used to assess historical trauma evaluate factors of feelings of loss and grief, even among generations who were not alive during a westward expansion) (Whitbeck, Adams, Hoyt, & Chen, 2004). These measurements of loss also include feelings of grief over the loss of people to contemporary issues such as alcoholism and lack of cultural cohesion (Whitbeck et al., 2004). Historical trauma is an amalgamation of physical and cultural genocide, continued structural oppression, and the grief symptoms which respond to the wake of such events.

AI/NA communities have experienced a host of traumatic genocidal events including dispossession of land and culture, forced removal from sacred and traditional homelands, famine and disease, forced sterilization, political disenfranchisement, forced removal and relocation of

children, and massacre (Dunbar-Ortiz, 2014, p.11; Evans-Campbell, 2008b). Contemporarily, continued assaults to land rights, such as construction of oil pipelines through sacred lands, inadequate living conditions and spaces, substance abuse epidemics, and violence perpetrated by non-AI/NA people (Evans-Campbell et al., 2006; Lowe et al., 2016; National Congress of American Indians, 2018) perpetuate structural oppression and trauma.

Health. Historical trauma goes beyond contemporary health diagnoses. Routine stress heightens cortisol levels and increases fight-or-flight responses triggered in daily life as a result of continued present and historical treatment (Struthers & Lowe, 2003). Unresolved grief can increase stress, and historical trauma is a product of unresolved generational grief over the loss of land, culture, and people (Yellow Horse Brave Heart & Debruyn, 1998). Historical trauma is associated with increased substance use, suicide, hypertension and diabetes, heart disease, obesity, and cirrhosis (Struthers & Lowe, 2003).

Resilience. Despite the impacts of historical trauma on AI/NA tribes including the Keetoowah, there remains astounding resilience measured by renewed and continued efforts to engage in cultural practices and ways of life. Resiliency denotes coping that can persevere despite adversity, develop adaptive coping mechanisms, and the build capacity to avoid psychological symptoms more associated with the experienced adversity (Schultze-Lutter, Schimmelmann, & Schmidt, 2016). For AI/NA people, having a strong cultural identity is essential to resiliency, as are self-mastery and close personal relationships (Grandbois & Sanders, 2012). Activities that actively develop cultural identity contribute to AI/NA resiliency, and research that provides implications for such events is actively contributing to indigenous resilience (Grandbois & Sanders, 2012). Using cultural traditions and values to address substance use issues has been effective and acknowledges the strengths of Keetoowah people (Lowe et al.,

2016). Similarly, initiating culturally sensitive approaches to birthing and postpartum care is happening in various ways; a birth center focused on traditional birthing was opened with positive preliminary results in New Mexico, for instance (Miller, 2018). An entire conference centered around decolonizing birth and moving away from wester-centric authoritative birthing practices began in 2015 ("decolonizebirth," 2018).

In general, birthing practices that can strengthen cultural identity can also contribute to increased resiliency for AI/NA people and potentially affect maternal mental health outcomes. Using a historical trauma framework to assess the ways that historical contexts have shaped becoming a mother for AI/NA mothers can illuminate the unique risk and resilience factors of this distinctive group. As such, using historical trauma framework to evaluate the cultural values and history of birthing and mothering for the Keetoowah people, and the potential for historical trauma to be a risk factor can impact future research on resilience-building interventions.

Reproductive Justice Framework

In addition to postpartum mental health concerns, the cultural context of BAM is vital to the well-being of mothers in a myriad of ways. One perspective to evaluate the importance of BAM for AI/NA mothers specifically is through the reproductive justice framework. Due to historical contexts, such as forced removal, cultural erasure, and disenfranchisement, historical trauma is interwoven into the unique challenges of becoming a mother for AI/NA women, such as the subjugation of women during colonization (Dunbar-Ortiz, 2014; Evans-Campbell, 2008b). The reproductive justice framework concerns reproductive health and rights. Also, reproductive justice involves the intersectional impacts of economic injustice; and social and political inequalities, such as historical trauma that contribute to inequitable reproductive rights of marginalized groups of people (Hoover et al., 2012). Furthermore, reproductive justice involves

many aspects of Nussbaum's core capabilities, such as the right to bodily autonomy, the right to have or not have children, and the ability to parent (mother) in a safe and sustainable environment and with parental autonomy (Nussbaum, 2005).

That said, motherhood for indigenous women was controlled historically in the United States by colonizers (white male physicians) via forced abortions, forced or coerced sterilization, and political agendas limiting or restricting abortion and birth control access for AI/NA women (Cackler, Shapiro, & Lahiff, 2016; Rutecki, 2011). Moreover, sterilization, and therefore the outcome of not becoming a mother among AI/NA mothers, relates to poorer mental health outcomes (Cackler et al., 201). These mental health outcomes are speculated to be related to historical trauma of forced sterilization among ancestors, indicating the unique experiences of becoming a mother AI/NA mothers have, which affect mental health outcomes (Cackler et al., 2016). Additionally, indigenous mothering has been repeatedly criminalized via racist child welfare policies and tactics, including forced removals or adoptions of children (Howze & McKeig, 2019; O'Sullivan, 2016). Becoming a mother and reproductive justice both also concern pregnancy. AI/NA mothers, especially those who have lower educational status, are much more likely to have a cesarean delivery than other ethnic groups even when controlling for health issues, risks, and complications, indicating a higher rate of non-medically necessary cesarean delivery (Roth & Henley, 2012). These rates are possibly linked to racism by perinatal providers, illuminating the intersection of racism again, and colonizing infringements upon becoming a mother for AI/NA women (Roth & Henley, 2012). Monitoring and controlling of breastfeeding and maternal practices of AI/NA mothers has also been racially motivated and cultural disambiguation can contribute to lower rates of breastfeeding (BF) initiation (Louis-Jacques, Deubel, Taylor, & Stuebe, 2017). AI/NA mothers who are involved in traditional

medicines of their culture have higher rates of BF as well as longer BF durations, demonstrating the link between historical trauma, breastfeeding rates, and becoming a mother (Louis-Jacques et al., 2017). All told, becoming a mother for AI/NA women involves unique experiences compared to other groups of women in the United States, which in turn requires a more culturally relevant approach, utilizing a reproductive justice approach to evaluate such experiences.

Cultural Differences and Becoming a Mother

The experience of becoming a mother has some universal experiences, such as new maternal identity, bodily changes, and adjustment to new family dynamics (Evans et al., 2012). However, culturally imposed roles and expectations may create vastly different experiences of BAM. For instance, as previously noted, expectations surrounding motherhood, such as motherhood being a woman's "destiny" as with Indonesian mothers (Afiyanti & Solberg, 2015) may vary across cultures. Migration may prompt challenges regarding becoming a mother for some cultures as well (Benza & Liamputtong, 2014). The ability to perform birth in a culturally expected way, such as at home with family or perhaps without the western intervention of drugs, is another example of how diverse the experience of becoming a mother is. For instance, the birthing ability is tied to perceptions of maternal strength, such as with Hmong mothers (Corbett, Callister, Gettys, & Hickman, 2017). Ecuadorean women believe that enduring labor provides them with the "gift" of birth and is a rite of passage as a mother (Callister, Corbett, Reed, Tomao, & Thornton, 2010). Tongan mothers associate unmedicated vaginal birth with the strength of spiritual and cultural associations (Reed, Callister, Kavaefiafi, Corbett, & Edmunds, 2017). As such, the process of childbearing is revered in many cultures, and therefore a deviation from unmedicated vaginal birth may prompt anxious feelings for mothers within such cultures. For some cultures, such as Gulf Arab mothers, childbirth itself is strongly tied to cultural and religious identity, and therefore, motherhood is a transition into fully

becoming culturally integrated (Missal, 2003). Also, women in the Kalahari, for example, feel accomplished after they've given birth "outdoors in the bush alone" (Biesele, 1989).

Other cultures, such as women in Zambia and Nigeria view mishaps during birth, such as the infant being stuck in the birth canal or a breech birth, to be a product of witchcraft which often is blamed on behavior of the mother (Maimbolwa, Yamba, Diwan, & Ransjö-Arvidson, 2003; Okafor & Rizzuto, 1994). They are not alone in this perception since another study investigating Aboriginal women's PPD experiences discusses their cultural view that depression following childbirth is due to the sins of the mother (Clarke, 2010).

Maternal competence is also dependent upon cultural values and expectations. Chinese mothers, for instance, rely on having a strong understanding before birth about how to care for the baby properly. If they do not possess this level of knowledge, they feel incompetent as mothers (Ngai, Chan, & Holroyd, 2011). Other mothers, such as those in rural Thailand, feel competent if they can heal themselves with traditional rituals following the birth of the child, which applies to the mind, body/heart, and spirit (Elter, Kennedy, Chesla, & Yimyam, 2016). Similarly, within a cultural context, Taiwanese mothers discussed competence as relating to their ability to construct their new maternal identity within cultural expectations and to adhere to cultural values as a mother (Chang, Kenney, & Chao, 2010). Inuit elders, and community members, view birthing not as a medical act, but rather as a "community, social, and spiritual act" (Davis-Floyd & Sargent, 1997).

To summarize, all aspects of BAM, from preparation during pregnancy to birthing ritual to postpartum practices, are reliant upon a mother's cultural contexts. As such, it is imperative to understand the cultural expectations of the maternal role for women when addressing PPD since incongruence with cultural expectations of BAM can provoke anxiety and feelings of diminished maternal competence and self-esteem.

Traditional BAM among Cherokee and Keetoowah Peoples

The United Keetoowah Band is a Federally recognized tribe of Cherokee people that historically opposed western infringement on cultural values and traditions as well as plantation slavery (Stremlau, 2011). Keetoowah people believe in a stricter interpretation of Cherokee spirituality and values and began as a "network of practitioners of traditional Cherokee religion" (Stremlau, 2011). The United Keetoowah Band, the Cherokee Nation of Oklahoma, and the Eastern Band of Cherokee Indians are all made up of Cherokee people, but are each individually recognized by the United States as being separate sovereigns. As Cherokees, each of these tribes share a common history and many cultural values and traditions.

Before western encroachment, the Cherokee were a matrilineal society wherein women were central to the household (Miles, 2006; Perdue, 1999; Stremlau, 2011). Within the household domains, tribal and clan ties rested solely on maternal lineage, and children belonged to the clan their mother did (Perdue, 1999). Similarly, when a woman married, the man moved into her household, and children remained under the mother's clan affiliation (Perdue, 1999).

Maternity was revered; menstruation and birth were regarded as a powerful time as blood was considered to be sacred and capable of altering wars, family life, and hunting for food (Miles, 2006; Perdue, 1999). Pregnancy was also a time of power, and pregnant women were restricted from activities, including ceremonies because of the power pregnant women had over events (Stremlau, 2011). Pregnancy was accompanied by spiritual rituals meant to "guarantee safe delivery," such as drinking mixtures of elm bark, consulting with leaders for purification rituals, and avoiding foods that were thought to leave the baby maimed (Perdue, 1999). Contrary to accounts that Cherokee women birthed alone in the woods, women would attend the birth as would healers and medicine people who would sing and aid in the birthing process (Miles, 2006; Perdue, 1999). A woman would never lie down during birth, and the baby was not caught by a person but rather by a bed of soft

leaves (Perdue, 1999). After birth, many women aided in the recovery time as well as the development of the infant's character (Perdue, 1999). Before contact, Cherokee women held sexual autonomy within their sexual, pregnancy, and birthing practices (Miles, 2006). Motherhood was the source of power and status within Cherokee tribes, and this status was tied to the identities of Cherokee women until settler colonialism upset traditional gender roles.

During the time of settler colonialism, white male settlers who interacted with Cherokee people were dumbfounded by the relative freedom and control exerted by Cherokee women (Miles, 2006; Stremlau, 2011). These men often attempted to convince Cherokee men that they lacked in masculinity; that by allowing women to maintain household control- over children, belongings, marriage arrangements, and household management- they were waiving their "God-given" rights as men of the household (Stremlau, 2011). In conjunction with this pressure to shift culturally was also the push for capitalism in the form of monetary exchange for goods and possession of slaves (Miles, 2006). The lack of acculturation by AI/NA people was referred to as the "Indian Problem" by American society, as the goal was to insist indigenous people fully assimilate (Stremlau, 2011). Furthermore, the Cherokee practice of marriage was not as strict or delineated as modern-day marriage or the puritanical marriages of early settlers (Stremlau, 2011). Practice of polygamy was standard and accepted attributes of Cherokee women's position in society and gender norms and were not stigmatized within Cherokee society (Perdue, 1999: Stremlau, 2011). Cherokee concepts of "sin" before contact had little to do with individual moral constructions and more about the disruption of life for all the people in the tribe or activities that "upset the equilibrium" (Stremlau, 2011) of purity. However, during the 1899-1907 Dawes Commission, which set to formally document all people of the "five civilized tribes" by the U.S. government, Cherokee marriage practices were seen by western settlers as morally objectionable, and Congress was urged to outlaw their practices by forcing them to define their marriages legally (Stremlau, 2011). This attempt was a further assault to Cherokee women's traditionally held power as matriarch and sought to supplant

Cherokee women as the head of the household to acculturate Cherokee people into a world where capitalism and patriarchy dominated.

Although the Cherokee people managed to adapt to acculturation, meaning they are still in existence and can maintain some traditional and spiritual practices, this forced shift in gender roles and power undoubtedly prompted the disenfranchisement of women who were no longer seen as the powerful entities they once were. The changes resulting from removal from traditional lands, shifting gender roles, and assimilation into capitalist society contributed to modern-day historical trauma experienced by Cherokee and Keetoowah people. As such, investigating the contribution of historical trauma to modern values and practices regarding birth and becoming a mother among Keetoowah women is warranted to understand potentially unique risk factors these mothers may face. Since we do not yet understand the process of BAM for Keetoowah mothers, we also do not know how it relates to the development of PPD among this population, meaning an essential piece of PPD etiological knowledge may be missing.

Postpartum Depression

To understand the gravity of how BAM influences maternal mental health, a comprehensive look at PPD, its risk and resilience factors, and how AI/NA mothers are uniquely affected by PPD is warranted. The following sections first explore the risk and resilience factors for developing PPD in the general population. Then, the literature review surveys the specific and unique risk factors for AI/NA mothers. Following that, this section discusses the relationships between BAM and PPD in existing literature, as well as what prevention and treatment options currently exist in the existing literature.

Risk Factors

Extant research indicates a multitude of biological, environmental, and psychosocial risk factors for developing postpartum mental health disorders. Biological determinants of

postpartum depression (PPD) include sensitivity to hormonal fluctuations, oxytocin levels, sensitivity to estrogen and progesterone (Pearlstein, Howard, Salisbury, & Zlotnick, 2009), genetic influences (Costas et al., 2010), pre-pregnancy illness and diabetes diagnosis (Katon, Russo, & Gavin, 2014). Similarly, pre-eclampsia, or pregnancy-induced hypertension, also elevates the risk of developing PPD (Grote et al., 2010). Although biological risk factors are an essential aspect of understanding PPD, psychosocial risk factors are also multitudinous.

Multiple meta-analyses and systematic reviews have been conducted to ascertain the risk factors of developing postpartum depression. Antenatal diagnosis of depression and anxiety, as well as undiagnosed symptoms of both, are well-documented as a risk factor to postpartum depression (Dennis et al., 2004; Koutra et al., 2014; Robertson, Celasun, & Stewart, 2003; Sidebottom, Hellerstedt, Harrison, & Jones-Webb, 2017). Controlling for past mental health diagnosis or symptoms, working during pregnancy, educational level (Koutra et al., 2014) and unplanned or unwanted pregnancy (Koutra et al., 2014; Rich-Edwards et al., 2006) are also risk factors which have correlations with development of postpartum depression. Even though PPD is not limited to socioeconomic status, SES is related to an increased PPD risk (Rich-Edwards et al., 2006; Robertson, Grace, Wallington, & Stewart, 2004), and financial poverty is also a significant social risk factor to developing PPD (Segre, O'Hara, Arndt, & Stuart, 2007).

Low levels of social support or partner support (Atkins, 2010; Clout & Brown, 2016; Koutra et al., 2014) is associated with postpartum depression, as well. Relative to social support, lacking time for personal care or attention contributes to depressive symptoms post-birth (Woolhouse, Small, Miller, & Brown, 2016). Similarly, perceived lack of partner support, including not contributing to household duties, is also related to a higher prevalence of PPD (Smith-Nielsen et al., 2016). Depression is higher among single mothers (Atkins, 2010), so

combined with diminished social support, single mothers may be at a higher risk for postpartum mental health disorders as well. Additionally, strong relationships exist among intimate partner/marital stress (Clout and Brown, 2016; Liu, Giallo, Doan, Seidman, & Tronick, 2016), intimate partner violence (Desmarais, Pritchard, Lowder, & Janssen, 2014) and postpartum depression.

Trauma before or during pregnancy and birth can also increase the risk of postpartum mental health disorders. Previous life events and the existence of depression and anxiety (which can arise from childhood trauma or other traumatic events) can influence the development of PPD (Robertson et al., 2003, 2004). Indeed, adverse childhood experiences (ACEs) are associated with the onset of depression and anxiety during the postpartum period (Kettunen & Hintikka, 2017). Similarly, the prevalence of Post-Traumatic Stress Disorder (PTSD) also relates to the development of depression during and after pregnancy (Seng et al., 2013). PPD risk factors also include sexual trauma (Silverman & Loudon, 2010), traumatic childhood experiences (Kettunen & Hintikka, 2017), and even generational maternal postpartum depression (Séjourné, Alba, Onorrus, Goutaudier, & Chabrol, 2011). Considering roughly 1 in 5 women expecting their first child experienced some sort of trauma in childhood (Seng et al., 2013), this is a large population of mothers predisposed to developing PPD.

In some studies, cesarean birth has led to increased prevalence in postpartum depression (Koutra et al., 2014; Lee, Liu, Kuo, & Lee, 2011; Seng et al., 2013), whereas others have found it not to be a risk factor (Adams, Eberhard-Gran, Sandvik, & Eskild, 2012; Carter, Frampton, & Mulder, 2006). That said, control over the birthing environment as well as alignment with birth expectancy (such as expecting a natural birth and then giving birth naturally) decreases fear and negative emotions associated with delivery which may reduce PPD risk (Preis, Lobel, &

Benyamini, 2018). Other obstetric factors increase the risk of postpartum mental health disorders, however, such as perineal tearing (Sorenson & Tschetter, 2010), extreme birth pain, or loss of control during the birthing process (Reynolds, 1997).

Protective Factors

Cognitive flexibility and resiliency are two protective factors that can alter mental health outcomes. Cognitive flexibility, a trait associated with better mental health, is one's ability to ascertain that there are options in the future, the options are viable, and the willingness to adapt and understand that those options may even be more fruitful than previously anticipated options (Brewster, Moradi, DeBlaere, & Velez, 2013). Increased cognitive flexibility is associated with reduced depressive and anxiety symptoms and can help a person make more informed decisions that they are comfortable with (Landstra, Ciarrochi, Deane, & Hillman, 2013). Indeed, acceptance and commitment therapy (ACT), an intervention that relies on increasing cognitive flexibility, leads to reduced depression and anxiety symptoms (Bohlmeijer, Fledderus, Rokx, & Pieterse, 2011), which survivors of trauma experience at increased rates.

Resiliency is a similar concept. A systematic review (Dray et al., 2017) covering findings from resiliency-based school interventions found that depression symptoms, anxiety, and hyperactivity, externalizing, and internalizing symptoms were all reduced by enhancing resiliency factors for school children. Similarly, studies investigating the importance of resilience to mental health outcomes found that nurse's well-being was tied to resilience (Gao et al., 2017), resilience of gender non-conforming adolescents enhances mental health outcomes (Bockting, 2016), and most relevant to this dissertation, Sexton et al. (2015) expressed that resilience is an essential buffer for effects of childhood trauma, postpartum mental health disorders, and the combination of the two. Resilience and aspects of emotional regulation such as emotional

intelligence and relational resources are negatively associated with the development of postpartum depression as well (Liu, Giallo, Doan, Seidman, & Tronick, 2016; Rode, 2016). As such, resiliency and survivance, which is an indigenous term for surviving and resisting despite continued oppression (Vizenor, 1999) can relate to a reduction in PPD prevalence.

AI/NA Specific Risk Factors for PPD

American Indian/Native American (AI/NA) mothers have the highest prevalence of PPD out of any other group in the United States; an estimated 17.5% of AI/NA mothers experience PPD (Ko, Rockhill, Tong, Morrow, & Farr, 2017). There are multiple factors that contribute to these higher rates, such as physical and mental health disparities, disparate poverty, cultural erasure, and communal isolation, which can be directly tied to a continued perpetuation of oppression and a result of historical trauma (Evans-Campbell, 2008b). The following presents multiple known PPD risk factors for their unique contribution to the high rates of PPD among AI/NA mothers.

Physical health. AI/NA mothers have an increased risk of pregnancy-related hypertension or pre-eclampsia compared to other groups (Zamora-Kapoor, Nelson, Buchwald, Walker, & Mueller, 2016), both of which are positively correlated with experiencing PPD (Dennis, Janssen, & Singer, 2004). Similarly, obesity can contribute to perinatal health issues, such as low gestational weight, delivery complications, and gestational diabetes (Sundaram, Harman, Peoples-Sheps, Hall, & Simpson, 2012). Also, pre-pregnancy obesity is associated with positive screening for PPD (LaCoursiere, Barrett-Connor, O'Hara, Hutton, & Varner, 2010) and AI/NA people have not only the highest rate of obesity in the United States (Zamora-Kapoor, Sinclair, Nelson, Lee, & Buchwald, 2019), but AI/NA mothers have the highest rate of pre-pregnancy obesity as well (Hinkle et al., 2012). Diabetes diagnosis before pregnancy is another predictor of developing PPD (Katon et al., 2014), and AI/NA individuals are twice as likely to have a diabetes type II diagnosis than non-Hispanic white adults in the U.S. (Jiang et al., 2013).

Being a smoker is also a health determinant predictor of PPD (Katon et al., 2014), and AI/NA adults lead other ethnic groups in the US by a large margin in cigarette smoking (Martell, Garrett, & Caraballo, 2016).

Perinatal Care Disparities. Compared to non-Hispanic white mothers, AI/NA mothers are 2.8 times more likely to receive late or no prenatal care, which can alter postpartum mental health outcomes (The Office of Minority Health, 2017). Since pre-existing depression and anxiety diagnoses and symptoms increase the risk of PPD development, prenatal care can allow for appropriate screening and support, which may reduce the risk of PPD (Magliarditi, Lua, Kelley, & Jackson, 2019). Resultingly, those who only come in contact with perinatal care providers at the time of delivery are at an increased risk for PPD (Magliarditi et al., 2019). Furthermore, there are several barriers to prenatal care for AI/NA mothers which extend beyond access such as provider misunderstandings and miscommunication, lack of continuity of care within the institutions resulting in mistrust of providers, long wait times, and psychosocial problems which overshadow the need for prenatal care (Hanson, 2012). Since AI/NA mothers are less likely to receive prenatal care, they might not be screened for depression and anxiety.

Furthermore, AI/NA mothers might not be receiving support or information about postpartum mental health and, therefore, at an increased risk of undiagnosed PPD. Lack of continuity in care, or a rotating door of prenatal providers which AI/NA women experience frequently (Hanson, 2012) can result in AINA mothers perceiving less control over the birthing process, which is linked to more negative thoughts and fear surrounding the birth of a child (Preis et al., 2018). Further, many AI/NA people utilize Indian Health Services (IHS), particularly for childbirth, and those using IHS have worse health outcomes than AI/NA people using non-IHS services (Williams, 2012). That said, mothers using IHS for perinatal services

may have different care experiences than those who do not, which may also contribute to PPD rates. Postnatal care for the mother is another factor that contributes to postpartum mental health outcomes, which disproportionately affects AI/NA mothers. Limited information is available regarding postnatal care for AI/NA groups. Still, the low participation rate in prenatal care indicates that it is also likely AI/NA mothers do not engage as much as non-Hispanic white mothers do.

Breastfeeding. When compounded with other risk factors such as higher stress, reduced social support, and poverty, lower engagement in breastfeeding is associated with a higher risk of developing PPD (Pope, Mazmanian, Bédard, & Sharma, 2016). AI/NA mothers have the second-lowest rate of breastfeeding initiation among all other ethnic groups (aside from African American mothers), and the second-lowest rates of breastfeeding duration, with the median duration being 13 weeks (Jones, Power, Queenan, & Schulkin, 2015).

Institutional Racism. Recent research indicates that the disparities in maternal mental health outcomes that disproportionately affect women of color are related to lifetime stress, which is compounded by stress brought on by racism (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008). Perceived racism experienced by mothers of color during perinatal care can influence stress levels and contribute to low birth weight, which in turn, contributes to a higher prevalence of PPD (Dominguez et al., 2008). To date, no studies have evaluated AI/NA specific experiences with racial stress as they relate to perinatal care. However, it is documented that many groups of women of color have experienced such institutional racism, and it is documented that institutional racism happens in other healthcare arenas for AI/NA people (Findling et al., 2019; Williams, 2012). Indeed, overall, 23% of AI/NA people report experiencing healthcare discrimination and, as a result, actively avoid proper healthcare unless

necessary (Findling et al., 2019). These numbers likely contribute to the low rate of perinatal care for AI/NA mothers as they actively avoid care due to anticipated discrimination, particularly during the vulnerable time of pregnancy as 41% of AI/NA mothers do not receive the recommended number of perinatal visits (Maternal Health Task Force, 2015). Low engagement in perinatal care is of importance to maternal mental health because it reduces the probability that a mother will be screened for PPD and receive resources that may be helpful to improve postpartum mental health outcomes.

Cesarean, Induction, and Birth Trauma. AI/NA mothers, especially those who have lower educational status, are much more likely to have a cesarean delivery than other ethnic groups even when controlling for health issues, risks, and complications, indicating a higher rate of non-medically necessary cesarean delivery (Roth & Henley, 2012). Induction also can lead to increased risk for cesarean delivery, and induction is sometimes a tool of convenience due to hospital scheduling and provider preference for birthing timelines (Roth & Henley, 2012). Since there is a link between cesarean births and PPD risk, the higher rates of non-medically necessary cesareans may be related to PPD prevalence within AI/NA communities. Furthermore, postpartum physical complications, arising from either cesarean or birth trauma, are also significant risk factors for developing PPD, which AI/NA mothers experience more frequently.

Preterm Birth. Psychosocial stress can be traced to historical trauma and is experienced at much higher rates among AI/NA women, particularly within the 12 months before giving birth (Raglan, Lannon, Jones, & Schulkin, 2016). These stressors, such as poverty, increased violence, and somatic symptoms, as well as delayed prenatal care, are linked to higher rates of preterm birth (Raglan et al., 2016). Aside from non-Hispanic black women, AI/NA mothers have the highest rate of preterm birth in the United States (Raglan et al., 2016). Having an infant in the

neonatal intensive care unit (NICU), which often occurs when a child is born preterm or has a low birth weight, can influence the maternal role and perceptions of maternal instincts, possibly affecting maternal efficacy and self-esteem (Klawetter et al., 2019). Furthermore, both low birth weight and preterm birth strengthen the risk of developing PPD as well as lengthen the time PPD symptoms are experienced (Poehlmann, Schwichtenberg, Bolt, & Dilworth-Bart, 2009). Given that AI/NA mothers experience preterm birth at a much higher rate than many other ethnic groups in the United States, the experience may contribute to tenuous maternal role transition, thus effecting maternal mental health outcomes.

Mental Health. Preexisting mental health diagnosis is a risk factor for developing PPD (Koutra et al., 2014; Reid & Taylor, 2015). Also, women who have prenatal depression symptoms are more likely to have elevated PPD symptoms (Gaillard, Le Strat, Mandelbrot, Keïta, & Dubertret, 2014; Sampson, Duron, Mauldin, Kao, & Davidson, 2017). AI/NA people have higher rates of mental health issues, both diagnosed and undiagnosed, than other ethnic groups in the United States (American Psychiatric Association, 2017). AI/NA people experience posttraumatic stress disorder (PTSD) at rates more than twice the general population (American Psychiatric Association, 2017). AI/NA women experience higher rates of mood and anxiety disorders than other ethnic groups of women in the United States as well. However, screening tools for such disorders can be culturally biased and fail to fully capture prevalence and experience for AI/NA women (Duran et al., 2004). Ultimately, this underdiagnosis and resultant undertreatment contributes to the fact that suicide rates for AI/NA women have increased by 139% since 1999, which is much higher than suicide increases in other ethnic groups in the United States (Leavitt et al., 2018).

Single and Teen Motherhood. Unmarried women have a higher risk of preterm birth, potentially due to work stress, lower-income, and less social support, and preterm birth increases the risk of PPD (Raglan et al., 2016). AI/NA mothers are more likely to be unmarried and be living with children than non-Hispanic white women (Raglan et al., 2016). Also, compared to a rate of 39 in every 1,000 births for the overall U.S., teen mothering among AI/NA women occurs at a rate of 55 in every 1,000 births (Palacios, Strickland, Chesla, Kennedy, & Portillo, 2014). Teen mothers are at an increased risk of PPD, and AI/NA teen mothers have a higher risk of substance use, dropping out of school, and housing instability (Barlow et al., 2015). Such risk factors, which can be tied to historical contexts due to cultural decimation and forced removal, in turn, increase poor maternal mental health outcomes and have lasting effects on the child's social, emotional, and cognitive well-being as well (Barlow et al., 2015).

Substance Use. Substance use is another risk factor for developing PPD, particularly in conjunction with intimate partner violence (IPV) (Dennis & Vigod, 2013). Furthermore, there is a relationship between maternal substance use and PPD, even when controlling for socioeconomic status and history of depression (Dennis & Vigod, 2013b). Even substance use by a partner during pregnancy, as it may relate to an increase in IPV and stress levels for the mother as well as reduced social support, is associated with the development of PPD as well (Dennis & Vigod, 2013). Maternal cigarette smoking and prenatal secondhand smoke exposure are also correlated to PPD development (Koutra et al., 2014).

AI/NA people are at an increased risk for substance abuse (Lowe, Liang, Henson, & Riggs, 2016). Within the opioid crisis, AI/NA people have the second-highest overdose death rates from heroin and third-highest overdose death rates from synthetic opioids (Indian Health Services, 2018). Alcohol use among AI/NA people is well documented, and alcohol initiation

occurs on average between the ages of 11 and 13 among the population (Kopak & Kulick, 2017). Early initiation to a substance is related to the development of peer substance use, and as such, AI/NA teens have an increased risk of substance use disorders (Kopak & Kulick, 2017). The high prevalence of substance use among AI/NA people, particularly in adolescence, is of concern to AI/NA maternal mental health since substance use increases PPD prevalence, and teen pregnancies are the highest among AI/NA mothers in the U.S. (Barlow et al., 2015).

Rurality and Transportation. Living in a rural area does not contribute to higher rates of PPD when controlling for socioeconomic status, social support levels, and a history of depression (Vigod et al., 2013). However, social isolation is a predictor of PPD (Knudson-Martin & Silverstein, 2009), and lack of consistent and quality transportation can contribute to social isolation, particularly in rural areas (Knudson-Martin & Silverstein, 2009). Furthermore, lack of connection to a larger urban center, wherein social support, access to resources and goods, and perinatal care choice also relates to a higher prevalence of PPD regardless of rural or suburban living, which can be exacerbated by lack of quality transportation (Vigod et al., 2013). Lack of quality transportation access increases the risk of PPD prevalence in AI/NA populations, particularly for those in more rural areas who have a marked deficit in access to reliable, safe, and affordable transportation (National Congress of American Indians, 2010). One reason transportation is associated with PPD is it plays a critical role in mobilizing mothers to engage in social groups that are protective against developing PPD (Barlow et al., 2015; Ginsburg et al., 2012). Due to historically forced relocation, the decimation of ancestral lands, and an increased risk of poverty, AI/NA mothers are uniquely positioned to have limited access to quality personal or public transportation (Barlow et al., 2015; Ginsburg et al., 2012). Geographic isolation with lack of transportation access contributes to increased suicide rates among AI/NA people (Leavitt et al., 2018), and suicide resulting from PPD is the main contributor to maternal mortality within the first

year after the birth of a child (Doe et al., 2017). Furthermore, limited transportation can decrease cultural and spiritual engagement, and is cited as a resilience factor against PPD symptoms as well as a coping mechanism (Keefe, Brownstein-Evans, & Rouland-Polmanteer, 2016).

Forced relocation during the Trail of Tears led to the relocation of Keetoowah and Cherokee people from ancestral homelands near modern-day Georgia and South Carolina to Oklahoma. Part of this relocation involved land allocation wherein the U.S. government, during the Indian Reorganization Act of 1934, provided land parcels to those relocated (Stremlau, 2011). Such plots are often passed down through generations, and only those holding ¼ blood quantum requirements can maintain ownership over the land plots (Reed, 2016). As such, small familial communities reside in rural areas where these plots were allotted, often far in driving distance from both Tahlequah, where a majority of the Keetoowah reside, and the local hospitals. This relegation to rural plots with little or substandard road infrastructure means limited transportation access for those without personal vehicles. In addition, poverty, which is an effect of historical trauma, historical oppression and marginalization, and lack of economic mobility opportunities, intersects with the inability to afford or maintain personal vehicles. As such, women who reside in these rural communities, mainly because their family community is there and because the land is free, are at a disadvantage of accessing perinatal care. Furthermore, access to socialization and cultural ceremonies is limited, which can further prompt feelings of isolation and enhance maternal mental health symptoms (Mamisachvili et al., 2013).

Physical Environment. The physical environment is integral to the health and wellbeing of all individuals, but especially to AI/NA people since their culture and health are so intrinsically tied to the environment in which they reside (Alaazi, Masuda, Evans, & Distasio, 2015). AI/NA people's sense of place impacts their well-being in all domains (physical, mental, spiritual) as access to cultural and spiritual traditions as well as a community rely on indigenous

values of interdependence and are woven into many AI/NA cultures (Alaazi et al., 2015). The physical environment a mother is in during the perinatal period is also relevant to maternal mental health. Increased air pollution and particulate matter are associated with an increased risk of PPD (Niedzwiecki et al., 2020; Sheffield et al., 2018). Water insecurity is also a stressor that expands the odds of PPD in developing countries (Aihara, Shrestha, & Sharma, 2016). Overall, environmental stressors are a major PPD risk factor and can increase stress on the mother during the perinatal period (Shin, Park, & Kim, 2006; Vigod et al., 2013). Residential noise is another environmental stressor that heightens the occurrence of PPD (He et al., 2019) as well as housing issues and insecurity (Aris-Meijer et al., 2019). Housing quality and neighborhood stability can impact mental health postpartum as well and are both associated with increased depressive symptoms (Jones et al., 2016).

AI/NA populations experience increased exposure to environmental toxins, so much so that environmental justice has become an active part of fighting physical and cultural genocidal tactics perpetrated against their communities (Vickery & Hunter, 2016). Proximity to abandoned uranium mines disproportionately affects AI/NA communities, and uranium exposure can lead to an increased risk of developing hypertension, which also impacts PPD risk (Lewis, Hoover, & MacKenzie, 2017). Furthermore, AI/NA lands are often targeted for hazardous waste dumping, and these sites remain contaminated for decades, and exposure to such sites contributes to a multitude of health disparities (Brook, 2016).

Housing in areas where AI/NA populations reside, particularly in rural areas, is often of poor quality or disrepair, structurally unsound, can lack drinking water access, and can have exposed asbestos (Pindus et al., 2017). In addition, many lack kitchens and bathrooms, or have exposed electrical wires or lack of sufficient heating and cooling (Pindus et al., 2017).

Generational stressors impact those whose families participated in forced relocation as well, often leading them to these contaminated lands. Studies indicate that health disparities exist, even rippling out to multiple generations, for those born to ancestors who were forcibly removed, including a higher prevalence of depression (Walls & Whitbeck, 2012). In addition, AI/NA environmental health expands beyond levels of toxicity into the utility of the land for cultural and traditional practices. As such, pollution can impact the spiritual well-being of communities and, in turn, impact tribal mental health (Vickery & Hunter, 2016). This prevalence of depression and health disparities again points to the potential that historical trauma, including forced relocation and environmental stressors, may play a part in the high prevalence of PPD in AI/NA communities.

Poverty. Even though PPD affects women of all socioeconomic status, poverty remains related to PPD development (Halbreich & Karkun, 2006). Financial poverty is a significant predictor of the development of PPD (Segre, O'Hara, Arndt, & Stuart, 2007), and AI/NA women have the lowest median income out of all other ethnic groups in the United States (Institute for Women's Policy Research, 2015). There are many facets of poverty that contribute to stress and, therefore, PPD. Employment levels, such as unemployment and underemployment, are also statistically significant predictors of PPD (Shin et al., 2006). Food insecurity, as well as economic dissatisfaction, also predispose mothers to PPD (Ezzeddin, Jahanihashemi, Zavoshy, & Noroozi, 2018). Food insecurity during pregnancy can also lead to disordered eating and obesity among mothers, which also increases PPD risk (Laraia, Vinikoor-Imler, & Siega-Riz, 2015). Renting a home as opposed to owning one is also associated with PPD risk (Johnstone, Boyce, Hickey, Morris-Yates, & Harris, 2001). In addition, poverty contributes to reduced maternal self-esteem and confidence, two factors of becoming a mother, which are both related to a higher

prevalence of PPD (Denis, Ponsin, & Callahan, 2012; McGrath, Boukydis, & Lester, 1993). The prevalence of poverty among AI/NA people is high; between 27.4% and 29% of people living on either reservation or tribal trust land are in poverty (Mauer, 2017). Generational attributes, such as forced relocation and limited access to transportation, job opportunities, and increased substance abuse all contribute to high rates of poverty in Indian country, which in turn, contribute to higher rates of maternal mental health issues.

Trauma. Trauma is broadly defined as the experience of an event that prompts a person to feel overwhelmed, without power, and fearful of harm befalling either themselves or someone known to them (American Psychological Association, 2013). Beyond this definition, trauma can be experienced either through an isolated event or an ongoing, chronic, or cumulative exposure to such events (Levenson, 2017). The connection between trauma and development of PPD is well documented (Sexton, Hamilton, McGinnis, Rosenblum, & Muzik, 2015; Zvara, Meltzer-Brody, Mills-Koonce, & Cox, 2017). Interpersonal violence is a major risk factor for PPD (Gaillard et al., 2014). AI/NA people experience interpersonal trauma and childhood abuse at higher rates than non-Hispanic white women (Burnette, 2015), as well as experiences with systemic and historical oppression and trauma, which are risk factors for PPD (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). AI/NA women also experience an increased risk for experience with IPV (Burnette & Cannon, 2014), another risk factor for developing PPD (Garabedian et al., 2011; Kothari et al., 2016). In fact, many of the PPD risk factors which are outlined above can be folded under the umbrella of historical trauma, particularly poverty, physical environment, violence, and structural and institutional oppression and racism (Evans-Campbell, 2008a). As such, lasting and persistent effects of historical trauma may contribute to

such a high prevalence of PPD in AI/NA communities, particularly as historical trauma intersects with becoming a mother.

BAM and PPD

Another factor related to the development of PPD well documented in the literature is the experience of becoming a mother (BAM). Perceptions of the postpartum experience, such as satisfaction with life changes and maternal identity shifts, are related to PPD (Beck, 2002; Horowitz, Damato, Duffy, & Solon, 2005). The transition to motherhood is marked by maternal confidence, which is also positively associated with maternal mental health outcomes (Denis, Ponsin, & Callahan, 2012). Part of the maternal identity is also spiritual orientation—either religious or philosophical—and lack of such an orientation is tied to lower maternal confidence and increased risk of PPD (Lynn, 2007).

Similarly, dysfunctional beliefs towards mothering -beliefs in which the mother feels inept or has disproportionately negative views about her maternal competence, as well as negative perceptions of the postpartum period- are related to PPD (Horowitz et al., 2005; Preis et al., 2018). Conversely, positive regard to maternal identity, role as a mother, and feeling attached to their infant are related to more healthy maternal mental health (Horowitz et al., 2005). For this reason, BAM is an important psychosocial risk factor when researching PPD.

Prevention and Treatment of PPD

There are both psychopharmacological and cognitive-behavioral interventions for PPD. Psychopharmacology is effective at reducing PPD symptoms, yet the safety of using these while breastfeeding remains unclear (Gigantesco, Palumbo, Mirabella, & Cascavilla, 2013). Some women are also hesitant to utilize psychopharmacological interventions for fear of side effects and preference towards more “natural” approaches (Gigantesco et al., 2013). Fortunately, there

are multiple effective interventions that do not involve medication. There is exercise therapy, which reduces stress, and is highly effective at reducing PPD symptoms (Lewis et al., 2018).

Peer support groups, both in-person and online, are also effective at reducing PPD symptoms. Increasing social support can be helpful at reducing loneliness and stress, both of which contribute to PPD (Xie, He, Koszycki, Walker, & Wen, 2009). A free, peer-led support group for PPD reduced feelings of the stigma of PPD, increased social support, and prompted acceptance (Prevatt, Lowder, & Desmarais, 2018). A systematic review of group-based PPD interventions discovered that mothers felt validated, empowered, and healed by group interventions (Gillis & Parish, 2019). Further, the sharing of knowledge among other mothers, both practical and emotional, was helpful in their processing of PPD and was a positive aspect of group-based interventions (Gillis & Parish, 2019).

Interventions focusing on the mother and baby relationship are another approach to PPD interventions. One intervention, Mothers and Babies, is a cognitive-behavioral program delivered in-home by trained facilitators and focuses on increasing the relationship strength between the baby and mother (Tandon, Ward, Hamil, Jimenez, & Carter, 2018). Participants found it enjoyable and a randomized controlled cluster trial showed it was effective at reducing PPD symptoms (Tandon et al., 2018). Additionally, an in-home intervention that centered on better mother-baby interactions improved maternal self-esteem and lowered maternal stress, both related to PPD symptoms (Paris, Bolton, & Spielman, 2011). Interventions using relationship-based therapy to increase infant-oriented behaviors also reduce PPD symptoms (Goodman, Guarino, & Prager, 2013).

Cognitive-behavioral therapy focuses on the cycle of thoughts, behaviors, and actions of an individual (Anne Denis & Luminet, 2017). A web-based program using informational

content, CBT coping skills, and activities was efficacious at reducing PPD symptomology (Danaher et al., 2013). Multiple systematic reviews have found CBT interventions to be highly effective at reducing PPD symptoms across multiple populations (Dennis, 2005; Dennis & Creedy, 2004; Sangsawang, Wacharasin, & Sangsawang, 2018).

In summation, current clinical practice for postpartum depression include cognitive-behavioral therapy (Dennis, 2005; Dennis & Creedy, 2004; Sangsawang, Wacharasin, & Sangsawang, 2018), psychopharmacology, home visiting programs to increase social support and parenting knowledge (Leis, Mendelson, Tandon, & Perry, 2009), and exercise-based interventions (Carter, Bastounis, Guo, & Morrell, 2018).

Gaps in Literature

This research aims to address the gaps in current literature to inform innovation towards postpartum depression prevention and intervention models into more culturally informed, while also incorporating trauma-informed preventative models that address historical trauma as well. The literature previously outlined highlights the severity of PPD as a public health issue and one that social work should address by infusing a strengths-based and culturally competent approach. Furthermore, the literature illuminates a marked need to address the disproportionate rates of PPD among AI/NA mothers, since there is a substantial lack of PPD research focusing on AI/NA populations.

BAM relies on culturally prescribed mothering and is strongly related to the development of PPD (Callister, Beckstrand, & Corbett, 2010). Since Keetoowah women may have different cultural experiences than other populations of mothers, they also may have different experiences of becoming a mother. Literature surveying other indigenous mothers' experiences of BAM indicates understanding how AI/NA mothers experience maternal role transition can illuminate

unique risk and protective factors relating to their maternal mental health. BAM has been validated mainly with non-Hispanic white American and European women (Maxwell, in press). However, BAM measures have also been validated with teen African American mothers to evaluate the association between BAM and PPD (Birkeland, 2004).

Although there are many studies evaluating BAM for diverse cultures, none address this specific culture. One aspect of addressing these high rates is to determine how the distinctive culture of a homogenous tribe, the Keetoowah, influences BAM by considering historical trauma and reproductive rights. Even though literature documents the link between trauma and maternal mental health outcomes (Desmarais et al., 2014; Valentine et al., 2011; Zvara et al., 2017) including the prevalence of PTSD among those who develop PPD (Seng et al., 2013), interventions are often limited to screening for trauma at prenatal appointments. Although screening plays an important role in trauma-informed care and has the potential to decrease PPD risk factors (Gjerdingen & Yawn, 2007), if there are no resources or interventions provided, it does not do enough. Also, trauma screening for sexual trauma, domestic violence, and other trauma is not the standard (Zvara et al., 2017) and is not always comprehensive.

To date, there are no studies evaluating BAM with this population. Also, there are no studies that frame PPD through reproductive justice and historical trauma frameworks to evaluate the culturally specific historical contexts which may interplay with BAM for AI/NA mothers.

Research Questions

This study aims to address the gaps outlined above by acting as foundational qualitative research on tribe-specific expressions of BAM. It aims to begin building a literature base focused on AI/NA mothers, their maternal mental health, to inform future culturally-

derived interventions. Using BAM, historical trauma and reproductive justice frameworks, it poses the following research questions (RQs):

RQ1: What are the experiences of becoming a mother and postpartum mental health among Keetoowah mothers?

RQ2: How does Keetoowah culture relate to the postpartum experience for Keetoowah mothers?

RQ3: How does historical trauma intersect with Keetoowah mother's experiences of the postpartum experience?

RQ4: What do Keetoowah mothers perceive as the unique protective and risk factors related to postpartum mental health?

RQ5: What structural barriers influence self-sufficiency for Keetoowah women, postpartum, that may inhibit mental health care access (i.e. transportation, health care coverage, provider response, racism)?

RQ6: What do Keetoowah mothers see as the most important issue for them and what are their perceptions of solutions and supports for future generations of Keetoowah mothers?

Chapter 3: Method

To answer the research questions guiding this study, the method was chosen to intentionally reflect the cultural values of the population participating in the study and to establish a decolonizing research agenda. Specifically, story inquiry was the method most appropriate to evaluate Keetoowah mother's experiences of BAM qualitatively. This chapter first describes decolonizing research and its importance when conducting research with AI/NA populations. Then, the story inquiry method is explained. Following that, the researcher's positionality and the protection of human subjects are discussed. The chapter ends with a detailed description of study methods, including recruitment and sampling, data collection, data management, and analytic approach.

Decolonizing Research

Historically, research methods and scientific approaches have been shaped by western Euro-centric approaches to the acquisition of knowledge (Tuhiwai-Smith, 1999). Accordingly, results of sociological research focused on indigenous populations represent pathologizing, victimizing narratives, and assume that indigenous peoples are passive bystanders to both historical and contemporary issues that may be harmful to their communities (Tuhiwai-Smith, 1999). Decolonizing research is a type of research that attempts to understand other ways of knowing and to recognize that current "empiricism" is defined and valued by mainly white men (Tuhiwai-Smith, 1999). It differs from other research as it may involve art, oral stories, dance, and particularly, the input of indigenous people from the conception of the project and seeks to be a source of resistance rather than conformity (Mutua & Swadener, 2004). Also, decolonizing research does not try to empirically define and rename things for the advancement of non-indigenous people; it provides a strengths-based approach that is informed by and often

conducted by indigenous community members. Decolonized research may be reported in original (non-English) languages without attempting to create work that is "palatable" to Euro-informed scientists, insisting that there are other ways of knowing and reporting knowledge (Mutua & Swadener, 2004). Decolonizing research approaches situate power within the indigenous community, not outside of it, and gives voice to the participants rather than making homogenous, generalized claims about the population participating in the study (Mutua & Swadener, 2004; Tuhiwai-Smith, 1999). Decolonizing research seeks to decenter knowledge from Western academia and reclaim knowledge of people for their benefit. In this way, decolonizing research differs radically from most of the research reported in scientific journals and is the most appropriate approach to use when investigating experiences of indigenous populations.

Connectedness and empowerment are hallmarks of decolonizing research. Connectedness is an essential factor in AI/NA resilience. Since connectedness allows indigenous people the opportunity to maintain cultural identity, it allows them to keep their stories, values, traditions, and language alive and thriving (Mohatt, Fok, Burket, Henry, & Allen, 2011). Connectedness embraces the relationship among individuals, families, natural environment, and community (Mohatt et al., 2011). Further, connectedness is not just the existing relationships an individual has with others, but rather relationships which "build a sense of belonging and nurture a sense that one is valued" (Rao, Pell, & England-Kennedy, 2017, p. 350). Part of that empowerment lies in fostering connectedness. Empowerment within AI/NA communities allows the communities to utilize interdependence to develop interventions and actions that best serve the community (Chino & Debruyn, 2006). Connectedness is essential to resiliency building, and as such, this study intends to foster a sense of connectedness among the participants as well as discuss to what extent the participants feel connected.

Using story inquiry and aiming for a decolonizing approach and lens, this study approaches Keetoowah maternal mental health through storytelling, a well-known decolonizing method (Tuhiwai-Smith, 1999). This work strives to provide a foundation for decolonizing maternal mental health as it allowed the participants to craft the future research agenda in their own words from their own cultural positioning.

Existing Decolonizing Methods

There are many ways to approach decolonized research methodologically. Tuhiwai-Smith's work (1999) on decolonizing methodologies has greatly contributed to a growing body of knowledge on such methods. Some suggestions for decolonizing work involve the use of testimonies from people within indigenous populations. Testimonies are oral attestations to the experiences of indigenous people and act as the “voice and witness" (Tuhiwai Smith, 1999) of either the individual or collective memory of a people.

Envisioning and survivance are two other approaches to indigenous research that are strengths-based and use both a celebration of survival after the historical trauma but also offer up hope and future visions (Tuhiwai-Smith, 1999). Survivance is a concept which describes the continued presence of Native stories that denounce prevailing narratives of tragedy, dominance, and victimization and instead promote persistence to exist and thrive (Vizenor, 1999). The term is a combination of survival and resistance (Vizenor, 1999). Through storytelling, these two approaches can be used as they add the celebration of survival to narratives told as well as the collective future vision.

Story Inquiry

Storytelling is embedded in decolonizing research as an oral history shared by people, which insists that individual contributions to the collective story are all-powerful and

meaningful. Each individual's story is an arm of the collective oral historical tree and offers a richness to indigenous values and experiences. Storytelling is meant to be educational as well as historical and honors the diversity of perspective within the collective "truth" of a group (Tuhiwai-Smith, 1999, p. 146). Storytelling is respectful as it allows both the teller and listener to exchange information and dialogue, which provides for the decolonization of knowledge and history.

The story inquiry method arose from story theory, which was developed within the nursing discipline. Story theory insists that storytelling is a “fundamental dimension of human existence” (Smith & Liehr, 2013, p. 225). Developed for nurses working with patients, story theory promotes the utility of story to help aid in the healing of an ailment. Furthermore, story theory assumes that (1) people change as they interrelate with their world within an array of connected dimensions, (2) people live in an expanded present moment where past and future events are connected to here and now, and (3) people experience meaning as a resonating awareness in the creative unfolding of human potential. Because of these assumptions, story theory also insists that the act of telling personal stories allows people to make meaning, which has the possibility of transforming experience. Story theory also imparts that individuals and communities who are ready to embrace their story are more prepared to make meaning of an event, such as birth or death, and begin healing. Further, story theory maintains that the story is a process that allows the person or community ownership over their health story as it emerges (Smith & Liehr, 2013). There are three main concepts of story theory that allow for these assumptions to be demonstrated, which involve (1) intentional dialogue, (2) connecting with self in relation, and (3) creating ease (Smith & Liehr, 2013).

(1) Intentional Dialogue

Intentional dialogue occurs when a researcher purposefully engages with a participant to hear their story about something that is challenging them, in this case, maternal mental health and well-being. This dialogue requires trust, and the facilitator must be flexible enough to allow their own consciousness to be altered while hearing the stories (Derezotes, 2014). It requires freedom for the storyteller to share what they feel is most important, and as such, requires the facilitator to set aside their own ego and personal experiences and allow for the story to emerge (Smith & Liehr, 2013). This approach requires the dialogue facilitator (researcher) to have “true presence” wherein they focus their energy on the storyteller, not on what they will say next or how it relates to their own experiences.

(2) Connecting With Self-Relation

The recognition of self in relation to the health challenge unfolds through storytelling as a person begins to recognize their unique contribution to the larger communal story while they are dialoguing (Smith & Liehr, 2013). This connection allows individuals to recognize their personal history and gives them an awareness of their personal history as it is situated within the current context and communal time. This "reflective awareness" allows participants to think about how their bodies feel, how their feelings and emotions relate to their story, and how they are more than their discomfort or pain (Smith & Liehr, 2013).

(3) Creating Ease

Ease from the storytelling process is simply the cathartic release that follows from sharing a story that relates to a person’s health challenge. This ease contributes to flow in dialogue wherein previously disjointed thoughts begin to come together in a cohesive pattern,

that can be recognized by the storyteller (Smith & Liehr, 2013). These whole stories then allow participants to process the reality of their lived experience.

Story theory offers an empowering approach for individuals and communities as it allows the participants to actively process through their experiences without the interjection of imposed perspectives (Smith & Liehr, 2013). Such stories also allow for healing, both individually and collectively, which is an integral part of story theory. Furthermore, stories provide more details than traditional question and answer interviews because it allows participants to fill in nuance, setting, and emotion. Because of the richness of detail, the story becomes a more culturally appropriate way to report people's experiences as it doesn't run the risk of being too medicalized or reductionist (Smith & Liehr, 2013).

Story Inquiry Method

Since AI/NA American cultures rely heavily on oral tradition and storytelling, a story inquiry narrative approach is a culturally appropriate qualitative methodology (Kelley & Lowe, 2012). Story inquiry differs from narrative methodology as it allows for participants to understand their place within the communal narrative. Story inquiry expands beyond individual narratives as it ties in historical stories, contemporary experiences, and allows participants to reclaim their communal story collectively (Smith & Liehr, 2013).

Furthermore, storytelling allows the individual participant to recognize their power and contribution to their community's larger narrative and their ability to affect change (Tuhiwai-Smith, 1999). Similarly, stories offer the potential for healing and, as such, relate to holistic human health by allowing people to organize their thoughts around a phenomenon or experience (Smith & Liehr, 2013). Stories also provide intricate details often lost within quick conversations of quantitative assessments, allowing story building to provide a unique and comprehensive

understanding of what a population is experiencing. By allowing the participants to express their experiences through stories, a storytelling approach is not only culturally appropriate but also allows for the interviews to gather rich data to capture the essence of the phenomenon (Creswell, 2007; Kelley & Lowe, 2012). Story inquiry approach has also been used in prior research with the Keetoowah tribe (Kelley & Lowe, 2012). Although story inquiry was developed for use in nursing research, it is easily adaptable to social work research and remains a culturally sensitive and decolonizing method (Smith & Liehr, 2013).

Story inquiry method begins with gathering stories about a health challenge. This study evaluated mental health challenges but argues that a holistic approach is necessary, given that historical trauma affects both psychological and physical health and has shaped the culture and systems that define it today. Therefore, maternal mental health falls within the umbrella of health challenges. Following the story gathering, deciphering dimensions of the challenge begin, and then a story with low and high points is developed. Then, the movement towards resolution is identified. In the instance of this study, discussions of resilience, as well as suggestions for increasing maternal mental health outcomes, will be highlighted in Chapter 5. Finally, the stories are synthesized to "address the research question" (Smith & Liehr, 2013, p. 242), and to report the results found in Chapter 4.

Researcher Positionality

As a function of story theory, researcher reflexivity and personal reflection are necessary to limit bias in data collection and analysis. Furthermore, personal reflection allows for greater credibility of results since it allows the researcher to be aware of potential biases towards data analysis (Creswell, 2007). For that reason, I will outline here my relationship with AI/NA people, the Keetoowah people specifically, and my positioning as a researcher.

Earlier in my career, I was first a preschool teacher, then an administrator, then a family services coordinator for a local, non-profit, sliding scale preschool in urban Seattle. The school served mainly families from disadvantaged populations, and I had the opportunity to work with many children who were a part of Pacific Northwest tribes. Through that work, I developed close personal relationships with many parents as well. I became engaged in indigenous activism centered on survivance and cultural revitalization. Such activism had me involved as a volunteer development coordinator for a starting non-profit dedicated to decolonization and cultural revitalization within the greater Pacific Northwest. I organized fundraising events, collaborated with diverse interdisciplinary agencies, attended protests, and was invited to and attended a large number of cultural and spiritual events. This work illuminated to me the resilience of indigenous people despite historical atrocities and the importance of not only their culture to their own people's existence but also the necessity of preserving and maintaining cultural practices to add to the larger fabric of our societal diversity.

Later in my life, I married and my father in law, is not only Keetoowah, but a former chief of the UKB, a dedicated mental health professional focusing on culturally-specific interventions, and an elder who holds much of the Keetoowah traditional practice within his stories. In addition, he is also a grandfather to my children. My children have been bestowed Keetoowah names, often learn Cherokee language from him, and he frequently shares Keetoowah stories. Because of this, I am deeply invested in their cultural education, and the Keetoowah has a special place in my heart. Our family is an amalgamation of white western culture and Keetoowah spirituality, values, and sometimes, stout resolution.

When I began my social work education, I had many opportunities to work with both the Keetoowah tribe as well as surrounding agencies that serve Cherokee and Keetoowah people.

Through this work, I was able to volunteer with agencies dedicated to victim's advocacy services for indigenous women. I got to know many community members, often mothers, through this endeavor. From there, I conducted a study with the Keetoowah elders wherein I was able to discuss historical expressions of Keetoowah's motherhood from their perspectives. This study was also a story inquiry, that allowed the elders to tell their stories of how their mothers experienced BAM, but also how they navigated BAM, how they saw their daughters and other tribe members becoming mothers, and what they hoped for the future. This study illuminated the necessity for Keetoowah's motherhood to be discussed, as well as the hesitancy towards mental health services, the presence and strength of Keetoowah spirituality and tradition within the community, and the desire of the elders to see a resurgence in traditional maternal behaviors. This allowed me to understand the meanings of words, phrases, and what some of them called "superstitions." Ultimately their input was used to shape this study. In fact, the elders helped design the interview guide.

All these experiences undoubtedly influence the results of this study with the mothers, and it was meant to. I found it necessary to understand the historical and communal context within which these mothers existed because their stories were not isolated events; they existed within a unique cultural evolution beginning before time immemorial, navigating genocide, forced relocation, cultural erasure, and assimilation. All these contexts dramatically shape motherhood, the meaning of which is often overlooked since it is assumed to be something more here by evolution and biology. As such, I found it imperative to understand all of this before attempting to ask contemporary mothers about their experiences, and it shaped my positionality towards this study.

Protection of Human Subjects and Ethics

Approval from the Internal Review Board of The University of Texas at Arlington was acquired prior to initiating data collection. Research participants were informed that participation is entirely voluntary. Written informed consent was obtained before any research activities, and all participants were provided a copy of the signed consent form. Due to cultural power hierarchies, specific attention was given during recruitment to ensure complete voluntary participation. This included using snowball sampling and not having tribal elders or tribal members in positions of political power recruit for the study. Because the interviews had the possibility of provoking painful memories or deeply personal stories, the researcher provided participants with a list of valid, accessible, and relevant resources to be given at any time off during the interview and was also be given a list of local, affordable resources at the close of the interview. Participants gave informed consent, including an agreement to be audio recorded.

Recruitment & Sampling

Recruitment took place in Tahlequah, Oklahoma. This study was limited to mothers who had given birth within the last two years, who were age 18 or older, and were a part of the Keetoowah tribe. The requirement of using only participants who had given birth within the last two years was chosen to reduce the possibility of retrospective memory issues.

Due to the particular inclusion criteria making the population hard to reach, snowball sampling was used in conjunction with purposive sampling using flyers, social media recruitment and on-site recruitment in a variety of civic locations. Study participants were offered a $20 gift card for their participation. I also attended Keetoowah cultural events, with tribal permission, and discussed the study with potential participants, recruiting through that means. Recruitment primarily happened at an annual cultural event held at the UKB center,

which entails a fair, stomp dances, prayers, and music. In addition, snowball sampling wherein participants have told their friends, and community members about the study yielded referrals for potential participants. This study had the desired sample size of 15 mothers to allow for enough rich qualitative data and will ideally only approach saturation (Creswell, 2007).

The initial recruitment at the cultural event recruited 12 mothers who were interested in participating, and snowball sampling led to another six interested participants who contacted the researcher to participate. The initial 18 participants all agreed to participate, signed informed consents, and gave the researcher their contact information, including a time to be interviewed. This study used data collection saturation -- when the data yields no new information during the analysis process and becomes redundant (Saunders et al., 2017) -- as a marker to discontinue recruitment. As I collected data, I also took field notes to help indicate when saturation was reached. Once the eight interviews were coded, it was apparent that the story themes were overlapping with a great frequency, and saturation was being reached. Recruitment ended at this point, resulting in a final sample of eight. The other ten initial participants who signed consents did not return the researcher's phone calls or did not answer during the agreed-upon time for an interview. There were also four of the participants who continually set up times to be interviewed but did not follow through. It was made known by these four that cellular service was not reliable at their place of residence, so they did not end up participating because of scheduling inabilities. It is possible that this led to some selection bias as the final sample of eight all lived less rurally.

Data Collection

Data were collected via recorded phone calls. Participants were offered the opportunity to be interviewed anywhere they felt most comfortable, including via telephone. Interviews were digitally recorded using an encrypted recorder. In addition, informal talks with midwives and

other service providers, such as social workers, occurred off the record and prior to and during the study; field notes were taken during these instances for researcher reflectivity. During the interviews, notes were taken to guide the questions and follow-ups, but also to document researcher thoughts and emerging thematic content.

Interview Questions and Guide

To gain context of the current experiences of Keetoowah women as they become mothers and create a relational story along a timeline, the participants were asked to recall any stories from the past they held about pregnancy, birthing, parenting, and becoming a mother. The interview questions were derived with the help of tribal elders and their responses from a previous study investigating their perceptions of motherhood within their tribe both in the past and present. In addition, the interview questions were based on the research questions which were guided by current literature on Keetoowah culture, maternal mental health, and birthing experiences. The interview guide is based on story inquiry; was semi-structured; and follows a story inquiry approach as these inquire about an issue (becoming a mother, PPD); personal thoughts and feelings on the issue; strengths and resilience regarding the issue; and potential resolutions of the issue. The questions were meant to provoke storytelling by participants; the questions were mainly used to continue conversation flow and to ensure the research questions were answered within the stories. The interview guide is included in Appendix A. The interviews lasted between 22 and 47 minutes.

Data Management

All digital recordings were uploaded to a secure university drive managed by The University of Texas at Arlington. This drive was only accessible by the researcher's password. Professional transcription services were used, and a confidentiality agreement was signed by the

transcriber. Upon transcription, digital recordings were destroyed. All identifying information was struck from the transcripts, and the transcripts were stored on The University of Texas at Arlington secure drive. All informed consent forms were scanned and uploaded to the secure drive at The University of Texas at Arlington as well. The paper copies of informed consent were shredded. Interviews were documented using only code numbers to tie to informed consent.

Data Analysis

The analysis of the collected data followed the established story inquiry data analysis method (Smith & Liehr, 2013). The first step in the analysis was to transcribe the storytelling interviews verbatim. Once the interviews were transcribed, the stories were then read twice by the researcher with breaks between to allow for immersion into the data. During these initial read-throughs, the researcher documented thoughts, potential themes, and shared plot ideas. Only after reading each transcript twice did the coding begin using atlas.ti (v.8.1).

The transcripts were thematically coded for plot points and shared plots (Smith & Liehr, 2013). Plot points are aspects of a story that are similar and can be organized into the seven essential story elements: characters, setting, plot, point of view, symbolism, conflict, and resolution (Smith & Liehr, 2013). Then, atlas.ti (v.8.1) was used to organize thoughts, themes, high points, and low points of the plots. The story plot points were also coded for theoretical thematic content, specific aspects of the story that are relevant to historical trauma, and becoming a mother since these are theoretical support for the study. A story plotline was developed for a visual representation of the data in graphic design software, using Picktochart (Figure 1, Chapter 4), indicating a shared story with shared and unique plot points. These themes and visualizations were then triangulated with one other researcher who is on this dissertation

committee and aided in the original study design, as well as participants (mothers), midwives, social service workers, and tribal council.

Synthesized Member Checking (SMC) was utilized to ensure the voices of the participants and the community were at the forefront of the findings. SMC is a five-step member-checking process, which differs from other member-checking approaches as it ensures participants get to see the interview and interpret data to validate their experiences being reported in the study (Birt, Scott, Cavers, Campbell, & Walter, 2016). Following the tenets of SMC, I prepared a synthesized summary in non-scientific language for the participants with the emerging themes and quotes. In the second step, I asked participants if they are willing and in an emotional space to review the materials. In the third step, I sent out the summary to participants with relevant questions such as "does this match your experience?" and "do you want to add anything?" (Birt et al., 2016). In the fourth step, I then added the responses to the data; then in the fifth step, I integrated the responses into the findings; emergent codes and new codes were created when necessary. All of the steps of SMC were used in this study.

Using SMC, the feedback from these community members was taken back to the data to ensure representation of not only the participants' intents, but also to ensure only approved knowledge was being shared in publication. Then, the final story was created with supporting quotations and thoughts from the participants.

Credibility

Credibility in qualitative research regards the rigor in which a study was conducted and the degree of reliability of the results (Noble & Smith, 2015). Credibility also describes the level of researcher confidence in the findings of the study (Noble & Smith, 2015).

Credibility in this study was enhanced by using at least three methods of triangulation. First, this study used numerous coders, including the primary researcher and a member of the committee, to reduce potential confirmation bias that may be experienced by the first author. Second, as outlined above, member-checking was used. Third, theoretical triangulation, which is filtering the findings through multiple theoretical lenses to ensure the findings are valid (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014), was also used by filtering and coding the story results through historical trauma theory and the theory of becoming a mother guiding the analysis.

Credibility was further established in this study by addressing researcher bias through field notes. Further, I engaged at multiple time points with a researcher on my committee working with a similar research population to reduce my own bias. Additionally, since this study uses story inquiry, the results are reported with accompanying "rich and verbatim descriptions of participants' accounts" (Noble & Smith, 2015, p. 35) in the story. These credibility techniques have been used in similar research with AI/NA populations, particularly in conjunction with story inquiry (e.g., Kelley & Lowe, 2012).

Rigor

As noted above, due to the continued historical disenfranchisement as well as pathologizing and misrepresentation, research with AI/NA populations has many ethical hurdles to cross to be of worth and growth to tribal participants. Burke (2007) describes the necessity of disclosing ethical concerns when working with AI/NA populations and endeavors to minimize those concerns in research. To this end, several actions were undertaken to address potential ethical concerns. First, the method of story inquiry was explicitly chosen to approach a decolonizing research project particularly to embody a comprehensive picture of the experience

of Keetoowah mothers as opposed to the pitfall of picking and choosing “selected traits” (Burke, 2007). As a component of the study design, consultation with tribal members prior to the study, including the tribal chief, midwives, and other birth workers, was conducted to include tribal input into study design and approval. Similarly, member checking, which occurs when the researcher returns to the participants and other stakeholders of the research (in this case, mothers, midwives, birth workers, and council members) to ensure the findings represent and resonate with them (Burke, 2007), was used to ensure that the stories shared were representative and that the analysis did not impose western-centered views onto the voices of the participants.

Chapter 4. Results

The findings from this study are presented within this chapter. Explanation of the setting wherein the study took place is first given to place the themes contextually. Then, to align with story inquiry, each theme is presented within the context of past, present, and future. Each subtheme within the past, present, and future is then explained in detail as well with supportive verbatim quotes.

Setting

Among high hills, there is a town which is verdant and lush. There is a vast lake with deep blue waters; and towering out of this sacred lake is strong limestone pillars where children jump off and enjoy the coolness and natural beauty. Not far from this lake is a town with a population of around 15,000 people. It has a university near the center of the town and has sprawling neighborhoods spanning between 12 and 25 square miles from the center. There are also rural community pockets flung out on land parcels made up of families and long-standing communal groups. This town, Tahlequah, or “da-li-qwa” and is thought by the Keetoowah to be the Keetoowah word for grain of rice. Tahlequah is also an end stop of the Trail of Tears (an incident wherein AI/NA people were forcibly removed from their ancestral lands by the U.S. government and promised reservation land in treaties that were either not upheld or were scantily upheld; many people died along the trail as well) and is a product of the forced relocation of Cherokee people (Stremlau, 2011). That said, the Keetoowah people exchanged their lands in Arkansas long before removal but were forced to move from Arkansas to Indian Territory long before the Trail of Tears and settled in Tahlequah before the Cherokee arrived there (Henson, 2019). It is now home to both the United Keetoowah Band (UKB) and Cherokee Nation of Oklahoma. The town’s energy is both heavy and light- it has a youthfulness from a younger

crowd of students- but a reserved heaviness from elders. The Keetoowah's consider themselves to be spiritually conservative and maintaining sacred knowledge. There are many tribal buildings peppered throughout the landscape, casinos, social services, museums, elder centers, and veteran services. There are a few murals on walls of retail stores, and statues of notable tribal leaders. Every year, there is a Keetoowah celebration holiday comprised of a parade, a stomp dance, corn stalk shoot, marbles, blow guns, stick ball, a festival, and a meal that takes place on Keetoowah grounds. The celebration is happy, and people are received with warmth and understanding regardless of how long they've been gone or out of touch with one another.

In contemporary terms, the Keetoowah are defined by their holistic relationship with themselves, each other, and the earth (Henson, 2019). Furthermore, another key Keetoowah facet is to "bring things to the fire," which explains a process of bringing ailments, stress, and joys to the fire wherein ancestors reside and help walk individuals through their current state of being (Henson, 2019). These aspects are integral to Keetoowah community and well-being; they are necessary to lead a healthy and happy life, and when they are unable to commune with one another and the fire, it is likened to "having an arm cut off and still expecting to be able to write with it" (Henson, 2019). This is important to becoming a mother as well, lacking the communal support and spiritual practices that bring strength and resilience to the community, prompt pain, hardship, and disconnectedness. There is a current dichotomy in Tahlequah as well since some people remain spiritually and culturally Keetoowah but have enrolled in the Cherokee Nation of Oklahoma for benefit provisions since members can only be enrolled in one federally recognized tribe in order to receive benefits. In addition, as explained by a Keetoowah elder, there is a resurgence by young educated Keetoowah people to reclaim and observe their spiritual and cultural practices in the face of assimilation (Henson, 2019). They describe navigating this path

of both “buying into the white man’s world” by becoming educated at institutions of higher education while also simultaneously attempting to bring their spirituality and cultural values to the forefront through events, education, and even academic research (Henson, 2019). This attempt shadows over the environment in Tahlequah as there are people deeply invested in the resilience and strength of their tribe’s community but also actively shunned at times from engaging in cultural activities because they are “too white” (Henson, 2019). Despite this, mothers are teaching their children the Keetoowah language (which the Cherokee use) and bringing them to the fire, demonstrating a fierce resilience and hope to bring their values back into the center of their lives.

Sample Characteristics

The mothers included in the sample had a mean age of 31.5 years. The mode level of education for the mothers was “some college.” All the mothers either worked or resided in the same geographic location and the average distance from their homes to the Indian Health Services hospital where most perinatal health care takes place was 20 miles.

Indian Health Services (IHS) is an agency within the Department of Health and Human Services that provides health services to those enrolled in federally recognized tribes (IHS, 2020). One of the primary goals of the IHS is to ensure “comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaskan Native people” (Indian Health Services, 2020, p. 1). Since the health care services provided by IHS are free to tribal members, those who cannot afford private insurance or do not get it from their employer rely on the IHS for their perinatal services. As such, the participants in this study often received perinatal care at the tribal hospital, which is roughly five miles from the UKB headquarters. In addition, the average distance to the tribal hospital (excluding one participant

who no longer resides in Tahlequah) is 20 miles (N=8). This is important to note because even though there is a small bus system in Tahlequah, most people rely on cars. Moreover, this information was documented to understand how transportation may be a barrier to perinatal care.

Story Plot

Figure 1 (attached) represents the plotting of the story, based on themes found in the study, along a story plot line. These plot points include the background, which encompasses the themes representing the past. Then, the rising action and climax, which are the current themes, are displayed. Then, the falling action, which is when characters, or in this case, people experiencing a health challenge, work together to identify a resolution, is displayed as the future themes.

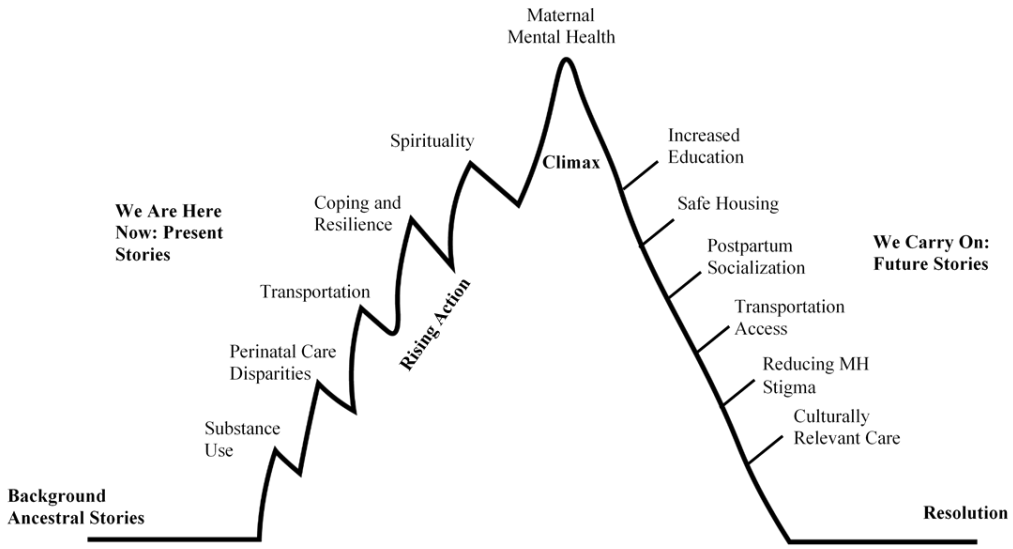
Themes

Within these findings, there is a flow of time, and stories sometimes slip from past to present the future, which indicates the connection of the three. As such, the thematic demarcations are superimposed, an artifact of language limitations, and represent as best they can the place in the time being discussed. The stories presented are set within the context of the past, present, and future plots. The past described ancestral stories passed down through generations. The present described how the Keetoowah is here now and how they experience BAM now while also accounting for the past stories. Then, the future story describes how the Keetoowah mothers hope for BAM to carry on among those in their community. From there, shared themes within each story are illuminated.

The past story was reflective of ancestral stories- recollections the participants had from their mothers and other elders sharing stories of their experience of BAM. One

main theme within the past stories was the pregnancy experience and how the womb had power. The other main theme emerging from the past was how being a mother for the elders was

Figure 1. *Story Plot Line*



different due to cultural and time contexts.

The present story portrayed diverse and in-depth aspects of becoming a Keetoowah mother in the present time. One present theme described the symbolism of tradition and how it influences their maternal role transition, as well as how it forged resilience and coping for such a transitory time in their lives. Another present theme was the perinatal care they experienced within IHS and the various shared experiences within that. Maternal mental health, particularly how their culture influenced their coping and beliefs surrounding postpartum depression, was another theme from the present. Barriers to perinatal care, as well as inhibitors to their maternal

role transition, such as lack of transportation access, poverty, and inadequate housing, were also all themes within the present story.

The future story discusses the stories the participants wanted to see for the future of Keetoowah mothers. The future themes include education about BAM as well as on child development. Safe housing was also a repeated theme that the participants wanted to see. Increased efforts at tribal and community socialization for mothers during the perinatal period was yet another theme. Finally, the future story the participants told included the theme of culturally relevant care.

Ancestral Stories: The Past

The women had numerous stories to share about what their mothers have shared with them about becoming a mother. They shared stories passed down for generations and stories about their own births. Regardless of the story's origin time, they discussed the loss of this knowledge and how they wished to bring these back into the greater knowledge of the women in the tribe.

The Past Theme 1: The World Outside of the Womb Has Power, and the Womb Has Power Over the Outside. Of these stories, the women shared, there were traditions and beliefs surrounding all facets of BAM; how their grandmothers and great-grandmothers thought about pregnancy, the birth process, and the postpartum period. Stories relayed that pregnancy and menstruation were a powerful time wherein the state of a woman's womb can impact the outcomes of events among people in the community. Participation in spiritual traditions is often taboo during pregnancy as Keetoowah see it as a time when the mother should be resting, and that the presence of blood or a fetus can alter the outcome of the ceremony. One woman described how she was taught that stomp dance, a spiritual tradition of the Keetoowah, had

special rules for women who were pregnant or menstruating, saying, "I do know that when a woman is menstruating, she's not supposed to touch the shells for shell shaking for stomp dances, but that's pretty much the extent of it. I think that extends to pregnant women." Another mother supported this sentiment regarding the importance of pregnancy and ceremony intersecting, as she related, "according to Cherokee culture and tradition, you don't want to dance when you're pregnant because you don't want any of the bad that you're trying to release or trying to cleanse or wash off, you don't want any of that to get to the baby."

Some of the women had other stories of cultural values surrounding BAM; for instance, all eight participants discussed ways to keep the baby safe while in the womb. One woman shared,

> The ladies in my office were like don't stand in the doorway because if the baby's going to do what you do and if they get stuck or they don't know whether to come in, they don't know whether to go out or come in if you've been standing in the doorway during your pregnancy. So, when you birth them, they get confused, and they can't figure out what to do, and it'll make your labor longer.

Another woman mentioned there were traditions about apparel that is worn during pregnancy, stating, "Oh, the other thing was necklaces, not to wear a necklace because the baby is inside of you and all they know is you. So, they do what you do. So, if you're wearing necklaces during your pregnancy, then they're going to try to put the cord around their necks." Despite knowing this, she went on to describe her experience wearing a necklace while pregnant,

> So, I didn't wear a necklace, well okay, I wore a necklace and then I went to my 13-week appointment or 12 or 13 weeks. I've been sitting in the doctor's office for about an hour, and I had my legs crossed the entire time. Then whenever they pulled the baby up on the

> ultrasound, she had her legs crossed, and I was like, "Oh my gosh, the old wives' tales are right." So that freaked me out. So, I didn't wear a necklace my entire pregnancy because I didn't want the cord to wrap around her because I was like, man, I don't know. It just freaked me.

Meanwhile, another woman explained the stories passed to her by other elders, calling them "old wives' tales." She shared,

> Another one was, what was it? Not sitting on hard surfaces or something not sitting on hard surfaces because it would make the baby not want to come out or something. Because we have this lady in our office, she's an older Keetoowah lady, and so she would always tell me all of these clearly old wives' tales.

There were other examples of tradition during pregnancy wherein the outside world was thought to affect the baby within the womb. These stories all illuminate the importance of the pregnant woman, the baby, and the power that pregnancy had towards the outside world as well. Another mother discussed traditions and discussed how pregnancy brought on more "superstition" than perhaps one would have during non-pregnant times of their lives. She said,

> Keetoowah traditions. Well, I know while you're pregnant, we're superstitious, like not standing in the doorway, not eating seafood or anything because your baby will walk backwards? You know, all the, I guess they're more native-related.

These accounts all illuminated the importance of the cultural stories from their ancestors, how much these stories tie into their current culture, and especially their identities as they become mothers.

The Past Theme 2: How Our Mothers Mothered. The women also discussed the parenting aspect of becoming a mother for generations before them. Beyond pregnancy and

birth, there were other traditions that Keetoowah people engaged in when their mothers were born or when they were born as well. Primarily, the focus was on the mother after the child was born, a tradition they felt was somewhat lost in the present world. The participants described how even though the birth of a baby was a blessing and the child was no doubt doted on and looked after, the mother was also a focal point of the community in the time following birth. For instance, one woman related,

> Traditionally, I mean, as far as, I mean, aside from kind of what we do now, where you make food, and you make sure the mom's comfortable and you help take care of the child, so the mom can rest and all of that. It didn't really seem that much different than what you would expect culturally, I guess.

Others described that traditionally there had been more of a balance in gender roles after a child was born. They explained that there was a cycle they had witnessed from what their elders discussed regarding a balance in parenting labor, wherein the elders experienced more of a balance. The participants' parents then experienced a heavily imbalanced distribution of parenting labor, that primarily fell on the mother. Now, however, they felt that even though there was still an imbalance, that there was an awareness that the men partners needed to be more of the labor distribution equation. Particularly as women are also in the workforce, they felt that they remnants of labor loads leftover from stay-at-home mom culture left them overtaxed. For instance, one woman shared,

> I know my dad didn't do nearly as much as my husband does, but there's still an imbalance in parental responsibilities. And she was a working mom, and I'm a working mom. And so, I don't think that she got as much attention as she needed.

Another related that she felt that although technology had changed and women were working outside the home more, that women were still held the primary role of ensuring the child and home were taken care of, saying,

> I don't know how much of that has changed. I'm sure a significant amount for modern technology, but as far as the care that we received, I think the biggest difference is the distribution of parental responsibility.

Finally, the women described how the traditions after birth that their mothers had access to had changed because of the slow loss of their culture due to assimilation and technology. Such traditions the women discussed were often lost to them because people who practiced them were no longer living, and frequently, such traditions were not passed on to others to perform them. One woman explained, “when you're born, you're supposed to be doctored. I was doctored when I was born. But my kids haven't been, because I don't know any medicine men anymore. The only one I knew died.” The fact that they knew of many traditions but were not able to practice them fully because they either didn’t know thse or there were no more medicine men available to perform these was a barrier to their ability to engage in such cultural practices. Many of the women lamented the loss of cultural values and knowledge that surrounded BAM and hoped to be able to pass on what traditions and values they did know about to their children.

We Are Here Now: The Present Story

The present story represented themes which were happening either in very recent time or now for the mothers. Themes within the present story presented here involved issues surrounding substance use, perinatal care, transportation access, coping, resilience and tribal community support, spirituality and mothering, and experiences with maternal mental health. Each of these themes represents shared experiences among the eight participants within their present story of

becoming a Keetoowah mother. These subthemes build up to the climax of the health challenge addressed within this dissertation, maternal mental health. These themes also have subthemes, explained in detail as well.

The Present Theme 1: Substance Use. Even though the participants in the study did not report substance use challenges, they expressed the enormity of substance abuse for mothers within the tribe. Additionally, they talked about how the more recent opioid crisis has infiltrated their community and impacted mothering for many mothers, particularly for those who were teen mothers. The participants discussed how they felt that unaddressed maternal mental health issues prompted self-medication for some mothers, and that substance use then prompted interaction with the child welfare system. The mothers lamented this connection, explaining that they felt that if maternal mental health challenges were better addressed, then perhaps more Keetoowah mothers would get the opportunity to mother their children. One mother shared their perception of drug use in her community and how ubiquitous it is, saying,

> Whenever I left [the community for the military], I didn't feel like everyone did it. Then it was rare to ever hear about someone using needles because that's disgusting. And I was like, "Ew." Then when I came back, my brother had told me, he was like, because I would see people, I'm like, "man, they look messed up." And he said, "You remember how we used to think needles are disgusting?" I was like, "Yeah." He's like, "It's like everyone uses them now." I was like, "Oh, my God." So, they use needles to shoot up. So, like I said, I really don't know.

Another mother lamented the resistance to seeking treatment or support for substance use among mothers in the tribe, sharing,

> Like they have to go extreme to even get help or be forced to be helped. By then they're already so strung out. When they could have got help before, when they weren't as, it would've been way easier for them to get out of it.

The prevalence of substance use and abuse within AI/NA communities is another remnant of historical trauma that continues to impact communities today. Correspondingly, this impact influences maternal mental health as well as involvement with child welfare and limits the extent to which AI/NA mothers can control their ability to parent.

The Present Theme 2: Perinatal Care. One primary theme regarding the present story of Keetoowah mothers was related to the perinatal care they received. Within this theme, there were subthemes of wanting their providers to focus on them as well as the baby once they were born. Another aspect of perinatal care heavily present, the second subtheme: the constant changing of care providers, with whom they could never develop a trusting relationship. In part, due to the dismissive care received, the third subtheme centers around not being able to listen to their bodies during the perinatal process.

The Present Subtheme 2A: Focus on Mothers, Please. The first subtheme discussing perinatal care in the stories of becoming a mother for the Keetoowah women as they wished perinatal providers would focus on them in addition to the newborn in the wake of birth. Many of the women felt that once they had given birth, they were figuratively and literally pushed aside and forgotten about by providers. Furthermore, they felt like the care they did receive was dismissive and lacked transparency. This dismissiveness prompted the mothers to feel like providers took on a paternalistic role that diminished their capabilities as mothers, prompted them to have reduced maternal confidence, and resulted in a lack of trust in their providers. For instance, one mother described how the child needs to be seen multiple times after the birth, but

that the mother has limited appointments to address concerns, particularly mental health concerns that may arise as they get further temporally from the birth. She shared,

> So, I went two weeks and then six weeks and then that's it. I haven't been back to the doctor. So, I think there's kind of a discrepancy in that there's so much focus on the child once the baby is born, which is needed. I'm not saying it's not needed. They go back for their one-week appointment, their two-week appointment, their two-month appointment, their four-month appointment, their six-month appointment. And I think once women are past that six-week mark or whatever, then it's like, all right, have a great time. And there's not really follow-up with that.

Others expressed that although they may have more education than their peers, they felt that the providers acting dismissive towards them could impact those with less education even more. They felt like providers not listening to them and assuming they didn't know anything about the childbirth process could lead to negative consequences, particularly for those who didn't feel like they had a voice when interacting with providers. Similarly, they expressed that less educated mothers may not know their options regarding prenatal testing and birthing plans, and the lack of provider transparency about such options could lead to issues for these mothers. One mother shared,

> It really, really concerns me [lack of provider transparency relating to less educated mothers]. In fact, after I had my baby, I sat down with the doctor who is over the department because he was my doctor, and I was like, "I have a lot of concerns." And I meant to write a letter, and I never got to it. But one of the concerns I had was the blood test that you get to determine whether or not your child has downs [Down Syndrome]. I

> wouldn't have had that done, but for my persistence. I said, "When am I supposed to get this taken care of?"

The Present Subtheme 2B: Rotating Door of Providers. All of the participants described their frustrations with IHS regarding not being able to maintain the same perinatal care provider throughout their pregnancy and birth. The mothers described how the rotating providers prompted uncertainty for them and continually led to having inconsistent information from perinatal providers. For instance, one mother said,

> So again, every time you go, you get a different midwife. But some of them were very dismissive of my questions. … So, I would always ask the same question like, "Okay, when is my next ultrasound? Okay, what about circumcision, because I found out I'm having a boy." And there were no consistent answers across the board. And one of the midwives was just dismissive, and she's like, "Oh, you'll be fine." Like, no, that's not answering my question. I want you to give me an answer.

Another mother insisted that the inability to have a consistent perinatal care provider is what prompted her not to like IHS care, saying, "Yes. I mean, for the most part, yes. So, the way I don't like the IHS visit is, every time you would go to your prenatal appointments, you would have a different midwife that was there."

Others described how not only was the lack of consistent provider frustrating because of the differences in information and care received but they also felt like it inhibited them from being able to form a relationship with the provider, meaning they didn't get an opportunity to build trust with the person who was providing perinatal care. One mother related,

> So sometimes you just get whoever's there. And I think that you lose the sense of a relationship. You have to have sort of trust and relationship. They're fixing to get real up close and personal with you.

This trust was essential because not only did it provide comfort for the mothers, it allowed the participants to be able to express their culturally relevant traditions regarding becoming a mother. Without this they were left either exhausted from repeating themselves, or they just abandoned their traditions altogether because the inconsistency in care disrupted their ability to communicate their traditional desires. One mother explained this, saying,

> I think because I personally, this was the third child that she delivered, so she was well aware of my ceremonial requests, and she was more aware of me personally. I think sometimes when you go to [IHS hospital], or you get, you go to those places, you're never stuck with one person.

The other issue with the rotating door of providers that influenced trust and ability to communicate about their cultural birthing preferences was the chance that they might get providers who outright dismissed their cultural traditions. The mothers described how they wished they could have the same provider so that they could build trust, explain their cultural practices, and be able to practice these without judgment. Many of the mothers discussed that providers knew how inconsistent they were, saying,

> They just didn't seem to care. They were dismissive. There was one midwife who kind of talked crap about the other midwives and were like, "Well, you better hope that you have her because I won't do that." And she was like, "If I have you, then this is when you can have your epidural." So, it was personality conflicts in a way. And I don't think they were used to having someone who asked as many questions as I do.

Unfortunately, many of the mothers expressed being shamed for their cultural practices. Hostility towards their birthing and approaches to new mothering were not taken seriously and were often visibly frowned upon by providers. One participant mentioned,

> Of course, that's hard [living traditionally] in the modernized world, but as far as giving birth to my kids, I, let's see, I had to have Cesareans. And so, with my kids, I kept the placenta and buried it afterwards. And so sometimes through that, you have doctor's kind of look at you weird and kind of want to ask questions, but understand at the same time that I'm not obligated to answer. And so out of niceness, I give them a little bit of information; I just don't ever go too much into detail.

Overall, the rotating door of providers meant that the mothers did not feel trust for the providers, lacked rapport with them, and in turn, did not feel comfortable or felt exhausted from sharing their cultural traditions. Even more impactful was that when they did share their cultural traditions, they felt judged and dismissed, so they often went without practicing them altogether. This systemic dismissal of indigenous mothering practices further enforces the erasure of their motherhood but also of the reproductive options they might have. Since providers were always changing, the women did not get consistent answers and missed out on prenatal tests, that could potentially mean they would have children with health issues.

The Present Subtheme 2C: Not Listening to Our Bodies. There were other reproductive choices that the women felt were foreclosed, primarily regarding how to bring their baby into the world. Due to a multitude of historical contexts, such as the increased prevalence of substance use and lack of educational opportunities, there is an increase in cesarean rates among AI/NA mothers. Providers often assume AI/NA mothers will need a c-section or induction, often failing to listen to the mother and her wishes to birth differently if it is possible and if it has no potential

impact on the infant's health. The participants described provider responses that often relayed a message that if they were American Indian, then they would have to have a cesarean. One mother described this,

> But I think that's just kind of the standard practice because there's the potential for risks during labor and delivery. Instead of evaluating that on a case by case basis, they're kind of just making blanket rules where if you haven't had the baby at this point, you're getting induced. If you have this, this, this going on, you're getting a C-section and just kind of really getting away from the more natural doing what our bodies were made to do type of thing.

Others explained that doctors outside of the tribal hospital were more willing to listen to them and that the providers within the IHS hospital were aware of the bias and did not seem to care. One mother described a doctor's response when she went to a well-baby check at the IHS provider after giving birth elsewhere, stating,

> When we had our first visit [at the tribal hospital, not where the child was delivered], their doctor said straight up, "If you would've had her here, you would've had to have a C-section. You wouldn't have been able to have her vaginally." So, the rates of induction, the rates of C-section, the rates of antibiotics during pregnancy, I think all of that is higher than what it would've been historically. There's obviously a need for that in some circumstances.

The participants described how they felt like there was no room for dialogue on their reproductive choices and how this lack of ability to interface with providers made them feel frustrated with the entire endeavor of giving birth. Even though they recognized there was merit in needing medical intervention such as c-sections and inductions, they felt like the rate was too

high within their community and that it had to do with the inability of providers to listen to them. The mothers also expressed how they felt like this inability to express their desires about birthing was another aspect of historical trauma wherein the colonizing doctors just wanted to do things their way and ignored the needs and cultural differences of the AI/NA community.

The Present Theme 3: Transportation and Becoming a Mother. Since many of the Keetoowah people live in rural communities outside of Tahlequah, the intersection of transportation and the experience of becoming a mother was a noticeable theme. Within the discussion of how transportation impacted becoming a mother, there were three main subthemes that connected plot points from the stories shared here. First, there was a discussion of how historical trauma had impacted transportation access for Keetoowah mothers. Secondly, the intersection of perinatal care and transportation as it related to not only access but maternal mental health was expressed. Finally, the circumstances of rurality and transportation impacted employment opportunities, that ultimately affected maternal mental health as well.

The Present Subtheme 3A: Transportation Access and Historical Trauma.

The women in this study expressed the lack of transportation, primarily for lower-income mothers, as a heavy burden that related to their experience of becoming a mother. For instance, one mother, who was a social worker describing what life is like for Keetoowah mothers she knows, said,

> Yeah, and that's interesting that you asked that because I just had a case where that was the mom was saying, "Well, I had no access to transportation." So, the problem particularly with the [organization] and prenatal care as far as [IHS hospital] is concerned is, your only option is [IHS hospital]. You can't go to one of the clinics. There's a lot of clinics now within the [Tribe], and the [IHS hospital] is available for the [tribe] or UKB

> tribal members. The problem being is that- that's generally, you're 45 minutes from [local town where many mothers live]. You're an hour and a half from [the clinics].

Another mother expressed that in her role as a social worker within the tribe, she witnessed how poverty, rural living, and lack of personal or public transportation impacted the use of perinatal care. She related,

> Being a social worker and working in child welfare, I've seen a lot of first-time parents that are having difficulty with transportation just to get to their appointments, and a lot of them miss their well-baby checkups and stuff.

In addition, the mothers discussed how living rurally and isolated from the tribal community without transportation can influence substance use during early motherhood. For instance, one participant shared, when asked how the lack of having personal or public transportation access influenced becoming a mother in her tribe,

> So, I feel like the reason why it's an issue is because the people that a lot of these women depend on or can dependent, they can't depend on because they have families that are drug addicts and they don't have the support that they need or they're just following in the cycle. So, that's where I feel like that, I'm from, and I see like a lot of the grandparents raising the kids too, and a lot of them are on fixed incomes and things like that. So, that's where I see those issues are.

Indeed, some of the mothers believed that lack of access to more urban areas, which was limited by lack of transportation access, exacerbated substance use by other mothers which ultimately influenced their maternal mental health as well. Another mother supported the thought that being cut off from economic mobility due to not having transportation led those mothers who lived more rurally to engage in substance use, relating,

> Oh, that's really helpful [getting out of the rural communities], because people don't have a ... A lot of people here never even left this place. So, like whenever they go to a place, the biggest place to go to is like Tulsa, maybe Oklahoma City. But they still never leave this place, and they don't know nothing outside of it.

Altogether, the influences of historical marginalization on rural land plots, as well as lack of transportation infrastructure and economic opportunities, intersect to contribute to barriers to becoming a mother for Keetoowah women who live in lower socioeconomic strata.

The Present Subtheme 3B: Perinatal Health Care and Transportation. For those who cannot afford to give birth or seek prenatal care outside of the tribe, this 20-mile average is something they have to deal with in order to seek care. One mother shared the distance needed to be traveled to access perinatal care, even with a personal vehicle, for those who may live in more rural communities, saying, “It's a 40-minute drive from Muskogee area. So we have [the tribal hospital], and it's a great facility, but we're talking about like an hour commute from most of these communities.” Furthermore, if they would prefer care provided by those that might be more culturally appropriate to them, they could not unless they could afford it out of pocket or have insurance provided by their employer. Due to the lack of transportation to other areas combined with the limitations of IHS service, mothers are forced to use specific perinatal care, which they may not prefer. That said, there is also the possibility that some mothers aren’t even close enough to a local IHS facility when they live rurally or perhaps in a different area with less IHS facilities. For instance, one mother described her privilege with having personal transportation and how that related to perinatal health care choice:

> I am very blessed that I do have my own transportation, and it wasn't a problem for me to drive an hour and a half to go to my prenatal appointment. But I can certainly anticipate

> that there are problems with Keetoowah in particular, who might not have access to a close IHS facility, and they might not have insurance to go and pay for it.

Similarly, those who had personal transportation expressed their gratitude for being able to access their perinatal care providers who were covered under IHS. One mother shared her experience with transportation, saying, “It was pretty easy. I mean, we had a vehicle at the time and either my husband would go with me or I would just go by myself.” Others discussed that while there were some public transportation options, they did not necessarily work for mothers who lived more remotely in the rural communities. One mother said,

> There is transportation available like with the KATS [KI BOIS Area Transit System], the KATS bus system, or whatever. But again, you've got to be able to have a phone or internet access to schedule that and you have to do it so many days in advance. So, I think that while we have transportation modes available to get there, there certainly are barriers that people in the lower-income communities definitely face.

The Present Subtheme 3C: Employment, Transportation, and MMH. In addition to reducing access to perinatal health care and limiting reproductive choices for Keetoowah mothers, limited transportation access also created hardships for obtaining and keeping gainful employment and economic mobility, which ultimately impacted their maternal mental health as well. Many of the mothers indicated having access to a personal vehicle. However, their positions within the tribe afforded them constant interaction with other mothers who did not have the resources to have a personal vehicle and, therefore, were limited in employment opportunities. Furthermore, not having personal transportation but needing to attend perinatal visits meant that for some mothers long waits for any public transportation or coordinating personal rides with family or friends meant they jeopardized the employment they did have.

Inevitably, this meant many mothers did not attend all of the perinatal visits they needed to, which increased the likelihood of not being screened for PPD or other health issues. One mother explained this, saying,

> I mean, luckily, I am in a position where taking off work wasn't a big deal, because I had them manipulate my schedule and I can do what I want. But, for someone who is pregnant and who has a very strict schedule that they have to follow and it's hard for them to miss work because you're going to have to miss work to your prenatal appointments and you have to miss work for your maternity leave. So, I can only imagine how difficult that might be for some people.

The mothers described here how important having access to transportation is to their upward mobility and mental health. Not only was personal transportation almost necessary for employment during the perinatal time so that they could attend appointments without missing work, but quality personal transportation also remains an issue for Keetoowah mothers postpartum as well.

The Present Theme 4: Coping, Resilience, and Tribal Community Support. Despite numerous barriers to becoming a mother within the Keetoowah community, the mothers also expressed innumerable strengths of the tribe and the culture. These cultural values that support the importance of mothering, children within the tribe, and continuing on the traditional culture shone through when the mothers were asked about their postpartum support. One mother said simply, “I mean, culturally, and within our tribe, we are all close, and if anybody did need help, we would be there to help.” Others validated tribal and community support, with one mother relating,

> At our center, we give out all the support we can. We tell them if they need anything, all they have to do is ask. We're there as not just teachers for their kids, but supporters for the parents too. If they need anyone to talk to or a shoulder to cry on, we're there for them. We're really close to our parents, and daycare is like that.

Another mother shared that the tribe and community had been a great support to her and was necessary for her maternal mental health,

> But as far as community, I feel like it was great. I had a lot of family and friends came up for everything the whole time. That's why I moved home for this last baby, one of my reasons why I moved. Because I have a good support as far as family.

The community was not only supportive of emotional and tangible support but also with spiritual and cultural support. The mothers explored the importance of needing companionship with other women from the same culture who understood the spiritual component of mothering and described how even though they found this important, it was often hard to connect with those who shared their spiritual and cultural values. For instance, one mother shared,

> But as far as help, there's a few of ceremonial women that I can look up to. There's a few tribal people that I look up to. I hang around with a lot of older people than my, older people. I try to keep them, keep them in mind when I have these issues, because I know it's, it made me want to pick up the phone and call my mom.

Furthermore, the mothers felt comfort in being with people who understood them and felt companionship being around others who were Keetoowah. They discussed how the support of people in the tribe alleviated stress for their families and helped reduce mental health issues and fatigue. One mother exemplified this, saying,

> Yeah. And then the tribe, I know my cousin who had a baby a couple of months before me, his wife is Keetoowah too. We're all Keetoowah. The Councilman went and bought her a stroller and stuff. So, I knew if I needed something, which I don't, thank God, that I have the support of the tribe too.

Overall, one of the most salient coping mechanisms during the postpartum period for the Keetoowah mothers was the feeling of belonging among other Keetoowah people and having access to other women who understood their cultural values and parenting positions. This kinship amongst their peers allowed them the freedom to mother in ways they felt appropriate and ultimately increased their ability to become mothers in a more culturally relevant way.

The Present Theme 5: Spirituality and Becoming a Mother. Beyond the kinship and spiritual support of other Keetoowah mothers and the tribe, spirituality from both more formal religious involvement as well as Keetoowah spirituality provided the mothers with a coping mechanism which not only helped them through any postpartum mental health issues they may have had but was also infused into their process of becoming mothers. They described how prayer helped them feel safer and more comforted with the process of pregnancy and birth, as well as with entering motherhood with a new infant. A few of the mothers explained that their spiritual commitment had grown since becoming pregnant or having a baby, as one mother related, “So, I definitely have prayed a lot more to God since I have been pregnant and since I have had a baby.” Another explained that spirituality was infused into all aspects of becoming a mother for her, including even prior to becoming pregnant, she said in response to a question asking her what helped her through the process of becoming a mother,

> So yes, I have definitely prayed a lot more since getting pregnant. I was very blessed in that pregnancy was very easy for me. My husband and I just decided that I would stop

> taking birth control, and we would start trying for a family. Literally, one month after being off birth control, I got pregnant. I knew that statistically, there was a 25% chance I would lose the baby up until 12 weeks, and I knew that, and I was prepared for that. But that never happened. So, I was super thankful and blessed for that, because I had so many friends, so many friends that have struggled with miscarriages and infertility and stuff like that. So, I was so thankful. Just praying that he would be okay and that he would be blessed.

Other mothers shared their experiences with spirituality after their child was born and discussed how it was not only a source of strength for them with their mental health but also helped them feel at ease and feel closer to their babies. A mother revealed,

> [I prayed] He [the baby] would know God, and I prayed for him every night. And I just prayed God watches over him, and God has a relationship with him. So yes, it has definitely strengthened my relationship with God, and it's also made me realize so much more.

Another said,

> We don't really go to church, but I was always taught you don't have to go to church to believe in God. Simply just reading your Bible at home will do. I believe in that a lot, but I do want to get more in church just to introduce my daughter to that, and she knows that part of her life. All of our family is big on God, and really big on all of that praying and stuff like that because that's a big important part of our life.

The loneliness of PPD was another aspect of becoming a mother, which prompted the mothers to turn to their spirituality and prayer. When asked what helped during the dark times of her PPD, one said,

> Yeah. I just prayed through it and seeing my way through. I asked for help, and other people helped me just by getting out and hanging out with my family and friends and seeing her there. That helped me because that was my reason God gave me her.
>
> I do believe that God had his hand in it because I had the best doctor, and I had my favorite midwife.

Many of the mothers emphasized the importance of prayer and spirituality to their process of becoming a mother regardless. One said,

> We are very, really religious, but we don't go the Native way. I know that the Natives have a huge, different culture on religion, and we're mostly like, I guess, the white man's way that we go to church and everything. We've always believed in God. I wouldn't really say it really played a big part on my pregnancy, but they were there. I mean, we always pray to God to help us get through things, and so I would say that He got me through the pregnancy, especially when [the baby] was not breathing when she was born.

Other mothers felt more comfortable engaging in traditional Keetoowah spirituality and religious practices for coping and support during their transition to becoming mothers. They expressed the importance of not only practicing spiritual traditions, but also of how essential it was to their spirituality to have a relationship with the land. This relationship was intrinsically tied to their spirituality because many traditional practices involved relating to the land and, therefore, to their process of becoming a mother. One mother explained this process,

> But other than that, as far as ceremonial, all my kids have, I've taken them to water within seven days after they were born. That's just to cleanse them, and to ceremonially, anytime you're surrounded by blood or death or certain elements in the world, we go to water and

> cleanse. So, it's kind of like a baptism; I guess if you were to parallel it to Christianity. And so, we took them to water, all of them.

Another espoused this important intersection of land, spirituality, prayer, and maternal mental health, stating,

> I grew up traditional. My family's from Flint Rock [traditional rural land]. So, I'm very spiritual. I believe in u nw lv nv hi, I believe in prayer. So, yeah, that's what gets me, helps me.

For the Keetoowah mothers who participated in this study, the ability to engage with their tribal community for emotional, tangible, and companionship support was essential to their experience of becoming a mother and acted as a coping mechanism for their maternal mental health struggles. Also, being able to engage in religious and spiritual practices, both traditional and contemporary Judeo-Christian ones, was essential to their BAM process. Prayer was involved even before conception and influenced their pregnancy, birth, and postpartum experiences. Beyond this, the connection of Keetoowah tradition and spirituality to the land, through both practices involving cleansing the newborn with the flowing water as well as having space to engage in dances and prayer, was crucial to their BAM process and highlights the significance of land to maintaining the ability to become a mother freely within their culture for Keetoowah mothers. Such a connection of land and spirituality becomes an issue not only of reproductive justice in that it intersects with their parenting choices, by way of being able to engage in their spiritual practices postpartum, but also environmental justice as having access to ancestral land which is spiritually important is a cornerstone of indigenous mothering.

The Present Theme 6: Maternal Mental Health. A salient aspect of BAM for the participants was their mental health. This theme encompassed their experiences with PPD, the

intersection of historical trauma with becoming a mother and their mental health, and their need to "be strong" in the face of mental health challenges prompted by historical contexts.

The Present Subtheme 6A: PPD Experiences. Seven out of the eight participants discussed experiencing PPD during their most recent pregnancy. Some of them discussed having mental health challenges as long as they could remember, others discussed being somewhat blindsided by PPD after the birth of their child. They discussed various experiences with PPD symptoms. One mother described her mental state in the postpartum period saying,

> Oh my gosh. So, I've always kind of struggled with anxiety and depression. I think whenever you do that, whenever you have those issues, before you have a baby after you have a baby and your hormones are out of whack, especially, at least my experience was if you're breastfeeding, my issues didn't go away until I stopped breastfeeding. So, in hindsight, I wish I would have recognized or knew that earlier. I think I still would have breastfed as long as I did, but those first few weeks were hard. Mentally you're all over the place.

Others described that despite having people in their lives to support them, PPD still prompted them to feel isolated and lonely. One mother shared,

> I would just get in my own head and think about stuff and second-guess myself and felt lonely even though I knew I wasn't lonely. I knew a lot of people were there for me, but that's just what it felt like to me.

Another mother described that she felt like since her main support, her mother, was no longer living, she didn't have anywhere to turn, saying, "Well, my mom's gone. She passed early. And so, I kind of slipped through the cracks. I kept, with this one, I had postpartum. And I hid it."

This hiding was present in many of the stories, and the participants hid for various reasons. Some felt they simply didn't have "time" to be depressed due to their hectic lives, such as this mother who said,

> I did a lot of hiding; I did a lot of withdrawing. And finally, I had to come to terms with this could be my family that's going to lose me, or I'm going to lose my family. So that and work, work stress, having a high stressful work environment. I just had to go with it. I had to go get on medication because I could, I was pretty close to suicide. After I came to senses, I realized okay, that's not me. And I went and got on medication.

Others hid because they felt guilty feeling depressed because they have more economic and educational resources than other mothers in the tribe. This guilt prompted them to compare their suffering to others, ultimately ruling that they didn't think they had the "right" to be depressed. On the other hand, this recognition of privilege acted as a metric for them to know they needed help with their PPD. One mother exemplified this experience with withdrawal, hiding, and seeking help with her PPD when she shared,

> I did because I realized… I live on 120 acres. I have a vehicle. My kids are taken care of. Why am I not happy? There's so many other reasons, and I've been down the rough road with the other kids' dad where they didn't work. It was me doing all of it. And here I have someone that was doing all of it, and I still couldn't be happy. So, I knew something was wrong with me.

Overall, the experience of PPD symptoms for the participants was similar to existing research in that they felt isolated and lonely. That said, the addition of knowing that many of their peers were not as financially secure or didn't have as much access to education as they did prompt guilt that kept them from seeking informal and formal support and services. Even deeper, the

mothers felt guilty for being mothers who had resources, which ultimately impacted the way they felt about motherhood, and their mental health. The intersection of historical marginalization among the tribe (such having higher rates of poverty and substance abuse) and finding success within the Westernized world created guilt.

The Present Subtheme 6B: Historical trauma. The past treatment of AI/NA peoples and, more specifically, mothers, was not lost on the participants concerning their transition into motherhood. Many participants expressed that although they recognized that they had PPD, they felt the experience was deepened by recalling historical trauma and how even being an indigenous mother was an act of resistance that was painstaking. They discussed how their cultural mothering practices and being denied the ability to be Keetoowah fully in their mothering was just a reminder of all that had also happened to their ancestors. Additionally, the mothers expressed how the dismissive and substandard perinatal care and support they received, including a judgement for mothering within their culture, was a continuance of the perpetuation of oppression and erasure of their unique experiences with motherhood. One mother expressed her relation to historical trauma when asked why she thought PPD was such an issue for mothers in her tribe, stating,

> I think it all goes back to; I think most of the issues that we face today in Native communities all go back to, I mean you have to evaluate how Indians have been treated for the past 200 years. While we may not have felt that specifically today, one, our ancestors did, so if you have done any research on epigenetics, it's literally imprinted on our DNA.

Another mother supported this, relating that the historical grievances perpetuated against AI/NA people were the root of maternal mental health issues and that ignoring the past when evaluating the current status of mothers in the tribe was deleterious. She said,

> I think it all goes back to the intentional attempt to annihilate the tribes and tribal members. I mean, you can't tear apart communities and strip people of their culture and expect that to go away in one generation. I think all of the, most of the issues we're facing today can all be tied back to that. Obviously, we're not holding people, necessarily holding people today accountable for stuff that happened in the past. But it would be stupid not to understand how past dealings are affecting today.

Another mother discussed the incongruence indigenous mothering had with western-colonizer parenting styles and how that has prompted a dichotomous approach to mothering within her community, sharing,

> Also, the effects of that are our communities now where we have higher rates of poverty, higher rates of unemployment. Parenting, traditional parenting, did not buy well with Anglo parenting. So, there was kind of a disconnect between what was appropriate and what was not appropriate. So, I think there's also kind of a; I don't know, I think we're still feeling it today.

Beyond the inability to mother in a traditional way due to cultural erasure and genocide, the mothers shared that historical trauma perpetuated by colonizers has created fragmentation in trust with care providers, that ultimately impacts their access to perinatal care and reduces their reproductive options. Even more so, they felt that this historical oppression made it hard for them to want to disclose mental health issues. For instance, one mother explained,

> Well, and it goes back to the disclosure and seeking help historically when you're told not to use your language or your culture of allowing your male child to wear long hair is inappropriate. So, we're just going to cut it, and we're just going to tell you, you can't wear it. You can't talk about it, you can't speak your language, and you can't go do your ceremonial dances because why should you keep children up all night long? Whenever they take that all away, why would then Indians go and try to seek help when every time they have, they've just been told, stop it. You're doing it wrong anyways.

Finally, the mothers expressed that they felt that historical trauma deepened the PPD symptoms they experienced, adding fuel to their anxiety, anger, and depression postpartum. In addition to the more documented PPD symptoms, such as worrying about the baby, feeling isolated and lonely, and feeling like an inadequate mother, they felt angered by what has happened and still happens to their people. Sharing this, one mother said,

> I'm so angry all of the time. I'm not violent. I'm just generally angry. I mean, that was my thing. It was like I was so resentful, and I was just frustrated, and a lot of it went back to anxiety and depression and all that stuff. But even, I think even if our more affluent tribal members are afraid to admit that and are afraid to seek help because they're afraid of the consequences, what do you expect someone with maybe a high school education who probably has a criminal history who can't keep a job, what do you expect them to do?

Despite experiencing PPD symptoms that seem universal, the participants had added symptoms, including anger and anxiety arising from historical marginalization. This added grief impacted their motherhood as it illuminated for them the juxtaposition of their motherhood experience with others in their tribe and sometimes created guilt.

The Present Subtheme 6C: We Have to Be Strong. Beyond historical trauma, the historical context of Keetoowah matrilineal society impacted the participants' experiences of becoming a mother as well. Even with assimilation, the values from their ancestors that insisted that women run the household remained salient for the mothers. The need to be the rock of the family promoted a silence of PPD symptoms as well as a distrust in providers to handle them appropriately. One mother described how the pressure to be a superwoman kept her from seeking support,

> Yeah. I mean, I'm good now. But it was definitely a big change from having this one to having my first, second, and third. And I don't know that if; I'm guessing maybe it's because I'm a little bit older. Maybe the hormones or whatever is totally different. It took more of a toll on my body. It was harder; it just hurt more. I was more tired. And so, I realized I wasn't a superwoman like I was with the first, second, or third. I had to learn to; it's okay to take maternity leave, it's okay to be at home. But I had, having a great man helped to alleviate some of that stress.

Similarly, even when friends and family outright recognized the symptoms of PPD, mothers discussed how they remained steadfast in their appearance of being the strong mother. Describing her dismissal of family noticing her PPD, one mother shared,

> My dad would come over, and I would be sleeping or something. He'd be like, "Are you all right?" I'm like, "Yeah. I'm fine." He was like, "You don't have postpartum, do you?" I was like, "I don't think so. I think I'm just tired."

Meanwhile, other participants recognize that the stigma of mental health challenges among AI/NA people is shifting, even if slightly. This shift allowed them to give themselves some grace, even if they still didn't admit their symptoms. Another aspect that contributed to their

silence was their standing in the close community of the tribe. The participants felt that if they were more involved in the tribal government or were in high community standing, it was harder to disclose their mental health challenges because they needed to present as strong mothers heading the household that much more. For instance, one shared,

> And we're kind of in a more of an era now that it's okay to say, but still at the same time whenever, I guess whenever you have a high stressful job, or you're in a spotlight … so we have to be careful. So, I think our reputation sometimes, depending on your reputation, you have to kind of keep some things under wraps. I think those were some of them. But I think maybe I was allowed to get a little bit; I think with more support, I wouldn't have got in deep.

Furthermore, they again discussed how the historical treatment of AI/NA people had left them not willing to share their feelings or trust non-indigenous providers, resulting in a cultural stigma of talking about mental health in general. One mother summarized the hesitance to discuss PPD, saying, “I don't think it's [PPD] talked about a lot. I think that there's kind of the sentiment where, well, I can just take care of it on my own. I don't need help or anything like that.” Another reinforced the resistance to sharing about mental health, revealing, “Okay, so I get medication, but I think the indigenous part of me doesn't want to talk to anybody because I know that they're not going to understand.” When asked if she talks to people about her PPD, one mother responded, “Not really. I just kept them to myself. I'm not big on expressing my feelings.” Others related that the lack of disclosure of mental health challenges was a feature of being AI/NA with statements such as “A lot of Native people are more keep everything balled in” and “Native people are more stubborn, like to come off as tough and like nothing can get to them.” This self-described stubbornness leads to internalization and a lack of seeking support for

PPD symptoms. When asked what perinatal care providers in their community can do better, one mother reported that she felt that AI/NA mothers experienced PPD more frequently, saying,

> There certainly should be a focus on it [PPD] because I know it's something I struggled with. I don't know. It's funny because I know that my non-Indian friends, some of them struggle with it too, but thinking about it, it's like those moms who are just fine and carry on with their lives, and they're able to go on trips with their baby. It's almost as if having a baby didn't affect them. But then I think about all of my Indian friends, and I really reflected on it. It's like man; I don't know any who have responded that well or at least pretended to respond that well to having a baby. My Indian friends really struggle with it.

Additionally, the resistance to disclosing PPD arose out of a desire to remain true to traditional practices that don't involve "western" medicine and use traditional medicine to support mothers who are experiencing mental health challenges. Some of the mothers felt that by telling providers about their PPD symptoms, they would be given psychopharmaceuticals and not be encouraged to engage in traditional medicine they felt was necessary to heal. One mother summarized this, saying, "I hid it [PPD] for a long time because I felt less than. I'm still trying to get that under wraps as we speak. And being ceremonial, you don't want to act, I rarely turn to medication."

We Carry On: The Future Story

When asked what they hoped for the future of Keetoowah mothering, the mothers had many shared themes across their stories of the future. First, they felt that education about child development, Keetoowah mothering, and birthing were all supports that could positively impact mothers within their community. Secondly, they felt that safe housing was needed to address the base needs of the mother and infant in order to create better mental health outcomes. Third, they felt that socialization efforts to increase interaction with other Keetoowah mothers and women

elders were essential to maternal well-being. Fourth, increasing the quality and access to transportation or addressing the lack of transportation for mothers in a variety of ways was expressed as a vital factor in bettering maternal mental health in their community. Fifth, the mothers articulated a need for the Keetoowah community to address mental health stigma and begin talking about PPD. Finally, the sixth theme relating to the future was that the mothers wanted to see an increase in culturally relevant perinatal care.

The Future Theme 1: Education and Becoming a Mother. Education among Keetoowah women was a prominent theme among the story the mothers wanted the future to tell. Within this were two subthemes, one regarding education surrounding how a child develops, and a second theme about education normalizing the birthing process along with teaching women, particularly young women, how to mother.

The Future Subtheme 1A: Child development. The participants felt that maternal mental health would be greatly improved for Keetoowah mothers if they had a better understanding of how a child develops. They discussed how not understanding child development could lead to more stress for a mother and may prompt her to think she is not a "good" mother even when her child might be doing something that was developmentally appropriate. They felt educating mothers, particularly young moms, on the stages of development would reduce stress in the household and reduce more physical disciplinary responses. When asked what she felt was important to improve maternal mental health, one mother said,

> Well, really, I think it comes down to education first and foremost. I think from the time that our kids are young, we need to start teaching them basic life skills of how to be a parent.

Another mother supported the need for child development education, particularly focused on attachment during infancy stating,

> We have a very high rate of teen pregnancy in that 14 County jurisdiction. I think that education needs to be brought on how to be a good parent because oftentimes you've had uninvolved parents, and then they get teenage pregnancies, and I feel like it's a cycle. It's a never-ending cycle. So education on how to parent. I would love to see our schools teach child development in school because I think a lot of people don't understand that. They don't understand the attachment that happens with babies, because babies know the second they're born whether or not they're wanted.

Beyond attachment, one mother felt that knowing what to expect from young children would reduce stress and maternal mental health symptoms, relating,

> I really do think that education is vitally important because we just don't have that anymore. So I mean, I think there needs to be more done and not just for Keetoowahs. Those child development classes that would be amazing to have because people just don't understand that two-year-olds aren't just saying no because they like to say no. It's a developmental thing, and I think it would help a lot of people with their patience if they understood the developmental milestones.

Equally important to educating Keetoowah women about how a child develops, other mothers felt that education focusing on comprehensive sexual education as well as educational opportunities for teens might delay the desire to become a mother so young within their community. One mother addressed this, saying, “But at the same time, I think our young people need more advocacy for higher education rather than just jumping in and having babies.”

Meanwhile, another mother supported the need for more educational opportunities in general for young Keetoowah women, replying,

> I think there definitely needs to be a higher, more education there. Luckily, I've been there, done it all so I can, I talk, I have a good relationship with my 17-year-old. And so, she's seen firsthand how hard it was for me to be a young parent, and to go to school. She's seen the struggle. I think that we need more advocacy and education, and to have them maybe think about giving birth so quickly.

The participants felt that educational opportunities, about mothering and child development, and also knowing the potential higher educational pathways for young mothers would decrease the number of teen mothers from their community and also shape the future of maternal mental health. The proliferation of comprehensive sexual education and child development courses would allow for young Keetoowah mothers to make more informed decisions about reproduction, both before getting pregnant young but also towards parenting and the process of becoming a mother.

The Future Subtheme 1B: What Motherhood Is: Normalizing Birth and Child Rearing. In addition to education surrounding sexual education and child development, the mothers expressed that having birthing and mothering education, particularly on the Keetoowah process of becoming a mother, would normalize their cultural practices and birth in general for the women in their community. The mothers felt that this normalization process would reduce maternal mental health challenges as it would better prepare mothers in their community for what Keetoowah mothering looks like. For example, one mother said her desire for the future of Keetoowah mothering involved the tribe having a stronger relationship with the pregnancy and birthing process, saying, “And, what pregnancy is like, what birth is like, what having a baby

really is like. Because we're not exposed to the child birthing process as much as we used to be." Another mother reinforced the need for increased exposure to birth, answering, "So, I really think just education in general and start from a young age and normalcy of pregnancy, and I don't know, just education." In general, normalizing BAM for Keetoowah mothers was encapsulated in more than one story theme as it is present in many of the present themes as well, that call for the validation and normalization of their cultural mothering practices to address maternal mental health issues better.

The Future Theme 2: Safe Housing is Needed to Focus on Mothering. The future of Keetoowah mothering also relies on access to safe housing. The mothers often expressed that to focus on being a "good" mother or to address maternal mental health issues, the mothers in their tribal community needed access to safe, affordable housing first. Moreover, the participants described the dichotomous experience of going to a new well-funded healthcare facility only to return home to a domicile that was in ill-repair and increased stress for some mothers. One mother relayed this, saying,

> You can spend an hour a day at a brand-new healthcare facility, and then you have nowhere to go home to because you're homeless. So then your kids have no stability, and they have no sense of security. It just kind of perpetuates the issues that we've had for generations now.

Echoing this sentiment, another mother described that without safe housing, other efforts to support Keetoowah mothers might be lost, stating,

> We can have the best schools available with the most qualified teachers. We can have beautiful healthcare facilities that will provide you excellent care. But at the end of the day, if you have nowhere to go and put your head down, that's chaos.

Another mother described the importance of not only safe housing but safe, affordable housing that is proximal to schools to ensure that mothers are close enough to take their children and also be near employment opportunities. When asked what her story for the future of Keetoowah mothering looked like, she replied,

> I think number one, man, we need more housing, more safe, clean housing. I like the idea; the idea has been tossed around that the tribes buy up land around the schools and put tribal housing there. That way, they're right there by the school. The kids just have to walk. That would be my number one, housing with running water and electric because you really can't focus on anything else as a parent if you can't do those things and getting food on the table.

Not only was an increase in housing efforts important to the mothers, but also programs that actually worked for mothers in their tribe. One mom explained that even though they are often given opportunities for a house, access to those programs come at a cost that not every mother can afford. She said,

> I mean housing would be absolutely, and not housing in a sense that "Oh, go buy a piece of land, pay off your mortgage, and then we'll put a house on it." Like no, that might work for middle-class individuals. Sure. Maybe. But I mean the people who really need it are the ones who have exposed insulation on their walls without any sheetrock, they're not going to be able to buy a piece of land. So that frustrates me. But housing number one.

The Future Theme 3: Socialization and Becoming a Mother: Tribal support.

Although the mothers were grateful for the support of the tribe and the Keetoowah community, they also felt that efforts to increase socialization of mothers in a cultural and spiritual way

would support better maternal mental health outcomes and create a more culturally responsive BAM experience. When telling their hopes for the future story of Keetoowah mothers, the participants described ways they felt Keetoowah women could be more supportive of each other. One suggested,

> Like, you know, there are a lot of teenage pregnancies, you know. It was pretty common. A lot of my best friends or my best friend and a lot of my cousins all have kids when we were in high school. So, I know that as a teenager, you definitely don't have money to buy stuff. So, it'd be cool to have tribal baby showers and get to meet other mothers who are expecting just like you and just people to come out. So, you're not alone.

Another mother voiced a desire to see more support from women within the community and suggested that a more systematic approach to being able to reach community support would be valuable to new mothers. She stated,

> Can call out to these women, and these women are going to show up, they're going to be there. So after you have your baby, they're going to come and help you cook a supper for the rest of your family. Or you need a ride, and they're going to show up. Or you, they have a list of resources if you can't afford a pack of diapers.

Another mentioned the necessity of the support of tribal women when there was an absence of other maternal figures in their lives,

> I would like for that one to have a support system really for, and maybe an older women's support system or a middle-aged to older women supports where people like me who don't have their mom, or maybe they are not in a good relationship with their mom.

The perinatal period for these women, especially when they experienced mental health challenges, was isolating and lonely, which was exacerbated when there was a lack of maternal

figures to reach out to for support. Since the participants recognized this, they expressed that the future story of Keetoowah mothering meant that they could act as those maternal figures for others and felt that creating a system of Keetoowah mothers who would support one another would be a goal worth engaging in the future. Describing her ideal future supports for mothers in her community, one summarized this goal, saying, “It's easy to lose yourself in that time set. So some kind of support, a better support system with a women group.”

The Future Theme 4: Transportation Avenues. Since a salient theme of the present story of BAM among Keetoowah mothers was transportation access, it was only natural that the future story included ways to increase either transportation access or home visiting services for new mothers in the Keetoowah community. When asked what the future story should look like to better support Keetoowah mothers, one said,

> Probably offer more support for new mothers, maybe even start a service where they can go and check on them, those that don't have transportation, just to see, even offer them if they have an appointment like, "Hey, I can come pick you up at this time."

Others described that the future of BAM for Keetoowah mothers needed to include better access to public transportation options. Many of the mothers expressed this desire, one described her suggestions for increasing this access,

> Aside from having a shuttle, which is kind of like instead of just the KATS [community transit] where you've got to schedule your appointment, if there was a shuttle that was like, okay, here's the shuttle that runs from Hastings to Stillwell, here are its times. Get on the bus. I know that the KATS system is I think 50 cents one way maybe. Well, in town there's still a fee for it to have to use it. So if there was some sort of shuttle system from

> the hospital because that's where you have to go to Hastings to get your pediatric care as well.

Another mother related that navigating doctors visits when you have newly had a baby was difficult enough without personal transportation and she felt that in the future a more streamlined approach to public transportation access was needed, stating,

> So if you've got to take your child to those first couple of weeks, man, you're at the doctor every other day. Yeah, if there were a shuttle, a free shuttle that went to and from the communities, and there were times. I mean that almost seems more effective than KATS because I don't know. That would be helpful to me. Like if they could at least get to the bus station or the shuttle stop and then not have to worry about getting to the actual facility, I think that would be helpful.

In addition to increasing public transportation access, the mothers felt that a free service was necessary for those mothers who couldn't afford any of the existing options, even if they did work for them regarding scheduling. One mother thought, "Maybe offer like a free service because a lot of them I would say there's a KATS bus that you could catch or there's other buses, and they don't have any money to do it." Another echoed this when asked what would be most supportive in the future story of Keetoowah mothering, saying,

> You know, things like that [programs with transportation] would be great just for the pregnant women to help them get to their appointments or help them, you know, whatever. Just for you [during pregnancy] and then after birth.

The participants also expressed wanting to create an advisory board to discuss future transportation access endeavors and related that they felt that focus groups centering on the

experiences of Keetoowah mothers without personal transportation in the more rural areas of the community would be beneficial to future strategic planning on transportation access.

The Future Theme 5: We Need to Talk About This. Relating the present story of stigma and how they felt like needing to be strong and historical trauma, had reduced their likelihood to disclose mental health challenges, the future story the participants wanted includes themes of having more open conversations about mental health in their community. The mothers desired for more awareness efforts as they felt that talking about mental health challenges, particularly maternal mental health challenges, would help reduce substance use as well as promote general well-being in the community. For instance, one mother said,

> I think the depression, the rates of depression, and anxiety are pretty high in Native communities. But at the rate that it's talked about is pretty low, and nobody wants to admit that they might, not realizing, "Oh man, I've been sad and angry my entire life. What's going on?" Nobody really acknowledges those kinds of things.

Another related,

> So in that way, I think that if there were more conversations, there's a lot of conversations about the depression, but there's not really a whole lot about the anxiety. I think that for a lot of people that can manifest differently.

Mental health education and awareness efforts were something the mothers felt were necessary since many felt that women in their community didn't know what PPD was or how the symptoms of PPD were expressed. When asked if she thought that Keetoowah mothers needed more screening for PPD, one mother shared, "I think so. I think more education on postpartum, and for women to be okay with admitting that they have postpartum." Likewise, many of the participants felt that the mental health challenges they faced were similar to other AI/NA

communities and that even though some of the more rural communities were more culturally connected, they still faced the same challenges that came with historical trauma such as poverty, substance use, and depression, They felt that this warranted the need for more culturally centered conversations surrounding mental health, regardless of how traditional people were. One mother who was also a social worker described this,

> But I mean you go out into these communities and the higher blood quantum, more culturally connected communities, and it doesn't look any different than a reservation out on the West coast or out in Arizona or New Mexico. We have those same issues [mental health and substance use] here. It just appears to be on a smaller scale because of how our Indian country jurisdiction works.

Overall, a need for interventions targeted at talking about mental health in culturally appropriate ways was defined as a need and something the women wanted to be a part of the future story of not only BAM but for Keetoowah people in general.

The Future Theme 6: Culturally Relevant Care. The final story theme relating to the future that the participants wanted to see was culturally relevant care. Much related to the previous theme, wherein they felt that mental health should be a larger conversation in their community, they felt that the best way to target mental health challenges in the future was with culturally relevant care. Furthermore, the mothers wanted to see people who looked like them and were fully aware of the culture in their community. Historically, they felt that psychopharmaceuticals had been over-prescribed as a result of not understanding culture and how their traditions could be integrated into mental health care. When asked how to better support mothers experiencing PPD, one mother replied,

> Come and tell us what's going on, and then we'll give you a pill to take when we already have higher rates of opioid abuse and substance abuse and all that stuff. It just goes back to treatment not being culturally appropriate or not taking culture and history and all of that into consideration when you're formulating these plans, treatment plan.

Others described that the hesitance to see mental health providers would be shifted if the providers were Keetoowah or they saw them as peers in some way. One mother described her ideal future for addressing maternal mental health in the Keetoowah community, saying,

> That would be the magic wand thing where, because I mean you could say, I mean, okay, so when you say that you're a doctor for those types of things, we kind of naturally just shut down. But if you're sitting there with an older woman or someone of experience, I think I'm rather going to open up to them than to open up to some shrink who doesn't know nothing about my culture, doesn't know nothing about my life. And how are they going to fix it when they don't know me or my life?

The future story for these mothers always centered around knowing their culture and how ensuring those working in their community as well as those in their community knew the importance of their cultural traditions. A salient point of their cultural values was to see betterment for their people and that the new generations could be able to provide that if they had cultural and higher education. To encapsulate the importance of culture and their well-being as mothers and women, one mother summarized,

> As a Keetoowah woman, I would want my daughter raised as knowing her tribe and to better our tribe for everybody else. I know, right now, we're coming from the bottom and we just need to fight to the top and to have better education for our Native American children.

This theme within the future story demonstrates the importance of culturally relevant care to the future experience of BAM for Keetoowah women and stresses the importance of culture and reproductive justice. Without an understanding of their culture, those providing perinatal care as well as mental health services cannot fully present the options of BAM for Keetoowah mothers. The lack of culturally relevant care diminishes their capabilities as mothers and impedes their reproductive choices. As such, going forward, culturally relevant care is one pathway to increasing reproductive justice within this, and many other AI/NA communities.

Conclusion

These findings encapsulate the context of the time continuum of BAM for Keetoowah mothers by relating the trauma and strengths of the past to the problems and resilience of the future that then translate into the hopes and desires for the future. The next chapter will place these findings in the contexts of the current literature, practice, research, and policy.

Chapter 5. Discussion and Implications

The shared stories of these mothers highlight so many poignant aspects of BAM by tying in the past, present, and future experiences among Keetoowah mothers. When framed through both the historical trauma and reproductive justice frameworks, the findings in this study highlight the necessity of addressing how indigenous mothers have historically been denied access to their motherhood, which is not only inhumane but also serves as another agent of cultural erasure and genocide. The past story of motherhood for Keetoowah women describes a time when they had more opportunity to practice cultural traditions in mothering as well as unearths a vibrant cultural tie to the beauty of all aspects of reproduction, including conception, pregnancy, birth, and parenting. When juxtaposed against the past, the present maintains some of the cultural heritage infused into the experience of BAM for Keetoowah mothers; however, their motherhood has been shaped by forced relocation, land allotment, marginalization, poverty, transportation and educational opportunities, high rates of substance use, and an infiltration of Euro-centric technocratic perinatal care which denies them the ability to maintain their cultural mothering values. That said, the cultural values these mothers have been able to retain have been a source of resilience despite colonization, and cultural spirituality and traditions offer strength and support for Keetoowah women. This resilience is what allows them to look toward the future and maintain their values of ensuring their people have access to their culture and community and the strengths that come with that.

Just as highlighted within these stories, perinatal care disparities within marginalized communities have come to light due to the ever-increasing maternal mortality rate in first-world countries despite access to higher-quality care (Ozimek & Kilpatrick, 2018; Truschel & Novoa, 2018). Literature evaluating the disparities in perinatal health care among historically oppressed

women supports the need for more culturally relevant training and inclusion to address better the maternal mental health needs of these populations (Edge, 2010). In addition, the importance of cultural responsiveness to building rapport with mothers seeking perinatal care is essential to increasing access to maternal mental health services for them (Edge, 2010). Multiple studies have illuminated the importance of culturally responsive perinatal care in increasing the likelihood that those women who experience PPD will seek mental health care (Knudson-Martin & Silverstein, 2009; Maxwell et al., 2018). Additionally, the inability to experience BAM in a way that aligns with a mother's culture can influence maternal mental health outcomes and increase stress for the entire family (Henshaw et al., 2014; Sockol, Epperson, & Barber, 2014; Vanvaria & Singh, 1983). The lack of provider focus on mothers highlights the erasure of indigenous mothering that continues to happen today. Such dismissive care and paternalism perpetuate an agenda that prevents mothers from being fully informed about their reproductive options, such as prenatal testing, and continues to engender inequities in mothering ability and perinatal access.

The maternal mental health experiences of these mothers elucidate the impact of acculturation, cultural genocide, and erasure, and historical atrocities committed against AI/NA people. It illuminates how their experience envelopes historical trauma within their PPD symptomology. Additionally, ancestral matrilineal culture wherein the mother was the center of the household is still present within their values. However, it sometimes prompts the inability to ask for help, even during mental health challenges. Furthermore, the dismissive care and erasure of AI/NA people has influenced the hesitance of AI/NA people to disclose mental health challenges. When examined through the reproductive justice lens, these experiences with PPD illustrate how AI/NA mothers have not been able to parent with dignity in the way they desire, as

well as the inability to mother in a safe environment that allows for free expression of mental health challenges. Moreover, continued attempts at erasure of indigenous mothering act to continue the violence that has been executed against AI/NA women since the first Europeans settled in the United States. This violence means that AI/NA mothers have never been allowed to mother freely, which ultimately impacts their mental health.

Moreover, the experience of historically being denied the ability to reproduce freely (e.g., coerced sterilization) has contributed to hesitance to trust perinatal providers, especially when the rates of inductions and c-sections are so high among AI/NA populations. This lack of trust the participants in this study expressed is commonplace for many historically oppressed mothers, particularly African-American mothers as they also share the historical experience of forced sterilization, forced procreation, and inability to access quality, unbiased reproductive care (Maxwell et al., 2018; Patel, 2017). Latinx mothers also experience hesitance to trust perinatal care providers due to perceived racism experienced in care settings (Dominguez et al., 2008). Through historical trauma and reproductive justice frameworks, the findings of this study relating to the inability to trust perinatal providers as well as a lack of listening to indigenous women's perspectives on BAM become more apparent, and many other marginalized women experience this.

The maternal mental health experiences of the women in this study highlight the similarity and unique experiences of the Keetoowah women to other historically oppressed mothers. Similar to the stories in this study expressing the importance of having consistent providers so that they know the mother's culture, mothers from other marginalized groups have expressed the need for culturally consistent care in order to allow for them to feel comfortable and also to not have their symptoms lost in translation (Corbett, 2013; Maxwell et al., 2018).

Experiences of loneliness and isolation while enduring PPD that the women shared in this study are also experienced by a large population of mothers who have PPD, in addition to the link between unemployment, isolation, and higher PPD rates (Doe et al., 2017).

The unique distinctions of the mothers in this study from other historically oppressed mothers' experiences of PPD in existing literature lie primarily in need to engage in traditional birthing practices that were consistently dismissed by providers. No doubt, other indigenous mothers experience this dismissal of culture, especially in more culturally-assimilated places (Clarke, 2010). However, the unique need of the Keetoowah women lay both in the unique position of the power of the womb and in need to connect to the land to carry out their traditional practices of BAM.

The relationship of historical trauma to the mother's experiences of BAM is one finding that, while unsurprising, is unique to extant literature surveying risk factors to PPD that relate to BAM. However, when broken down, there is plenty of literature to support the relationship between BAM, PPD, and individual facets of historical trauma. For instance, racism, poverty, and traumatic stress— all of which are products of historical trauma—increase PPD rates (Abrams, Dornig, & Curran, 2009; Kozhimannil, 2011; Seng et al., 2013). Furthermore, denying access to reproductive rights is not new, however, keeping indigenous mothers from practicing culturally relevant aspects of BAM— pregnancy traditions, birthing techniques and spirituality, postpartum mothering—are all continued efforts to deny indigenous mothers their ability to reproduce in the way they see fit and continues to erase their culture. When considering how prevailing PPD risk factors in the literature relate to aspects of historical mistreatment, it illuminates the ways in which historical trauma contributes to maternal mental health challenges for the Keetoowah women. The future story the mothers told highlights the need to address

historical trauma and how it is still unfolding within their community. The inability to mother the way they want because they do not have access to quality housing further stresses the intersection of historical marginalization, poverty, and the failure to BAM in a culturally saturated way. This once more points to ostracism from mothering that Keetoowah mothers have experienced as lack of safe housing is something that keeps them from mothering to their full potential and doesn't allow them to be a part of the conversation which is often more present regarding more mainstream media on mothering.

It seems the Keetoowah mothers are also not alone in their hesitance to talk about their PPD struggles with those close to them or to more formal providers since many other culturally homogenous groups experience similar expressions of "needing to be strong" for their families. For instance, Latinx women also feel responsible for "healing" themselves from postpartum depression and recognized that the inability to share their experiences with others, due to stigma, had amplified their PPD symptoms (Hayden, Connelly, Baker-Ericzen, Hazen, & McCue Horwitz, 2013). Although the mothers in this study related that they felt there was a need for increased culturally relevant conversations about mental health challenges, they also simultaneously described a self-defined stubbornness to share, rooted both in cultural values of maternal leadership but also in distrust of white, westernized mental health care providers. This sentiment is echoed by other mothers who are ethnic minorities, for instance, African American mothers expressed that although they may avoid more formal maternal mental health care, they espoused the importance of talking about mental health challenges among mothers (Abrams et al., 2009)

Despite this inability to speak about their mental health challenges to providers, the women in this study defined the support they receive by being a part of a culturally homogenous

group and their spirituality as the coping tools they relied on toe get through both BAM and PPD. Indeed, their spirituality allowed them to strengthen their maternal identities and reinforced their commitment to motherhood, two important aspects of BAM. Mothers in other cultures have also conveyed the importance of spirituality to the journey with role shifts to maternal identities (Gohman, 2015) and spirituality has been essential to other's processing of PPD (Gonzales Sifuentes, 2012; Keefe et al., 2016; Oates et al., 2004). The need to integrate spirituality into the transition to motherhood and the ability of spirituality to help cope with maternal mental health challenges promotes the necessity of interventions that consider the importance of spirituality, either religiously inclined or not, to the experiences of BAM and ultimately, maternal mental health outcomes.

Although the coping and resilience from cultural and spiritual support were positive aspects of living so close to the tribal center, living within the area still presented transportation challenges that the participants felt inhibited Keetoowah mothers from being able to mother freely. Lack of quality and accessible transportation, public or private, already creates barriers to marginalized communities. Still, the intersection of perinatal care access and the stress that arises from navigating these systems is exponential for those who reside in more rural areas. Due to a relative lack of transportation access, aside from some community transit that could be scheduled in the more urban areas of Tahlequah, choice in perinatal care, as well as the birthing environment, is limited to those who have more economical means or access to personal transportation. This limit in transportation highlights again the intersection among those historically marginalized to rural lands, their lack of economic mobility, their ability to engage in the community and access to preferred quality, culturally relevant perinatal care. The daily stress of trying to navigate limited, if any, public transportation options can impact mental health for

mothers (Callister, Beckstrand, & Corbett, 2011). Indeed, mothers who belong to marginalized groups are less likely to seek perinatal mental health care due to logistical issues with transportation (Stevens et al., 2018). Maintaining social engagements, social relationships, and connections within the community are essential to AI/NA people's culture and can be accomplished through access to transportation and transportation opportunities (Lowe, Liang, Henson, & Riggs, 2016). Women of color have less access to transportation, which impacts both individual and community outcomes (Women of Color Network, 2016). Social support after the birth of a child is critical for a mother during her maternal role transition as it provides her with both emotional and instrumental support, as well as spiritual connection (Elter, Kennedy, Chesla, & Yimyam, 2016; Keefe, Brownstein-Evans, & Rouland Polmanteer, 2016). Furthermore, the ability to connect with family and friends, as well as cultural supports for AI/NA women postpartum, is critical to community-level health and sustainability. Transportation access appears to be a crucial and overlooked factor related to the high prevalence of postpartum depression among AI/NA mothers. In addition, since many AI/NA cultures rely on collectivist child-rearing, evident in the findings of this study by the importance the mothers placed on engaging with other women who were within their culture, limited access to transportation can reduce a mother's ability to engage in such culturally appropriate perinatal socialization.

Limitations

The results of this study should be interpreted in the context of its limitations. The study parameters were very narrow, so the pool for potential participants was quite small when considering the need to be enrolled in the Keetoowah tribe, having had a child within the last two years and being over the age of 18. There are many more new mothers within the tribe; however, many of them are not yet 18 years old, so this limited the available population of participants.

Furthermore, due to the rurality of many of the potential participants, many of them did not have cellular phone service that limited their ability to contact the researcher even if they had expressed interest in participating in the study. As such, the sample size of eight participants is smaller than originally targeted. However, the data reached saturation, and story inquiry often uses smaller sample sizes, including case studies.

Another notable limitation of this study is the relative lack of demographic diversity. Even though the study parameters required that the mothers be Keetoowah, which limited the ethnic diversity, there was also a lack of diversity in education levels, since most of the participants had at least some college. This distinction means that this study may not include mothers who are child welfare engaged or enrolled in substance use treatment, which may lend to a unique experience of BAM. In addition, most of the participants that engaged in the interviews did not live in the rural communities, which means that their experiences of BAM are the only representative of those living in the areas closer to town and the IHS hospital. Furthermore, a larger portion of Keetoowah mothers is under the age of 18. As such, the findings in this study only highlight the BAM experiences of mothers who were adults and may miss out on the unique BAM experiences of teen Keetoowah mothers.

Implications

The findings of this study feature numerous implications for both social work practice and future research needed to enhance our understanding of both this specific population, the Keetoowah, but also of other AI/NA mother's experiences of becoming a mother.

Implications for Social Work and Other Care Providers

The importance placed on the need to have perinatal and postpartum mental health providers be culturally responsive within this study demonstrates the need for the social work

profession to engage actively and maintain a commitment to increasing the numbers of maternal mental health specialists and providers. Furthermore, social workers are often involved in multi-disciplinary teams in care settings, and part of their role could be to advocate for culturally derived care and welcoming of culturally appropriate practices. Social work educators could increase focus on maternal mental health within human behavior coursework and address maternal mental health issues in practice classes more fully. Furthermore, social work advocacy efforts addressing reproductive justice, at state and national policy levels for the inclusion of expanded reproductive rights and services can enhance the access that AI/NA mothers have to reproductive services.

To achieve such advocacy efforts a stronger focus on recruitment of AI/NA students within social work programs, notably ones that can provide training and internships within the student's home communities, could increase access to maternal mental health providers who are culturally aware of the unique challenges AI/NA mothers face during their experiences of BAM and PPD. More generally, a focus on culturally respondent care for perinatal providers beyond social workers, such as doulas, midwives, OBGYN's, labor and delivery nurses, and pediatricians, can enhance the BAM experience for AI/NA mothers and may reduce deleterious PPD affects.

Another avenue of awareness and advocacy that the social work profession can address maternal mental health disparities among AI/NA mothers is through continuous acknowledgment of the complacency in colonizing that the social work profession has adhered to. By acknowledging how social work has been involved in denial of reproductive justice to AI/NA communities, through engaging in non-culturally relevant care, by involving the child welfare system at disparate rates, or by not addressing reproductive rights directly as a primary example

of health disparities for ethnic minorities, social work can begin to craft a research and education agenda that is responsive to the unique needs of AI/NA people. Since AI/NA mothers aren't able to birth their children in the ways they want, aren't able to receive perinatal testing they want, and aren't able to mother the way they want (burying placenta, washing baby in river, forced c-sections and inductions, etc.) their reproductive rights are continuously denied. Additionally, through acknowledgment, the social work profession can begin to engage in more dialogue for transformative healing surrounding historical trauma. Such dialogue provides numerous opportunities to ensure advocacy efforts are in place not to overlook indigenous mothering since such dismissal leads to further cultural erasure as well as infringement on their reproductive rights.

Acknowledgment, which leads to transformation dialogue also has the capacity to ensure advocacy efforts to actively engage in community-based participatory research (CBPR) with AI/NA communities and that such research enterprises are conducted in ethical ways, grounded in decolonizing approaches which seek to benefit the communities wherein they take place. Other advocacy measures where the social work profession can engage with a goal of increasing maternal mental health outcomes is through recognizing the intrinsic relationship among indigenous peoples and the land and how land-based tradition impacts mothering and mental health. Advocating for indigenous peoples to retain tribal lands and for the US government to uphold treaties can help align social work with the goals of indigenous sovereignty as well as interdependence with the land.

Social work academic work focusing on increasing funding and awareness to create programs that allow AI/NA students to be trained in their communities with the goal of practicing within those communities is another implication of the findings of this study. Not only

will having culturally aware practitioners increase access and use of mental health services, but it would also diversify the approaches being used and reduce stigma among AI/NA communities. Those students who know their communities can propose methods of mental health intervention that may have more successful outcomes than other Euro-centric interventions traditionally used to address maternal mental health.

As part of increasing AI/NA social workers, interventions targeted at increasing the coping and resilience discussed in this study, such as traditional practices and spirituality, can be implemented more effectively. Advocacy for either the creation of culturally relevant birthing centers, such as one that exists in Arizona developed for AI/NA mothers there to give birth in a culturally appropriate way (Perez, 2015), or for implementation of similar services within existing perinatal provision structures is another avenue where social work can become involved in AI/NA maternal mental health.

Another implication for social work is to understand the importance of the intersection of transportation and mothering, especially for historically oppressed mothers and those living rurally. Either through creating programs to streamline transportation access or through advocating for transportation policies that support mothers and their perinatal care access, social workers can influence transportation access and therefore impact maternal mental health.

Implications for Research

Indeed, there are numerous implications for research that arise from the findings of this study as well. Since this study only focused on a small sample of culturally homogenous mothers within a specific geographical area, there are many other populations within the United States that may have similar barriers such as lack of transportation, poverty, and the impacts of historical trauma, which should be investigated to create more generalizable findings and to

expand this study's reach. In the same fashion, future research focused on the BAM experiences of AI/NA teen mothers would increase the knowledge base on the unique etiological forces contributing to such high rates of PPD within this population. To that end, evaluating provider perspectives on maternal care with primarily AI/NA populations may illuminate better potential interventions to address this mental health disparity. Evaluations of provider racism, as well as perceived racism experienced by AI/NA mothers, may also illuminate essential aspects of perinatal care that contribute to maternal mental health challenges. Research that appraises any statistical relationships between perceived racial stress and low birth weight or early term birth for AI/NA mothers may also provide insight into unique forces relating to indigenous maternal mental health.

Factors such as provider racism can illuminate how historical trauma contributes to PPD as well. Furthermore, research exploring how specific tribal groups of AI/NA mothers score on the Historical Loss Scale (Whitbeck et al., 2004) and the Historical Loss Associated Symptoms Scale (Whitbeck et al., 2004) in relationship to their scores on the Edinburgh Postpartum Depression Scale (Cox, Holden, & Sagovsky, 1987) might be of interest to quantitatively assess the relationship between the two. Beyond that, more research is also needed to evaluate the effectiveness of a community-based culturally relevant PPD intervention that utilizes the coping and spirituality described in this study. By understanding how impactful interventions that increase socialization and kinship among those with similar cultural and spiritual values are, the knowledge base on culturally relevant PPD interventions may lead to a decrease in PPD symptomology for these populations.

Finally, the findings regarding the impact of transportation on BAM and maternal mental health from this study elucidate the necessity for more research involving reproductive justice

and transportation access. Beyond studies involving abortion access and transportation, there is a paucity in research focused on mothering, perinatal provider choice, family stress and maternal mental health that uses a feminist geography approach. Future research that evaluates how women, and mothers specifically, navigate their transportation options in the face of sexism and violence while also mothering would lend to a better understanding of the intersection of transportation and maternal mental health.

Policy Implications

Advocacy for the inclusion of traditional pregnancy and birthing practices, including expanding culturally-relevant doula and midwifery care covered by either IHS or private insurance providers, can increase access to culturally appropriate perinatal care, particularly for those residing in more rural areas. Other policy advocacy involves increasing both maternal and paternal paid leave in the United States to offset potential maternal mental health challenges experienced by all groups, but disproportionately by AI/NA mothers. Beyond these efforts, expanding home visiting programs which already operate in more urban areas of the United States to areas which serve higher percentages of AI/NA mothers can offset some stress and support AI/NA mothers better postpartum, particularly if the home visiting programs are culturally sensitive. Finally, when viewed through the reproductive justice framework, another policy implication resulting from the findings of this study relates to the expansion of reproductive care access in areas with higher populations of AI/NA women.

Conclusion

This study evaluated the unique experiences of becoming a mother for a small group of indigenous women, the Keetoowah, within the two years following the birth of a child. Using both historical trauma and reproductive justice frameworks, the findings provide a unique story

of how historical events such as forced relocation, cultural genocide and erasure, forced sterilization, forced child adoptions, restrictions in reproductive access, land allocation, and poverty impact the maternal mental health of this group today. Within these stories, however, are also themes of resilience, the importance of culture and spirituality, and the support and hope of the tribe to overcome such losses. From these stories, there are numerous implications for practice, policy, and research. This research supports a call for social work to become more involved in advocacy of culturally responsive perinatal care and increases in the education of AI/NA social workers to return to their home communities to practice ultimately. Also, by acknowledging colonizing events, social work is uniquely positioned to create a transformational dialogue to heal historical trauma that would ultimately impact maternal mental health in many indigenous populations. Furthermore, the involvement of social work in acknowledgment of historical trauma has the potential for social work to create a healing research and policy agenda.

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Appendix A: Interview Guide

1. Would you please share with me anything about your traditions surrounding pregnancy or birth; either that you've heard from others or that you've experienced?

2. How do people in your tribe care for mothers after they've given birth? Has this changed since you've been alive? Has this changed since your parents or grandparents were alive?

3. Would you say the way people in your culture have babies is different from when you were young? How about from when your parents or grandparents were young? What would you say is different?

4. Will you please share your birth story with me?

5. What can you tell me about your experiences after your child was born?

6. Did you have had a hard time after you gave birth to a child? If so, what was that like? How would you describe your experience? Do you think this is an issue for your community?

8. If you could change the way people in your tribe go through pregnancy, birth, or taking care of babies, what would you change? Anything?

9. Will you share with me who or what helped you with your pregnancy or after your child was born? Will you share with me how you feel about your birthing experience?

10. Are there things that got in your way of your pregnancy, birth, or new motherhood that you would have changed if you could? For instance, what were things that may have limited your experience?

11.Will you tell me about getting around your area during pregnancy, birth, and after the baby was born? *Possible Prompts:* How did you get to your appointments?

12. Will you tell me about getting around to prenatal and postnatal appointments? What about getting to spend time with family and friends- how did you get there when you were pregnant, or your baby was very young? How do you get places now?

13. If you could wave a magic wand and have anything happen, what would you wish the wand would do for you or/and your people? *Possible Prompts:* What would you change about getting around your area? What would you change about the care your received before and after your baby was born?

14. Are there any other stories about pregnancy, birth, or young motherhood that you would like to share with me?