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Using Critical Ethnography to Explore Issues among Immigrant and Refugee Women Seeking Help for Postpartum Depression

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Critical ethnography was used as a pragmatic research methodology to explore the postpartum depression (PPD) experiences of immigrant and refugee women. We examined the social, political, economic, and historical factors that affected the help-seeking behavior of these women during PPD episodes. The critical ethnography method allowed participants to share their experiences with each other and afforded opportunities to the researchers to acknowledge and validate, rather than simply observe and record, their testimony. This study of PPD thus increased our awareness and understanding of the health issues of immigrant and refugee women.

Critical ethnography has become a well-recognized methodology for researching issues that are significant to nursing (Hardcastle, Usher, & Holmes, 2006; Holmes & Smyth, 2005). In this article, the authors propose that there is a need for a critical research method to explore the related problems of immigrant and refugee women who seek help for postpartum depression (PPD) and access to mental health care. Critical ethnography, guided by the principles of critical theory, engages in cultural critique, allowing us to examine wider social, political, historical, and economic differences that influence immigrant and refugee women's situations and thus shape their PPD experiences. Critical inquiry approaches are different from conventional methodologies as they represent new ways to contribute to knowledge that addresses health inequities and structural constraints. It is necessary to examine how broader determinants of health, such as social isolation, poverty, economic status, and discrimination, might affect immigrant and refugee women's lives. Critical

ethnography is a complementary, pragmatic method of exploring factors that influence women's decisions to manage PPD and the health care practices they employ. In this article we apply critical ethnography to explore the experiences of immigrant and refugee women and their help-seeking behavior.

DEFINING CRITICAL ETHNOGRAPHY

Critical ethnography has its theoretical underpinnings in critical theory (Carspecken, 1996; Quantz, 1992). In recent times, critical methodologists have expanded conventional ethnography to examine larger social, political, and economic issues that focus on power, oppression, and inequality (Schwandt, 1997). Although health care decision making in both health and illness occurs within a cultural context, factors such as social, political, historical, and economic differences influence the individual's situation and shape his or her experience. Thus, critical ethnography may be viewed as "ethnographic studies that engage in cultural critique by examining broader political, social, and economic issues that focus on oppression, conflict, struggle, power, and praxis" (Schwandt, 1997, p. 22).

Carspecken (1996) expanded the definition by highlighting that critical researchers have a value orientation and a critical epistemology that influences their work. He postulates that a key element of critical ethnography is working against power and oppression on two levels. On one level, the critical ethnographer works against oppression by revealing and critiquing it. Of equal importance, however, is the researcher's understanding that knowledge itself is a social practice and interwoven with power. Carspecken emphasized that, unlike conventional ethnography, critical ethnography research exists to refine social theory, not to simply provide a description of social life.

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Distinctions between Critical Ethnography and Traditional Ethnography

According to Thomas (1993), critical ethnography is a "style of analysis and discourse embedded within conventional ethnography" (p. 3). As a result, conventional and critical ethnographies share several fundamental characteristics as well as several distinguishing ones. Both traditional and critical ethnographies attempt to explain social phenomena from the participant's viewpoint, emphasizing local knowledge and experience, and both are interpretive in nature. A central element in both ethnographic and critical ethnographic research is immersion in the local context (Castagno, 2012). To grasp what participants experience as meaningful and to generate more insights, ethnographers seek deeper immersion. The researcher in the field can explore from the inside how people think and act in the different ways they do (Emerson, Fretz, & Shaw, 2001).

Thomas (1993) and Thomas and O'Maolchatha (1989) offered several distinctions between conventional and critical ethnography: (1) Conventional ethnography generally alludes to the traditions of cultural description and analysis that provide meanings to interpretations. "Critical ethnography refers to a reflective process of choosing between conceptual alternatives and making value laden judgments of meaning and method to challenge research, policy, and other forms of human activity" (Thomas & O'Maolchatha, 1989, p. 147); (2) Conventional ethnographers may often speak for their subjects, usually to an audience of researchers. A critical ethnographer's research task is to speak to others on behalf of his or her subjects as a method of empowering them by giving more authority to the subjects' voices. As a result, critical ethnography exists in an explicit framework that invokes a call to action and attempts to use knowledge for social change; (3) Conventional ethnographers observe culture for the purpose of describing whereas critical ethnographers do so to affect change. "Critical ethnographers celebrate their normative and political positions as means of invoking social consciousness and societal change ... they use their work to aid emancipatory goals or to negate the repressive influences that lead to unnecessary social domination of all groups" (Thomas, 1993, p. 4); and (4) Conventional ethnography assumes the status quo, whereas the critical ethnographer looks below the surface, disrupts the status quo, and problematizes the taken-for-granted assumptions by revealing operations of power and control. The critical ethnographer resists domestication from "what is" to "what could be" (Carspecken, 1996; Denzin & Lincoln, 2001; Madison, 2005; Noblit, Flores, & Murilla, 2004; Thomas, 1993). Madison (2005) commented that the ethnographer who resists domestication "uses resources, skills, and privilege available ... to break through the confines in defense of the voices and experiences of subjects whose stories are otherwise restrained and out of reach ... the critical ethnographer contributes to emancipatory knowledge and discourses of social justice" (p. 5).

Thus, the assumptions that guide the critical ethnographer's work are: (a) power shapes an individual's experiences, relationships, and daily living; (b) surface level appearances are not always what they seem to be; (c) marginalization and oppression exist; and (d) equity is valued with social change being possible (Castagno, 2012). The critical ethnographer challenges the status quo, empowers the individual to have more authority, addresses unequal power relations, and obtains new understanding through critical thinking (Carspecken, 1996; Thomas, 1993).

This research explores the PPD experiences of immigrant and refugee women after childbirth. It is concerned with social inequality and its goal is positive social change; by change we mean that centralized power will be distributed more equally. Thus the objectives of the research were best achieved through the critical ethnographic method. Critical ethnographic research has a value laden orientation. A value laden orientation implies that the critical ethnographer imposes a value system that places the studied culture into a wider frame of power relations and history that serves an emancipatory interest (Quantz, 1992). The researcher attempts to determine how his or her perspectives and values affect the research process. Thus the focus and process of this research has a political intent, and addresses issues of power, domination, inequality, empowerment, and voice (Carspecken, 1996; Creswell, 2007). The research questions were concerned with how immigrant and refugee women seek help and access health care and what external factors, such as social injustice, unequal social relations, unequally distributed health care resources, and inaccessibility of health care services for immigrant and refugee women, might contribute to the health care practices of these women.

THE CRITICAL ETHNOGRAPHY APPROACH—IMPLICATIONS FOR IMMIGRANT AND REFUGEE WOMEN

The unequal distribution of power and knowledge in Western society is particularly troublesome for women struggling with mental health problems such as PPD (Ardiles, Dennis, & Ross, 2008; Chui, Ganesan, Clark, & Morrow, 2005; Donnelly et al., 2011). Through internalizing their mental health label and diagnosis they become complicit in the subjugation and distortion of their own knowledge and self-representation (Ali, 2002). Therefore, in the research of immigrant and refugee women's mental health care experiences, emancipatory knowledge is significant as it enables individuals to change through self-reflection and a deeper understanding of their particular situation (Lather, 1986, 1991). Knowledge is especially important for immigrant and refugee women struggling with PPD, because through dialectical practices they learn to recognize and challenge the societal forces that have oppressed them in the past (Morrow, 2008). Immigrant and refugee women in this study challenged oppression by speaking out; they wanted to bring attention to their individual experiences of social injustice and unequal social relations.

They wanted to contribute to improving PPD health care services and delivery of these services to immigrant and refugee women in the postpartum period. Participants also gained transformative knowledge, that is, new knowledge that had the potential to transform them from passive struggling individuals with PPD to individuals that could actively advocate for women suffering from PPD.

APPLYING CRITICAL ETHNOGRAPHY

We draw on Carspecken's (1996) five stage process to illustrate the applied steps in critical qualitative research. The five stages are: compilation of the primary record, preliminary reconstructive analysis, dialogical data generation, description of system relations, and application of the system relations to explain the findings. Carspecken suggested that the five stages should be used loosely and cycled throughout the investigation. For an in-depth description of each stage the authors refer the reader to Carspecken's (1996) work entitled, "Critical Ethnography in Educational Research." In this research study, in-depth interviews were the primary method of data collection.

RESEARCH QUESTIONS

Carspecken (1996) recommended that research questions be general, comprehensive, wide-ranging, and amenable to modification as the research progresses. The research questions used in this study were:

1. How do immigrant and refugee women conceptualize postpartum depression?
2. How do immigrant and refugee women utilize available health care services and social support networks to cope with postpartum depression and its related problems?
3. How do contextual factors (e.g., social, cultural, political, historical, and economic factors) influence immigrant and refugee women's mental health care experiences?
4. What services or strategies could address postpartum depression care and treatment of immigrant and refugee women?

The experiences of immigrant and refugee women were examined within the context of their lives. A deeper immersion was sought to grasp what they experience as meaningful and most important. This examination prompted ontological and epistemological questioning such as: What is this experience all about? What is credible knowledge and how will it be used to better meet immigrant and refugee women's health care needs? Examples of questions used to gain a deeper understanding of a participant's social and cultural context and a description of her behavior, activities, and social relations were: Do you have friends or family living in Calgary? Who did you ask for help? Was it easy to get help to manage PPD? If it was, what made it easy for you to obtain help? If not what made it difficult?

DATA COLLECTION

To provide answers to the research questions within this qualitative study, in-depth critical ethnographic interviews and field notes were used to provide more comprehensive information. At the start of each interview we explained the project, answered the participant's questions, and asked for the participant's consent to take part in the study. Each immigrant or refugee woman was individually interviewed once for approximately 1–2 hours. The length of the interview was determined by the participant. Ten participants were invited from the initial 30 interviews to do a second interview. The second interview was done as a form of member check. Interviews were conducted over a span of six months.

Field Notes

Data for this study included information gathered from field notes made during interviews with immigrant and refugee women. Field notes comprised details of the social and interactional processes that make up the everyday life of a participant. Field notes involve inscriptions of social life and discourse. Inscriptions can reduce the complexity of the social world to written words that can be studied, reviewed, and thought about over and over again. Emerson et al. (2001) maintained that different descriptions of the same situation and events can occur because the descriptions involve issues of interpretation and perception. Thus it is not a passive activity of copying facts about what happened, but rather invites active processes of interpretation and sense-making of what is significant versus facts deemed not significant, ignored, or missed altogether. As a result, the same or similar event can be described for different concerns and purposes. Detailed and focused records were kept about the women's daily experience, their social interactions, and their decision making about their help seeking and management of PPD.

DATA ANALYSIS

Interview data and field notes were taped and transcribed verbatim as soon as possible following the interviews. To ensure accuracy, as data were obtained, transcripts were rechecked against audiotapes, corrected, and then a hard copy was obtained for preliminary analysis. We revisited the audiotapes frequently as "listening" to the women's narratives was the most powerful way to increase our understanding of their often complex experience. In the early stages of analysis, transcripts were coded to identify preliminary themes from the data, and a list of code categories was formulated for organizing incoming data. Code categories were refined as subsequent data were gathered. The reasoning process was iterative and also cyclic as it moved back and forth from data collection and analysis to problem reformulation and back (Sandelowski, 1995). In addition to an iterative thinking process, the elements of collecting, analyzing, and writing were pursued.

Dialogical Data Generation

In Carspecken's (1996) stage three, generating dialogical data, data are created through dialogue between participants and the researchers. Open-ended modes of inquiry helped the researchers interact with participants and interpret participant perspectives in a hermeneutic dialectic mode. Guba (1990) acknowledged that the hermeneutic approach focuses on data interpretation and refining individual constructions; while the dialectical emphasis is on comparing and contrasting dialogue between researcher and participant. Throughout each interview, participant and researcher discussed, negotiated, and decided on what the researcher understood to be the meaning of the data. On a number of occasions, further exploration with the participant clarified the researcher's interpretation and led to a deeper understanding of the participant's experience.

Power and Meaning Reconstructions

As mentioned earlier, critical ethnographies are concerned with the possession of power. Indeed, according to Carspecken (1996), "all qualitative studies should examine power relationships closely to determine who has what kind of power and why" (p. 129). Data categories were partially based on the meanings participants gave to their narratives; therefore we paid attention to the ways in which meaning was reconstructed. Meaning reconstruction is performed to help researchers clarify the impressions of their data and observations (Carspecken, 1996). The validation of meaning reconstructions is most credible when participants themselves construct them when facilitated in an open-ended way by the researcher. This was carried out during the second interview, where we further explored, negotiated, and clarified our interpretations with participants. In many instances this led to a greater understanding of their experiences. Conducting member checks on reconstructions to equalize power relations is essential to share meanings implied, either implicitly or explicitly (Carspecken, 1996). There may always be an element of ambiguity or doubt in what researchers interpret, therefore meaning reconstruction is necessary. To ensure rigor and credibility of this study the researcher employed member checks, critical self-awareness, and a recognition that the researchers' social position and perspective might influence the research (Lather, 1991). By paying careful attention to interpretations with achieved or agreed consensus by participants, the validity of content was confirmed.

A further consideration was "reduction of power inequalities among researchers and participants as a means of preserving the subjective validity of participants' statements, affects, and behaviors" (Hall & Stevens, 1991, p. 25). Oakley (1981) suggested a method to support mutuality in the interview. Mutuality requires that the researcher's actions and questions convey appreciation and respect for a participant's unique experience, as well as valuing her time and giving, in exchange, meaningful information from the research study that might be useful to the participant's circumstances. This was a powerful emotion for the researchers during the interviews as we felt privileged to enter these women's lives and used every opportunity to treat the ensuing relationship with respect. We sometimes found it difficult to terminate an interview because some women had so many complex problems and had shared so much with us. One participant stated she had never shared this kind of information with her own mother. Some asked if we could come back and visit again and several requested a summary of the project once completed. The women expressed that the research process had given them new knowledge and insights into their own experiences and thus new feelings of empowerment.

Member Checking

To determine the accuracy of the qualitative findings, member checking was done by reviewing the final results with participants. Informally, researchers engage in member checking each time they ask for clarification, elaboration, or verification of the evolving interpretation of data. Sandelowski (1993) asserted that "the member check involves a professional obligation to do good science and specifically an ethical obligation to support the participant's right to know" (p. 4). Thus participants verify whether the findings portray an accurate account (Creswell, 2007).

Positionality

The positionality of the researcher is acknowledged and incorporated into the research analysis. The researcher is an integral part of the research. We must acknowledge that our work and our words are grounded in the particular standpoints we occupy. The researcher must be aware of his or her own subjective experience in relation to those of participants; this awareness is key to acknowledging the limits of objectivity (Deutsch, 2004). Castagno (2012) maintained that critical ethnographers must devote time to issues of representation (how we describe our participants, data, and positionality). Critical ethnographers must consider that their ways of representing people and situations are acts of domination even as their work has the goal of ending domination (Carspecken; Noblit, Flores, & Murillo, 2004).

Positionality considerations have urged us to ask questions of ourselves such as: "How can we best represent these women's voices?" "Who does the research benefit the most?" "Will our work make a difference in these women's lives?" As Madison (2005) noted, "it is a turning back on ourselves" (p. 14) where we examine our purpose and method and any potential effects of the research process. These questions have motivated us to acknowledge our power and authority as nurses and researchers, and to accept a moral responsibility to account for our interpretation and representation of the information obtained from participants in the study.

Reflexivity

Reflexivity is an introspective process in which researchers constantly challenge themselves to see how their own perspectives are affecting the method, analysis, and interpretations of the

research (Lobiondo-Wood, Haber, Cameron, & Singh, 2009). Reflexivity acknowledges that (a) the researcher might have influence on or be influenced by the research, and (b) reciprocal influence is an important element of the research process (Lamb & Huttlinger, 1989). As knowledge is constructed, attention must also be paid to the process by which the research is produced and justified as knowledge. Reflexivity is not only about setting aside personal beliefs and bias; it provides an added dimension of integration and application of new understandings through critical thinking (Lamb & Huttlinger, 1989). We kept a journal to document how we perceived our own values and interests were affecting the research and for speculation about growing insights, feelings, and other emotions that were generated during the research.

Final System Analysis

Data coded in one category was at times seen to be relevant to other categories. The outcome of data from the initial analysis was a statement about a set of complex interconnected concepts and themes. This approach to data analysis was adaptable and evolving and helped us to systematically and rigorously develop code categories and subcategories. The initial analysis was used in the coding of subsequent transcripts. Team meetings were arranged to review and share reflections on interview conduction, personal feelings, and analytic descriptions. The final analysis concerned discovering specific systems relationships such as relationships between immigrant and refugee women's PPD help-seeking experience and the structural systems, such as "economic, political, and cultural structures . . . which are the result of external and internal influences on action" (Carspecken, 1999, pp. 38–39).

Four themes emerged from data analysis: (1) the conceptualization of PPD, (2) complex challenges in seeking help for PPD, (3) facilitators in seeking help for PPD, (4) intervention strategies for PPD care and treatment. As the intent of critical ethnography is to give voice to participants in the study, we offer exemplar quotes from each theme. Other findings are reported elsewhere.

RESULTS

Theme 1: Conceptualization of PPD

There was some awareness of PPD within this group of women, however, it was identified that for many ethnocultural groups the concept of PPD was nonexistent in their country of origin. A number of participants voiced that in their home country PPD was not a common event after childbirth. Kate admitted that her level of knowledge was limited concerning PPD:

> Even though I'm educated I didn't know that there is something called postpartum depression. I was so suddenly alarmed and scared. Am I turning into an evil person? Am I a bad person? So somehow I should change this . . . How do I do that? I had no idea that many other women are facing this . . . I never went through an episode of depression before this.

Many of the participants acknowledged that there were many different understandings of PPD and much depended on their life experiences. Although they were able to identify causes and had a general understanding of PPD there was reluctance, along with fear and confusion, to acknowledge they were depressed. Participants expressed that it was difficult to acknowledge emotional distress because of the cultural stigma attached to a mental illness such as PPD:

> In my culture, they don't believe in postpartum depression. They say, "Everybody feels it, but they come out of it . . ." I never got help or explained my problem to any Indian woman because I know how they think . . . they wouldn't understand. As a joint family, you tell anyone in or outside your home, people start to talk. "She is feeling this way so maybe she's going crazy" . . . slowly the problem gets bigger. That's why we hide this.

Most participants felt that the cultural stigma attached to PPD and help-seeking prevented immigrant and refugee women from seeking help. It was felt that, in many cultures, negative feelings about mental illness made it difficult to acknowledge needing help within the family; therefore, seeking treatment such as medication and counseling became problematic.

Theme 2: Challenges in Seeking Help

For many of the immigrant and refugee women, the multiple changes they were faced with, simultaneously, during the migration experience increased their vulnerability to PPD. Participants cited a number of contextual factors that influenced their PPD experience, including lack of language skills, limited resources, environment changes, employment transitions, influence of perceived status of social class, and education level. Carmel reflected on several issues that she faced upon arrival in Canada:

> Language, transportation, medical issues . . . you don't know where to go, what to do, who to trust, especially when you are coming by yourself . . . you believe that you speak English, but when you get here you realize that you don't. It's also painful because you have to pay the bills . . . You try to go forward, but you struggle because of money . . . You go to the agencies that are supposed to help you but sometimes give you the wrong information . . . because they don't always know.

Unsettled immigration status, gender relations, dominance and control of partners, and role changes within the family presented tumultuous difficulties to immigrant and refugee women. Many participants described how their partners' behavior had contributed to PPD. Five women expressed how volatile relationships with their partners ended in domestic abuse. Clearly it was not easy for these women to remove themselves from emotionally abusive relationships because of their dependent immigration and economic status, limited access to information about their rights, social isolation, and fear of losing their infant and or being deported. Thus, decisions to not report relationship problems and emotional difficulties and to refrain from accessing health care services that might reveal such problems

were understandable. Roberta did not have valid immigration papers, which resulted in a multitude of problems for her and her family. In her circumstances gender played out with other health determinants such as socioeconomic factors, social support networks, and immigration status. In social conditions of inequity, and particularly in instances of poverty, barriers are created to obtaining appropriate mental health care for immigrant and refugee women. That is, women without financial resources have fewer choices when it comes to mental health care treatment:

> I don't have insurance. It's been nine months that I have given birth ... I need a pap smear but I just don't have support. You can't go to school and you can't learn English ... it causes a lot of difficulties. I became very depressed. I don't have electricity; it was disconnected because I have no money. I tried to ask for assistance at immigration services, but my papers expired.

Coupled with the multiple demands of new motherhood is the expectation, typical of many cultures, that the mother will care for the entire family. The many difficulties occurring simultaneously throughout the perinatal period make these women vulnerable to depression.

Theme 3: Facilitating Factors in Help-Seeking

Immigrant and refugee women spoke about their instinctive survival and adaptation strengths. Strong resolve to maintain health, a determination to work hard, and resilience were dominant traits clearly shown by these participants. It was identified that other positive strengths and coping skills lay in the women's strong family and community centered values and collective sharing. Spiritual and religious practices were also sources of strength and hope and provided a way for these women to cope with their mental health problems. Participants expressed great optimism and a willingness to move forward into the future:

> I want only to have a better life ... My husband used to abuse me because of my bad English. I don't want that to happen again. I want to learn about problems and how to solve them ... I need to take care of myself in order to take care of my baby. Having experienced this, slowly you get more strong ... having knowledge, you know how to protect yourself and your baby ... your life gets better.

> [The home visitor] gave me different ideas ... and confidence to think in another way about life for I felt I was going to die ... She told us about the Salvation Army, the milk program, and the Food Bank to make less stress on us ... and, most important, helped me to set goals.

Theme 4: Intervention Strategies for PPD Care and Treatment

We propose that how immigrant and refugee women understand their PPD help-seeking experiences has important implications for both for how they manage PPD and how health care providers can enhance future care and treatment strategies for this population. Our endeavors, listening and sharing though dialogue and bringing our participants' powerful voices to the forefront, brought forth more awareness of how to create more social justice.

The women in this study had varying views as to what was most helpful in obtaining professional support, but it was very clear that the majority of women preferred individual therapy over group interventions. This was in part because of their limited English skills and their uneasiness in opening up to others in a larger group:

> If it's one on one, I have more time to express. I prefer maybe one person, because it is more confidential ... In a group they use English and I don't want people to wait for me. That's why I become a little bit shy or not really willing to share in a big group.

Several participants said providing support through telephone-based services was a helpful way to provide support services. One participant proposed that having daily support sessions would have been very beneficial to her recovery, especially at the onset of PPD when frequent support was very much needed. She felt telephone-based services might be preferred by other women experiencing depression. Pam reflected on the many times that misunderstandings took place because of not having an interpreter. Yet, for her it was not only about language clarity; she said telephone support provided her with more privacy and confidentiality:

> I think if the language is okay the phone is a better way. Because you don't know who is speaking with you and you don't know the face. I can tell you something more about my uncomfortable [feelings]. Because if we are face to face, mmm ... I will keep something inside ... if the people speak my language this would be better, because we have same culture background and maybe you can easier understand what I'm thinking.

Through acknowledging the insights and knowledge that immigrant and refugee women have obtained during their struggles with PPD, and understanding the factors that cause women to feel powerless, dependent, and isolated, we can offer more appropriate care during the perinatal period. To do this, the paradigm that recognizes culture as a social characteristic of the client must be replaced with one that recognizes culture as a fluid and dynamic process that is important to the everyday situations of immigrant and refugee women. Understanding the ways culture can shape immigrant women's reactions to health and illness will help health care providers adapt their practices to be more responsive to the needs of this population.

It is strongly recommended that awareness of and information about PPD be offered numerous times throughout pregnancy and be extended to include family members. Anna explained why it is valuable to provide education about PPD early in pregnancy and offer information more than once in the perinatal period:

> You know when you hear about it several times, a lot, then you start to accept the idea ... if you already know this, then you can seek help more easily because it's not your first time [hearing about] this problem. It's better if somebody can explain what postpartum depression is ... Because it lets you know how to deal with the

situation. So if we are having any kind of feeling, we can talk and be open to someone instead of closing it to ourselves.

The women in this study emphasized the importance of receiving support from their partner and family. They suggested that more attention be given to educating their partners about PPD, enabling them to provide better support and care. Family members also can be instrumental in a woman's decision to access or not access support. Therefore, extending education about PPD to family members is critical to increasing their understanding and encouraging their participation in the recovery process. Family members often do not understand the seriousness of PPD or how to support someone who is depressed. Taylor (2006) pointed out that mothers who are depressed are not likely to go against the wishes of their family or cultural beliefs or seek help independently. Encouragement to utilize mental health services needs to come from the family. Kate had an unsupportive husband and now, after regaining her health, she is convinced of the importance of PPD education for all family members. She did not take the medication early on and her PPD worsened. There was strong resistance to accepting her mental illness and taking medication from her husband and family:

> My husband stopped me from taking medication. He said, "If you start on medication, it's a slippery slope ... once you enter into that vicious circle you never come out," so that's why I never took medication. I thought maybe I should start on medication, so I talked to my cousin, a doctor from my home country, and she said it's all in your mind ... you are all right.

Lily agreed with Kate and asserted that education for the family is very much needed because family members can provide emotional support and can advocate a search for outside help. Lily acknowledged that family support is particularly important with mental health problems and she believed it would have made a difference in her recovery. Her husband did not understand her emotionally labile state or her desire to go out and meet others outside the home:

> I believe your home is about the most important people to you ... if your husband gets more education they will know better. If my husband had got more education about those things he wouldn't always think everything should be perfect.

Regular PPD screening is a shared responsibility between obstetrics, primary health, and pediatric health care providers. Nurses and other health care providers are well positioned to identify women who may need help during the perinatal period. Community health nurses in particular have frequent contact with postpartum women and thus have opportunities to screen for PPD, make referrals, and use their strong communication skills to provide supportive counseling. Health care providers have a key role and the opportunity to intervene in promoting mental health, preventing mental illness, and improving access to mental health services. They also have a role in educating the public and reducing stigma.

A consideration of how broad determinants of health such as social isolation, poverty, economic status, and discrimination may affect their lives is necessary. Only through listening to the women's voices can we deepen our understanding about the ways in which social determinants impact their mental health and well-being. By doing so we can better understand their thoughts and views from within the context of their lives rather than labeling their despair as mental illness. It is necessary to enable all women to recognize symptoms of depression and support available interventions. This may also decrease the powerful stigma attached to a treatable condition such as PPD. The participants in this study all had some contact with a health care provider at some point during their postpartum period. Many of these women gave detailed accounts of the care received, both negative and positive. Reflecting on these past experiences, they were able to articulate which interventions would improve care and treatment of PPD.

LIMITATIONS

The findings of this Canadian study cannot be generalized to all immigrant and refugee women or to other contexts due to the small sample size and the nature of qualitative research. Future investigations could be strengthened by using a larger sample and a mixed methodology and by including the perspectives of health care professionals who provide direct postpartum care for this population. An additional limitation in this study was the utilization of interpreters. While it is essential to hear the views of non-English speaking immigrant and refugee women, meanings ascribed to these experiences might be altered through the translation process.

IMPLICATIONS FOR RESEARCH WITH IMMIGRANT AND REFUGEE WOMEN

Critical ethnography gives the research participant a voice and affords the participant active engagement with the researcher in negotiating findings and impacting emerging analyses. Through reciprocity with the researchers, participants acquired knowledge of the multiple factors that affected their postpartum health, and thus gain power over circumstances that shape their lives. The critical ethnography methodology provided participants with opportunities to share their experiences. The researchers could then acknowledge and validate participants' accounts to convey that their voices were being heard and respected.

CONCLUSION

A critical inquiry approach enabled us to examine connections among individual immigrant and refugee women, their families, their communities, and how the broader social and cultural environment can shape their health care practices and mental health care access. Consistent with the critical ethnographic approach, we brought to the forefront the immigrant and refugee women's voices and their ideas concerning available social support services and strategies that could address PPD

care and treatment. Our aim was to empower new immigrant and refugee women in Canada by making their voices heard and to call attention to the need for more appropriate support and access to mental health care services for this population.

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