UNIVERSITY OF CALGARY

Immigrant and Refugee Women’s Voices: Exploring Postpartum Depression Help
Seeking Experiences and Access to Mental Health Care

by

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FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Immigrant and Refugee Women's Voices: Exploring Postpartum Depression Help Seeking Experiences and Access to Mental Health Care" submitted by Joyce Maureen O'Mahony in partial fulfilment of the requirements of the degree of Doctor of Philosophy.

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Abstract

Recent immigrant and refugee women may be particularly at risk of less than optimal health outcomes following childbirth because of language difficulties, as well as cultural and socioeconomic factors that shape their postpartum experiences. Postpartum depression (PPD), one of the most common complications of pregnancy, can have long lasting traumatic effects on women and their families, but is also treatable. Therefore early detection and treatment of the problem is both valuable and important. While there has been research conducted on immigrant and refugee women’s mental health care experiences, there is limited understanding of how these women access multiple levels of health care to deal with mental illness such as PPD, and how contextual factors such as cultural, social, political, historical, and economic influence their mental illness treatment and prevention.

The purpose of this qualitative study was to explore how contextual factors interacted with race, gender, and class to affect and shape the ways in which immigrant and refugee women seek help and manage their PPD. The objectives were to increase understanding of how immigrant and refugee women made decisions about postpartum care; what factors may have influenced their health seeking behaviour and what kind of strategies they would find helpful in PPD prevention and treatment.

Informed by Kleinman’s explanatory model (1978, 1980) and the postcolonial feminist perspective (2002) a qualitative study was conducted with a purposive sampling of 30 immigrant and refugee women in a western province of Canada. Recruitment of participants was done via health care providers and organizations that provide mental
health care services for this population. In-depth interviews using semi-structured questionnaires were used to obtain information about their PPD experiences.

The study’s findings revealed that (a) more awareness and understanding of PPD is necessary to meet the mental health needs of immigrant and refugee women within the postpartum period; (b) women experience diverse, complex challenges and facilitators in seeking help to manage their PPD treatment and prevention; (c) women’s health care practices are influenced by both cultural background and socioeconomic, historical, and political factors which intersect with race, gender, and class; (d) immigrant and refugee women’s resilience and coping strategies with PPD need to be recognized. Based on the study’s findings intervention strategies for PPD care and treatment, are suggested to assist with implementing and planning more culturally appropriate and equitable health care services among immigrant and refugee women living in Canada.
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My husband Noel reminded me to keep ‘balance’ in my life and to maintain a positive mindset that would sustain me to keep working hard toward success.

My mother, who recently celebrated her 90th birthday, understood why my time was in short supply, and she always provided encouragement to do my very best.

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Dedication

To the immigrant and refugee women who participated in this research study. Their respected voices are powerfully present in this study to acknowledge, validate, and bring more awareness and understanding about the immigrant and refugee women’s PPD experiences.

To the health care providers who work and provide care for immigrant and refugee women in the postpartum period and enthusiastically supported this research to improve health care services that are more equitable and culturally appropriate among this population.
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Transformation is only valid if it is carried out with the people, not for them. Liberation is like a childbirth, and a painful one. The person who emerges is a new person: no longer either oppressor or oppressed, but a person in the process of achieving freedom. It is only the oppressed who, by freeing themselves, can free their oppressors.

Paulo Freire, Pedagogy of the Oppressed
CHAPTER 1: INTRODUCTION

This chapter provides an explanation of postpartum depression (PPD) as well as the initial problem that prompted this research study. Postpartum depression is a serious illness which can have long-term debilitating effects on immigrant and refugee women and their families. In this chapter we will explore PPD, its risk factors and the dangers of failing to recognize and treat this condition. The chapter concludes with the purpose of this research study as well as a brief summary of forthcoming chapters.

Witnessing the fragility and vulnerability of immigrant women who feel overwhelmed and unable to seek appropriate care, I have been motivated to explore the difficulties immigrant and refugee women face. I have also observed the strengths and resiliency of the hard working immigrant woman striving to care for her family. My experience as a community health nurse has encouraged me to explore further the everyday experiences of immigrant women. I found that some of these women were struggling with mainstream health care services and may have experienced inequitable care, either through the health care providers’ negative attitudes or another form of discriminatory action. Likewise, I have observed colleagues struggling with providing appropriate care for mothers from the new immigrant and refugee communities. Thus this study was motivated by the need to enhance opportunities for improved health through the perspectives of immigrant and refugee women in the postpartum period.

In previous work (O’Mahony, 2005) I explored with health care providers their concerns about immigrant women’s mental health and how immigrant women access mental health care. As the continuation of this previous research, informed by
Kleinman’s explanatory model of health and illness (1978; 1980) and the postcolonial feminist perspective (Anderson, 2002; Donnelly, 2004; Guruge & Khanlou, 2004; Racine, 2003; Reimer Kirkham & Anderson, 2002; Reimer Kirkham, Baumbusch, Schultz, & Anderson, 2007), I conducted a qualitative study from the immigrant and refugee women’s perspective.

In this dissertation I refer to the ‘immigrant’, commonly defined as a person who has moved themselves and often their families to take up permanent residence in the new country. Immigrants may apply for admission into Canada as a permanent resident under four categories as follows: family class (family reunification), economic class (business and skilled workers), refugees (individuals escaping persecution, torture or cruel and unusual punishment), and or/other (individuals accepted under humanitarian and compassionate grounds (Citizenship & Immigration Canada, 2007).

The family class immigrant requires a relative, spouse, common-law or conjugal partner who is a Canadian citizen or permanent resident of Canada to sponsor them. The sponsor assumes financial responsibility up to ten years. Economic class differs in that the immigrants may enter and become permanent residents on the basis of their skills and ability to contribute to the economy. Refugees are defined as those “individuals who, because of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion, are outside their country of nationality or habitual residence, and are unable or unwilling by reason of that fear to return to that country” (Citizenship & Immigration Canada, 2005). In Canada, application for humanitarian and compassionate grounds can be made due to family violence or abuse. I have chosen to include both refugee and immigrant women as participants.
because their voices are equally important, although their particular experiences may be different due to forced immigration, past insecure living conditions, and violence. These women’s previous circumstances may differ, however they face similar cultural, language, and economic challenges in help seeking.

**Background**

The number of immigrants and refugees coming to Canada from non-European countries has increased significantly over the past several decades. There are over 31 million people living in Canada, of which over 6 million are immigrants (Statistics Canada, 2007). According to the 2006 census, Alberta has a population of over three million, of which 34% are immigrants. In Calgary, Alberta immigrants make up 22% of the total population. Additionally reported refugee numbers for Alberta are 27,100 and in Calgary 11,880 (Statistics Canada, 2007).

**What is Postpartum Depression?**

Postpartum depression is an umbrella term used to cover a variety of emotional problems that can affect the new mother after childbirth. It is usually described as a group of symptoms that can negatively affect and alter the mother’s mood, attitude, and behaviour. Depressive symptoms can start anytime during the pre and postpartum period. The symptoms range from mild blues to total despondency. Serious depression is a constant, strong, sad, and empty feeling that lasts 2 weeks or more. Women with PPD suffer from feelings of anxiety, inadequacy, guilt, irritability, anger, and fatigue. It is an illness that requires professional help (BC Women's Hospital, 2010; Parent’s Link Centre, 2011). From a medical perspective it is important to know there are various forms of postpartum disorders that range from a transitory experience of postpartum blues to a
more severe form of postpartum psychosis. Postpartum psychosis and depression may happen in women without a past history of mood disorders. The likelihood of women developing postpartum depression or psychosis increases if they have had major depressive or bipolar disorder, history of postpartum depression, or psychosis with previous births (Taylor, 2006). The postpartum or ‘baby blues’ are a common postpartum experience, with up to 80 per cent of mothers experiencing this temporary emotional distress the first three to five days after delivery. These changes in mood may be due to the quick hormonal changes after delivery, fatigue, emotional letdown, and the stresses of being a new mother (Beck, 2006).

Unlike the baby blues, postpartum depression causes much more serious symptoms and is a major depressive disorder. Early recognition of this mood disorder is challenging because it may be carefully concealed by the mother (Beck, 2006). The signs and symptoms of pregnancy may mimic the neurological signs and symptoms of a depressive illness; as a result both the patient and the physician are often unaware of the onset and progress of the illness.

According to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), PPD is not classified as a separate disease but is included within major depressive disorders (American Psychiatric Association (APA), 2000). Within this DSM-IV criterion for major depressive disorders there is a specifier with “postpartum onset” to identify affective episodes occurring within the first four weeks postpartum. However, many researchers and clinicians agree that this description is too restrictive as it is thought that PPD can occur anytime in the first year after childbirth (Beck). A diagnosis of major depression is determined by five or more of the
following symptoms during a two week period: anxiety, anhedonia (inability to experience pleasure), mood fluctuations, fatigue, appetite changes/significant weight loss or gain, psychomotor retardation or agitation, decreased concentration ability, feelings of excessive guilt or worthlessness, insomnia or hypersomnia, and suicidal ideations. Symptoms must represent a change from previous behaviour and the mother must exhibit at least depressed mood and anhedonia (APA).

**Global Phenomenon**

PPD in the first three months after birth affects 3–25% of all new mothers globally (Beck, 2008a; Dennis & Hodnett, 2008; Horowitz, 2006; Posmontier & Horowitz, 2004; Robertson, Celasun, & Stewart, 2003). PPD is a universal phenomenon and not just restricted to industrialized Western societies or immigrant and refugee women (Affonso, De, Horowitz, & Mayberry, 2000; Halbreich & Karkun, 2006). Affonso et al. investigated differences in postpartum symptoms among an international sample of 892 women from nine countries and representing five continents using the Edinburgh Postnatal Depression Scale (EPDS) to measure the risk of PPD. The study revealed that the western European countries such as Sweden and Australian women have the lowest levels of symptoms. While it is unclear why Australian women scored low on the EPDS, Wickberg and Hwang (1996) found significant state support for Swedish women after childbirth including paternity leave. Mid-range levels of risk for PPD were found in American women. The researchers postulate that advances in assessment, as well as education and treatment programs in Western countries may buffer these women from depressive symptomology and may be responsible for the lower rates compared to high risk countries. The highest levels of PPD were found in selected Asian and South
American sites. Within these sites it was suggested that PPD may not be fully recognized as a health concern or illness.

Kumar (1994) asserted that the physiology of pregnancy and childbirth is the same globally. However, the event is conceptualized and experienced differently by mothers and their community. Traditional Asian healing practices differ from Euro-American practices in that the focus is on achieving harmony and balance of internal and external forces (Fitch, 2002). It has been established that some Asian women somatize their depressive symptoms (Kleinman, 1980), for example, referring to their depressed feelings as wind inside the head (Lee, Yip, Chiu, Leung, & Chung, 2001) or express emotional problems as physical or childcare issues (Yoshida et al., 1997). Halbreich and Karkun's (2006) literature review on the prevalence of PPD from 143 studies in 40 countries revealed that there was a broad range of reported prevalence ranging from 0% to about 60% and that the widely cited mean prevalence of 10–15% was not the actual representation of the magnitude of this global problem.

Oates et al. (2004) conducted research in 11 countries to explore whether PPD is universally recognized and to enquire into new mothers', fathers', and health professionals' perceptions of appropriate health services available. The author concluded that participants described a morbid unhappiness comparable to PPD, however concerns were raised about the cross-cultural equivalence of PPD, and whether it was an illness remediable by health interventions.

**Statement of Problem**

PPD may be the most common complication of pregnancy (Stocky & Lynch, 2000; Teng, Robertson Blackmore, & Stewart, 2007). However it is a devastating
condition which can have long lasting traumatic effects on a woman and her family (Beck, 2008b; Logsdon, Wisner, & Pinto-Foltz, 2006; Mechakra-Tahiri, Zunzunegui, & Seguin, 2007; Small, Lumley, & Yelland, 2003). PPD can result in tragedy such as maternal suicide and infanticide (Beck, 2007). PPD is treatable and early detection and timely treatment of the problem is important. For a variety of reasons outlined below, immigrant and refugee women may be more at risk than Canadian born women for lack of early detection and treatment of PPD. This is important because studies have shown the longer treatment is delayed, the longer the duration of PPD (Bonari et al., 2004; England, Ballard, & George, 1994; Goodman, 2004; Klier et al., 2008).

Immigrant and refugee women in Canada may be particularly vulnerable to PPD with less than optimal health outcomes following childbirth because of language difficulties, as well as cultural and socioeconomic factors that shape their postpartum experiences (Katz & Gagnon, 2002; Sword, Watt, & Krueger, 2006; Zelkowitz et al., 2008). Studies reveal that many immigrant and refugee women suffer serious mental health problems such as depression, post-traumatic stress disorders, suicide, and psychosis (Beiser, 2010; Bhui et al., 2003; Fang, 2010; Khanlou, 2008; Vasilevska & Simich, 2010). How best to assist these escalating numbers of immigrant and refugee women to adapt to their new environment and to cope with mental illness such as postpartum depression (PPD) is a pressing issue for health care providers (Dennis & Chung-Lee, 2006; Meadows, Thurston, & Melton, 2001; Morrow, Smith, Lai, & Jaswal, 2008; Teng et al., 2007). Depression during pregnancy and postpartum is a challenging illness to treat. Physicians from different specialties such as family medicine, obstetrics, and psychiatry often find themselves in a dilemma when it comes to diagnosing and
treating the illness. A most difficult challenge in early recognition of this mood disorder is how covertly it is suffered by these new mothers. The social stigma associated with PPD makes it difficult for women to seek professional help. The other reason is some health professionals may contribute to under-diagnosing of PPD because of limited training in the identification and management of PPD. For some women their symptoms may be attributed to causes other than depression such as relationship problems, fatigue, or mood swings. Thus it may be difficult to identify the presenting clinical symptoms as depression (Dennis, 2003).

Although there has been research conducted on immigrant and refugee women’s mental health care experiences, there is limited understanding of how they access multiple levels of health care to deal with mental illness such as postpartum depression, and how contextual factors such as cultural, social, political, historical, and economic intersect with race, gender, and class to influence their postpartum depression treatment and prevention. Until recently postpartum depression research was focused more on the population as a whole and not specifically on the needs and issues of refugee and immigrant women (Bostock, Marsen, Sarwar, & Stoltz, 1996; Dennis, Janssen, & Singer, 2004; Diaz-Granados et al., 2006; Goyal, Murphy, & Cohen, 2005; Kumar, 1994; Stewart, Gagnon, Saucier, Wahoush, & Dougherty, 2008). Research on specific risk factors for PPD among immigrant and refugee women has been limited (Small et al., 2003; Zelkowitz et al., 2008). From the few qualitative studies done, the most commonly identified risk factors are lack of social support, multiple roles, stressful life events, and language barriers. (Dennis, 2004b; Katz & Gagnon, 2002; Small et al., 2003; Zelkowitz et al., 2004).
The goals of this study are in line with the Vision 2020 document (Alberta Health & Wellness, 2008). Services in public health are the cornerstone from which to build a more effective and sustainable health care system. A central goal in Vision 2020 is to build a strong foundation for public health. Disease and injury prevention services, and health promotion strategies will help protect the health of the population and are effective ways to decrease disease and injury. Vision 2020 is also about building a stronger, more effective and sustainable publicly-funded health system. Mental health is an area where providing the right service, in the right place, and at the right time in the community can be improved (Alberta Health & Wellness). Additionally, a mental research partnership has been formed to improve mental health outcomes for Albertans through research evidence and transformation of best practices into mental health promotion, prevention of mental illness, and enhanced service delivery.

A mental health research program in 2006 was established through a roundtable discussion by Alberta stakeholders, including policy-makers, service providers, academics, and consumer groups to advance the mental health research agenda. As an end result, communities in Alberta – mental health and research – have come together to develop the Pan-Alberta, integrated Research Program (Alberta Mental Health Board, 2006). Two identified areas of priority are the effectiveness of mental health system services and child and adolescent mental health (Alberta Mental Health Board). The focus of the Alberta Mental Health Research Partnership Program is on applied health service and population health research, as these activities might be quickly transferable to system improvements and have the greatest potential to enhance mental health outcomes. Therefore the results from my study could be very useful in planning future strategies and
targeting support interventions for this vulnerable immigrant and refugee population.

The purpose of this qualitative study was to explore how contextual factors interact with race, gender, and class to affect and shape the ways in which immigrant and refugee women seek help and manage their PPD. The objectives were to increase understanding of how immigrant and refugee women made decisions about postpartum care; what factors may have influenced their health seeking behaviour and what kind of strategies they would find helpful in PPD prevention and treatment. In order to assist health care providers to identify appropriate strategies for various ethno-cultural groups, we also need to know what motivates immigrant and refugee women to seek help, what kind of social supports do they utilize as part of their health care practices, and the appropriate health care program to fit their diverse needs.

The overall goal of my study is to increase awareness and understanding of what would be helpful in meeting the mental health needs of the immigrant and refugee women.

Summary

This chapter provided relevant background information about postpartum depression and framed the research problem enabling the reader to better understand the forthcoming chapters. It also sets the stage as to why this important problem is being addressed within the immigrant and refugee women population during the postpartum period. In the next chapter a review and analysis of the literature is presented with in-depth information about the phenomenon of postpartum depression and the currently identified barriers and facilitators which may influence immigrant and refugee women’s health seeking behaviour and decision making about postpartum care.
CHAPTER II: LITERATURE REVIEW

In this chapter a review and analysis of the literature is presented to increase understanding about PPD and its related problems, and also the complex underlying issues that many immigrants and refugees experience in the postpartum period. In order to fully understand how these women utilize available health care services and social support networks one also must be aware of the impact of social, economic, cultural, historical, and political factors. Not only are they recent refugee and immigrant mothers, but they are striving to settle and adapt to a new country. Drawn from the literature are descriptions of the barriers and facilitators which may influence the immigrant and refugee women’s help-seeking behaviour and decision-making about postpartum care. I describe how this knowledge and increased understanding of these women’s circumstances has guided me to conduct a qualitative study and assisted me in the selection of the methodology of inquiry. To conclude the chapter, research questions are stated addressed from the immigrant and refugee women’s perspective.

Consequences of Postpartum Depression

Drawing from the preceding chapter one can appreciate that PPD is not only a serious mental health issue but has far reaching implications for the mother, child, and family (Amankwaa, 2003; Beck, 2008b; Boath, Pryce, & Cox, 1998; Boyd, Pearson, & Blehar, 2002; Dennis & Creedy, 2007; Logsdon et al. 2006; Mechakra-Tahiri et al. 2007). Postpartum depression has also been described as a ‘thief that steals motherhood’ that is, it robs women of happiness during the first several weeks to months of the postpartum period (Beck, 2006, p. 40).
Considerable attention has been focussed on the negative effects on child outcomes, which include decreases in social development, behavioural and emotional difficulties, and numerous physical health problems (Avan, Richter, Ramchandani, Norris, & Stein, 2010; Lovejoy, Graczyk, O’Hare, & Neuman, 2000). Any factors that adversely affect a woman’s ability to mother her infant are public health concerns (Dennis & Hodnett, 2008; Logsdon et al., 2006; Stewart, 2005). A meta-analysis of 19 studies was conducted by Beck (1995) on the effects of PPD on mother-infant interaction in the first year after birth. The results revealed that PPD had a moderate to large negative effect on mother-infant interaction which has been linked to attachment insecurity. Hipwell, Goossens, Melhuish, and Kumar (2000) and Murray and Cooper (1997), also found similar results that PPD can cause impaired interactions between mother and infant. Other research findings point to cognitive developmental delays (Hipwell et al.; Logsdon et al.) and communication difficulties (Cummings & Davies, 1994; Murray, 1992). Decreased motor development, delayed growth and lowered social responsiveness have been reported during the infancy stage (Abrams, Field, Scafidi, & Prodromidis, 1995; Hay, 1997). In extreme cases, tragedy such as maternal suicide and infanticide can be the result of this devastating mood disorder (Beck, 2007).

Further Beck (1998) investigated the prolonged effects of PPD on child development and conducted a meta-analysis of nine studies which showed a small but significant negative effect on children’s cognitive and emotional development. Reported research has shown consistently damaging long-term effects of PPD on school-aged children’s emotional and behavioral development (Essex, Klein, Miech, & Smider, 2001; Hay, Pawlby, Angold, Harold, & Sharp, 2003; Sinclair & Murray, 1998).
There is also recent suggestion in the literature that PPD may affect some new fathers. Although it is unclear why expectant fathers have received little attention in the past (Paulson, Dauber, & Leiferman, 2010), PPD is a significant problem in new fathers (Field, 2010; Goodman, 2004; Paulson, 2010; Pinheiro et al., 2006). Paulson and Bazemore (2010) conducted a meta-analysis of 43 studies which documented depression in fathers between the first trimester and first year postpartum. Of these reviewed studies, depression was evident in 10% of these men. Moreover paternal depression showed moderate positive association with maternal depression (Melrose, 2010; Roberts, Bushnell, Collings, & Purdie, 2006). Paternal depression is also associated with adverse parent health behaviours and less positive parent-infant interactions (Paulson et al., 2010; Ramchandani et al., 2008). Thus PPD in mothers and fathers may have negative implications for family health and well-being. It is suggested that universal screening of maternal and paternal depression and early interventions be implemented to meet the childbearing family’s needs (Field, 2010).

**Risk Factors of Postpartum Depression**

The exact cause of PPD remains uncertain, with general consensus suggesting there are psychological and psychosocial factors that predispose women to this condition (Beck, 2008a; Dennis & Creedy, 2007; Dennis & Letourneau, 2007; Stewart et al., 2008). There is little evidence to support an endocrine or biological origin (Beck; O’Hara, 1997; Paulson, 2010). All women are at risk of developing postpartum depression following childbirth (Robertson et al., 2003). Women who have one or more of the following risk factors have a significantly higher chance of experiencing postpartum depression. Robertson and colleagues (2004) synthesized two meta-analyses, Beck (2001) and
O’Hara and Swain (1996) incorporated over 70 studies to summarize potential risk factors. Predictors are identified in order of magnitude: 1) strong to moderate risk factors—depression or anxiety during pregnancy, past history of depression, recent life stress, lack of social support; 2) moderate risk factors—high levels of childcare stress, marital relationship, neuroticism, low self-esteem, difficult infant temperament; 3) small risk factors—obstetric and pregnancy complications, socioeconomic status. It is of interest to note the following factors were not associated with postpartum depression: maternal age when the mother is over 18 years of age, (although the incidence is much higher in teenage mothers), length of relationship with partner, parity, and education level (Robertson, Grace, Wallington, & Stewart, 2004).

Lack of Social Support

Psychosocial factors such as lack of support from formal and informal sources have been well documented as contributing causes (Beck, 2001; Bernazzani, Saucier, David, & Borgeat, 2007; Cairney, Boyle, Offord, & Racine 2003; Dennis & Letourneau, 2007; Robertson et al., 2004; Sword et al., 2006). In this study, social support is defined as:

Interactions with family members, friends, peers, and health care providers that communicate information, esteem, aid, and reliable alliance. These communications improve coping, moderate the impact of stressors, and promote health...supportive interactions are elicited with different associates, forms of expression of social support, and how social support can be miscarried or dissipate over time. (Stewart, 1993, p.7)
Although a range of definitions have been used to assess the concept of social support, it is usually classified as either perceived or received support. Social support is also grouped as one of three essential types, each of which may be experienced as positive or negative: 1) emotional (e.g., feeling loved, cared for and valued); 2) informational (e.g., advice or guidance is given); and 3) instrumental (e.g., tangible help or assistance with tasks) (Broadhead, Gehlbach, DeGruy, & Kaplan, 1989; Orr, 2004). Social support is also a recognized determinant of psychological and physical health which may affect health-related beliefs and behaviors (Dennis & Hodnett, 2008; Thornton et al., 2006).

It is widely established that women with less support also perceive increased symptoms of depression (Dennis & Ross, 2006; Forman, Videbech, Hedegaard, Salvig, & Secher, 2000; Letourneau et al., 2007; Sequin, Potwin, St-Denis, & Loiselle, 1999). There have been consistent findings in epidemiological and meta-analyses studies that suggest lack of social support, whether it is emotional, informational, or instrumental significantly increase the risk of PPD (Beck, 2001; Dennis, 2003; Forman et al., 2000). It is thought that during stressful times receiving support from family and friends is a protective factor against depression (Brugha et al., 1998). Analyses in predictive studies reveal that the following factors increase the likelihood of PPD: 1) social isolation (Barclay & Kent, 1998; Small, Johnston, & Orr, 1997); 2) lacking friends or close confidant/partner (Cairney et al., 2003; Dennis & Ross, 2006; Logsdon & Usui, 2001); 3) lack of perceived support from primary social network group (Brugha et al.); and 4) not having someone to share feelings with who has experienced a similar problem (Dennis &
Letourneau, 2007). In Canadian women lower social support has been found to be an important predictor of PPD (Dennis, Janssen, & Singer, 2004; Dennis & Ross, 2006).

**Limited Financial Resources**

Sequin et al. (1999) reported in a Canadian longitudinal study that low socioeconomic status (SES) new mothers were more likely to experience higher depressive symptoms in the second month postpartum than higher socioeconomic status (SES) mothers. They found that chronic stressors (lack of money for daily needs, maternal and infant health issues, conflicts in social networks) coupled with poor social support were associated with postpartum depression symptomology. Many studies have suggested that low income, unemployment, and financial strain have a predictive relationship to PPD (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Beck 2001; Boyce, 2003; Goyal, Gay, & Lee, 2010; Sequin et al., 1999; Sword, 1997). Sword and Watt (2005) examined learning needs of postpartum women and SES at time of discharge from hospital and at four weeks postpartum. Learning needs at discharge were assessed with a focus on health related topics concerning the physical and emotional care of the mother and infant. At four weeks women were further assessed concerning service usage since discharge and any unmet learning needs. Women of low SES were significantly more likely to report unmet learning needs (nine out of ten areas) as compared to higher SES. Recently Kurtz Landy, Sword, and Ciliska (2008) compared socioeconomically disadvantaged postpartum women’s health, health service needs, and utilization patterns with higher socioeconomically advantaged postpartum women. Findings within this study of 1000 postpartum women reveal that socioeconomically disadvantaged women were
(a) less likely to report very good health, (b) more likely to be discharged from hospital < 24 hours; (c) had increased rates of postpartum depression symptoms.

Sword et al., (2006) found that immigrant women were considerably more likely than Canadian-born women to have low family incomes and less social support; however they are less able to obtain financial support and appropriate social support. An assessment of 1250 women (one-third born outside Canada) revealed that 15% scored above the cut point on the EPDS, as compared to 7% of Canadian born women. Many immigrants and refugees may not have the informal family support that traditionally is available to them in their country of origin. Another recent study among immigrant mothers revealed that 79.4% of immigrant mothers had insufficient incomes compared to 20.6% of Canadian-born mothers (Mechakra-Tahiri et al., 2007).

**Migration**

Past research has indicated migration status as a risk factor for depression during pregnancy and in the post partum phase (Hyman & Dussault, 2000; Mechakra-Tahiri et al., 2007; Zelkowitz et al., 2008). Little attention however has been focused on the relationship between immigration and postpartum depression (Small et al., 2003). Immigrant and refugee women are exposed to significant risks factors that may affect mental health such as marginalization and minority status, pre-migration experience, int tolerable memories, socio-economic disadvantage, poor physical health and difficulty adapting to host cultures (Bhui et al., 2003; Dhooper & Tran, 1998; Li & Browne, 2000; O'Mahony, 2005; Thompson, 2000; Ziguras, Stankovska, & Minas, 1999). Although they may be at risk for poor health in the postpartum period, studies show that these women have difficulty meeting their mental health care needs and do not necessarily get the care
they need even when health care is universally available (Donnelly & McKellin, 2007; Morrow & Chapell, 1999; O’Mahony & Donnelly, 2007a; Sword et al., 2006).

Battaglini et al. (2001) investigated factors associated with immigration and perinatal risk of 91 immigrant and refugee women in Eastern Canada. Their findings suggest that factors (arising from migration) such as social isolation, poverty, stress caused by war or persecution from country of origin, and loss of family through immigration negatively impact the perinatal period. Zelkowitz et al. (2008) examined differing trajectories from pregnancy to postpartum and found that immigrant women who were not depressed prenatally but had developed postpartum depressive symptomatology showed various predisposing risk factors during pregnancy. These included premigration stress, high perinatal anxiety, and numerous somatic complaints. Zelkowitz et al. (2004) also found that stress associated with migration (housing difficulties, discrimination and prejudice issues, changes in income) were more common among immigrant women, scoring 12 or higher on the EPDS.

Social Isolation

Immigrant may be at a higher risk because they are separated physically and culturally from their support systems. Studies often demonstrate that new immigrant mothers report feeling socially isolated and overwhelmed (Barclay & Kent, 1998; Katz & Gagnon, 2002; Robertson et al., 2004). Zelkowitz and Millet (1995) reported that immigrant women living in Montreal had a 9.4% higher risk of depression compared to Canadian-born women (5.5%). Stewart et al. (2008) found similar results comparing postpartum newcomer women and Canadian-born women. Not only did they find newcomer women were at more risk for postpartum depression, but that all groups of
newcomer women with elevated EPDS scores had lower social support scores. Recently Zelkowitz et al. (2004) examined psychosocial risk factors in a sample of 121 Canadian pregnant immigrant women. The EPDS was used to screen women at risk with a cut-point of 12 and above. Post-assessment found that 42% of the immigrant women scored above the cut-point for depression, implying they were at risk for PPD. These immigrant women reported a lack of social support, marital difficulties and an increase in stressful life events (for example- difficulties at work /school, financial problems, housing, and illness/death in family). The women described their networks as having fewer friends and family members from their own ethnic group and a greater need for social support. The support of family members and others from one’s own ethnic group familiar with norms and practices surrounding childbirth may be particularly important to pregnant women (Zelkowitz). Barclay and Kent point out that the new immigrant mother’s difficulties are exacerbated because they often come from cultures where women are held in high esteem, valued, and supported during this period in their life. Similarly Oates et al. (2004) found that immigrant mothers may find themselves without a support net where normally they would have found recognition, nurturing, and assistance within their culture.

Stuchberry, Matthey and Barnett (1998) found that the type of social support and its significance varies according to the mother’s cultural background. Culture may create expectations of support and even contribute to the women’s high expectations and her consequential feelings of failure. Stuchberry et al. concluded that cultural factors intervene between social supports and PPD. Therefore it is not surprising that child bearing immigrant and refugee women may be at considerable risk of PPD because of new environment stressors such as language barriers, separation from extended family,
and financial difficulties (Katz & Gagnon, 2002; Logsdon, Birkimer, & Usui, 2000; Stewart et al., 2008; Teng et al., 2007; Zayas, Cunningham, McKee, & Jankowski, 2002; Zelkowitz et al., 2004; Zelkowitz et al., 2008).

**Postpartum Depression Screening**

Cox, Holden and Sagovsky (1987) developed a ten-item self-report scale Edinburgh Postnatal Depression Scale (EPDS) to screen for PPD in the community (Appendix A). During development of the EPDS, Cox, and colleagues found that the cut-off score of 12 reported a sensitivity of 86%, specificity of 78%, and post predictive value of 73%. The alpha reliability of the ten-item scale was .87. In the EPDS, sensitivity refers to the ability of the instrument to identify accurately all screened women who actually had PPD (true-positive). Specificity is the ability of the instrument to identify all screened women who were not depressed (true-negative rate). The scale indicates how the mother has felt during the previous week, and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders (Cox et al., 1987). The mother must respond to the statements without any assistance. The answers are based on her interpretation only.

Evidence from screening by means of the EPDS indicates higher risks and prevalence of PPD (Stewart et al., 2008; Sword et al., 2006; Zelkowitz et al., 2008). Although it is a valid and reliable screening tool for identifying women who are at risk for PPD it should be noted that a high score on the EPDS does not constitute a psychiatric diagnosis of depression (Miller, Gupta, & Scremin, 2011; Zelkowitz et al., 2004).

Positive factors of utilizing the EPDS include: (1) no cost involved for usage; (2) time efficient (ten minutes to complete, quickly scored and interpreted by nurses and
other health care professionals); (3) easy to fill out (consists of ten statements with four possible responses to choose from); (4) scale is well utilized by Canadian researchers with widespread use of the instrument.

The EPDS is widely used to assess maternal depression subsequent to childbirth in many English speaking countries and is increasingly being used through translated versions in non-English speaking countries (Small, Lumley, Yelland, & Brown, 2007). Small and colleagues compared different population samples, English speaking and non-English speaking postpartum mothers in Australia to test the performance of the EPDS. They conclude that the EPDS was an effective tool with good item consistency and stability in factor patterns across the samples. In other words, the scale is understood and completed similarly by women in these different groups. However the authors do specify that careful translation processes and piloting of translations are always necessary. Recently, Miller et al. (2011) reported that the EPDS emerges as an appropriate ‘perinatal’ depression screening tool and is validated for use in pregnant women. While some general depression screening tools appear to be acceptable in postpartum populations they have not been validated for pregnant women. Moreover EPDS validation studies have been conducted in diverse ethno-cultural groups and translated into 23 different languages (Cox & Holden, 2003).

**EPDS in the Canadian Context**

In Canada the EPDS is widely used to screen for postpartum depression (Clarke, 2008; Dennis, 2004b; Dennis & Boyce, 2004; Dennis & Ross, 2006, Stewart et al., 2008). Recent research by Zelkowitz et al., (2008) found that 37.7% of the 106 immigrant women in their community sample collected in Canada scored above the cut-point on the
EPDS. Stewart et al. (2008) also found immigrant women (35.1%) and refugee women (25.7%) significantly more likely than Canadian women to score above the cut-point in the EPDS. A further sample of 1250 women (approximately one-third born outside of Canada) was assessed by Sword et al. (2006) in Ontario. It was found that 15% of the immigrant women scored above the cut point as compared with 7% of Canadian-born women. Furthermore immigrant women reported that they experienced poorer overall health in the first four weeks postpartum than women born in Canada. In spite of the greater likelihood of PPD coupled with poorer health, these same immigrant women were no more likely to ask for help than women born in Canada for their physical and emotional problems. Researchers in Vancouver found immigrant women were at greatest risk of developing persistent postpartum depression from 1 to 8 weeks after childbirth (Dennis & Ross, 2006).

In Calgary, population health and surveillance data from Alberta Health Services (2009) revealed that from July 2007 to June 2008 there were just over 15,000 maternal events (births). Within this population EPDS scores revealed that 1,162 women scored above the cut-point (10-15) and 236 women scored over 16. This indicates that 1,398 (10.7%) women were screened as high risk for postpartum depression during this timeframe. Universal PPD screening occurs at the two month clinic appointment at the community health centre. Cut-point scores of (10-11) in English or translated Punjabi indicate further follow-up to appropriate resources and communiqué to the physician. Scores >12 in English and Punjabi and scores >10 in translated Chinese, Arabic, Vietnamese or Spanish also indicate higher risk for PPD and therefore referral to postpartum support services and the physician. As part of the assessment to universal
PPD screening, the community health nurse assesses postpartum coping and adjustment by observing maternal and parental behaviours, and as needed, asks key questions about activities of daily living such as sleeping, eating, and perceived available support (Alberta Health Services, 2008).

**Intervention and Treatment Options**

Generally treatment may be divided into three key areas: support groups, psychopharmacologic treatment, and interpersonal psychotherapy. A systematic review of 21 randomized controlled trials of preventative interventions was conducted by Boath, Bradley, and Henshaw (2005) with five of the studies focused on support groups. They found that two of these studies were found to reduce depressive symptoms whereas the other three trials did not decrease depressive symptoms. Psychopharmacologic options may be used for acute PPD which includes a combination of antidepressant medications and psychotherapy (Beck, 2006; Dennis & Creedy, 2007; Wallington, 2003). Most common groups of antidepressant medications to treat postpartum depression are specific serotonin reuptake inhibitors which include fluoxetine (prozac), sertraline (zoloft), paroxetine (paxil), and tricyclic antidepressants such as tofranil (imipramine) and elavil (amitriptyline) (Wisner, Gelenberg, Leonard, Zarin, & Frank, 1999).

Stuart and O’Hara (1995) suggest that disruption in relationships may contribute to postpartum depression. In their study interpersonal psychotherapy, which is short-term therapy with a focus on relationships was found to reduce depressive symptoms in the early postpartum period. In a similar study Zlotnick, Johnson, Miller, Pearlstein, and Howard (2001) also found that this therapy reduced symptoms early in the postpartum period but longer term impact remains unclear. In Dennis’s (2003) literature review there
is continuing evidence indicating favorable results with lowered depressive scores and significant changes reported by participants (Klier et al., 2001; O’Hara, Stuart, Gorman, & Wenzel, 2000; Spinelli, 1997; Stuart & O’Hara, 1995).

Findings have consistently suggested the importance of psychosocial factors and the salience of social supports, therefore a variety of psychosocial and psychological interventions have been developed (Dennis & Creedy, 2007). It is also plausible that psychosocial and psychological interventions may prevent postpartum depression due to the many risk factors that are apart of pregnancy and the early postpartum period. Not only are these interventions effective as treatment but they could be used during pregnancy and in the early postpartum stages to prevent postpartum depression (Dennis & Creedy). Interventions include cognitive-behavioural therapy with or without antidepressants (Appleby, Warner, Whitton, & Faragher, 1997; Cooper Murray, Wilson, & Romaniuk, 2003), telephone-based peer support, (Bullock, Browning, & Geden, 2002; Dennis et al., 2009), non-directive counseling (Holden, Sagovsky, & Cox, 1989; Wickberg & Hwang, 1996) and interpersonal psychotherapy (Beck, 2006; O’Hara et al., 2000; Zlotnick et al., 2001).

Trained family home visitors also play a role in the treatment of PPD by offering support and opportunity for women to share their feelings and develop more insights about their situation (Meyer, Estable, Maclean, & Peterson, 2010). Moreover home visitation and peer support may benefit high risk populations by improving the mother’s knowledge, emotional and physical health status, skills related to parenting, and further community-based PPD resources (Dennis, 2010; Hull, 2007; Shaw, Levitt, Wong, & Kaczorowski, 2006). Segre, O’Hara, Arndt, and Beck, (2010) suggest nurses in
perinatal settings are well positioned to provide screening and treatment of PPD as are community-based primary health professionals. Research from the U. K., indicates that ‘trained health visitors’ (Cowley, Caan, Dowling, & Weir, 2007) (similar to Canadian baccalaureate nurses) identify and provide counselling and treatment to new mothers reduces postnatal depression (Davies, Howells, & Jenkins, 2003; Morrell et al., 2009).

Dennis and Kingston (2008) conducted randomized controlled trials of telephone support for pregnant and early postpartum women. The review included 14 studies involving 8,037 women to assess the effects of telephone-based support on postpartum depression, low birth weight, pre-term birth, breastfeeding, and smoking. Overall preliminary results show that proactive telephone support may (a) decrease depressive symptomology, (b) increase duration of breast feeding, (c) play a role in low birth weight, (d) aid in smoking relapse. The authors suggest a role for telephone support in improving outcomes among pregnant and new mothers. Of recent a randomized controlled trial of 701 high risk women was carried out by using telephone based peer support or standard community care as intervention. Telephone based peer support was provided by women who had a previous experience with PPD. The findings suggest that this type of support delivered within the first 12 weeks postpartum may prevent PPD in high risk mothers (Dennis et al., 2009).

Beck (2008b) conducted an integrative review of PPD research and found inconsistent findings reported in the interventions studies done by nurse researchers. For example, educational material such as pamphlets and videos provided to women in the postpartum period did not lessen their depressive symptoms (Logsdon, Birkimer, Simpson, & Looney, 2005; Webster et al., 2003). In contrast Heh and Fu (2003) achieved
significant differences in women who received informational material. This area of intervention strategies continues to be underdeveloped and more research is essential (Beck). Future research needs to focus on intervention strategies that have been developed in collaboration with immigrant and refugee women. This will further the understanding about PPD care and provide significant information about immigrant and refugee women’s support needs and their preferences.

**Barriers and Facilitators to Help-Seeking Among Immigrant and Refugee Women**

It has been recognized that immigrants and refugees often encounter difficulty accessing health care services. These factors may hinder immigrant and refugee women from seeking help. Barriers that influence their access to mental health care include poverty (Dhooper & Tran, 1998; Pilowsky, 1991), employment status (Beiser, Johnson, & Turner, 1993; Bhui et al., 2003; Thompson, 2000), marginalization, discrimination, gender roles, and language barriers (Ahmed et al., 2008; Dennis & Chung-Lee, 2006; O’Mahony, 2005), cultural differences (Dhooper & Tran, 1998; Li & Browne, 2000; Whitley, Kirmayer, & Groleau, 2006), social stigma and lack of knowledge, age, socio-economic position, unrecognized needs, and ethno-cultural status and availability of services (Beiser, 2005; Donnelly, 2006; Fung & Wong, 2007; Morrow & Chappell, 1999; Wu, Penning, & Schimmel, 2005).

Scheppers, Van Dongen, Jos Dekker, Geertzen, and Joost Dekker (2006) reviewed 54 articles from diverse countries and ethnic origins to determine potential barriers of health care service usage. Their findings suggest that potential barriers occur at three levels: individual, health care provider, and system levels. At the individual level, characteristics were identified as demographic variables, social support variables, health
beliefs and values, personal and community enabling resources, and perceived personal health practices. At the provider level, attitudes and skills of the health care provider were reported as potential barriers, while at system level, barriers were associated with the organization of the health care system.

**Individual Barriers**

New immigrants are ten times more likely than Canadian-born individuals to identify barriers related to individual circumstances such as transportation, cost, and lack of information and where to go to access health care services (Canadian Research Institute for the Advancement of Women (CRIAW), 2002; Sanmartin & Ross, 2006). Moreover, Stewart et al. (2008) found that immigrants, refugees, and women seeking asylum in Canada were four to five times more likely to experience PPD than women born here. Teng et al. (2007) identified two main types of barriers to access postpartum care for recent immigrant women, from a health care provider’s perspective: practical barriers and culturally determined barriers. Practical barriers include language difficulties, unfamiliarity with how and where to access health care services, low socioeconomic status and childcare issues (Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002; Steele, Lemieux-Charles, Clark, & Glazier, 2002; Wu et al., 2005). Culturally determined barriers include the stigma of mental health illness and lack of knowledge and comprehension of postpartum depression (Teng et al.) by the immigrant women and her family. New immigrant mothers suffering from postpartum depression may experience conflict between understanding PPD and a reluctance to reveal feelings to family and friends and to seek help for their problems (Dennis & Chung-Lee, 2006).
Health Care Provider Barriers

Many healthcare providers have recognized that immigrants often encounter difficulty accessing health care services to deal with health problems (Anderson & Reimer Kirkham, 1998; Donnelly, 2004, 2006; Hirota, 1999; O’Mahony, 2005; Stephenson, 1995; Wu et al., 2005). Health care providers play a significant role in either promoting help-seeking behaviours or hindering the access of treatment according to literature on PPD (Dennis & Chung-Lee, 2006; Tran, Young, Phung, Hillman, & Willcocks, 2001; Webster et al., 2001). It is suggested that if healthcare providers have a tendency to minimize or normalize the mother’s depressive symptoms, those mothers may become reluctant and less likely to access further care and treatment (Amankwa, 2003; Dennis, 2004a; Edge, Baker, & Rogers, 2004).

It has also been noted that health care providers are sometimes frustrated about the passiveness of immigrant women’s participation in available health care prevention services. Rather than recognizing barriers in the healthcare system, generalizations may be made by the healthcare provider to explain complex issues related to marginalization and access to health care (Browne, Johnson, Bottorff, Grewal, & Hilton, 2002). Some immigrant women experience structural barriers such as low income and socioeconomic status and lack of social support. Improving quality of and access to care requires examining the structural constraints in these women’s lives. Social support and access to financial resources are determining factors that influence immigrant women’s health care access and profoundly affect their ability to obtain help.

In previous research, (O’Mahony, 2005) it was found that the health care provider-client relationship had profound effects on the immigrant woman seeking help.
Health care providers were mixed in their views on who should initiate contact for mental healthcare services. It was suggested that the immigrant women needed to be aware first. Some providers felt that responsibility for seeking mental health care should be shared with the client. Differing values and perspectives between health care provider and client were seen as barriers in the health care relationship. Misunderstandings precipitated breakdowns in communication and promoted negative feelings within the relationship. The relationship between the client and health care provider was also a determinant of whether the women sought treatment or not. Trust and faith in the health care relationship were found to be essential components to immigrant women's continued use of the health care service.

**Health Care System Barriers**

There has also been much attention on perspectives of healthcare responsibility and how this influences health care service delivery and how individuals practice health care. Donnelly and McKellin, (2007) point out that discourse which is responsible for maintenance of health and prevention of disease often focus on individuals, yet underlying Canadian ideology position it as a shared responsibility of both individuals and society. Healthcare restructuring with an emphasis on reducing costs has placed even greater responsibility on individuals. There is strong focus on the interrelationship between individuals and the social context in which they live as well as particular circumstances that can affect an individual’s health care seeking behaviour (Morrow et al., 2008; Stamler & Yui, 2008; Vollman, Anderson, & McFarlane, 2008). Even though keeping healthy and mobilizing preventative actions toward disease and illness may often be considered the responsibility of the individual, of real concern is the offloading of
responsibilities to these people who are vulnerable through illness, have few resources and are least able to assume the responsibilities that the empowerment movement suggests (Anderson, 2000; Donnelly & McKellin, 2007).

The focus on individualism and self care in our health care system makes it difficult for economically and culturally marginalized women to be able to afford, or to allocate household resources, on personal needs (Anderson & Reimer Kirkham, 1998; Evans, 1994; Spitzer, 2004). Taking an individualistic approach excludes broader social, political, historical, and economic contexts and the ways in which they intersect with particular women's circumstances (Berggren-Clive, 1998; Mauthner, 1993, 1999; Nicolson, 1998).

**Biomedical model.** Within the literature there is suggestion that biomedical perspective might act as a barrier as it is based on the biomedical explanatory models of health, illness, and healing (Berggren-Clive, 1998; Fung & Wong, 2007; Kleinman, 1980; Mauthner, 1993, 1999; Nicolson, 1998; Scheppers et al., 2006). Nicolson (1998) pointed out that scientific researchers focus on the measurable, observable, and objective data, and thus the complexity and experiences of the women's everyday lives are often overlooked. According to feminist sociologists and psychologists (Nicolson, 1992, 1998; Oakley, 1980; Romito, 1990) criticism of the medical model of PPD lies primarily in these four areas (Mauthner, 1993): 1) PPD is not only a medical issue but a social one. Taking an individualistic approach excludes broader social, political, historical, and economic contexts and the ways in which these contexts intersect with particular women's circumstances; 2) Determinism has limits; implying women are not seen as actively engaging in circumstances surrounding them. In this context no recognition is
given for differences between mothers or differences between birthing events (difficult labour, lack of support, infant health) whereby meanings may be different depending on individual circumstances; 3) source of the problem (PPD) is the individual mother. Implicit in the literature is that the women who do not experience happiness after childbirth, exhibit negative emotions and or have difficulties coping are viewed as abnormal or pathologized and often blamed for their behaviour (Mauthner, 1993; Nicolson, 1998). However Mauthner (1998) noted that while researchers have criticized the medical perspective in blaming the individual women for their difficulties, some women have felt that the medical label of PPD has had the opposite effect of ‘legitimizing’ their condition and thus freeing them from responsibility and blame; 4) The women’s voice is silenced. Women’s personal accounts of their experience are disregarded (Mauthner, 1993) and the failure to listen to their voice has virtually made women stay silent and isolated with no one to share their feelings and knowledge. Mauthner noted “Rather than listen to what the women are saying and feeling, and attempt to understand women’s accounts on their own terms, researchers are preoccupied with their own concerns, namely that of discovering what is the objective truth about the matter” (p. 353).

Nicolson, (1998) stated that patriarchal knowledge-claims based on traditional research serves the interests of those who want to position PPD as a problem rather seeking strategies to assist the depressed woman. Knowledge about PPD impacts health care policy and nursing practice although it is based upon science defined in limited parameters. Usher (1992) contended that this process is part of a larger persistent underlying medical discourse concerning women’s bodies:
Pregnancy, childbirth and the postnatal period have been pathologized in the same (convenient) way, positioning women’s experiences as an illness in need of intervention... since male obstetricians wrested control of childbirth from the women midwives as early as the sixteenth century childbirth has been construed as a technological accomplishment on the part of the expert— the women herself positioned as a passive recipient...in ubiquitous stirrups. (p. 47-48)

With this understanding in mind Nicolson (1998) pointed out that as a result only patriarchal knowledge is used to inform clinical practice, health care policy and popular beliefs and women’s perinatal experiences are designated to the margins of knowledge. Nicolson concluded “what is missing, [in the medical model] it seems, is a means and willingness to explore the complexities in the lives of the women... transition to motherhood can never be a standardised event, because everyone’s life is different” (p.35). With more recent research on PPD, critique has been about the absence of the women’s voice and perspective. Feminists seek to critique the medicalization of PPD and therefore strive for a broader view and analysis of the contextual factors which may influence individual mothers.

**Social Policy**

The past few decades have seen many changes in Canada’s policies with the ideologies of equal opportunities for all and individual effort being responsible for success of reducing inequities. Although overall improvements in health have been made significant health inequalities persist among all Canadians (Wilkins, Berthelot, & Ng, 2002). Reports (such as the National Forum on Health, 1997) document that some groups are at risk for poor health, including people from ethnic groups that require them to
access health care. However when health care services are accessed, they may experience barriers to equitable health care. Despite a widely accepted and shared ideology of equality, Li (1988) asserted that social inequality remains well-established in Canadian society. Nonetheless the notion persists that every person has equal opportunity to improve their own circumstances. This ‘mobility dream’ also fosters the popular belief that individual effort is responsible for success while social failures are the result of personal weaknesses and failing to respond to opportunities. Li (1988) also pointed out that social forces widen inequalities, for example gender, nativity, ethnic origin and age are often used as grounds for discrimination.

Canadian contributions over time have theorized the relationship between social and economic conditions. For example the Lalonde (1974) document “A New Perspective on the Health of Canadians” identified determinants other than the health care system. The Health Promotion Framework (Epp, 1986) document also identified the need to reduce inequities between income groups. Even at that time, it was argued that:

There is disturbing evidence which shows that despite Canada’s superior health services system people’s health remains directly related to their economic status... Within the low-income bracket, certain groups have a higher chance of experiencing poor health than others. Older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants all fall into this category. (p.4)

For example several social districts in Calgary are shown to be hardest hit by lower income, higher unemployment, and lower literacy rates. Yet these same districts reveal the highest immigrant populations (Health Atlas, Calgary Health Region, 2007).
CRIAW (2007) reports social programs in Canada have undergone a number of changes over the years to impact women with low incomes. In 1995 the elimination of the Canada Assistance Plan (CAP) which ensured specific rights for individual on government assistance was replaced with the Canada Health and Social Transfer (CHST) as a block transfer for health care, postsecondary education, social assistance, and other social programs. This was accompanied by deep funding cuts, further restrictions on unemployment insurance eligibility, and cut-backs of benefits. To some extent the federal government withdrew from funding social housing, leaving Canada as the only industrialized country without a national housing plan. These changes reflected federal budget surpluses but for provinces a budget deficit and a strain on social programs. For some women this brought about deeper disparity and fewer avenues to escape poverty. A further step in 2004 divided the CHST into the Canada Health Transfer (CHT) with 62% of the funds and the Canadian Social Transfer (CST) with 38% of the funds. The CST funds social programs. In 2007, the government identified priority areas such as early learning and child care, but provinces do not have to prove that they made changes, or developed programs with the transfer, only prove the money was spent.

CRIAW further emphasized that coupled with reductions in social spending has been a different underlying social welfare philosophy, one that is strong on punitive measures and assigns blame to the individual. Rather than viewing the broader context for how and why problems occur, there is a top-down view of poverty which does not consider why individuals become poor and presupposes the worst for these individuals living in poverty.
Cultural Influence

As part of an immigrant and refugee women’s health care behaviour, cultural values and social practices may influence the women’s responses to health and accessing mental health services. Cultural background has a significant influence on individual’s lives, perceptions, emotions, diet, dress, identity, health care behaviours, family units, concept of space and time, and attitudes to illness and pain (Helman, 1994).

Culturally determined barriers include fear of stigma and lack of validation of depressive symptoms within family and own ethnic community. Mental illness is heavily stigmatized in many cultures (Dennis & Chung-Lee, 2006; Holopainen, 2002; Morrow & Chapell, 1999; Teng et al., 2007). In some cultures there is perception that it is inappropriate to seek out external help for depressive symptoms. PPD may not be viewed as a medical problem and therefore medical assistance is not considered appropriate (Holopainen; Rodrigues, Patel, Jaswal, & DeSouza, 2003; Teng et al.; Ugarriza, 2004). Rodrigues and colleagues found that Asian Indian mothers suffering from PPD perceive their symptoms as normal, natural effects of childbirth, and therefore they are unlikely to access health care services. In Asian Indian communities it has been reported that maternal depression often goes unrecognized and as a result, the mother remains alone and isolated within her own family (Bostock et al., 1996; Goyal et al., 2005; Hearn et al., 1998). Some studies have shown that shame, stigma, and fear of being mentally ill are significantly strong predictors of whether immigrant and refugee women will seek help or not (Rodrigues et al., 2003; Whitton, Warner, & Appleby, 1996). For example, the role of informal social support within Asian families is highly regarded and the majority of Asian immigrants would rather seek help for mental health problems from family
members and friends rather than from a health care provider (Cheung & Lin, 1999; Li & Browne, 2000).

Descriptions of the cultural aspects of the postpartum experience may be found in the literature (Affonso et al., 2000; Amankwaa, 2003; Kirmayer, 1989; Oates et al. 2004; Zelkowitz et al., 2004), however research on the impact of cultural factors upon PPD is limited (Bina, 2008). Bina conducted a comprehensive literature review globally and found 70 articles on culture and postpartum women; however only 14 articles investigated the impact of cultural factors on PPD. This is quite noteworthy since cultural factors can greatly influence PPD. Findings reveal that cultural traditions and rituals were alleviating factors upon postpartum depression in many of the studies, and lack of cultural tradition could lead to increased depression in many of the reviews.

Dankner, Goldberg, Fisch, and Crum, (2000) examined social, cultural, and religious factors underlying PPD and found that greater religiosity was associated with a decreased risk of postpartum depressive symptoms. It is also important to note that it is dependent on the mother’s perception of tradition during the postpartum period. It was suggested that the cultural tradition of ‘doing the month’ (mandating new mothers to rest for a month while extended family offer emotional and practical support) offered protection from the risk of PPD. Heh, Coombes, and Bartlett (2004) noted that this traditional ritual is protective only if support meets the women’s actual needs. With regard to relationships with in-laws and extended family it was found for mothers who did not view the rituals as helpful, negative impacts on the postpartum mood could occur. Therefore, as part of the immigrant and refugee women’s health care behaviour, cultural
values and social practices may influence the women’s responses to health and accessing mental health services.

**Gender Roles as Barrier**

Gender has been well established as being a determinant of health and is interlinked with biological and social determinants (Health Canada, 2003; Spitzer, 2005). When examining factors that affect health it is necessary to recognize gender as a key social determinant. The interactions of race, gender, class, sexual orientation, age, and disability influence social support networks, access to education, employment, and other resources affecting health. Gender analysis has been identified as particularly relevant and helpful in immigrant research.

In addition, gender sensitive research has become more focused on the notion of intersectionality, meaning that gender is experienced by women at the same time as their experiences of class, race, and sexual orientation and any other forms of social difference. Forms of oppression and inequity are viewed as inseparable and are reinforced by each other as they interact (Varcoe, Hankivsky, & Morrow, 2008). Moreover Thurston, Meadows, Este, and Eisener (2006) explored the influence of employment, socioeconomics, gender, social support, community, and access to health care. They assert that gender plays a significant role in immigrant’s health as it interacts with and changes their migration experience, socioeconomic opportunities, and individual circumstances. They concluded that the relationship between migration experiences and the health of immigrant women is shown in individual characteristics and experienced simultaneously by other health determinants such as gender, socioeconomic factors, and social support networks.
Barriers in access to services and cultural conflicts may arise when women from other countries have different expectations of sex roles. Gender is also a complex variable due to the changeable and dynamic nature of social and cultural systems. Viewing through a gender lens one can determine different exposures to particular risks, different help seeking patterns, and differential impacts of social and economic determinants of health (Greaves et al., 1999). The cultural and social environment affects immigrant and refugee women’s responses in accessing and using mental health services (British Columbia Center of Excellence of Women’s Health, 2003; Morrow & Chappell, 1999).

Female gender roles often require women to be accountable for a disproportionate amount of domestic work, rearing of children, attending to family social relations, and employment outside the home (Anderson & Reimer Kirkham, 1998; Spitzer, 2004). The role of gender influences the immigrant women in her everyday experiences and might limit or make it impossible to even consider accessing help for mental health needs. The multiple changing roles of immigrant women situate them in a vulnerable, high-risk position. The shifting of the gender roles and the underlying power relations within the family greatly influences the immigrant woman’s access to mental health care services. (Greaves et al., 1999; Jiwani, 2001; Kinnon, 1999).

A relevant study revealed that immigrant women’s health care behaviour is influenced by their cultural knowledge and values, their socioeconomic status, social support networks, gender roles, and expectations (O’Mahony & Donnelly, 2007b). Spitzer also found that health service utilization is influenced by gender as it interplays with socioeconomics, immigration status, and gender roles. These interactions have been neglected in research and in the development of policies with respect to immigrant
women (Thurston et al., 2006). To provide effective health care services to immigrant and refugee women, health care providers need to recognize that the women’s social position and conditions in which they work and live could be major deterrents to the appropriate management of illness (Anderson, Blue, Holbrook, & Ng, 1993; Donnelly, 2004).

**Immigration Policy**

It has also been identified that social policies create bias against immigrant and refugee women which affect them directly (Beiser, 2005; CRIAW, 2002; Kinnon, 1999; Thobani, 1999). Immigration laws and policies may act as barriers in the usage of health care services for this population (Alaggia, Regehr, & Rishchynski, 2009; Boyd & Grieco, 2003; CRIAW, 2003). This creates difficulties for immigrant and refugee women seeking help for PPD as it places them in a disadvantaged status and prevents them from accessing certain social supports and resources. Through a gender-based lens CRIAW (2006) identified discrimination as part of immigration laws that situate women in a vulnerable and helpless position and creates dependence on their spouse or family. For example, English training programs are made to support labour demand and are often available only within a timeframe. Thus, for some immigrant and refugee women language training is not an option due to being home raising children, patriarchal ideologies and practices which may limit their choices, insufficient income to attend programs or programs that fail to provide affordable child care, and lack of access to social support. Over time these women become ‘isolated in a language ghetto’ (CRIAW, p.13).
Many feminist and anti-racist scholars contend that the Immigration Act is part of the ongoing gendering of immigration and racialization of the nation (Abu-Laban, 1999; Anderson & Reimer Kirkham, 1998; Boyd, 1998; Jiwani, 2001; Thobani, 1999). The Immigration Act originated in 1976 and was updated in 2002 to provide laws that govern immigrants upon entry to Canada (Citizenship & Immigration Canada, 2002). The objectives of this act are threefold: 1) to allow Canada to receive the maximum social, cultural and economic outcomes of immigration; 2) to ensure families are reunited in the host country; 3) to offer a safe place to individuals with a well-founded fear of persecution and mistreatment (Li, 2003).

Immigrants are a heterogeneous group. They include, for example, those arriving in Canada in the independent class of immigrants including investors with a great deal of economic and other resources, family members arriving to be reunited with their families and therefore may having a social support structure in place upon arrival, and refugees, who may have significant histories of violence, varied economic and educational resources, and a reduced social support structure. Immigration policy has been framed largely based on the Immigration Act objectives to admit four types of immigrants: family, economic, refugee classes, and other (people accepted as immigrants for humanitarian or compassionate reasons):

1) Family class: A relative, spouse, common-law or conjugal partner who is a Canadian citizen or permanent resident of Canada may sponsor the family class member. Although Canada has a universal health care system, coverage for immigrant families vary with immigration status and province. The sponsor is required to assume financial responsibility for dependence up to ten years. During this time sponsored immigrants are
not eligible for various publicly funded programs such as income security (Chard, Badets, & Howatson, 2000). Family sponsorship policy influences the sponsored women in two critical ways. The women may be pressured to work despite ill health. She may also seek financial assistance to obtain health care attention. Secondly, the immigrant's women's dependence on the sponsor may leave her vulnerable to domestic violence. Studies have shown that these sponsored women often believe that their sponsor or the government can revoke their status and deport them, which is a major deterrent in reporting problems or using public services (Oxman-Martinez et al., 2005; Jiwani, 2001). Further Oxman-Martinez et al. argued that policy support for equitable access for some immigrant women is partly an illusion. There is a contradiction that exists at the intersection between Health Canada policies that support equitable access and Citizenship and Immigration Canada (CIC) policies that limit access to certain groups. For example in British Columbia, Ontario, Quebec, and New Brunswick sponsored family members, temporary resident students and workers must wait three months to obtain provincial health care (Gagnon, 2002).

2) Economic class: This category differs in that they become more permanent residents by being selected for their skills and ability to contribute to Canada's economy. Although the independent class has been changed to the name 'economic class' the Immigration Act reinforces patriarchal control. Men are defined as economic heads of households and women as dependents, or family class. Immigration officers have tended to process applications of women under the family class, while men are more likely to be processed under the independent class as heads of households (Abu-Laban, 1998; Boyd, 1998; Ng & Strout, 1977; Thobani, 1999).
3) Refugee class: This refers to those persons needing protection. Canada, through its refugee protection system, provides safe haven to those with a well-founded fear of persecution, or are at risk of torture or cruel and unusual treatment, or punishment (Citizenship & Immigration Canada, 2002).

4) Other: This refers to individuals accepted as immigrants for humanitarian or compassionate reasons as a consequence of family abuse or violence. With relationship breakdowns, a humanitarian and compassionate (H&C) assessment and application for permanent residence may be carried out (Citizenship & Immigration Canada, 2007).

Therefore it is clearly evident that immigration policies can influence the migration of men and women in various ways. Immigration policy affects the ability of women to migrate by assuming dependant status for women; they are classified in relation to men (such as a spouse) while men enjoy an independent migrant status. By implicitly defining women as dependant it places them in a ‘family role’ rather than a ‘productive and economic role’ (Boyd & Grieco, 2003). This strengthens many factors which are responsible for the social vulnerability for immigrant and refugee women. Li (2003) also pointed out that Canada’s public discourse of immigration has taken up a narrow approach; one that ignores the multiple objectives of immigration and puts more emphasis on how well immigrants perform economically. This discourse assumes:

1) immigrants should be allowed entry by their economic abilities; 2) comparisons between immigrant earnings and those of Canadian born will determine economic value; 3) those earning more are productive and contribute to economic growth while those who earn less are deemed unproductive and more likely to use welfare support (Li). This utilitarian approach establishes a binarism dividing the legal categories of immigrants
into two types which asserts a relation of dominance: economic classes who are seen desirable, and able to meet the selection criteria of education, language skills, and work experience versus those who are less desirable, self selected and admitted as family class. This is particularly significant when examining the contextual factors that impact immigrant and refugee women’s PPD experiences as there is need to further analyze the social processes that intersect with race, class, and gender that influence the ways in which these women seek help.

**Facilitator Factors**

Although numerous barriers exist, many immigrant and refugee women seek help because of facilitative factors such as support received from their partner and family members. Most women want to receive help from their partner and it has clearly emerged in the literature that this is an important source of instrumental and emotional support in providing assistance. Supportive interactions from partners, family members, and friends help women to cope with PPD and its related problems (Ahmed et al., 2008; Dennis & Chung-Lee, 2006; Dennis & Ross 2006; Grewal, Bhagat, & Balneaves, 2008; Ornelas, Perreira, Beeber, & Maxwell, 2009; Thornton et al., 2006).

Spiritual and religious practices have also been reported as sources of support and protection with enabling resources for many immigrant women (Amankwaa 2003; Callister, Corbett, Reed, Tomao, & Thornton, 2010; Choudhry 1998; Nadeem, Lange, & Miranda, 2008). For some women it is an integral part to their migration experience because multiple changes and resettlement and loss of pre-existing support networks may provoke undue stresses. It is strongly suggested that closer links with community spiritual
organisations may increase the awareness and capacity for services to recognize the role of spirituality in preservation of mental health (Collins, 2008; Edge & Rogers, 2005).

Holistic health beliefs, valuing healthy behaviours, diet, lifestyle, and rituals have all been reported as facilitating good health care practices by immigrant women in the perinatal period (Collins, 2008; Grewal et al., 2008; Hoban, 2007; Posmontier & Horowitz, 2004; Thornton et al., 2006). It is duly noted that many immigrant and refugee women have successfully overcome numerous adversities and have demonstrated resilience and coping mechanisms post migration (Bhugra, 2004; Graham & Thurston, 2005; Thurston et al., 2006).

Through a health care provider’s perspective it was viewed that family relations, strong cultural beliefs, community-centred values, sharing within the cultural unit, and resiliency of the immigrant women impacted the ways in which they solved their problems individually and within the family. These characteristics were seen as positive coping mechanisms in problem solving through very complex and difficult situations (O’Mahony, 2005).

**Significance**

This in-depth literature review provides relevant knowledge about PPD and other related factors concerning immigrant and refugee women in the postpartum period. There is an abundance of research focusing on mainstream populations and PPD, however research on the needs and issues and specific risk factors for PPD among immigrant and refugee women has been limited (Sword et al., 2006; Zelkowitz et al., 2004; Zelkowitz et al., 2008). From the few qualitative studies done the most commonly identified risk factors are lack of social support, multiple roles, stressful life events, and
language barriers (Dennis, 2004; Katz & Gagnon, 2002; Small et al., 2003; Zelkowitz et al., 2004).

The literature review illuminates some knowledge gaps. Descriptive accounts regarding culture and PPD may be found in literature; however the impact of cultural factors upon PPD has not been well investigated. Many studies have focused attention on how health care practices based on Western cultural concepts influence the ways in which immigrant and refugee women use mental health care services. However, not many studies have examined how social support, gender, institutional, and organizational structures present barriers to women’s health seeking behaviour. There is limited research to date that have examined immigrant and refugee women’s perspectives about their social support needs, the barriers they experience, and their preferred support interventions (Letourneau et al., 2007). There is also suggestion that existing mental health services may not provide appropriate support to women with PPD and that additional research is required to evaluate women’s health service needs and barriers to service (Kurtz Landy et al., 2008; Sword, 1997; Sword et al., 2006).

In order to fully understand immigrant women’s values and experiences there is a need for more gender analysis. Such understanding will enable the health care system to provide more appropriate and accessible mental health care services to women of different ethno-cultural backgrounds. New research is warranted in areas of policy concern where there are gaps in knowledge. This includes building on existing knowledge and the development of research methodologies for immigrant and refugee women populations.

Further research investigating barriers and facilitating factors would be beneficial
in providing a clearer picture of service usage by immigrant women with mental health problems such as PPD. Investigating the reasons for differences in health care utilization may prove useful for developing mental health care programs that are culturally acceptable and appropriate to immigrant women. Furthermore, future research needs to focus on intervention strategies that listen to the immigrant and refugee women’s perspective. This will further the understanding about PPD care; provide significant information about the immigrant and refugee women’s support needs and their preferences.

In my past research (O’Mahony, 2005) I explored with health care providers their concerns about immigrant women’s mental health and how immigrant women access mental health care. It was found that (a) immigrant women face many difficulties accessing mental health care due to cultural differences, social stigma, insufficient language skills, unfamiliarity/unawareness of services, and low socioeconomic status; (b) participants identified structural barriers and gender roles as barriers to accessing the available mental health services; (c) the health care provider-client relationship had great influence on whether or not immigrant women sought help for mental health problems. As the continuation of this previous research, and knowledge gained from critical analysis of the literature I was prompted to select the methodology of inquiry, critical ethnography. This type of ethnography engages in cultural critique, allowing me to examine broader social, political, historical, and economic differences which influence the immigrant and refugee women’s situation and thus shape their PPD experiences. It also enables me to generate transformative knowledge towards equitable and improved health care for immigrant and refugee women. Thus this study is motivated by the need to
enhance opportunities for improved health among immigrant and refugee women in the postpartum period. Drawing on the literature of immigrant and refugee help-seeking practices and access to care, Kleinman’s explanatory model of health and illness (1978; 1980) and the postcolonial feminist perspective (Anderson, 2002; Reimer Kirkham & Anderson, 2002), I conducted a qualitative study with these guiding research questions addressed from the immigrant and refugee women’s perspective:

**Research Questions**

1) How do immigrants and refugee women conceptualize postpartum depression?

2) How do immigrant and refugee women utilize the available health care services and social support networks to cope with their postpartum depression related problems?

3) How do contextual factors such as social, cultural, political, historical, and economic influence immigrant and refugee women’s mental health care experiences?

4) What services or strategies could address postpartum depression care and treatment among immigrant and refugee women?

In the next chapter I present the theoretical foundation of this study: Kleinman’s explanatory model of health and illness (1978,1980) and the postcolonial feminist perspective (Anderson, 2002; Reimer Kirkham & Anderson, 2002) which provided a conceptual framework and theoretical perspectives in which to understand postpartum immigrant and refugee women’s help-seeking experiences and access to health care.
CHAPTER III: THEORETICAL FRAMEWORK

In this chapter my goal is to illuminate how Kleinman’s Explanatory Model (1978, 1980) and the postcolonial feminist perspective (Anderson, 2002; Donnelly, 2004; Guruge & Khanlou, 2004; Racine, 2003; Reimer Kirkham & Anderson, 2002; Reimer Kirkham et al., 2007) will guide my research study and provide a conceptual framework and theoretical perspectives in which to understand postpartum immigrant and refugee women’s help-seeking experiences and access to health care. Accordingly this will answer my research questions. These theoretical perspectives go beyond the biomedical framework and social science perspectives and are ways to generate transformative knowledge that can lead to equitable and improved health care for immigrant and refugee women (Anderson, 2002). Transformative knowledge is knowledge that reveals unequal power relations and issues of subordination and domination based on race, class and gender relations (Anderson & Reimer Kirkham, 1998). With these insights in mind I have selected a qualitative research method with Kleinman’s explanatory model and the postcolonial feminist perspective as theoretical foundations to provide guidance for me throughout the research study.

First, I offer my researcher stance and describe how I became interested and motivated to pursue this research study. Second, I present Kleinman’s Explanatory Model and discuss the relevance of using this framework in my research approach in exploring how immigrant and refugee women with PPD experience seeking help, including their access to mental health care. Third, because postcolonial feminism has been influenced by the critical social perspective, I highlight several important critical inquiry concepts,
and explain why this theoretical lens provides an avenue to extend knowledge regarding the immigrant and refugee women’s situation. Fourth, I discuss the foundations of the postcolonial feminist perspective theory and the utility of this perspective in exploring immigrant and refugee women’s mental health care experiences. I discuss the implications of how these philosophical and theoretical perspectives will guide knowledge production in my research study, future practice, and education.

**Role of the Researcher**

My strong interest in health promotion and prevention has spanned over 30 years within my nursing practice. Having worked with marginalized populations in northern British Columbia and in several urban acute care settings, I became increasingly interested in how best to provide appropriate care for immigrant and refugee women. At the same time I observed other health care providers struggle in situations, become frustrated, and blame or stereotype the immigrant women for their inability to understand health care issues or participate in prevention activities. I often wondered about the quality of care that was being provided and how these immigrant women coped with such adversity. This also prompted my attention towards the complexity of the barriers and facilitators to care and resources within the health care system. More recently as a community health nurse working with new immigrant and refugee mothers who are at high risk for PPD, I wanted to understand and in turn increase awareness of their experience.

As part of this research and as a researcher I am very aware that I may bring certain biases, values, and beliefs into this research process. My background as a Canadian privileged middle-class woman and health care provider are acknowledged.
Through years of providing nursing care to immigrants and refugees, I am highly motivated to conduct this research in order to provide more appropriate and quality care to immigrant and refugee women in need. Reflexivity is an acknowledgment and introspective process where researchers constantly challenge themselves to see how their own perspectives are affecting the research method, analysis, or interpretations (Lobiondo-Wood, Haber, Cameron, & Singh, 2009). My desire to incorporate reflexivity is based on my assumptions that there is potential that: a) the researcher may have influence or be influenced by the research study, and (b) the researcher must understand that reciprocal influence is an important element of the research process (Lamb & Huttlinger, 1989). My interactions within the research process and theoretical insights required regular self-reflection. A reflexive journal was kept to keep a record of insights, feelings, and other emotions which were generated as part of the research process. An essential part of the reflexive journal as Lincoln and Guba (1985) suggested is “a personal diary that provides the opportunity for catharsis, for reflection upon what is happening in terms of one’s own values and interests and for speculation about growing insights” (p.327). I used my journal regularly after each interview and throughout data analysis because it was a place for me to write down my thoughts and reflect on what the participants had shared with me. Many times after interviewing I was ‘emotionally exhausted,’ bewildered, and felt quite helpless after hearing some of the women’s narratives. Recording my thoughts was a way of releasing my intense emotions, as well as reflect on the way I expressed myself. Because of these reflections I made changes in my use of language and concepts, which made it easier for the women to understand what I was asking of them. Recognizing the participants were from diverse countries, had
varying levels of facility in English, and were from varying educational backgrounds I
became more conscious of adapting an individual approach to each interview.

**Kleinman’s Explanatory Model**

Kleinman’s (1978, 1980) explanatory model was used as a theoretical perspective
in this study. This model is a way of conceptualizing and understanding how health,
ilness, and healing could be viewed as cultural systems. According to Kleinman (1980),
examining social and cultural processes are important because these processes shape the
ways in which people feel, act, and utilize health care services. In turn the ways in which
people use health care services are influenced by how they conceptualize health and
illness. Thus, by being able to elicit and identify the immigrant and refugee women’s
beliefs, values, and understandings of health, illness, and treatment, I can explore how
their health care behaviour is influenced by their cultural knowledge and values.

Conceptualizations of culture have multiplied with the many definitions
anthropologists have posited over the years. For example Barker (2008) insisted that
culture can be best understood as “criss-crossing discursive meaning which form zones of
temporary coherence, shared but always contested significance in a social space.
Production and exchange of meanings, or signifying practices lead to a distinctive way of
life” (p. 477). Barker (2002) stated the central concept of culture does not represent an
independent unit in an objective world but rather enables particular ways of talking about
human activity that emphasize different uses and achieve different purposes. Thus the
concept of culture is political and contingent and stresses the interlocking of power and
meaning with an aim to promote social change and improve human circumstances
(Barker). Moreover Hall (1997) emphasized that “cultural meanings organize, regulate
social practices, influence our conduct and consequently have real practical effects” (p. 3). This is particularly important as it strongly relates to the overall goal of this study to increase understanding of the immigrant and refugee women’s PPD experience and what would be helpful in meeting their mental health needs.

My conceptualization of culture is drawn from authors Barker (2002, 2008), Hall (1997), Helman (1994) and Kleinman (1978, 1980). Culture is learned, shared, and is transmitted knowledge of values and beliefs, and may influence thinking, decision making and actions in particular ways. Culture determines the construction and exchange of meanings within a given group or society. Meaning is thought to be produced and constructed rather than found. Emphasis on cultural practices is significant for this is how individuals in a culture give meaning to people, events, and objects. Through our use of ‘things’ we can represent them and give them meaning (Hall, 1978). Meanings regulate our behaviour and every day practices and in turn help to govern the norms, customs, and rules of society. Kleinman (1978) viewed culture as a system of symbolic meanings that may influence the social reality and experience of others. In my research of immigrant and refugee women this is important because the environment that one lives in is linked to culture as well as to experiences of health and illness. This view of culture supported my thinking that in order to understand the immigrant and refugee women’s health care behavior there was a need to understand their conceptualizations of health, illness, and disease, as well as how their cultural values and knowledge may shape this experience. Helman (1994) summarized from various anthropologists that culture is a set of implicit and explicit guidelines which individuals inherit as being a part of a particular society. It tells them how to view the world, experience it emotionally, and behave in relation to
others, to supernatural forces/gods, and to the environment. It is a way for transmitting these guidelines to the next generation by use of art, language, symbols, and ritual. Helman also influenced my thinking about how ‘culture can be seen as an inherited lens’, one that an individual uses to observe and understand the world that he lives in and also learns how to live in it.

Culture is also representative of a constant evolving network of dynamic meanings intertwined within social, economic, political, and historical processes. Therefore, it is essential that in order to provide adequate PPD care to immigrant and refugee women an awareness and consideration of all factors that influence their responses is necessary. Moreover, it is the aim of this research to address and examine culture as one of the ways that shapes immigrant and refugee women’s responses to health and illness, most particularly during the postpartum period.

Kleinman and Good (1985) ask ‘what is cultural about depression?’ What can anthropologists and cross-cultural psychiatrists offer to deepen the understanding about depression? Do depressive symptoms present differently in other cultures and societies? Arthur Kleinman (1978, 1980), a cultural anthropologist and psychiatrist, has worked for several decades exploring how people of different Eastern cultures practice health care. He has studied cross-cultural aspects of depression and upholds that culture is of significant importance to the experience of depression, the meaning construction, social relationships, and depression within families and communities and the trajectory and constitution of the depressive illness (Kleinman, 1988). From an anthropological stance the emotion of depression may display the same physiological responses in many cultures; however as a psychological event it is a lived experience to suffer depression
ensuing physiological processes to interact with the social world and the construction of meaning. ‘Suffering’ is a cross-cultural phenomenon worldwide and is also part of clinical depression. But what suffering means to one individual may be experienced quite differently by another (Kleinman, 1991). Further through an anthropological lens, the category and function of mental illness are not givens but “emerge from a dialectic connecting – and changing – social structure and personal experience… the golden thread running through ethnographies of life in different cultural systems” (Kleinman, 1988, p.3). This dialectic acts as a go-between within the social world and the thoughts and actions of the individual creates experience. Language mediates the ties between the social and personal worlds and value hierarchies, symbolic meanings, and visual forms that make up the cultural processes which orders social life (Kleinman, 1988). This is important to understand because one must take into account the ethnographic narrative of the changing social context of the immigrant and refugee women’s cross-cultural experiences in how they perceive and cope with PPD.

Kleinman’s anthropological concepts are applied in this study because the cultural construction of mental illness as a psychosocial experience involves complex socio-psycho-somatic processes that influence sickness and healing. Past treatments of mental health problems have proven to be ineffective for immigrant and refugee women, because adequate attention has not been paid to their social context (Beiser, 2005; Khanlou, 2010; Kinnon, 1999; Morrow et al., 2008; Vasilevska & Simich, 2010).

Health Care System Structure

Arthur Kleinman (1978) viewed culture as a system of symbolic meanings that may influence experience and social reality of individuals. Social reality is defined as
“human interactions existing outside the individual and between individuals…social roles are defined, people negotiate with each other in established status relationships under a system of cultural rules... sanctioned by society” (p. 36). Symbolic meanings, norms, attitudes and behaviours are internalized by the individual as social reality. Kleinman (1980) asserted that beliefs about illness, behaviours shown by sick people, treatment options, and the way sick people are cared for by family and health care providers are all parts of social reality. Therefore, depression as a social reality is not only the result of culturally influenced interpretations of an illness; it is an interpreted disorder. For example, in some cultures they may see depression as the result of moral weakness, while others see it as a chemical imbalance. Because culture plays such a powerful role (Kleinman & Good, 1985) in shaping perception and the interpretation of what is normal and valued it is imperative to understand how this may influence immigrant and refugee women’s management of an illness such as PPD. Immigrant and refugee women’s postpartum help seeking experiences are affected by their social reality which involves their beliefs, cultural norms, attitudes, decision making about treatment, and the interactions and responses by their family and health care provider.

To enhance the understanding of how cultural concepts in mental illness could be useful, Kleinman postulated that medical systems could be compared to cultural systems. He maintained that health, illness, and health care are parts of a cultural system and need to be understood in relation to each other. The internal structures of health care systems are composed of common and ‘culture laden components.’ The internal structures are similar across cultural boundaries; however the content would differ within the social, cultural, and environmental circumstances of each system. The inner structure of every
health care system is composed of three overlapping sectors: the professional, the popular, and the folk (see Fig. 1). Each sector has its own distinct explanation and understanding of health, illness, and treatment. This is vital in recognizing that different views of health and illness may be brought to the health care provider-client encounter. The meanings and value assigned to events within the context of the immigrant and refugee women’s experiences provide awareness and understanding of how the immigrant and refugee women may develop their ideas about what is most important in relation to an event and how their ideas may influence their behaviours. This particularly is important in understanding the women’s perspective in order to provide appropriate guidance and interventions in the postpartum period.

Figure 1. Kleinman’s Explanatory Model: Structure of health care systems:

![Diagram](image)


The three sectors are:

**Professional sector of health care.** This professional sector consists of health professionals who, in most societies, include physicians, nurses, and other healthcare
providers (Kleinman, 1980). In most societies it is referred to as modern scientific medicine. Unlike the popular and folk sectors the ill person is removed from continuous support of family and friends to an environment where the emphasis is on their physical disease with little reference to their home environment, personal relationships, or religion.

This professional sector requires complete acceptance of the clinical reality as being the only legitimate clinical reality. Clinical reality as defined by Kleinman (1980) “are the beliefs, expectations, norms, behaviours, and communicative transactions associated with sickness, health care seeking, practitioner-patient relationships, therapeutic activities, and evaluation of outcomes” (p. 42). Clinical realities are the health-related aspects of social reality. This process of cultural construction of clinical reality is through diagnostic activities where health care providers negotiate with clients’ ‘medical realities’ that become the focus of medical intervention and therapeutic treatments (Kleinman, Eisenberg, & Good, 1978). Special emphasis is on therapeutic relationships, attitudes, and norms regarding the illness. Therefore to comprehend how immigrant and refugee women practice health care and make decisions about mental health problems after childbirth we need to know about their explicit thoughts, expectations, communications, relationships with health care providers, and family members concerning appropriate postpartum care and treatment. Kleinman and colleagues (1978) uphold that the interplay between client and health care provider expectations shape the clinical reality that is negotiated in clinical practice and as a result the clinical reality may vary by health care provider and social setting.
Popular sector of health care. Between 70-90% of illness is managed in the popular sector in both Western and non-Western societies (Kleinman, 1980). Within this sector the family plays a central role in making decisions of what to do and whether to comply in certain types of health care activities. It is the most immediate determinant of care; it is where illness is first defined, treatment is offered, and progress evaluated. Decisions are influenced by the popular culture’s values and beliefs about illness and health. Should people decide to enter either the professional or folk sector to choose more treatments, they will encounter different sets of beliefs and values in the cognitive structures of professional or folk practitioners (Kleinman). For example, an immigrant woman suffering from depression in the postpartum period may try to draw on past experiences and cultural knowledge within her family to cope. However, the family also might seek outside help such as a physician or administer herbal therapy, or both. In all aspects of the popular sector, from self treatment to consulting with others, the family may facilitate or impede access to health care, with the latter resulting in negative effects on the patient’s health.

Folk sector of health care. According to Kleinman (1980), the folk sector is particularly large in non-Western societies and is made up of individuals which specialize in forms of healing. These healers occupy an in-between position between the professional and popular sectors. There are two distinct sides to health care in this sector: overlapping sacred and secular parts. The sacred healing refers to studies of folk religion and includes ritual curing. Folk healers share common cultural values including beliefs about the origin and treatment of ill-health of the communities in which they live. Folk healers are extremely common in societies where ill-health is blamed on social causes
such as witchcraft, evil eye or supernatural causes such as Gods, spirits or ancestral ghosts (Helman, 1994). Secular folk healers include technical experts such as bone-setters, tooth extractors, herbalists and spiritual healers. The secular forms of healing involve herbalism, specialized exercise, traditional surgical and manipulative therapy, and symbolic non-sacred healing.

Some values and beliefs may be common to all three domains and there are no clear cut boundaries between them. There is interaction between sectors as individuals may use all three. For example, the immigrant or refugee woman may enter at the professional sector of health care for treatment of post partum depression, but in the course of action may draw from her knowledge acquired from all three sectors of the healthcare system.

**Explanatory Models**

It is also useful to clearly distinguish that the explanatory models (EMs) are held by both clients and health care providers which are anchored within each sector of the healthcare system (Kleinman 1978, 1980). Explanatory models are personal beliefs used to identify, interpret, and cope with particular illness. They are tied to specific systems of knowledge and values among the different sectors of the health care system. Specifically EMs may provide explanations of one or all of these five aspects of an illness experience: cause of condition; onset/timing of symptoms; pathophysiological involvement; natural course and severity of the illness and treatment options (Helman, 1994; Kleinman, 1978). A central component of health care is the interaction between the EMs of patients and healthcare providers (Kleinman, 1980). It has been shown that individuals' cultural backgrounds shape their EMs of illness and disease, and their expectations toward
treatments, which in turn influence how they make decisions regarding coping with illness and health care practices (Good, 1994; Kleinman, 1978, 1980; Lock, 1980). Therefore not infrequently EMs conflict along with unacknowledged cultural influences which lead to problems in communication and the health care provider-client relationship. Moreover, Fung and Wong (2007) found that while explanatory models may have impact on attitudes toward seeking professional help, this influence may be important only if access and help are perceived as available. By exploring their PPD experience with the immigrant and refugee women we create a narrative about what they view as causes of their problem and in particular the meaning it holds for them (Kleinman, 1988).

A significant contribution Kleinman (1978) makes is the conceptual distinction between disease and illness (Anderson, 1987; Donnelly, 2004). This distinction holds that disease is more commonly associated with the EMs of the healthcare provider. It denotes the malfunctioning of psychological and biological processes. Biomedicine is primarily concerned with identifying and treating disease and therefore disregarding illness as a legitimate object of clinical concern (Kleinman). In comparison, illness is the experience of disease which represents how the sick person and their family perceive, explain, and respond to disease. Illness behaviour is influenced by cultural factors and individuals learn accepted ways of being ill (Kleinman). It is often part of the EMs of the popular sector where sickness is managed within the family in a more personal manner. The illness experience is strongly influenced by the individual’s culture, social, and economic circumstances (Anderson, 1990). The important point here is that not only are discrepancies bound to occur between client and health care provider perceptions of
illness and disease, but to provide effective health care, and to ensure the clients' cooperation, health care providers need to negotiate and treat illness in a way that is socially and culturally acceptable to the client.

Kleinman's theory therefore provides a framework for the systematic investigation and analysis of how immigrant and refugee women's healthcare behaviour is influenced by their cultural knowledge and values. The experience of health and illness is linked to the environment in which one lives as well as to culture. This approach will enable me to understand immigrant and refugee women's health care behaviour and their mental health care experiences by: (a) Asking carefully constructed interview questions to explore from the immigrant and refugee women perspective their knowledge and beliefs about PPD. To answer my research questions, I must understand their conceptualizations of health, illness, and disease, as well as how their cultural values and knowledge may shape health care experience. (b) Examining whether there are any difficulties accessing mental health care services for postpartum depression. These types of questions provided data on problems and structural barriers immigrant and refugee women may face. It also provides information on the facilitative factors that enable many immigrant and refugee women to seek help. This, in turn, helps increase my awareness of the contextual factors that organize the women's mental health care experience. (c) Asking interview questions about how these women seek informal and formal support to cope with their PPD. The participants will be asked what is or would be helpful to meet their mental health needs. These kind of questions help generate data concerning the importance of the health care provider-client relationship as well as the problems that arise when meanings assigned to events are not shared by both. This type of information
is also beneficial to illuminate meanings assigned to events within the context of the immigrant and refugee women’s experience, an understanding of what is important to an event and how it may influence the immigrant and refugee women’s behaviour. Therefore relevant information as to how the health care provider encounter could influence immigrant and refugee women’s help-seeking will be obtained.

Overall, Kleinman’s explanatory model provides a framework in which to look into the interactions of immigrant and refugee women, their families and social support networks, and health care access for this study. It will increase my understanding as to how cultural knowledge, beliefs, and values influence immigrant and refugee women’s help-seeking experiences within the postpartum period. Although it is important to study health behaviour as an individual phenomena it is also necessary to use perspectives that broaden understanding of the social, political, historical, and economic influences that shape the health of a society (Butterfield, 1990). As Kleinman’s framework does not elaborate on broader social, political, historical, and economic factors nor illuminate how gender, race, class, and power relations influence the women’s help-seeking experiences, I will turn to postcolonial feminist theory. Because postcolonial feminism has been influenced from a critical social perspective embracing women’s subjugation and domination, there is a logical unity between the emancipatory and empowering approaches of critical social theory and feminist theory (Campbell & Bunting, 1991). I will first present an overview of critical inquiry, and discuss why critical epistemology gives us ways to conduct valid inquiries into the immigrant and refugee women’s situation.
Critical Inquiry

The origins of critical theory date back to Germany and establishment of the Frankfurt school in the 1930’s. Max Horkheimer and colleagues Herbert Marcuse and Theodor Adorno all contributed to the foundation of critical theory. Horkheimer’s primary ideas were about developing social philosophy which would provide criticism of positivism. He was very concerned about natural scientists’ acceptance of empirical observations being the only legitimate form of knowledge (Campbell & Bunting, 1991). Thus the criticism of positivism and attempts to provide alternative epistemology were the foremost principles underlying the works of the Frankfurt school (Kim & Holter, 1995).

The notion of positivism was first introduced through the works and perceptions of Auguste Comte, a nineteenth century philosopher. The central assumption underlying positivism is that there is a specific relationship between the world (objects, events, phenomena) and our view and acceptance of it. Kirk and Miller (1986) defines positivism as assuming that “the external world itself determines absolutely the one and only correct view that can be taken of it, independent of the process or circumstances of viewing” (p14).

These central ideas of the rejection of positivism and formulating alternative epistemologies were carried on in the 70’s by Jurgen Habermas, a dominant contributor to the field. Habermas (1971) asserted that “positivism wants to eliminate orientations of inquiry that are meaningless because they are undecidable; that is to be done by restricting to ‘facts’ the object domain (Objektbereich) of possible scientific analyses” (p 74). He argued against the idea that objective knowledge is hardly interest-free and that
we are a part of the social world we study and participate in. He continued the refinement of critical theory and offered an alternative epistemology for social theory. Habermas’s epistemological reflections suggest three distinct but interrelated domains of knowledge in which to capture social reality: practical, technical, and emancipatory knowledge. Practical knowledge is about understanding, reflecting and interpreting social life, whereas technical knowledge is focused on reasoning and control in dealing with objects. Emancipatory knowledge is about liberating individuals from the constraints of domination and unequal power relations by creating further knowledge that involves increased understanding, autonomy and responsibility (Kim & Holter, 1995). Habermas claimed that critically oriented sciences acknowledge that technical, and practical knowledge are necessary and there is a ‘critical’ interest in emancipation which should govern the social sciences (May, 1980). May proposed:

Habermas does not seek to eliminate interest from research but rather engender an interest in liberation. He encourages a social research...orientated to advocacy and criticism...The critical sciences are orientated to the future rather than the past. They are defined by anticipation rather than reminisce. As knowledge, they interestedly press for human emancipation (p 366).

Thus, a significant goal of critical theory is to produce emancipatory knowledge that promotes social change and a more just society (Allen, 1985; Campbell & Bunting, 1991; Morrow & Brown, 1994; Quantz, 1992).

Emancipation, an important concept toward knowledge building, is closely tied to Foucault’s (1980) notions of resistance and counter-acting opposition. Emancipation as defined by Inglis (1997) “concerns critically analyzing, resisting and challenging
structures of power” (p. 4). Inglis asserted that emancipation is a continuous struggle to reveal the ongoing nature of power. Yet it is not just about viewing power as always desirable or advantageous, rather it is showing people how they can come to know and understand power and to see how it operates in their lives, their family and community. Foucault (1980) argued that we cannot consider knowledge without viewing the structural and power relationships. Power can never be seen as something that is owned or remains static. He asserted: “It is never localized here or there, never in anybody’s hands, never appropriated as a commodity or piece of wealth” (p.98). Power circulates in multi-directions and is seen in all levels of society. This means that the nexus of power and knowledge can be transformed by all individuals, even those who are disempowered. Yet those individuals must work harder against their subjugated forms of knowledge which previously had been silenced through dominant discourses. Foucault (1978) defined power as dependant on resistance:

When there is power, there is resistance and yet or rather consequently this resistance is never in a position of exteriority in relation to power.

I’m not positing a substance of power. I’m simply saying: as soon as there’s a relation of power there’s a possibility of resistance. We’re never trapped by power: it’s always possible to modify its hold, in determined conditions and following a precise strategy (p.95).

Foucault’s writing has asserted that power relations arise when there is difference or conflict; that when one individual or group is affecting the other. Power solicits the resistant forces into its own realm by labelling them, defining difference and determining norms (Sawicki, 1991). Secondly within Foucault’s description of power he claimed that
whenever there is a relation of power one is never trapped because it is possible to make modifications on the hold of power. He described the social field as unstable however containing an open system of possibilities of domination as well as resistance. Moreover Foucault emphasized how localized forms of resistance and power occur at the micro level of society in daily interactions (Sawicki). Such resistance serves to reveal the contested space between what is unknown and what is thought to be fact. For example this could be played out in the field of psychiatry where patients' self-knowledge has been subjugated through psychiatric labelling and decontextualized interventions. This process provides a way of bringing an emancipatory element to knowledge building; one that acknowledges contextual factors, considers political forces that disempower individuals, and recognizes marginalized voices as legitimate (Ali, 2002; Anderson, 2002). This process of new knowledge construction is a more open ended dialogic approach and one that is committed to the long term, broad based ideological struggle necessary to change structural inequalities (Lather, 1991).

So what does this imply for groups of women such as immigrant and refugee women struggling with PPD? This unequal based distribution of power and knowledge is particularly troublesome for some women struggling with mental health problems such as PPD. 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 calls for approaches that allow a powerful opportunity to enable individuals to change through self-reflection and a deeper understanding of their particular situation (Lather 1986,
1991). For immigrant and refugee women struggling with PPD it is especially important for it is through dialectical practices they are learning to recognise and challenge societal forces, the same forces that have oppressed them in the past. It is in my view that immigrant and refugee women of this study challenge oppression by speaking out and wanting to bring attention to their individual experiences of possible social injustices and unequal social relations. They want to contribute to improving PPD health care services and how care is delivered for immigrant and refugee women in the postpartum period. These participants also gain transformative knowledge; that is new knowledge constructed to guide them from being a passive struggling individual with PPD to one that actively advocates for women who are suffering from PPD.

From the perspective of critical inquiry, then, let us start with immigrant and refugee women’s experiences and examine these experiences within the context of their lives. This examination prompts 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? It also has meant the introduction of praxis-oriented paradigms into the discipline of nursing (Thorne, 1997). The concept of “praxis” is: “Research and practice are inevitably theory-laden... in praxis nurses become more aware of the links among theory, research, and practice. Nursing practice and research become theory-in-action and practice informs research and theory building” (McCormick & Roussy, 1997, p. 269). For example, praxis is used as a central tenet in feminist theory to direct attention toward the political action required to bring about changes for women. Research as praxis is not only a way to understand and critique
power imbalances but also to “change that maldistribution to help create a more equal world” (Lather, 1986, p. 258).

Carspecken (1996) a critical ethnographer, described the value orientation that underpins critical inquiry. “Criticalists find contemporary society to be unfair, unequal, and both subtly and overtly oppressive for many people. We do not like it and we want to change it” (p. 7). A value orientation is shared and a concern with social theory that has had struggles with issues such as social structure, power, human agency and culture since the nineteenth century. Researchers attempt to clarify how and where subjugation works by juxtaposition of and dialogue about alternative forms and images of oppression. An important distinction is that critical inquiry research exists to refine social theory and not just to provide a description of social life (Carspecken, 1996).

A critical inquiry approach has enabled me to examine the connections between each immigrant and refugee woman and her family, the community, and how the broader social and cultural environment may shape their health care practices and mental health care access. Moreover developing an increased understanding of how gender, race, and class influence these women’s mental health care practices it will help develop more effective PPD care and treatment among immigrant and refugee women. It may also contribute to empowering new immigrant and refugee women in Canada by making their voices heard and providing more appropriate support and access to mental health care services for this population.

Carspecken (1996) stated that critical epistemology has evolved as a way to understand the relationship between power and truth, and to uncover systemic societal practices that have oppressed disadvantaged groups. A critical epistemology is an
understanding of the relationship between power, thought, and truth claims. Critical inquiry challenges the status quo and the dominant powers in society and thus offers new ways for nurses to address health care issues and practice (Allen 1985). One of the most important goals of critical inquiry is to establish conditions for open communication and to expose hidden power imbalances. It involves the questioning of assumptions, taking on a more reflexive approach and recognizing the ways in which these views may be affecting our nursing practice. By developing critically reflexive practices and consciousness we can be more aware of the extent in which we hold knowledge, power and privilege in relation to other societal groups (Allen 1985; Browne, 2000). Anderson (2002) tells us that critical inquiry helps us to reflect on how production and presentation of knowledge within a certain ideological foundation sustain existing power relations, helplessness and inequities, which in turn further marginalize immigrant and refugee women.

Another important dimension of critical inquiry is its goal of transformative change in favour of social justice. Critical inquiry approaches represent new avenues for contributing to advancing new knowledge to address health inequities by using reflection to generate strategies for social justice. It gives us ways to conduct valid inquiries into the context of any human experience and in particular an interpretive lens to address sociopolitical oppressive conditions influencing health and health care (Browne, 2000). Past studies have examined immigrant and refugee women’s mental health care experiences, but there is limited understanding of how the complex relationship between these women and the environment in which they live influence their mental health experiences. Therefore, critical inquiry may illuminate how social injustices and unequal
social relations possibly contribute to unequally distributed health care resources and inaccessibility of health care services for immigrant and refugee women. With these insights I incorporate postcolonialism and black feminism into the study as theoretical perspectives to assist me in examining how immigrant and refugee women’s PPD help-seeking experiences are influenced by how contextual factors intersect with race, gender, and class.

**Postcolonial Feminist Perspective Inquiry**

Postcolonial feminism is one of the critical theories that provide a theoretical lens through which issues of social justice are examined and included in the analysis of the research. Why is the postcolonial feminist perspective so important in nursing research? What does it offer in health care? What is different about the postcolonial feminist perspective? This lens raises analysis beyond single causal factors of illness or micro level analysis to provide an enquiry into the multifaceted socio-economic, historical and political forces which shape the human experience (Anderson, 2002; Donnelly, 2004; Kinnon, 1999; Reimer Kirkham & Anderson, 2002). In critically reflecting about the interlocking influences of race, class, and gender and other social relations, it is important to be aware of how the complexities of these influences are played out in every day life. Beginning with the individual’s experience and working back to examine how lives are put together and the social relations that organization everyday experience, Smith (1999) asserted that social relations do not refer to relationships but instead social relations direct attention and analysis to what people are doing and experiencing at a given local site. Smith stated, “A social relation is not a thing to be looked for in carrying out research, rather it is what is used to do the looking” (p.74).
There are four central tenets of postcolonial feminist research which characterize how this research may be viewed.

**Central Tenets of Postcolonial Feminist Research**

Within the postcolonial feminist perspective, there are central tenets of how qualitative research may be viewed and supported. First, researchers who conduct postcolonial feminist research are critical of the traditional social sciences, and in particular its ontological and epistemological underpinnings. They argue against the objectivism and value free epistemology of traditional scientific inquiry (Ghandi, 1998). These researchers theorize that knowledge is socially constructed and value laden. With this awareness and understanding, I selected a qualitative method of inquiry whereby knowledge obtained is socially constructed rather than using patriarchal knowledge-claims based on past research which served the interests of those who want to position PPD as a problem rather than seeking strategies to help the depressed woman (Nicolson, 1998). Patriarchal universal ideology refers to a set of ideas and beliefs that justify male domination. This social ranking is an important determinant of gender relations as it creates larger gender differences in power (MacKinnon, 1983). Moreover while the medical model perspective is recognized, the focus is not on the physiological and psychological causes which define the immigrant and refugee woman as being ‘ill’ and requiring treatment but rather seeking a solution for these women. In this research study I have paid careful attention to the complexity and experiences of the immigrant and refugee women’s everyday lives which often may be overlooked.

The researcher’s race, class, gender, and culture also shape the research process. The positionality of the researcher is acknowledged and incorporated into research
analysis. Researcher as instrument is an important and integral part of participant observation and demands complete commitment by the researcher to analyze and interpret the culture. We must acknowledge that our work and our words are grounded in the particular standpoints we occupy. Highlighting positionality allows the researcher to be aware of his or her own subjective experience in relation to that of their participants and is key to acknowledging the limits of objectivity (Deutsch, 2004). Thus with these views in mind and as a committed researcher I have incorporated my positionality as a Canadian middle-class woman and health care provider into the research analysis. It has urged me to look at and acknowledge my own power and position of authority as a nurse and researcher who is morally responsible and accountable for how I interpret and represent the data from my participants. It has urged me to ask questions of myself such as ‘how will I best represent these women’s voices? And who does it benefit the most? Will my work make a difference in these women’s lives?’ As Madison (2005) noted ‘it is a turning back on ourselves’ where we examine our purpose and method and any potential effects of the research process.

Second, postcolonial feminist research is committed to examining how race, gender, and class relations influence social, cultural, political, and economic factors, which in turn shape the lives of marginalized women. Therefore, in this research study I will examine how racialization, gender roles, expectations, and class hierarchal relations shape individual health care practices of immigrant and refugee women living with mental health illness. Instead of viewing each woman as being totally responsible for her health care (behaviours which are dictated by their cultural beliefs), researchers shift their gaze toward examining how health care institutions and policy affect women’s health and
health care (Donnelly & McKellin, 2007). One of the important functions of postcolonial feminist research is to examine how inequity and unequal social power relations influence the distribution of health care resources and accessibility of health care services for women of marginalized social groups (Anderson 2000, 2002; Anderson & Reimer Kirkham, 1998). Through the immigrant and refugee women’s narratives I will be able to examine and gain a deeper understanding of the barriers and facilitators that have influenced these women in seeking help for PPD.

Third, a feminist project is a social justice project which places women’s experiences at the centre of analysis (Anderson, 2002; Collins, 2000a; Donnelly, 2004). The aim of feminist research is not only to generate a more accurate account of women’s lives from everyday experiences, but also to change the oppressive conditions in which they live. Feminist research is politically driven in the sense that it challenges the dominant forces that shape women’s lives and seeks answers to how to defeat or neutralize those forces. Thus the aim of this research is not only to generate an accurate account of women’s health care activities in relation to mental health care, but also to improve the conditions in which they live, practice, and access health care. This theoretical perspective “recognizes the need for knowledge construction from the perspective of the marginalized female subject whose voice has been muted in the knowledge production process” (Reimer Kirkham & Anderson, 2002, p.10). Mental illness such as PPD can be identified and addressed from the perspective of women who have experienced the illness.

Lastly, postcolonial feminist research pays attention to the interlinking of knowledge and power relations. Foucault’s (1980) work underlies many of the
postcolonial feminist scholars which connects the production of knowledge with power relations and discourse. He asserted that knowledge cannot be reduced simply to language, meaning, or whether or not the investigations of theories are true. Knowledge is political, that is, it is subject to change under the effects of power relations within social institutions and disciplines. His theory about discourse places much emphasis on the relationship between knowledge, truth and power. Foucault urges us to look at the present forms of truth and rationality as determined by dominant discourses in the healthcare sector and recognize it for what it is: a dominant discourse embedded where power and knowledge are both produced and maintained. These present forms of truth and rationality determine the issues acceptable for mainstream health (Cheek & Porter, 1997). It is important to be aware that medical knowledge and practice frame the discourses through which health and illness are explicated. Relationships between the values of the profession that discriminates against women and in the way knowledge-claims about women’s health are formed are essentially connected (Foucault). In exploring immigrant and refugee women’s PPD experiences it is especially critical to pay attention to where knowledge is generated and how it be used because women’s past experiences of childbirth and PPD have not been taken seriously nor considered a legitimate consideration for science (Nicolson, 1998).

Although postcolonial discourses are not well known in nursing research, there is an emerging need to incorporate postcolonial perspectives into nursing science as an alternative to the culturalist approaches that dominate nursing theory. Such theories perpetuate stereotypical views of culture and race in our health care settings and communities. Ideas about different cultures are often used to explain difference, without
an appreciation of the ways in which culture and race operate (Reimer Kirkham & Anderson, 2002). With these notions in mind I offer more about postcolonial theory in the next section.

Postcolonial Theory

Young (2001) defined postcolonial theory as an interdisciplinary grouping of theories covering a wide range of comprehensive knowledge while sharing a central and common concern about the effects of colonialism on cultures and society and how it continues to impact individual’s lives and circumstance. Postcolonialism is one of the critical theories that shed light upon the everyday experiences of marginalization, and includes an analysis of the micro politics of power and the macro dynamics of structural intersecting oppressions (Reimer Kirkham & Anderson 2002). An important feature of postcolonial theory, and one which sets it apart from other critical theories, is its focus on disrupting historical racist views and structural inequities that have emerged through the practices of colonization (Browne, Smye, & Varcoe 2007; Reimer Kirkham & Anderson, 2002). By drawing on postcolonial theory and feminist perspectives it provides more analytic depth in understanding the many-sided factors that affect immigrant and refugee women living in Canada. Factors such as racism, historical positioning, and gender are all important factors to explore for they shape the broad determinants of health (Browne et al.) and thus will provide more insight into immigrant and refugee women help seeking practices to manage their PPD.

Associated with the term colonialism is defining the type of cultural exploitation that developed in Europe over the past 400 years (Ashcroft, Griffiths, & Tiffin, 2000). Williams and Chrisman (1994) viewed colonialism as a “particular phase in the history of
imperialism and it is now manifested as the globalisation of the capitalist mode of production, its penetration of previously non-capitalist regions of the world, and the destruction of its social organization” (p.2). Said (1993) offered the distinction that “imperialism means the practice, the theory, and the attitudes of a dominating metropolitan centre ruling a distant territory; colonialism which is almost always a consequence of imperialism, is the implanting of settlements on distant territory” (p.8). The term postcolonialism is often associated in discussions related to nations colonized by Europe yet the processes of colonization and decolonization affect colonized societies in different ways (Hall, 1996). Therefore Hall posited that postcolonialism is not about a single society but rather involves multiple nations in the process. It has been widely used to signify the political, cultural and linguistic experiences of societies that were former European colonies.

Thus as a result of these complex processes and with the strategy to establish colonies to provide new markets and sources of labour and raw materials, economic exploitation of the indigenous people was significantly strengthened. Ashcroft et al. (2000) noted “It also meant that the relation between the colonizer and the colonized was locked into a rigid hierarchy of difference deeply resistant to fair and equitable exchanges, whether economic, cultural or social” (p. 46). In situations where people were of a different race or were minority indigenous people, the ideology of race was a critical part of the construction and naturalization of unequal relations and inferiority. These ideologies in which certain people are perceived as less advanced or subordinate have allowed the processes of domination to occur, creating tensions and inequality in other societies.
Race is particularly significant to the rise of colonialism because it gave colonist powers a way to divide people and establish dominance, thus justifying the imperial enterprise (Ashcroft). The binary logic of imperialism was to see the world in oppositions and could be articulated as black/white, colonized/colonizer, good/evil, and civilized/primitive to name a few examples. The most damaging binary system noted (Ashcroft) is the concept of race whereby using “complex physical and cultural differences within and between colonized societies toward the simple opposition black/brown/yellow/white is in fact a strategy to establish a binarism of white/non-white which asserts a relation of dominance” (p. 26). By reducing the importance of ethnicity, racial groups and specific cultural identities to either the unthinkable or to the representation of the Other which re/produces a sense of otherness, imperialism draws the concept of race into a simple binary; one that holds power. This is an important concept within postcolonial theory and most relevant in this study when examining contextual factors which may influence immigrant and refugee women’s mental health care experiences. Moreover there are constructions based on the assumptions about race that intersect with other relations of power to disadvantage some groups and may establish class position for others (Anderson, 2006). Therefore when examining the contextual factors that impact immigrant and refugee women’s PPD experiences, one needs to further analyze the social processes that intersect with race, class, and gender that influence the ways in which these women seek help.

Quayson (2000) proposed this working definition: “Postcolonialism involves a studied engagement with the experience of colonialism, its past and present effects, both at the local level of ex-colonial societies and the level of more general global
development thought to be in the after-effects of empire” (p 2). The term ‘postcolonial’ should not suggest that the colonial stage has passed. Postcolonialism does not refer to a certain period in time. Rather, the ‘post’ in postcolonial refers to a concept of working in opposition to and beyond colonialism (McConaghy, 2000). Indeed, Quayson argued that postcolonialism should be viewed as an ongoing process of the struggle against colonialism and its after effects. This postcolonial process challenges dominant ideologies that shape the social world to look at the material effects of subjugation (Quayson, 2000). Said (2000) defined subjugation as the process by which imperialism and colonialism relegates certain people to subordinate positions, or considers them more primitive and therefore inferior to the colonizer. Collins (2000a) further defined subjugated knowledge as “special knowledges generated by oppressive groups… typically remains hidden because revealing it weakens its purpose of assisting [the group] in dealing with oppression.” (p. 301). Foucault (1980) referred to subjugated knowledge as: “a whole set of knowledges that have been disqualifed as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity” (p 82). However the term is construed, Quayson (2000) asserted that a central underlying assumption is that focusing on the discourse and ideology of colonialism is as important as focusing on the material effects of subjugation under colonialism and after.

Dutton, Gandhi and Seth (1999) suggest postcolonialism may be best viewed:

As something more than a chronological marker (after colonialism) and something less than a global or grand theory. It is perhaps best thought of as a toolkit, a mere set of provisional strategies, protocols, and concepts which arise
out of a certain recognition of, and approach to, difference... these tools get amended and reshaped according to the disciplinary contexts and the purposes for which they are used. (p.124)

Postcolonialism is known for its distinct interdisciplinary character with contributions from political activists, cultural critics, anthropologists and sociologists and others. Far from being a unified field, Barker (2008) stated there are several central themes associated with postcolonialism: power, subjectivity, identity, ethnicity, nation, race, subalterns, and hybridity. Two key issues have also emerged through postcolonial theory; that is questions of domination-subordination and hybridity (Williams & Chrisman, 1993). Increasing attention has been directed to race, ethnicity, and hybridity within cultural studies in postcolonial times (Barker). To understand this further I offer background information expanding on several of these themes.

Most commonly power is thought of as a force by which individuals or groups can achieve their goals or interests against the wishes of others (Barker, 2002). In this context one either has power or not, and as a result people are organized into binary power groupings. However Foucault’s work stressed that power is also productive and moves through all social relationships and levels of society. Foucault’s theory regarded knowledge as implicated with power and therefore is inseparable from regimes of power. Knowledge is created within the context of the relationship and practices of power, and in so doing contributes to newly developed techniques of power (Barker). This concept of power is important in the research of immigrant and refugee women to illuminate how power relations, race, class, and gender influence immigrant and refugee women’s mental health care experiences.
Generally within cultural analyses there has been an implicit assumption that people share an essential cultural identity and therefore essentialism has been a vigorously debated topic within postcolonial theory (Ashcroft et al., 2000). Ashcroft and colleagues define essentialism as “the assumption that groups, categories or classes of objects have one or several defining features exclusive to all members of that category” (p.77). There is a tendency in postcolonial theorizing to assume incorrectly that all women belonging to a certain ethno cultural group share the same experience of oppression. By conforming to this dominant ideology that may hold cultural differences responsible, there is less attention given to other powerful structural barriers and environmental stressors that immigrant and refugee women face.

This kind of essentialism tends to ignore diversity and individuality in women’s groups and varying degrees of agency (De Souza, 2004; Mohanty, 1988; Narayan, 2000). Narayan proposed that useful strategies to resist cultural essentialism are those that focus on the historical understanding of the context, and those that carefully examine political processes by which particular values and practices have been deemed central components of a certain culture. In relation to this study it is especially important to recognize and understand that the difficulties these immigrant and refugee women have in accessing and utilizing mental health care services may not be due to their culture but rather historical processes that have produced oppression and systematic inequities (Anderson, 2000).

Ethnicity is a cultural term that denotes formation of cultural boundaries between groups of people who are discursively constructed as sharing norms, beliefs, values, cultural symbols, and practices (Barker, 2008). The emphasis on ethnicity in postcolonial theory may conceal unequal power relations of gender (Barker, 2008). Gayatri Spivak,
(1988) a postcolonial literary theorist, has argued through essay writings: “Can the Subaltern Speak?” Subaltern is a term adopted by Antonio Gramsci meaning ‘of inferior rank’ to those people in society who are subject to hegemony of the ruling power (Ashcroft et al., 2000). Spivak alluded to the dangers of letting the subaltern (oppressed) forces speak without identifying that their essential subjectivity is constrained by the dominant discourses within which they are constructed as subaltern. Moreover one should not think that the subaltern could be isolated in an essentialist way from the interplay of discourses and institutional practices that could give the oppressed voice (Ashcroft, et al., 2000). In Spivak’s example of the Indian women’s situation, she maintained that the ideological construction of gender keeps the male dominant. Spivak contended that marginalized women in colonial contexts neither have the language to speak nor the attention of colonial and indigenous men. Historically determined relationships of dominance and subordination continue to be key concerns of postcolonial theory (Ghandi, 1998; Williams & Chrisman, 1993). This is particularly important in this research study as it brings forth questions about the structured subordination of racialized groups and how this may influence and contribute to immigrant and refugee women’s health care issues.

Hybridity generally refers to the combination of different cultural elements which blur cultural boundaries, fusing to create new identities and meanings (Ashcroft et al., 2000). For example hybrid identities could be British-Asians or Chinese-Canadians. However hybridity is most commonly associated with Homi K. Bhabha who captures the displacement of dominant Western cultural representation toward particularities of Non-Western cultures. For Bhabha (1990) cultural identity emerges in the ‘third space’ or in-
between-space where cultural identities are negotiated to produce empowering hybrid cultures. He referred to this as "incommensurable forms of culture to bring about something new and unrecognizable" (p.211). Thus, neither the colonial nor the colonized cultures and languages can be offered in pure form nor can they be separated (Bhabha). Therefore this space of hybridity is where cultural identities and meanings always have traces of other identities and meanings. Bhabha (1994) goes on:

The production of meaning requires that these two spaces be mobilized in the passage called the Third space, which represents both the general conditions of language and the specific implication of the utterance in a performative institutional strategy of which it cannot be conscious. What this unconscious relation introduces is an ambivalence in the act of interpretation. (p. 36)

This concept of cultural hybridity and Bhabha’s notion of the third space is important in this study. It is here that negotiation and cross-cultural interactions of the immigrant and refugee women take place which offers a greater opportunity to negotiate cultural meanings and deepen understanding of their situation.

Ashcroft et al. (2000) defined race as a classification of humans into biologically, physically and genetically specific groups. Race is relatable to the rise of colonialism because the division of humanity is inextricable from the need of colonist powers to establish domination over certain people. Ashcroft noted, “[race] quickly became one of imperialism’s most supportive ideas, because the idea of superiority that generated the emergence of race as a concept adapted easily to both impulses of the imperial mission: dominance and enlightenment” (p. 198). Therefore racism is not so much a product of the idea of race but an underlying motivation for hierarchal domination.
Some key concepts that Anderson (2004) identified relevant to health are race and culture. The concepts of race and culture are frequently drawn upon and described in different ways in various clinical settings and especially with populations that are seen as different from the mainstream population. Culture rarely operates in isolation from constructions of race which is richly laden with social, political, and historical meanings. These understandings lead us to further question and examine the unequal relations of power that are present from the colonial past and the neo-colonial present (Anderson et al., 2003).

Thus an emerging question in this study is how does race contribute to immigrant and refugee women’s health care issues? Anderson (2006) invites us to use the concept of racialization as process, rather than race as category, as an analysing strategy in our health research. Ahmad (1993) expanded on this term, “Racialization assumes that ‘race’ is the primary, natural and neutral means of categorization and that the groups are distinct also in behavioural characteristics, which result from their “race” (p.18). Anderson (2006) reminds us, “Racialization serves to position women in different ways…all women do not share the same social reality and the fact that privilege operates along different socially determined axes of power” (p.12). Anderson further explains that, rather than categorizing people by race one should be examining how racial categories are constructed and used in everyday life to categorize people in order to interpret their behaviour. Although racializing processes can affect anyone, they are most harmful in situations of unequal power relations where individuals are constructed as subordinate, inferior, or needy. Therefore, these racialized assumptions when acted upon have dire implications for immigrant and refugee women’s health and their lives. Racial
discrimination and oppression can affect immigrants at both the individual and institutional levels of care. For example, at the individual level one may see racism as negative attitudes or behaviour shown by the health care provider towards the immigrant or refugee women. Barriers such as differing values and perspectives within the relationship may result in misunderstandings which precipitate breakdowns in communication and engender negative feelings. Health care providers need to be aware that their attitudes and behaviours affect the health care relationship and may indirectly create barriers to health care access, thereby making it less likely for immigrant and refugee women to seek appropriate care (O’Mahony, 2005). The health care relationship significantly influences how immigrant and refugee women seek help for mental health problems. Kearns and Dyck (1996) conclude it is critical to recognize “that each health care relationship is...unique, power-laden, culturally dyadic... it inevitably involves the convergence of two cultures...[this] not only involves unequal power and different statuses but often involves two cultures with differing colonial histories, ethnicities or levels of material advantage” (p. 373).

At the institutional level, although the commonly held views of Canadian society is that the health care system is equitable and non-discriminating, there is evidence that racism is enacted within institutional and organizations and is embedded in the structures and value systems of society (Brown et al., 2002). Access is therefore not equal for everyone. For marginalized immigrant and refugee women facing multiple forms of inequities based on race, class, and gender, access to mental health care services may be very constrained (Morrow & Chappell, 1999). These multiple inequities intersect and have great influence on the immigrant women’s life. In past research (O’Mahony, 2005),
health care providers expressed views that immigrant women were vulnerable targets for systemic discrimination. Examples included non-provision of translation services and discriminating attitudes and biases within the healthcare encounter. Coupled with the unfamiliarity of the system and often lacking language skills, most participants felt that immigrant women had less access to health care services. Characteristics of some immigrant women such as being non-English speaking, older and poor compounded the likelihood of being treated unfairly.

While postcolonial theory has direct significance to immigrant and refugee women’s health issues, we cannot assume that postcolonial theory has a gendered analysis. It has been argued that a gendered perspective is an important analytical dimension (Ghandi 1998) and should be included to extend the analytical boundaries. Therefore to address this gap we must then incorporate feminist perspectives towards developing a postcolonial ‘feminist’ perspective. (Anderson, 2002; Browne et al., 2007).

**Black Feminist Scholarship**

Black feminist scholarship and postcolonial scholarship are complementary as a theory and methodology for nursing scholarship (Anderson, 2002). When combined, these scholarships “shed light on the complex issues at the intersection of gender, race, class relations and culture, and further our understanding of how material existence, shaped by history, influences health and well-being for those” who, in Homi Bhabha’s (1994) words “have suffered the sentence of history…of diaspora, and displacement” (p.11). This type of analysis offers another perspective in knowledge development in nursing and helps us to address issues of equity in health more thoughtfully.

In this study, the term “*black*” is used as a political category and not as a
biological category (Anderson, 2002). “The term black is used by people of different shades of skin colour in a show of solidarity and coalition to resist labels such as ‘visible minority’ which, unwittingly, designate people as marginal with minority status and, therefore inferior” (Anderson, 2002, p. 15). Their purpose is to address together the impact of racialization processes.

Anderson (2002) draws on black feminists such as hooks (1981, 2000), Collins (1986, 2000a), Bannerji, (1999), and Brewer (1993) to describe the central elements of black feminism:

1) The conceptual anchor is recognizing that not all women share the same experiences and struggles; therefore black feminists theorize that historical positioning, racialization, class relations, or forces intersect at the same time within their experiences. The aim is to expose these sources of oppression. Thus, race, class, and gender are categories of critical analysis. In contrast race and class are not central in Western feminism discourse of gender. Wane (2002) asserted that situating Black women’s ideas within the discourse of their own language challenges mainstream discourses and simultaneously centres the experiences of oppressed groups. Further Russo (1991) contended that women of colour have challenged white feminists to deal with racism and classism because of the need for empowerment of all women and change in condition of all women’s lives.

2) Paying attention to the interlocking nature of race, gender, and class oppression is a recurring theme in the works of black feminists and is an alternative humanist vision of societal organization (Bannerji, 1999; Brewer, 1993; Collins, 1986, 2000a; Davis, 1981; hooks, 1981, 2000; Wane, 2002). According to Collins (1986), black feminists who
see oppression as simultaneous forces affecting Black women seem to be “more perceptive to how these same oppressive systems affect Afro-American men, people of color, women, and the dominant group itself...while Black feminist activists may work on behalf of Black women, they rarely project separatist solutions to Black female oppression” (Collins, 1986, p.21). According to Collins (1986), black feminists who see oppression as simultaneous forces affecting Black women seem to be “more perceptive to how these same oppressive systems affect Afro-American men, people of color, women, and the dominant group itself...while Black feminist activists may work on behalf of Black women, they rarely project separatist solutions to Black female oppression” (Collins, 1986, p.21). Oppression is defined “as an unjust situation where, systematically and over a long period of time, one group denies another group access to the resources of society. Race, gender, class, sexuality, nation, age, and ethnicity constitute major forms of oppression” (Collins, 2000a, p.299).

Moreover hooks (2000) commented on the Black women’s position in society:

As a group, Black women are in an unusual position in this society, for not only are [they] collectively at the bottom of the occupational ladder, but overall social status is lower than that of any other group. Occupying such a position [Black women] bear the brunt of sexist, racist and classist oppression...at the same time [this group] has not been socialized to assume the role exploiter/oppressor...and are not allowed no institutionalized ‘other’ that [as a group] can exploit or oppress. (p. 16)

3) Analysis begins in everyday experiences and is framed within a language from
their perspective. It is co-created through dialogue and multiple locations. Thus there is a commitment to listen and value the voices of marginalized women.

4) As critical social theory, black feminist thought is tied to lived experience and the aim is to “better” these experiences in some way. Thus it is a commitment to social justice for one’s group and others. As a social justice project black feminist thought must remain dynamic: “as social conditions change, so must the knowledge and practices designed to resist them” (Collins, 2000a, p. 39).

5) Black feminists have a special vantage point because their world views closely resemble the lived experiences of marginalized women in a patriarchal society and therefore can generate knowledge about equality and social justice (Collins, 2000a; hooks, 2000; Wane, 2002). Their struggles for social justice, dignity, and empowerment are apart of a broader view. This alternative world view is clearly expressed in the following passage from an 1893 speech given by the Black feminist educator, Anna Julia Cooper who advocated for social equality (cited in Collins, 1986, p. 21):

We take our stand on the solidarity of humanity, the oneness of life, and the unnaturalness and injustice of all special favoritisms, whether of sex, race, country, or condition...The colored woman feels that woman's cause is one and universal; and that... not till race, color, sex, and condition are seen as accidents, and not the substance of life; not till the universal title of humanity to life, liberty, and the pursuit of happiness is conceded to be inalienable to all; not till then is woman's lesson taught and woman's cause won— not the white woman's nor the black woman's, nor the red woman's, but the cause of every man and of every woman who has writhed silently under a mighty wrong.

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(Loewenberg & Bogin, 1976, p. 330-31)

This excerpt above represents a clear statement of the humanist vision present in black feminist thought. Thus, black feminism is not just about seeking social justice for Black American women but for all people.

Moreover Massaquoi and colleagues (2007) drawing on black feminist thought in the Canadian context illuminated the importance of the integration of the Black women’s identity and spiritual consciousness. They point out that spirituality is the first tool of resistance and it is where we question who we are or what our purpose is in this world. Spirituality is relational and defines how we live and build community and the relationships that surround us. It is about social justice, peace, harmony, and maintaining and sustaining healthy communities for our future generations (Wane & Neegan, 2007). Spirituality may be used as a lens: “to understand our lived realities and how to navigate the everyday world that is shaped by those realities. Black women have a long history of engaging in action-oriented feminism informed by spirituality and inner-strength” (Wane & Neegan, p. 31).

Drawing from the postcolonial feminist perspectives, my aim was to create awareness and increased understanding that the difficulties immigrant and refugee women face in accessing health care may not be due to their culture but rather historical processes that have produced oppression and inequities. It brings into focus that some women’s circumstances such as their past experiences may be shaped by the prevailing culture of their home country and by other displacement experiences. Language barriers, lowered socioeconomic status, discrimination, and inadequate social support may be also be disempowering through their effects on self-worth and perceived power, especially
when some social determinants of health (SDOH) are experienced simultaneously, thus increasing risk for depression (Mawani, 2008). Addressing the health of immigrant and refugee women includes the SDOH significant impact on the predisposition of individuals and groups to illness, and their experience and healing from illness. Addressing the SDOH requires a shift in some ways of thinking. “It requires people to realize the health system has an important - but limited - role in addressing health… and to challenge some of the ideas they may have about poverty, equity, and social justice. These are not individual issues, but structural ones” (Canadian Nurses Association, 2005, p.6).

Solutions to health problems originating from immigrant and refugee women who suffer PPD define what are important issues & effective strategies to address these problems. The postcolonial feminist perspective inquiry helped me to explore the intersecting forces that influence the immigrant and refugee women’s every day life and how they interpret and come to understand their health and access mental health care. Thus, I was able to illuminate how power relations, race, class, and gender influence immigrant and refugee women’s mental health care experiences by: (a) Asking open-ended interview questions constructed to explore and illuminate whether participants view themselves as having difficulties with mental health care access. By asking certain questions from a particular epistemological perspective one can take into account the context in which immigrant and refugee women’s lives are situated. For example questions such as: Who did you ask for help? Was it easy to get help to manage your PPD? If it was, what made it easy for you to obtain help? If it was not easy what made it difficult? This supported my understanding that historical forces shape the immigrant and
refugee women’s social position and thus their experiences. (b) Gathering information about the factors (facilitators and barriers) that influence their mental health care practices. I was able to explore with the participants as to whether any of these factors were viewed as barriers or facilitators in their management of PPD and its related problems. (c) Asking questions to explore whether gender issues affected their PPD experience helped me to understand the significance of gender roles and whether this influenced how the women sought help. For example: Has being a woman influenced how you have dealt with PPD? What would prevent immigrant & refugee women from seeking help for their PPD?

Other interview questions were aimed at whether or not the participants viewed gender, social position, racism, and discrimination as affecting their mental health care experiences and access to services, and if so, in what ways. An example of an interview question covering this subject was: Has being an immigrant or refugee woman living in Calgary influenced how you have dealt with PPD? If yes, Why? The participants provided additional insight into the structural barriers and gender processes that influence immigrant and refugee women’s lives and their health care practices. Immigration status, economic insecurity, family care-giving and responsibilities, and experiences of violence and abuse are examples of social conditions which affect immigrant and refugee women’s PPD experience and access to health care services. By exploring with the participants their perspectives on what they perceive as structural barriers and gender issues in help-seeking for PPD I am able to develop a deeper understanding of how race, class, and gender intersect with contextual factors to influence how these women access mental health care services.
My research study is about immigrant and refugees voices, thus I felt compelled to address this last notion of representing and speaking for others. Representation is an important methodological issue. Hall (1997) defined representation as a process that links things, concepts, and signs to produce meaning. To adequately present the participant's perspectives, while adhering to research goals, researchers need to be reflective and sensitive, not only to what kind of information they present and how they will present their work, but also to what kind of ideologies and discourses that they and their participants produce and reproduce (Donnelly, 2002).

As a researcher and writer I am particularly aware of the potential to reproduce essentialized portrayals of immigrant and refugee women. It is suggested that cultural knowledge without attention to political, structural, and positional constraints is marginalizing. Culture is one of many complex factors that impact the health care experiences of immigrant and refugee women. Meleis and Im (1999) note that it is more than cultural heritage that shapes the marginalized women’s experience, “It is the extent to which [the women] are stereotyped, rendered voiceless, silenced, ignored, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around” (p. 96).

Thus, I gave careful consideration to the interpretive process as I moved back and forth from the field to the text. My aim was to give close attention to what was spoken, what was implied and what was not spoken about; but foremost an honest account of the meanings of the participant’s experiences in my interpretation of the immigrant and refugees voice. This complex reflexive process is coined by Denzin (1994) as the ‘art of interpretation.’ The term interpretation, to me, denotes a point in time in thinking and
writing in which the researcher moves factual data and analysis towards further probing of what is to be made of the data. Interpretive practice engages both the whats and hows of social reality; it is centred in both how people construct their experiences, their worlds and institutional contexts in meaning making and social order (Gubrium & Holstein, 2000).

Further I draw on Alcoff’s (1991) question: “is it ever valid to speak for others who are unlike me or who are less privileged than me” (p.7)? She acknowledged that it can be problematic when one speaks for and about others; however she contended that speaking for oneself is also problematic. “If I don’t speak for those less privileged than myself, am I abandoning my political responsibility to speak out against oppression, a responsibility incurred by the very fact of my privilege” (Alcoff, p. 8)? Alcoff explained that there are ways to lessen the dangers of speaking for others. The location and social position of the researcher is important because it affects not only the meaning of spoken words and assigned events but of the significance of any claims made. The practice of speaking for others is sometimes the best possibility in existing situations; for ignoring the oppressed person’s speech is “to continue the imperialist project” (Spivak, 1988, p. 298). Alcoff (1991) encourages us to ask further questions about developing strategies for a more equitable distribution of the ability to speak and be heard thereby enabling the empowerment of oppressed people.

Sensitivity and reflexivity to the location of oneself and others must be critically and consciously exercised in the representation of the text. Therefore, in my construction and representation of the participants’ lived experiences, every effort was made to pay close and systematic attention to the diverse and complex relations between my language
of analysis and what it was meant to represent. I was aware that I would produce meaning through representation of my research which includes representing the immigrant and refugee women’s lived experiences, words, stories, images, values placed on data, and construction of identities. Cultural sensitivity and reflexivity to the spoken and written texts and the nature of discourses are important issues in the production and reproduction of social forms (Gubrium & Holstein, 1997). Homogenizing and stereotyping representational discourse can reproduce unequal social relations & feelings of otherness which in turn places the women in a disadvantaged social position.

I also needed to be aware that my positionality and power as researcher would influence discourse, shape social relations, identities, and have an affect on the way knowledge was represented (Donnelly, 2002; Hall, 1997). Social positionality holds the researcher accountable and responsible for interpreting and disseminating data (Alcoff, 1991). So that I justly represented and valued the immigrant and refugees women’s voices and narratives I checked in with myself regularly because my own experiences, my cultural background, my beliefs, values, and social position do have an influence on the entire research process.

This theoretical framework is one way of guiding immigrant and refugee women’s mental health research, but by no means the only way. As cautioned by Anderson (2004) “postcolonial feminist scholarship is not the definitive scholarship for the future – it offers new insights that help us to understand the world around us…the richest scholarship is produced when we can successfully stitch together different perspectives” (p. 245). Some would argue that by using the EPDS (developed by the medical model and Western world) that my articulations might run counter to the
postcolonial feminist perspective as ways of informing my research project. It is widely recognized that in some cultures the term 'PPD' is unfamiliar and therefore medical treatment is not sought after nor a medical diagnosis given. However many nurse researchers have used this screening tool as an effective way of identifying women who are at high risk for PPD. Moreover evidence suggests the EPDS is reliable with immigrant and refugee women (Gorman et al., 2004; Horowitz, 2006; Small et al., 2007).

**Summary**

In summary, Kleinman's explanatory model, postcolonialism, and feminism provide the theoretical foundations for this research. Kleinman's conceptual framework helped me to explore how explanatory models of illness and disease used by immigrant and refugee women influence their perspectives and ability to seek mental health care services. A postcolonial feminist perspective helped me to put immigrant and refugee women's marginalised experiences at the focal point of analysis. It also helped me to analyse the effect of historical forces, together with the present social and political processes, that influence their health and health care behaviour. Differences among immigrant and refugee women must be understood and theorized in order that one avoids essentialist generalizations about their problems (Narayan, 2000). Uncovering their voices is a positive step towards bringing them more control and choice over their mental health care. In the next chapter I focus on the qualitative tradition of ethnography and moreover offer critical ethnography as a preferred research method for this study. Major emphases of this chapter are the detailed steps of the research process in conducting this study.
CHAPTER IV: RESEARCH METHOD

The purpose of this qualitative study is to explore how contextual factors interact with race, gender, and class to affect and shape the ways in which immigrant and refugee women seek help and manage their PPD. This is accomplished by addressing the research questions of this study and selecting a fitting research method to conduct the study. The research questions are: 1) How do immigrants and refugee women conceptualize postpartum depression? 2) How do immigrant and refugee women utilize the available health care services and social support networks to cope with their postpartum depression related problems? 3) How do contextual factors such as social, cultural, political, historical, and economic influence immigrant and refugee women's mental health care experiences? 4) What services or strategies could address postpartum depression care and treatment among immigrant and refugee women?

Qualitative research methods are most appropriate for answering the research questions that form the purpose of this study. “Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem...the researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (Creswell, 2007, p.15). Qualitative work involves the researcher working closely with participants and treating the data with thoughtfulness to learn and understand more about their particular experiences. Sword (1999) asserted that it is the researcher’s familiarity with previous works and sensitivity with participants that increases understanding and enhances the construction of meaning. Thus qualitative research methods are particularly
helpful in gaining the perspectives of immigrant and refugee women and examining the complex contextual factors that impact their health and health care usage. Using a qualitative methodology allows an exploration of not only how the immigrant and refugee women make decisions about health care practice, but also provides a deeper understanding of their choices in how they manage illness and daily living. In-depth interviewing gave the participants an opportunity to describe their experiences and express more detailed contextual information (Spradley, 1979).

The next section includes an overview of ethnography, coupled with the characteristics and types of ethnography. This will lead into critical ethnography, the selected method for this research project. For the remainder of the chapter I will present how the research process was carried out.

Ethnography

Ethnography is a qualitative research method and one of the traditional ways to gather data on human behaviour from a broad range of disciplines and fields (Hughes, 1992). The term ‘ethnography’ originates from the Greek word *ethnos*, relating to people, a race, or cultural group (Smith, 1989) and by extension to their customs or social usages. The roots of ethnography lie in cultural anthropology. Ethnography origins also come from the Chicago School of Sociology dating back to the late 1920’s and early 1930’s whereby ethnographers focused on obtaining a monumental understanding of culture and on its shared elements (Holloway & Todres, 2003). Ethnographers use methods to reveal and document variations in the way social and cultural groups understand and explain health and illness. Ethnography differs from other kinds of qualitative research in that the focus is on the cultural perspective.
James Spradley (1979), an ethnographer and anthropologist, identified several particular contributions of ethnography. First, ethnography offers descriptions that reveal the explanatory models used by individuals and pays attention to how this defines their world rather than imposing our own theories and beliefs on them. In this study I paid specific attention to how the participant’s cultural backgrounds shaped their explanatory models of health and illness and their expectations toward treatments, which in turn affects their decision-making regarding coping with illness and health care practices (Good, 1994; Kleinman, 1978, 1980). Second, ethnography offers ways to understand complex societies and ways of life. It is clear that we do not have a homogeneous culture and different perspectives and values are complex features of modern society. Ethnography is one way to show the array of cultural differences and how people with diverse perspectives interact with each other (Spradley). Third, to understand human behaviour we need to understand and discover about the what’s and why’s of the individual’s actions and the meanings attached. Spradley asserted: “Ethnography yields empirical data about the lives of people... it allows us to see alternative realities and modify our culture-bound theories of human behaviour... offers other dividends to anyone involved in culture change, social planning, or solve a wide range of human problems” (p.13).

The core of ethnographic research is entering a social setting and getting to know the people involved in it. It is an attempt by the ethnographer “to learn what knowledge people use to interpret experience and mould their behaviour within the context of their culturally constituted environment” (Aamodt, 1989, p. 30). The main goal of most ethnographic research is to provide thick description (Geertz, 1973), and describe in
detail the observations, recording, and analysis of the culture being studied. This rich
description is interpreted to gain a deeper understanding of the ways in which people give
meaning to their actions and interactions. Ethnographic research explores phenomenon
within cultural contexts from the emic perspective; that is from the perspectives of the
participants. A deeper immersion is sought to grasp what they experience as meaningful
and salient. Ethnographers examine how people are positioned in a particular social
context, how they interact with one another and power relationships (Holloway & Todres,
2003). To provide answers to the research questions within this qualitative study, in-depth
critical ethnographic interviews were used to provide more comprehensive information.
Examples of questions used to gain a deeper understanding of the participant’s social and
cultural context and description of their behaviour, 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 easier for you to obtain help? If not
what made it difficult?
As Simon and Dippo explain:

When we speak of ethnography we reference more than a particular research
method. Because all methods are ways of asking questions which presume an
underlying set of assumptions, a structure of relevance, and a form of rationality,
to understand what is meant by the term ethnography one must avoid thinking
merely in terms of decontextualized techniques. To actually do ethnography is to
engage in a process of knowledge production... ethnography is organized toward
the accomplishment of a kind of knowledge that centers on and makes ‘topical’
both the actual practices and points of view of people within an organized set of social relations. (1986, p.195)

**Characteristics of Ethnography**

Despite the many variations of ethnography there are distinguishing characteristics of ethnography. According to Boyle (1994), most types of ethnography have certain hallmark characteristics which often overlap. One characteristic may be more emphasized than another depending on the ethnographer. Three fundamental characteristics of ethnographic research are: 1) contextual and holistic nature, 2) reflexivity within ethnography, 3) emic and etic data.

**Contextual and holistic nature.** “Ethnography focuses on a group of people who have something in common” (Boyle, 1994, p. 161). Through this tradition we can come to interpret and gain an increased understanding about the varied meanings that participants give to location, their behaviour, and relationships with others. Spradley (1979) stated the essential core of ethnography is:

This concern with the meaning of actions and events to the people we seek to understand. Some of these meanings are directly expressed through language; many are taken for granted and communicated only indirectly through word and action...in every society people make constant use of these complex meaning systems to organize their behaviour, to understand themselves and others, and to make sense out of the world in which they live. These systems of meaning constitute their culture; ethnography always implies a theory of culture. (p. 5)

Geertz (1973) best expresses the gold standard for field notes, as being a “thick description” enabling one to visualize the social action in context. Field notes describe
the experience and observations by the researcher, yet it is not as straightforward and transparent a process as one might think. It is more than a written description of conversation and observed activities. Participant observation and fieldwork are ways outsiders can interpret the world view of a cultural group, the meanings that individuals give to their actions and interactions, and also discloses how they are situated in a cultural context. The researcher relies on naturally occurring conversations in the field (Holloway & Todres, 2003). Similar to other approaches, there is a strong reliance on language and text. It is the most direct means for the researcher to obtain knowledge concerning the social action of a given group and the most rigorous means of capturing the essence of social structure and group life (Churchill, 2005).

Participant observation is a type of observational method that usually takes place in natural settings (e.g. a school or hospital), where the observer can be either in disguise (covert) or known as a researcher (overt). Participant observation necessitates the researcher to be involved in a range of activities together with participation, informal interviewing, documentation, and reflection. The researcher upholds a balance between participation and observation so that they can understand what is going on, yet remain detached enough to be able to reflect on the phenomenon under exploration (Emerson, Fretz, & Shaw, 2001; Willig, 2008).

Emerson, Fretz, and Shaw (2001) maintain 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. As data for this study is constituted of information gathered from field notes and in-depth interviews with immigrant and refugee women, I paid attention to detailing the social and interactional processes that make up their everyday lives and experiences in my field notes. It is important to remember that field notes involve inscriptions of social life and discourse. These inscriptions can reduce the complexity of the social world to written words that can be studied, reviewed, and thought about over and over again. Writing field notes is the inseparability of methods and findings; that is what is observed is inseparable from the observational process. The linkage of substance and method ensure an approach where one is discouraged from taking too readily one person’s version over what is important as the “correct or complete” account (Emerson et al.). These situational realities encourage viewing the findings not as absolute but contingent upon circumstances of their discovery by the ethnographer. Lederman (1990) remarked: “Having notes— all neatly typed or bound, stored safe and sound...validates our anthropological communications. But using notes is activity [that] shows field notes to be not fixed repository of data from the field but reinterpretable and contradictory patchwork of perspectives” (p.90).

**Reflexivity.** While addressed briefly in the past chapter as to the importance of incorporating reflexivity as an significant element of the research process I now place further emphasis as reflexivity is a fundamental characteristic of ethnography. Ethnography has a reflexive nature; Morse (1994) implied “the researcher is part of the world that he or she studies and is affected by it” (p. 165). The process of reflexivity in qualitative research is where the researchers continuously reflect and challenge
themselves to understand how their perspective may shape the method, analysis, and interpretations (Aamodt, 1989; Creswell, 2007). Hammersley and Atkinson (2007), emphasize reflexivity as the hallmark of all ethnography:

Neither positivism nor naturalism provides an adequate framework for social research. Both neglect its fundamental reflexivity, the fact that we are part of the social world we study, and that there is no escape from reliance on common-sense knowledge and methods of investigation. All social research is founded on the human capacity for participant observation. We act in the social world and yet are able to reflect upon ourselves and our actions as objects in that world. By including our own role within the research focus and systematically exploiting our participation in the settings under study as researchers, we can produce accounts of the social world and justify them without placing reliance on futile appeals to empiricism, of either positivist or naturalist varieties. (p. 18)

With conducting research it is also important not only to analyze knowledge that is constructed through research, but also to pay attention to the process by which research is produced and justified as knowledge. Reflexivity is not only about setting aside personal beliefs and bias but an added dimension of integrating and applying new understandings through a process of critical thinking (Lamb & Huttlinger, 1989). My interactions within the research process and theoretical insights required regular self-reflection. I kept a journal for reflection upon what was occurring in terms of my own values and interests and for speculation about growing insights, feelings, and other emotions which was generated as part of this research process.
**Emic and etic data.** Strongly related to the concept of reflexivity is the use of emic and etic data. The main aim of the ethnographer is to understand and combine the emic perspective, (the insider's view of the world) with the etic perspective, (the view the researcher brings) to develop generalizations about different societies. The emic perspective is at the heart of most ethnographic research and is valued for reliance on understanding and accuracy in describing the culture, language, and situations of the insider's world (Fettersman, 1998). It is the perspective of the participants or in the context of this study the immigrant and refugee women. According to Fetterman (1998), the emic perspective draws consideration to the awareness and acceptance of multiple realities:

Documenting multiple perspectives of reality in a given study is crucial to an understanding of why people think and act in the different ways that they do. Differing perceptions of reality can be useful clues to individuals' religious, economic, or political status and can help a researcher understand maladaptive behaviour pattern. (p 20-21)

The etic perspective originates from the word phonetic and was used by researchers to understand implicit knowledge (Leiningher, 1978). This etic dimension came about with the researcher's intent to understand and uncover hidden knowledge. An etic perspective is the “external, social scientific perspective on reality” (Fettersman, p. 22). In other words the etic originates from the outsider's view which is what ethnographers view or observe as they do their fieldwork. This may include the researcher's abstractions, interpretations of meaning, and theoretical explanations. Many ethnographers view the emic and etic views as markers along a continuum of styles and
varying levels of analysis (Fetterman). Both emic and etic perspectives are relevant in assisting the ethnographer to understand why individuals of a specific group do what they do and equally necessary if the ethnographer is to describe and interpret situations and behaviour accurately (Boyle, 1994). Fetterman reminds us that the job is not complete until the researcher steps back and examines both the emic and etic perspectives in trying to make sense of the data collected.

Types of Ethnography

There are many types of ethnography described in the literature. According to Spradley (1980) ethnographies may be placed on a continuum ranging from microethnography to macroethnography. His categorization is based on the size and complexity of the social units studied. For example on one end of the continuum, macroethnography is the study of complex societies and generally broad in reach. Microethnography in contrast, is characterized by a smaller, limited social unit such as a nursing unit or a community group. In the literature, ethnographic thought is generally classified into classical, systematic, interpretive and critical ethnography (Muecke, 1994):

1) Classical ethnography must be “both a description of behaviour and demonstrate why and under what circumstances the behaviour took place... involving working with people for long periods of time in the naturalistic setting” (Morse & Field, 1996, p. 126). A good example of a classical ethnography is Malinowski’s (1961) study of the Trobriand Islanders or Mead’s (1928/1949) study of a very complex culture, the Aborigines. A more in-depth comparison between classical and critical ethnography will be discussed further in the chapter.
2) Systematic ethnography, based on symbolic interactionism, (Blumer, 1969) differs in that the main aim is to define the structure of culture and what organizes the study group’s ways of living (Muecke, 1994; Streubert Speziale & Carpenter, 2003). It is critical of classical ethnography for being too unsystematic. The purpose in systematic ethnography is to discover the “native point of view”, and learn the organizational practices that shape the individual’s behaviour of that specific group (Geertz, 1973). Well known examples of systematic ethnography are Spradley’s (1970), “You owe Yourself a Drunk: An Ethnography of Urban Nomads” and David Fetterman’s (1989) “Ethnography: Step by Step.”

3) Interpretive ethnography or hermeneutic ethnography is concerned with discovering the meanings of observed social behaviour, thick descriptions of human behaviour, and deeper cultural inferences of the embeddedness of behaviour, resulting in higher levels of analytic power (Boyle, 1994). A well known example of interpretive ethnography is Geertz’s (1973), The Interpretation of Cultures or more recently from Way (1990) who used interpretative ethnography to explore the meaning of health and illness within a rural group in Newfoundland. Gubrium and Holstein (2000) emphasize that it is the aim of interpretive practice to document the interplay between constructing a sense of everyday reality in one sense and the institutional discourses that together substantively conditions meaning making and social order.

4) As critical ethnography is the research method for this study, a more in-depth discussion of critical ethnography is to follow in this chapter.

As well as the four main schools of ethnographic thought, focused ethnography has evolved with the emergence of medical anthropology in the health sciences. Focused
ethnography is frequently used in nursing research because the studies are problem focused, context specific, and used primarily to improve practice. Essentially most characteristics of classical ethnography are shared in focused ethnography which includes interviews, observations and field notes. (Morse & Field, 1996; Muecke, 1994). Next critical ethnography is presented as an appropriate research methodology to use in the study of immigrant and refugee women’s PPD help-seeking experiences and access to health care in the postpartum period.

**Critical Ethnography**

As a branch of ethnography that resonates with the critical paradigm, critical ethnography has its theoretical underpinnings in critical theory (Carspecken 1996, Quantz, 1992). In recent times, critical methodologists have expanded on conventional ethnography to examine larger social, political, and economic issues that focus on power, oppression, and inequality (Schwandt, 1997). Although healthcare decision making in health and illness occurs within a cultural context, factors such as social, political, historical, and economic differences influence the individual’s situation and shapes their experience. Thus, critical ethnography may be viewed as those “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, p.22).

There are many diverse definitions of critical ethnography (Carspecken, 1996). Critical ethnography is distinguished from other ethnographic methods by its focus on issues of social oppression and inequity (Germain, 2001). LeCompte and Preissle (1993) state the aim of the critical ethnographer is to explore the experiences of the oppressed, uncover the underlying social practices of every day life, and contribute in some way to
the emancipation or freedom of the oppressed group. Quantz (1992) claimed that "no answer is likely to satisfy critical ethnographers themselves, because to define the term is to assume an epistemological stance in which the social world can be precisely defined—a position that is not very critical" (p. 448).

Carspecken (1996) expanded the definition by highlighting that critical researchers have a value orientation and a critical epistemology that describes 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. Critical ethnographers must consider how 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).

Boyle (1994) further contended there are two schools within critical ethnography, postmodernist and feminist. She stated that postmodernism ethnographers are essentially concerned with rhetoric and descriptive processes. Both the reading and writing of ethnography is seen as artistic elements; whereas the feminist ethnographer is more concerned with exposing forces of oppression against vulnerable and less privileged groups in society. Critical ethnography challenges the status quo and the dominant powers in society (Carspecken, 1996). A past example of a critical ethnography is Street’s (1992) Inside Nursing: A Critical Ethnography of Clinical Nurse Practice. The aim of this study was to explore and describe clinical nursing practice through in-depth long term interactions with nurses in a critical care setting. Analysis was largely centred
on how nurses themselves critique and deal with gender politics, medical domination, hierarchies of power and privilege and institutional structures.

Quantz (1992) acknowledges there is utility in attempting to define critical ethnography as a way to understanding how to do critical ethnography, however he urges us to use caution in that it is not so much a thing in itself as a project in a wider discourse: Critical ethnography is one form of an empirical discourse, a form in which a researcher utilizes field methods that place the researcher on-site attempts to represent the “culture”, the “consciousness,” or the “lived experiences” of people living in asymmetrical power relations. As a “project,” critical ethnography is recognized as having conscious political intentions that are orientated toward emancipatory and democratic goals. What is key to this approach is that for ethnography to be considered “critical” it should participate in a larger “critical” dialogue rather than follow any particular set of methods or research techniques. (p. 448-449)

According to Thomas (1993) critical ethnography is a “style of analysis and discourse embedded within conventional ethnography” (p.3). As a result these ethnographies share several fundamental characteristics as well as several distinguishing ones. Thomas offered distinctions between conventional and critical ethnography:

1) Conventional ethnography generally alludes to the tradition 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 judgements 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 raise their voice to speak to others on behalf of their subjects as a method of empowering them by giving more authority to the subjects’ voice. As a result critical ethnography exists in an explicit framework that invokes a call to action and attempts to use knowledge for social change (Thomas, 1993).

3) Conventional ethnographers observe culture for the purpose of describing whereas critical ethnographers do so for change. “Critical ethnographers celebrate their normative and political position as a 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, p.4).

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 2001; Thomas, 1993). Madison (2005) commented that to resist domestication refers to the ethnographer that:

...will use the resources, skills, and privilege available to her to make accessible—to penetrate the borders and break through the confines to in defence of—the voices and experiences of subjects whose stories are otherwise restrained and out of reach...the critical ethnographer will contribute to emancipatory knowledge and discourses of social justice. (p.5)
Thus, based on understanding these characteristics of critical ethnography, I selected this critical methodology as the most appropriate way of exploring with immigrant and refugee women their PPD experiences after childbirth. I contend meeting the objectives of my research was best achieved through the critical ethnographic method because this research is concerned about social inequalities and its goals directed toward positive social changes. With this change is the hope to overcome centralized power and distribute it more equally. Central elements of critical ethnographic research include value laden orientation, challenging the status quo, empowering the individual to have more authority, addressing unequal power relations and applying new understandings through a process of critical thinking. A value laden orientation implies the critical ethnographer imposes a value system that places any culture into a wider discourse of power relations and history which serves an emancipatory interest (Quantz, 1992). The pointed efforts of the researcher are to see how their own perspectives and values are affecting 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; Quantz, 1992). This critical ethnographic approach was readily applied to the research of immigrant and refugee women, as one strives to not only seek how immigrant and refugee women seek help and access health care, but what other external factors influence their actions. Therefore this critical inquiry approach provided direction in illuminating how social injustices and unequal social relations possibly contribute to the unequally distributed health care resources and inaccessibility of health care services for immigrant and refugee women.
Clearly, one can see how critical ethnography is complementary with the chosen theoretical perspectives of postcolonial feminist theory (Anderson, 2002) and Kleinman’s explanatory model (1978, 1980). Kleinman’s explanatory model was used as a framework to explore how immigrant and refugee women’s health care behaviour is influenced by their cultural knowledge and values and a postcolonial feminist perspective to critically examine the connections between the individual woman, family, community and the broader social and cultural environment that shape immigrant and refugee women’s health and health care practices. Similarly shared with critical ethnography is the important function of examining how inequity and unequal social power relations influence immigrant and refugee women’s accessibility to health care services (Anderson, 2002; Anderson & Reimer Kirkham 1998). Another collective aim shared with critical ethnography (Thomas, 1993) is not only to generate a more accurate account of women’s lives from everyday experiences, but also to change the oppressive conditions in which they live (Anderson 2002; Collins 2000a).

Participants

A purposive sampling and snowball sampling of refugee and immigrant women was used in this study. Purposive sampling is the process of deliberately selecting individuals based on their particular knowledge of a shared experience (Morse & Field, 1995). Snowball sampling (a subset of purposive sampling) refers to asking individuals in the study to recruit other participants (Morse, 1989). Thirty women who live in and around Calgary, Alberta were recruited as research participants. Out of 30 women, there were eight refugee women and 22 immigrant women. Their ages ranged between 18-46 years of age with the average age being 32.5 years. Three women had infants with health
challenges and one had a stillborn at birth. Participants were from diverse ethno cultural backgrounds such as Central and South American, Chinese, Middle Eastern and South Asian. The majority of these women were married or living common-law with four women being separated from their partners and one single woman. Upon migration approximately one third of the participants had left well paying jobs or a career from their home country. Average family income per year varied: 1) less than $10,000 (12 participants); $11,000-20,000 (10 participants); greater than $70,000 (two participants) and the remaining six women were between $30,000 and $40,000 per year. The participant profile may be found in (Appendix B) to provide additional detailed characteristics.

Criteria for Selection

Inclusion criteria for immigrant and refugee participants included: 1) non-European women with immigrant or refugee status living in Canada < 10 years; 2) 18 years of age and over; 3) EPDS screening indicating high risk for PPD (score of 10 and above) < 5 years; 4) current stable mental health; 5) the ability to converse with the researcher or a translator for interviews will be conducted in the participant’s first language.

The following were the exclusion criteria: 1) non immigrant and refugee women; 2) under 18 years of age; 3) EPDS screening indicates low risk for PPD (score of under 10) < 5 years; 4) history of other psychotic problems; and 5) presently hospitalized, and or undergoing acute mental health care treatment.
Recruitment and Access

Recruitment and access to these women was done via health care providers who provide health care services to immigrant and refugee women. Recruitment commenced once ethical and administrative approval had been obtained. My past positions within the Alberta Health Services (AHS) assisted me to network and gain support from health care providers and access to these participants. Through the guidance and permission of key individuals, I was able to gain access to immigrant and refugee women that were either screened as high risk for PPD or had formally been diagnosed with PPD. Almost one third of the participants (nine out of thirty women) had been given a formal diagnosis of PPD whereas the remaining were screened as high risk by the health care provider. All participants were screened by the health care provider prior to meeting with them. Through referrals and conversations with health care providers in settings where health care services are provided to postpartum immigrant and refugee women, I carefully selected my participants which were based on the inclusion and exclusion criteria. For some participants it was necessary to rely on the key referral (health care provider) to assist me in arranging the first interview in order to reassure the participant and build trust. For others I initiated the first contact by calling the participant to set up a convenient time to meet for the interview. Additional back up posters were put up in strategic community locations inviting immigrant and refugee women to participate (Appendix C). This facilitated interested participants to call me with any further questions.

My central contacts were: Families Matter, Calgary Regional Home Visitation Collaborative (CRHVC), Calgary Immigrant Women’s Association (CIWA), Immigrant
Services Calgary (ISC), Calgary Catholic Immigration Society (CCIS), North East Calgary Women’s Clinic, Women's Mental Health Clinic, Foothills Medical Centre and several Community Health Centres which have higher immigrant and refugee populations. Formal letters explaining the proposed study was given to interested participants (Appendix D). My aim was to obtain a rich information source. The research data included information gathered from in-depth ethnographic interviews using a semi-structured questionnaire (Appendix E: Guiding Interview Questions) and field notes with immigrant and refugee participants. A sample size between 30-50 participants in qualitative research is suggested by (Morse, 2000), yet adequacy of sampling is prompted by the expertness of the participants and their ability to converse about their experience. Data saturation which is new data no longer emerging through data collection (Morse) was reached by interviewing 30 participants.

**Method of Data Collection**

Within this qualitative study, the method of collection was in-depth critical ethnographic interviews which were used to provide more comprehensive information about the immigrant and refugee women’s PPD help-seeking experiences and access to health care. A semi-structured interview questionnaire was utilized to encourage the participants to explain their experiences in their own words (Morse & Field 1995). Open-ended questions (Appendix E) were used as prompts to encourage the participant to talk about narratives that provided rich, descriptive context. Tables were constructed to illustrate how the research questions would be answered (Appendix F) and clearly showed the relationship between the research purpose, the questions and the development of the interview guide.
Spradley (1979) identified three groups of questions in ethnographic inquiry, (a) open ended & descriptive questions; (b) structural in-depth questions that increase and validate the unit of analysis; (c) contrast questions (ones that provide more clarity and criteria for exclusion. The face-to-face ethnographic interview provides participants the opportunity to fully describe their experience (Spradley). This interview guide was designed specifically for the study; however each interview was varied as I modified questions depending on the mother’s emotional state and interest in expressing her feelings in certain areas. I used open-ended questions frequently and prompts to encourage the participant to talk further about their experience. As the conversation content was quite sensitive and revealing at times I was mindful to proceed at a slower, more cautious pace to ensure the participant was feeling comfortable.

Individual in-depth interviews were conducted in the language the participant preferred. I hired an interpreter and or used the language line through the Margaret Chisholm Resettlement Centre (MCRC). Twelve women required an interpreter for the interviews. All interpreters used were professionally trained. Prior to each interview I ensured all interpreters were given the same instructions concerning the interview and general information about the participant’s circumstances. Careful attention was given to ensure full anonymity protection of the participants. Female interpreters were requested for all interviews due to the nature and sensitivity of the topic and vulnerability of the participants. I provided the interpreters with information regarding: 1) length of interview time (60-120 minutes); 2) topic (postpartum depression and maternal health); 3) potential breaks might be taken if needed by the participant; 4) flow of interview (I would state my open-ended questions in English and in return they would translate in the participant’s
first language). At times breaks were taken because the women either became tearful or they needed to attend to their infant. Participants were always given the choice to end the interview but this did not happen with any interviews. After brief periods of time they chose to resume the interview. At all times I had counselling contacts available should the participants have felt distressed or required further care and attention.

At the start of each interview I explained the project, answered any questions, and asked for the participant’s consent to participate in the study. All participants were asked to complete a socio demographic questionnaire (Appendix G). Each immigrant or refugee woman was individually interviewed once. The duration of these interviews were approximately 60-120 minutes. The length of the interview was determined by the participant. Ten participants were invited from the initial 30 interviews to do a second interview. This second interview was done as a form of member check. Member checking is done to determine the accuracy of the qualitative findings through taking the final results back to the participants (Creswell, 2007). Interviews were conducted over a span of six months (Dec 2009–May 2010). Childcare was also arranged as needed if the participant required this service. Interview settings included the participant’s residence or various community agencies and were dependent on the participant’s preference. All interviews were audio-taped with consent with the exception of one whereby the participant did not feel comfortable with the audio-taping. Therefore for this interview in-depth field notes were immediately written following the interview.

Participant observation was not done in this study because of several factors. First, my foremost concern was to safeguard that the rights of these participants were protected in a sensitive and appropriate manner. I chose to conduct in-depth interviews in
locations selected by the participant as this afforded privacy and convenience for them. Face-to-face in-depth interviews provided participants the opportunity to thoroughly describe their experience. The participant’s narratives provided valuable insights into their experiences whereas obtaining this level of interpretation may have not been possible through participant observation. Second, participant observation is a demanding and prolonged way of gathering data. Although participant observation is more commonly possible in traditional anthropological fieldwork, in this case it may be viewed as obtrusive or inappropriate. The type and intensity of participation most appropriate needs to be decided by the researcher (Spindler & Spindler, 1992). Third, the practical problems of gaining access to more public areas where mental health services are provided with vulnerable populations should not be underestimated (Quirk & Lelliott, 2002). Potential clashes in ethical principles, and primary ethical obligations to the participants being affected by the study may raise ethical issues due to difficulties in eliciting true informed consent (Spradley, 1979).

**Data Coding, Analysis and Interpretation**

Qualitative research methods use complex reasoning that is multifaceted and simultaneous (Creswell, 2007). Inductive reasoning is the foundation for most qualitative inquiry. Inductive reasoning moves from the specific to the general; certain instances are observed and then combined into a larger set (Chinn & Kramer, 1998). The reasoning process is iterative and also cyclic as it moves back and forth from data collection and analysis to problem reformulation and back. In addition to an iterative thinking process, the elements of collecting, analyzing and writing occur (Sandelowski, 1995). Agar (1986) also has pointed out that data collected by researchers in the field to describe similarities
and differences often lead to more questions about the culture. Reimer Kirkham & Anderson (2002) contend that specific detailing of the postcolonial perspective involves a particular angle of inquiry; one that may result in multiple methods and techniques, "There are no prescribed techniques for data collection or analysis. Different techniques can be drawn on depending on the focus of inquiry, as long as they meet the criteria for scientific adequacy and rigor" (p.14-15).

In this study, particular direction is taken from Carspecken (1996), Sandelowski (1995), and Denzin and Lincoln (1994). There are four specific steps involved: 1) The interview data and field notes were taped and transcribed verbatim as soon as possible following the interviews. As data was obtained to ensure accuracy, transcripts were rechecked against audiotapes, corrected and then a hard copy obtained for preliminary analysis. I revisited the audiotapes frequently as ‘listening’ to the women’s narratives was most powerful and helped to increase my understanding of their often complex experience. 2) In the early stages of analysis, transcripts were coded to identify preliminary themes from the data and a list of code categories were formulated for organizing incoming data. Code categories were refined as subsequent data were gathered. 3) Data coded in one category was at times seen as 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 process of data analysis, which is adaptable and evolving, does consist of systematic and rigorous development of code categories and subcategories. Data coded in one category may be relevant to other categories. This initial analysis was used to draw on in coding of subsequent transcripts. Meetings with my supervisor occurred to review and share reflections on the process of conducting the
interview, personal feelings, and analytic descriptions. 4) Themes and concepts were used to compare within and across transcripts in the data set and across cases. A higher level of data conceptualization and broader theoretical formulations were then generated. This step also involved a second interview which allowed the return of the preliminary data back to the participants along with any analytic interpretations as a type of ‘member checking’. This process enabled me to clarify, expand, and discuss with the participants emergent themes, ideas, and concepts. This step also helped me to develop a deeper understanding of the data and gain insight that helped to move my analysis from individual experiences to the exploration of the social processes and structures that organize experience. For my analysis to be considered valid by qualitative research standards, my interpretations would need to be agreed upon with the participants.

Although validating the accuracy of results occurs throughout the research process, there are critical steps to check for accuracy and credibility of findings. Trustworthiness and rigor is viewed as a strength of qualitative research (Creswell, 2007), and it is most significant to address in this study. In qualitative research my role as a researcher is to identify personal values, biases, and assumptions at the outset of the study. Therefore with this understanding I identified any biases and was careful to monitor my thoughts during the research activities by keeping a journal to write down my feelings. I continued to challenge myself in order to make certain that my own perspectives were not affecting the research method, analysis or interpretations (Lipson, 1989). The responsibility of the researcher is to remain true to the data. The way in which I asked questions could influence the data obtained, therefore every endeavour was made to avoid asking leading questions in the interviews.
A further consideration was “reduction of power inequalities among the researchers and participants as a means for preserving the subjective validity of participant’s statement, affects and behaviours” (Hall & Stevens, 1991, p. 25). Within the interview (Oakley, 1981) suggests a method to support mutuality; one that includes exchanges and dialogue to access the women’s experiences. In this way researcher actions and questions convey appreciation and respect for the women’s unique experiences, as well as valuing their time and giving in exchange meaningful information from the research study which might be useful to their individual circumstances. This was a powerful emotion for me during the interviews as I felt privileged to enter these women’s lives and tried to use every opportunity to treat the ensuing relationship with much respect. In retreating from the interview some times I found it difficult to leave for some women had so many complex problems and had shared so much with me. One participant stated she had never even shared this kind of information with her own mother. Some asked if I could come back and visit again and several requested a summary of the project once completed. They expressed how this research process had given them new knowledge and insights into their own experience and thus new feelings of empowerment.

Another primary strategy in establishing accuracy is the use of rich descriptions to convey findings. Creswell (1998) described three elements of this process of transforming data into findings. The elements include description, (capturing the participants’ perspective); analysis of constructing taxonomies, (grouping of predicable occurring patterns); and interpretation of the culture-sharing group, (drawing conclusions from the data to organize the study incorporating the researchers’ perspective).
Member checking was done to determine the accuracy of the qualitative findings through taking the final results back to the participants. Informally, researchers engage in member checking each time they ask for clarification, elaboration of meaning or verify evolving interpretations of the data. Sandelowski (1993) asserted “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). Data categories are partially based on the meanings participants give to their narratives; therefore I 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 the participants themselves construct them when facilitated in an open-ended way by the researcher. This was carried out during the second interview, where I further explored, negotiated and clarified my interpretations with the participants. In many instances this lead 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). 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 must employ member checks, critical self awareness, and recognition that the researchers’ social position and perspective may influence the research (Lather, 1991). By paying careful attention to interpretations with achieved or agreed consensus by participants the validity of content was confirmed.
Ethical Considerations

Lastly, I offer important ethical considerations that were addressed during each step of this research study. Ethical approval was obtained by the Conjoint Health Research Ethics Board (CHREB) in Calgary. Free and informed consent preceded all interviews. Each participant was given a full explanation of the study and their rights according to the Tri-Council Policy Statement (Appendix H). Participants were asked to give informed consent by signing the form after the study information was provided and after I was certain that the participant understood the implications of being in this study. A copy of the signed informed consent was given to each participant. I ensured anonymity was preserved and protected the privacy and confidentiality of each participant. Anonymity was protected as follows: 1) data is identified by pseudonym and code only; 2) all information stored is kept confidential in a locked cabinet, and locked environment; 3) consent forms are stored in a locked cabinet separate from the interview tapes and transcribed data. Computers are password protected. To maintain confidentiality, code numbers were used with no identifiable information on transcripts and interview questionnaires. At the close of the study, all final reports will not include any identifying information. Audiotapes will be destroyed seven years after the completion of the study. Electronic and paper versions of interview transcripts and field notes, with no identifiable information will be kept for educational and other research purposes, subject to ethic approval and according to standard procedure. Every effort was made to ensure that the participants were aware that they could withdraw from the study voluntarily and were not obliged to respond to any questions they may have felt
uncomfortable answering during the interview. I conducted the interviews with sensitivity and provided a thorough explanation of the research project.

Recognizing that social, economic, and perhaps political difficulties may exist, careful attention was paid to the ways in which interaction was carried out with the participants. I was attentive to the fact that by interviewing immigrant and refugee women I may uncover sensitive issues which may be distressing for them. During some of the interviews some participants felt very emotional and especially expressed much sadness. At these times we took breaks and then inquired whether the participant wanted to keep conversing or end the interview. In all instances the participants were willing to carry on through the interview and counselling was not required. Counselling service contacts were always made available if the participants experienced any level of distress. Indeed most women commented that the act of expressing and talking about their experience to me made them feel better. I was aware of the challenges of recruiting members of vulnerable groups, especially socially and economically disadvantaged and stigmatized persons. This awareness assisted in negotiating and establishing trust which is foundational in establishing a strong and sensitive research study.

Beattie and VandenBosch (2007) suggest these critical elements in preparation for working with vulnerable populations: (a) knowledge of the population; (b) knowledge of other research with this population- especially research that has been problematic; (c) appreciation of multiple vulnerabilities- being prepared in advance for issues in recruitment and retention; (d) identifying and building strong relationships with key members of the vulnerable group to understand norms and assist with problem-solving research related issues. I carefully addressed these important elements through various
approaches. From my past work as a community health nurse and research (O’Mahony, 2005) conducted I was very familiar with this population and knew the critical importance of networking with health care providers to gain their support and access to these participants. I was also prepared in advance through a review of the literature as well as the suggestions and guidance of health care providers who work closely with immigrant and refugee women. Being aware of the multiple vulnerabilities and the nature of this research I initially expected some recruitment issues. However over time and with the health care provider support to arrange the first interview I was able to conduct 30 interviews. The measures taken helped to ensure that the rights of this vulnerable population were protected in a sensitive and appropriate manner.

The dominant themes that emerged from data analysis are: the conceptualization of PPD, diverse, complex challenges and facilitators of seeking help, positive attributes of immigrant and refugee women and intervention strategies for PPD care and treatment. The next four chapters focus on the findings and discussion of these themes. The final chapter is a discussion and recommendations of this study, including implications for nursing and future inquiry.
CHAPTER V: FINDINGS AND DISCUSSION: CONCEPTUALIZATIONS OF POSTPARTUM DEPRESSION

This chapter reports on how immigrant and refugee women conceptualize PPD. This was found to be a major theme and an important concept. Based on Kleinman’s (1979, 1980) explanatory model (EM), individuals use their own notions of how to explain, organize, and cope with particular illness. Individuals’ cultural backgrounds shape their EMs of health and illness, and influence their health care practices and expectations of treatment. The meanings and value attached to events within the context of the immigrant and refugee women’s PPD experiences provide awareness and understanding of how these women may develop their ideas and define what is most important and how their ideas and values may influence their behaviours in relation to an event.

Pregnancy and childbirth may be similar worldwide, but how PPD is conceptualized and is experienced by women of diverse cultures may be quite different (Kumar, 1994; Morrow et al., 2008; Oates et al., 2004; Teng et al., 2007). How immigrant and refugee women define PPD and their attitudes toward it will be a strong influence in how they utilize and access their social support networks and mental health care services. Moreover a lack of knowledge and understanding about PPD is a significant barrier and limitation to help-seeking.

Data analysis revealed that how participants viewed and understood PPD was impacted by three predominant sub-themes: meaning and causes of PPD, stigma of mental illness, and influence of cultural issues. These sub-themes were closely
interconnected in the participant’s perspective of what PPD meant to them as well their beliefs surrounding the concept of PPD.

I asked the participants various open-ended questions to achieve a better understanding about a) what was their knowledge and beliefs about PPD; and b) what does this concept mean to them? For example I asked whether they were familiar with the term PPD and what they thought caused this condition. Other probing questions were: Is PPD a problem back home? Do you have friends that have experienced PPD or do you know how women prevent depression?

**Meaning and Causes of Postpartum Depression**

The first sub-theme was the meaning of PPD and its causes. These were tantamount to some participants and often intertwined within their responses. At first some participants had difficulty understanding what it was I was asking of them. To give them further clarification I asked what they thought caused PPD. Broadly, participants cited such diverse causes as environment and adjustments to a new country, lack of family support, financial and relationship problems. Other reasons for becoming depressed after childbirth, according to the participants, were impact of age, hormonal imbalances, lack of vitamins and having babies too close together.

As evidenced by the data, participants used their EMs to articulate ideas about the causation of PPD. Because explanatory models do not exist in isolation, they are powerfully shaped by the woman’s particular context. Participants gave a multiplicity of meanings and different explanations for the same illness because of their unique circumstances and experiences. Women’s beliefs on the causes of PPD focussed on numerous social factors that created vulnerability.
Anna put it plainly:

It’s easy for a woman to get depressed… so you’re more naïve and vulnerable to this problem… at the same time it’s easy for us or for any woman to get trapped… because you can fight one item, two issues, but three or four it’s really hard. So I think a lot of reasons at the same time… that can lead to this postpartum depression.

Gloria had a similar position concerning the genesis of PPD: “Too many changes… We are in a country where we don’t speak our language, its more pressure for my partner and for me and we’re apart from our family. It has a lot to do with the situation.” Eve too was firmly convinced that too many changes in a woman’s life could result in having PPD. Changes such as “more work, a new family member, hormonal changes… altogether the changes in my family, loss of my family, and change of country. In my country, Mexico… we have our mothers, our fathers or brothers and sisters, so it happens less.”

One participant was not fully aware of the devastating impacts of PPD, thinking it was merely a harmless feeling of sadness: “I knew about postpartum depression before, but I thought that you’re in a depressed mood all the time. I always thought depression means it will make you very dull and sloppy…[not] aggressive… until I experienced it.”

Some participants described their depressive symptoms including feelings of extreme loneliness, profound sadness, fatigue and uncontrollable crying. Simone described why she began to feel depressed: “I think because I’m lonely… nobody to talk to and only stay home and watch TV with nothing to do. I think if you have something to do… your mind is full, you don’t have space for problems.” Roberta, a Costa Rican
refugee woman who married young, described what she perceived as the cause that led up to her becoming depressed. Coupled with the birth of her first child and her husband wanting a divorce in the first week, she quickly realized she was being abandoned. She described her suffering: "As a stress on the body, the tiredness, the nausea, the feeling sick... sometimes you start crying, sometimes you are fine... and if you don't have a partner's support it is difficult to want to go forward."

Generally there was some awareness of PPD within this group of women, however it was identified that for many ethno cultural groups the concept was non-existent in their country of origin. A number of participants voiced that in their home country PPD was not a common event after childbirth. Kate noted: "[PPD] is not talked about. They don't feel any of this... in India they live in combined families, and the neighbours are very close to each other... mom isn't isolated. Every woman gets help from her parents or parents in law."

Although Kate is well educated she 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? I'm turning bad, 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.

Anna echoed a similar position:

We don't have all the circumstances that lead to this. Some of the women will get depressed, but you have your family support, everyone around you, you don't feel...
lonely. So it’s really different, here you’re alone and struggling with the baby and
don’t know how to seek help... we don’t know all the sources for help, that’s the
difference.

Bonnie pointed out:

I think in the Philippines [PPD] exists, but they just don’t bother about it. I think
there are lots of depressions [yet] they don’t call it depression... Because unlike
here in Canada, other countries are not so focused about depression. So I think
this country really takes care of the mothers, so they notice about depression.

This participant told us that from her past experience, depression isn’t always identified
and that a specific word for depression may not exist. However absence of a word or
concept does not mean that it doesn’t exist for some cultures may conceive sadness in
ways which differ from Western conceptions (Jenkins, Kleinman, & Good, 1991). For
some cultures, certain emotions are difficult to articulate as they are deep with in the
unconscious (Obeyesekere, 1985). Kleinman and Good (1985) maintain that sadness,
despondency, and lack of pleasure with social relationships have very diverse meanings
and expression in different societies.

Stigma of Mental Illness

Many of the participants acknowledged that there were many different
understandings about PPD and much depended on their life experiences. Although they
were able to identify causes and had a general understanding about 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 stigma attached to mental illness such as PPD. In many cultures it is not appropriate
to identify emotional distress and is discouraged in many families (Dennis & Chung-Lee, 2006; Fung & Dennis, 2010; Teng et al., 2007; Ugarriza, 2004). Kleinman and Hall-Clifford (2009) remind us that those who are stigmatized and those who stigmatize are interconnected through local social systems. Understanding the particular social and cultural processes that create stigma in these women’s lives should be foremost in efforts to understand and combat stigma. The knowledge obtained by in-depth ethnographic interviews allowed me to have a broader understanding of the result of this stigma on participants and how it can be addressed.

Most participants felt that the cultural stigma attached to PPD and help seeking was a strong access barrier for all immigrant and refugee women. It was felt that in many cultures there were significant negative feelings around the concept of mental illness that it is difficult to acknowledge within the family and therefore seeking treatment such as medication and counseling became problematic.

Participants who recognized they were experiencing some kind of postpartum depression often felt unable to share their feelings. For these women, PPD meant that they needed to conceal their emotional distress and admitted they had downplayed or minimized their symptoms to conceal their depression from family, friends and health care providers. There are abundant reasons for not disclosing their depressive symptoms including not recognizing the depressive symptoms, feeling guilty, maintaining honour within, or avoiding bringing shame to, the family and community. Among these participants there was particular emphasis on the fear of losing their infant or being deported if their problems were disclosed outside the family.

Fear of the unknown or being labeled with mental health illness was a strong
motivator in keeping quiet. Stigma and fear of being labeled with mental illness was a dominant voiced concern by participants because of the apprehension of losing custody of children. Once a diagnostic label of mental illness is given it is difficult to discard and individuals are dependent on society for ‘de-labeling’ them from the sick role. Helman (2000) noted there are certain culture-specific contingencies that may resist this labelling which include the individual’s power relative to the labeler based on their gender, race and socio economic position. Because of their socially disadvantaged position some participant narratives revealed the unequal social power relations through expression of great fear and the ensuing negative consequences for themselves and their family.

Power relations arise when there is difference or conflict whereby one individual or group is affecting the other. Power entreats the resistant forces into its own realm by labelling and defining difference and thereby determining norms (Sawicki, 1991). These localized forms of resistance and power occur at the micro level of the women’s everyday interactions (Foucault, 1980). Such resistance serves to disclose the contested space between what is unknown and what is thought to be fact. We come to understand how the participant’s self-knowledge may be subjugated through psychiatric labelling and decontextualized interventions. It is clearly shown that these participants were particularly fearful about revealing their mental health problems to others for fear of being labelled with mental illness and subsequent negative consequences within their family.

Several participants expressed fears about the authorities finding out about their mental illness problems. They were concerned about their precarious immigration status and possible child apprehension and even deportation of themselves if found out. One
mother accessed help by calling home to physicians in India to avoid sharing her emotional problems with her own physician in Canada. There was acknowledgement of the need to pretend everything was fine to family, friends and the family physician. Similar patterns of concealment and hiding their true feelings were expressed by many participants as ways to show they were good mothers and coping well, and to avoid embarrassment or dishonour to their families.

In contrast Dana had a different position and felt that her own ethnic community didn’t fully understand what mental illness was:

> Fears of perhaps being labelled with mental health illness... I don’t think that’s a problem. Because in our community from back home, most people don’t know what it is so, how would they know about it being a problem... you can just say, yeah I’m going to see a doctor or psychiatrist... It is kind of easier [in this city]. I don’t think people mind here...

These same concerns were also expressed with PPD screening and were voiced by some participants and several health care providers I encountered while networking within this population. A counselor from an immigrant community agency spoke about her encounters with these women: “Many of our immigrant and refugee women clients are in denial about their depressed feelings due to the stigma that prevents them from acknowledging their situation” (M. Smith, personal communication, January 15, 2010). Other health care providers suggested that some immigrant or refugee women may not give totally honest answers in the screening tool. Health care providers postulated that such women may give false answers to show they were not at risk for depression, perhaps because they do not fully understand the seriousness of PPD or are fearful of being
alienated or disrupting family harmony. Dana, a participant, felt this subterfuge was necessary for refugee and immigrant women in order to protect themselves or their families. She talked about how easy it was to deceive and hide your situation in a telephone call versus a health provider home visit: “On the phone I can say anything, and I can just hide things very easily.”

Dana was very candid in her description of the screening event. She felt that some of her immigrant women friends were filling out the screening form to show they were not having problems emotionally after the birth of her baby, although Dana knew her friends needed more help. She further revealed a situation whereby her friends shared their fear and mistrust of the PPD screening: “We can hide it... if we answer that question like this, maybe they will take our baby away...”

Dana experienced PPD with both of her pregnancies and knew the screening tool well. Reflecting on what other immigrant women had shared with her, she questioned the process and effectiveness of screening new immigrant mothers. She described in her experience that waiting until two months time to carry out postpartum screening was too much of a gap. With Dana’s second infant, depression exacerbated before two months time in the postpartum. She shared this concern: “Especially when you’re pregnant and your doctor and gynaecologist know that you have this kind of depression...They should send you to a psychologist because you had it before and in pregnancy.”

For some participants great apprehension was expressed about help-seeking for fear others would find out. Stigma and potential shunning from family and community may act as a barrier to treatment. Ciara expressed much concern over what family and friends would think: “I thought maybe this will help me, so that’s how I’ll take care of
my daughter... that’s why I went to see a psychiatrist ... I told my husband but no one else because they would think I’m kind of crazy.”

Bonnie, a participant, commented: “If you value your family of course you try to keep it secret... Not ashamed but I don’t want them to get hurt... because I know they would be hurt.” Pam also pointed out:

I think [immigrant women are] afraid to let people know they have some low depression. I don’t know the culture here but in China we usually don’t want people to know we have some bad or low depression. Maybe some will not feel good about you and maybe they would stay away from you.

Wendy also agreed that Chinese immigrant women bring these values and beliefs with them. She described the pressure to ‘save face.’ Some Chinese immigrant women do not want to tell anyone about their PPD for fear that others would think they are not strong enough and cannot manage things well. Moreover Wendy stated that Chinese women find it is easier to hear that their problems are caused by a physical reason rather than a mental reason. Therefore in trying to explain the nature of their illness there are numerous challenges for these women.

In traditional Chinese culture dysphoric emotion is suppressed because it is regarded as shameful not only to the self but to family members. While bodily symptoms garner support and care, psychological problems do not have the same social efficacy (Kleinman, 1986). Cross-cultural studies done by Jenkins, Kleinman and Good (1991) found that within a culture, social class influences how the individual expresses certain emotions. For example they reported that Chinese villagers may show dysphoria openly but educated middle class Chinese will display particular emotions only to close family
members. Further drawing on postcolonial theory we see how constructions based on the assumptions about the concept of race that intersect with other power relations disadvantage some groups and establish class position for others. Moreover in this study it is important to examine the contextual factors that shape the immigrant and refugee women’s PPD experiences as well as to analyze the social processes that intersect with race, class, and gender that influence the ways in which these women seek help for PPD.

Many participants also spoke of the overwhelming barriers created by the stigma of mental illness, as well as the danger of subsequent shunning by the ethnic community. This attitude could lead to the family’s concealment and denial of the mental illness, which could serve to exacerbate the situation. In other situations, it meant that the immigrant or refugee woman would isolate herself in order to conceal her problem from her community. This creates further barriers for her. Therefore even if mental health services were available for these women, the stigma and potential shunning from family and community would act as a barrier to treatment.

A participant noted that the community will judge a woman and that they cannot understand what she is going through, and yet they will think the worst of her. She feared: “Your problem maybe temporary but I don’t want people to think bad about me, my family or my husband…”

Anna is of the same mind:

Back home, it’s a very bad way of looking at others. If someone has this problem, everyone gossips, you get this feeling that people are not dealing with you normally or as if you are abnormal almost… I think this is in the back of our minds, and one of the things that prevent the immigrant from asking for the
help. They do not agree they are desperate or that they suffer from depression… maybe because back home it’s very rare... and we don’t have this knowledge.

In previous work (O’Mahony, 2005) I explored with health care providers their concerns about immigrant women’s mental health and how immigrant women access mental health care. It was found that immigrant women face many difficulties accessing mental health care due to cultural differences and social stigma. In this past study the health care provider participant expressed that immigrant women are being stigmatized as mentally ill and it is very hard for them to deal with the community because they are not allowed to tell other people that they are seeing a psychiatrist or have a mental health problem. It was also found that immigrant women would outright deny the diagnosis of being mentally ill and sometimes the family was complicit in trying to conceal the illness. Therefore by the time the woman or her family sought treatment, the illness was usually in the crisis intervention phase. These past findings from the health care provider’s perspective are very similar to the immigrant and refugee women’s expressed views within this study.

Moreover in the literature, studies conducted on immigrant mothers and their families found they are not immune to stigmatization of mental health illness such as PPD and is a serious issue in all cultures (Arboleda-Florez, 2003; Dennis & Chung-Lee, 2006). Qualitative studies found that social stigma can affect help-seeking for PPD particularly when the emotional expression is inappropriate or atypical in a certain culture (Collins, Zimmerman, & Howard, 2011; Postmontier & Horowitz, 2004; Teng et al., 2007). Fear of disclosure, labelling, stigmatization, and social pressures are consistently
reported as strong barriers for this population (Dennis & Chung-Lee; Fung & Wong, 2010; Sheikh & Furnham, 2000).

**Influence of Cultural Issues**

Cultural beliefs as a third sub-theme was also closely interwoven within the conceptualization surrounding PPD and stigma attached to mental illness and help seeking experience. The participants’ explanatory models are heavily impacted by cultural beliefs. The influence of culture had significant impact on the women’s emotional state. Cultural beliefs could be viewed as positive when they served a protective or preventative role within major transitions such as pregnancy and childbirth. Traditional customs or rituals during the postpartum period are geared towards providing support for the new mother. So lack of cultural traditions could leave the new mother more vulnerable and be viewed as detrimental to the women’s support system. It was also apparent that some of the participants had difficulty with inner conflicts (their own beliefs) and some with external conflicts (the woman’s perception versus family and other community members (Teng et al., 2007). Lack of cultural acknowledgment or recognition concerning PPD may further encourage new immigrant and refugee mothers to deny their emotional suffering.

Particularly from a cultural perspective, accessing mental health services was difficult for many immigrant and refugee women. Moreover if you confided in your Indian friends Kate shared this concern: “They would think that I’m crazy, I’m crazy and gone mad completely… My baby should be seized away. I never got help or explained my problem to any Indian woman; because I know a hundred percent how they think… they wouldn’t understand.” Kate went on to explain that she desperately needed the
support of her friends because of the overwhelming fear of being left alone with her baby. Her destructive obsessive thoughts centred on harming the baby. She saw no other option but to spend time with her friends because her family was far away. She said: “I would just stay with them; not telling them what the real problem is… I told them I had a phobia with knives, so please put the knives away...” Kate kept her distance from the Indian community before her struggles with PPD because she knew there were many women who did not work outside the home and consequently liked to gossip within the community. She added: “I knew that very well, that’s why I didn’t share it with anyone... that’s the cultural barrier that I faced.”

To illustrate the seriousness and enormity of this problem I draw from a local media story. A recent tragedy took place in Calgary whereby a young East Indian woman who struggled with mental health issues, had at least three secret pregnancies and is likely guilty of infanticide. She had given birth to these infants over the span of four years and had hidden them in her home. The woman’s family was equally perplexed by the mystery surrounding her death and those of her newborns. It turns out the woman kept her pregnancies a secret from her family and from her partner. She appeared to live an ordinary life, on the surface at least. It was reported that she had delivered the first infant in hospital but unfortunately follow-up did not indicate any further difficulties. Participating in the postpartum program is voluntary and unless a new mother appears high risk during the home visits some mothers may be overlooked particularly if there is a language barrier in the first two months postpartum (C. Hauer, personal communication, October 18, 2009).
Ciara told us that within South Asian culture there is limited discussion of pregnancy or maternal issues until a woman is facing these issues. Therefore within the culture, discussions about topics such as depression during pregnancy or after in the postpartum period were only allowed at select times. Ciara encountered these strong cultural taboos and gave an example of why problems may be hidden within her culture: 

Because when you are in a joint family, you say something to anybody in or outside of your house, people start to talk more… ‘she is feeling this way so maybe she’s going crazy’…words like this start to come up, and then slowly and slowly the problem gets bigger, and that’s why I think we hide this...

Another participant felt that in a positive way combined or joint families were protective against PPD but at the same time there may be challenges with seeking help for mental health problems. She noted: “In India there is no PPD because of combined families and having more friends…but there are some women who have depression but aren’t properly understood and won’t say it outside. It’s hidden, perversion, child abuse… things like that are hidden in India.”

Some participants strongly believed that problems should be kept within the family. Alice was adamant about how disclosure of emotional problems outside of the family was a key reason that prevents Iranian immigrant women from seeking help from a psychiatrist:

We can resolve the problem by ourselves… or particularly within the family.

[In this city] it’s a very small community of Iranians, if I seek help from a psychiatrist, I may see one Iranian working as a cleaner… she is going to tell another and everybody tomorrow knows that I was there, then the story goes
bigger and bigger… ‘She is depressed, she is mad, she is crazy’... but the talking about the problem never goes away.

Furthermore, the family was also seen as exerting pressure and deciding how the mental health problem should be solved. Dominance and control by the partner was also seen as a contributing force in preventing the women from accessing services. Some participants felt that the partner and other family members’ beliefs may differ from that of the depressed mom. Dana, a participant lamented that she needed her family to listen but not give unwanted advice.

Keeping knowledge of the problem within the family was a strong social pressure. Even if the immigrant or refugee women wanted to access services her actions were highly impacted by the familial pressures. For example, Dana shared her need to see a psychiatrist but her mother’s response was: “No, you will be fine. Everybody feels like that so don’t worry, don’t go to the psychiatrist. You will become more depressed.” Dana’s husband was also of the same mind. Dana commented:

So when I first went [to the psychiatrist] I didn’t tell anybody...even my husband wasn’t supporting it, because he said ‘you will feel like you are depressed for the rest of your life’... in my culture, they don’t believe in it. They say everybody feels it, but they come out of it and don’t need medication.

**Mistrust of Biomedicine**

The unfamiliarity of Western biomedicine affects immigrant and refugee women in various ways. This mistrust may centre on not understanding or trusting medications for mental problems such as PPD. Many participants expressed significant negative feelings in their culture around the concept of mental illness and towards the taking of
medication. Some women were unwilling to take medication for depression, and some felt that medication is not helpful due to side effects. Some did not understand reasons for medications, or felt that medications were a way to escape reality. Others feared becoming dependent on medications. Sara, who worked a double shift, found the medications made her too sleepy to be effective at her jobs.

Two participants felt taking medication for depression results in dependency. Roberta offered this explanation:

My family doctor offered to give me antidepressants… but those pills are a drug, so I don’t want this. You take medication when you have a headache or some kind of pain but it’s not good to tie yourself to a pill because you become dependent.

Anna, newly emigrated from the Middle East perceived that taking medications for depression could be habit-forming: “We believe when you take medication it becomes a habit and you can’t get rid of it, so we try to avoid this even if it would help us… I don’t want to be addicted to something, so I will not do it.”

Dana gave an example of how family members mistrust medications for mental health problems: “My cousin lives in London and has depression and takes medication… but now she has cysts… [family members] said by taking those medications she now has another problem.”

Kate, a participant, was one of the women who had a very difficult time with taking medication early on in her depression because of her mistrust and confusion over using medication. Often the mistrust centres on not understanding the biochemical role of these medications. She did not perceive herself as being sick and nor did she have her husband’s acceptance with the idea of taking medication. Instead she went with accepted
advice from her husband and family back home in India. In this narrative it is important
to illuminate how the effect of unequal gender relations influenced and impeded her
ability to access appropriate help. Kate told us that because she did not take the
medication earlier on, her PPD exacerbated. There was a strong resistance about
accepting mental illness and taking medication:

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 the reason 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 alright.

As well Kate’s partner had a very different perspective on the situation; one that strongly
conflicted with her own views:

He said if you get angry on something a calm and relaxed person would say
‘I’m upset, but I don’t have to show it’. If an angry person gets upset, they might
just go ahead and beat the other person... so it should be in your control. But he
said ‘I haven’t exercised control since my childhood.’ We have different
perspectives on that... for me, after facing [PPD], it has nothing to do with
control. If I didn’t have control, I would have hurt my baby.

Carol shared this example about the misunderstandings of service delivery and cultural
beliefs:

I heard this lady had some mental problems and went to a psychiatrist... In the
end they got divorced and the husband claimed the psychiatrist was the cause of
the divorce. So when I have problems, my husband doesn’t want me to see a
psychiatrist, because he’s afraid it makes things worse. Why? Because they don’t understand our culture… it could be another reason why we don’t [seek help].

Rather than accepting the diagnosis and supporting the use of medication, friends and family encouraged the women to look at alternative ways to deal with the situation or downplayed the seriousness of their PPD. These findings are consistent with Kleinman’s (1978) explanatory model whereby much of the decision-making as to whether one should seek help or to comply with treatment was made in the popular sector. This is where the family plays the central role and decisions are influenced by the family’s values and beliefs about illness and health.

Based on the postcolonial feminist perspective, we shift our attention towards the contextual factors that interact with race, class, and gender and examine how individual health care practices may be shaped in seeking help for PPD. It brings awareness as to how inequity and power relations may influence their health care behaviour (Anderson, 2002; Anderson & Reimer Kirkham, 1998; Donnelly, 2004). In the past, the dominant discourse of biomedicine has shaped the ways in which illness, disease, and health are conceptualized and has promoted certain treatment of mental health problems (Cheek & Porter, 1997). As a result this has prompted a particular treatment of health care issues to the exclusion of other ways. This ideology serves as a rationalization for the processes of social inequality, as it refutes inequality and blames immigrants for their shortcomings (Li, 1988). For the immigrant and refugee women, this may result in their needs and concerns not being fully understood or taken seriously. These same women who have felt misunderstood or not welcome are less inclined to access or seek appropriate health care within the health care system. The unfamiliarity of Western biomedicine coupled with
past inappropriate treatment propagates their fears and confusion about accessing mental health care services (O’Mahony, 2005).

Carmel also pointed out that the concept of prevention may be unfamiliar to new immigrant and refugee women: “It’s not part of our culture that somebody tells you shouldn’t do this... so here it’s difficult to understand. I don’t know if other countries do prevention, but... especially in the poor countries... there isn’t enough money to do this.” Furthermore the concept of health prevention maybe quite unfamiliar for many immigrant and refugee women and present further misunderstandings of health care service delivery.

The findings suggest that in many cultures significant negative feelings surround the concept of mental illness, as well as the forms of treatment such as medication. Mental illness is a taboo subject in some cultures. Because of this feeling, immigrant and refugee women may be ambivalent to reach out for help unless it is a crisis situation. For some women this meant denial and being silent about their situation for fear that others in the community would censure them. Therefore even if resources were available, access is limited because of powerful cultural beliefs and the stigma attached to PPD, making help seeking an overpowering access barrier for immigrant and refugee women.

Summary

In summary it is clearly evident that the conceptualization of PPD is very significant and a strong determinant of how immigrant and refugee women comprehend and view PPD. The findings clearly demonstrate that cultural beliefs may shape the immigrant and refugee women’s responses to PPD and accessing mental health services.
Culture is part of the contextual factors that influence the immigrant and refugee women's mental health care experiences. This is important as an awareness of the social cultural context is necessary to provide appropriate and quality care in order to meet the mental health needs of the immigrant and refugee women within the postpartum period. These women might not access health care services because of their powerful cultural beliefs toward mental illness coupled with misunderstandings, unfamiliarity and mistrust of Western biomedicine. Therefore, cultural beliefs can impact the way immigrant and refugee women address their mental health problems individually and within the family.

Barriers created by the stigma of mental illness, as well as the danger of subsequent shunning by the ethnic community may lead to the family's concealment and denial of PPD, which serves to exacerbate the situation. The shunning and stigma attached to mental health problems by the ethnic community contributed to increased access barriers for these women. Participants also felt that the ethnic community has a very explicit impact on how immigrant and refugee women and their families deal with mental health problems. Significant negative feelings around the concept of mental illness and towards the taking of medication were clearly revealed as part of some participant's experiences. The stigma attached to mental illness and help seeking was an overwhelming access barrier for immigrant and refugee women in this study.

Drawing from Kleinman's explanatory model I was able to examine more closely the meanings and value the participants have given to PPD and to further describe how these ideas may influence their behaviour. By being able to identify the immigrant and refugee women's beliefs, values, and understandings about PPD, I am able to explore further how their health care behaviour is influenced by their cultural knowledge, values
and background in future chapters. Moreover, consistent with the postcolonial feminist perspectives it was found that how these women define PPD, their attitudes, and lack of knowledge and understanding about PPD is not only due to their culture but also to contextual factors that interact with race, class, and gender. Inequity and unequal power relations may influence their participation in seeking help for PPD. As this chapter closes, the focus now shifts toward the immigrant and refugee women’s experiences in seeking help to cope with PPD.
CHAPTER VI: FINDINGS AND DISCUSSION: IMMIGRANT AND REFUGEE WOMEN’S PERSPECTIVES IN SEEKING HELP FROM THEIR SOCIAL SUPPORT NETWORK

This chapter focuses on the findings and discussion of the challenges and facilitators that immigrant and refugee women experience when utilizing health care services and social support networks to cope with PPD and its related factors. Relationships and connections within the social support networks can be supportive or non-supportive with resulting wide-ranging effects on physical and psychological health and well-being as well as on health care practices. Two broad categories were evident.

The first category was formal and community support. The immigrant and refugee women participating in this research spoke of various factors which influenced their help-seeking behaviour and experiences both positively and negatively. Facilitating factors had several sub-themes including the good health care relationships, and services provided by immigrant and other community agencies. Challenges for the immigrant and refugee women were difficulties accessing health care services and the poor health care provider relationships.

The second category was informal social support. Within this theme the women described challenges as well as facilitators. Sub-themes included particular measures to bolster the immigrant and refugee women’s social support systems, while challenges were about the lack of family support and issues of social isolation.

Cultural influences were also viewed as being helpful or unhelpful depending on the participant and her circumstances. As seen in the past chapter, cultural beliefs
influenced the conceptualization of PPD. In this chapter we will see that culture is also part of decision-making about using social support networks, and of health care behaviour. Participants were asked various open-ended questions to gather information about how they seek formal and informal help to cope with their PPD. Examples of questions were: Do you have family and or friends living in the area? Who did you ask for help and was it easy to obtain help? If not, what made it difficult? Other probing questions were about whether they found available health care services suitable and appropriate to cope with PPD and its related problems.

**Formal and Community Support**

In this study formal support is defined as assistance received from various health care providers and or community agencies which provide services for this vulnerable population. Psychosocial factors such as lack of support from formal and informal sources are related to increased risk of PPD and its related problems.

As suggested in Kleinman’s (1978) theoretical framework the professional sector consists of health care providers practicing in the Western world whereas the popular sector is made up of family, community, and social networks. While each sector has its own explanation for and understanding about health, illness and treatment it is important to understand that differing views of health and illness may occur. It is also necessary to recognize and have an understanding of those sectors when providing and negotiating meaningful care and support for these women.

The postcolonial perspective informed my exploration of how social injustices and unequal social relations affect immigrant and refugee women’s access to social support resources and health care services for PPD. The central aim of this work is to
give an accurate account of the women’s health care activities and to improve the conditions in which they live and access health care and treatment for PPD. The postcolonial perspective recognizes the need for knowledge construction from the women’s view, and that their voices have traditionally been silenced in the production of that knowledge (Reimer Kirkham & Anderson, 2002). The following section describes the participant’s perceptions about their needs, health care access, and available community supports that aided in their recovery of PPD. The participants expressed a wide range of views concerning the challenges and facilitator factors for seeking appropriate support and health care services for PPD.

**Challenges in Utilizing Formal Support**

**Unfamiliarity and unawareness of health care services.** Participants reported that they were unfamiliar with and unaware of the services that were available to help them cope with their PPD. Lack of information on PPD and misunderstandings of what they are experiencing compounds the seriousness of their situation. Jenny maintained this view: “I didn’t know that there are such resources here… I was thinking it will cost me even more money and I don’t have this kind of money, so I won’t, didn’t even give it a thought.”

Anna felt very vulnerable and overwhelmed in that she had gone from a safe secure social network back home to a very precarious situation as a new pregnant immigrant:

The biggest problem that I faced was arriving late in my pregnancy and didn’t have a specialist. So when it’s time for delivery they said just go to the ER… I was so stressed the words were gone & was unable to speak. It is my first
experience and everything is new... you’re alone and not with your family or
doctor and don’t know their system, so this is scary...

Another participant Sara confirmed that unawareness of support services was very
much a part of her situation. She worked at two jobs (days and evenings) and also felt
there was no time to seek out help: “There was a wall between myself and the health care
system and no time for learning.”

Carol spoke out generally about the immigrant women’s dilemma:

[Some women] don’t ask for help, mostly because they don’t know there is help.
Others are ashamed or not used to asking for help. I knew a person who was
inside her home all day. She didn’t know the language and she didn’t go out at
all until somebody told her, you cannot [survive] without getting help...

Alice also confirmed after living in this city for two years: “I think there are a lot
of programs that I’m not aware of in existence. I know that after two years being here. I
don’t know many of the programs that I could benefit from.” Roberta, a Spanish speaking
pregnant woman new to the city, spoke about how ‘by chance’ she found out about a
downtown clinic:

I met a lady at a bus stop... she asked in Spanish, ‘what was wrong?’ I told her I
am pregnant... she said, ‘why don’t you go to the doctor?’ Well I’m trying to look
for a clinic but I don’t have any documents. She said ‘you can go to this clinic’
and showed me exactly where to go...

Unfamiliarity with the city and with public transportation to attend a support
program for PPD women made attendance at programs difficult. Nellie, a participant,
noted that to participate in any of the programs she had to take the bus which precipitated
great anxieties and fear for her. She relayed a story whereby the bus driver had passed the address of where she needed to go. She left the bus, fell down with the stroller and felt very scared due to the unfamiliar surroundings and her poor language skills. Consequently this experience has made her reluctant to attend future programs.

Lack of information. Lack of information was consistently voiced by many of the participants. Migrant women who may have a non-existent social network will probably receive little information from family and friends. Given the shorter hospital stays after childbirth women have to rely more on community programs and resources in order to obtain information, and their access and knowledge of these may be limited as well. In short these new mothers are already vulnerable and disadvantaged in protecting themselves against PPD. The postcolonial feminist perspective provides a lens to reveal how often invisible taken for granted processes structure life and economic opportunities and experiences. In turn the women’s social positioning in the social structure may be a great disadvantage to their health and their ability to manage PPD and other related problems (Anderson, 2000).

Drawing on their past knowledge about formal PPD support services the majority of women in this study felt that health care services were very different compared to services in their country of origin. Some had no idea such support services even existed, having never experienced or heard of such services before. Thus it is important to understand and be aware that some immigrant and refugee women’s health care behaviours may be influenced by their past information or lack thereof about PPD. Jenny gave an example from her country:
Lack of information… I didn’t know that [PPD] existed because in Israel it is not that widespread like here… so people don’t really need it, but there are organizations that provide [PPD support] but I think the cases that go to them are not that numerous in Israel… it’s a poor country with poor services. Here it is more developed on a higher level, than in Israel.

Anna was of the same mind:

You don’t know that this kind of help exists… if you have depression it shows, it is serious and your family will take you to a doctor, but that’s it. There are no programs to help you from the beginning of your depression... So we don’t know when someone says the program for depression what this means.

In fact the very concept of a health care system such as the one we have in Canada was also unfamiliar to many participants. As one participant explained: “It’s totally different. Back home we don’t have this health care system. We don’t have the system itself. Everyone can go to the doctor and pay the money and that’s it… very cheap, but very cheap quality or service too.” Pam noted: “In China we don’t have so many services; we get help from friends or relatives but not from community... they do have prenatal workshop for the expecting mothers, but you need to pay.” Wendy, another Chinese participant further shared her concerns: “I’m not too sure about help from a stranger. I’m not familiar with that.”

Kleinman’s framework is congruent with these participant’s perceptions that having the support of strong family ties was an important factor. The role of the family is extremely significant for emotional support during illness. Similar ideas were expressed by two Mexican women who emphasized that family was their primary source of
emotional support and most commonly the only choice they felt comfortable with. Moreover in Mexico there is very little information distributed about PPD or about the existing mental health care assistance available. Kate, a South Asian woman, spoke about her ambivalent feelings of where to seek help and find appropriate support. In the end she listened to a family member who was also a physician back home:

While pregnant I was asked to take bed rest by my cousin who is a doctor.

The doctors here encouraged me to do little activity [but not] bed rest. But I wanted to be conservative and even resigned my job and took to bed rest. Probably that led me to postpartum depression. Somehow in India doctors are more conservative… They suggested bed rest for this same complication of placenta previa.

Overall the participants expressed in great clarity the desire of needing emotional and informational support from their families after having a baby. This was the most comforting and familiar way to reach out for help. Not being familiar with the Western style of using formal supports freely, most participants preferred the informal support of family and friends. Life circumstances such as migrating influenced and prompted these new mothers to be more indecisive about their choices in seeking help after childbirth. These participants may hold different models of explanation for their symptoms and illness which include how they view the causes and treatment. Differences in causal beliefs may influence their attitude in whether professional help is seen as valuable (Kleinman, 1980).

**Method of health care service delivery.** Delivery of postpartum services after childbirth is undergoing continuous changes to meet the growing demands of births in this city. At present, public health nurses care for new mothers and their babies for the
first two months. All new mothers are contacted within 24 hours after hospital discharge. This is either in the form of a telephone assessment or home visit. After 48 hours all mothers have received a home visit whereby the nurse conducts a physical assessment of mom and baby, offers training in breast feeding, safety, and parenting, and look for any symptoms of PPD. It should be noted that participation in these postpartum services are voluntary. If there are observed difficulties or any red flags raised by the nurse, the mother would receive telephone follow up or referred to community resources for support. Two months later the mother and infant are seen at the public health clinic for infant immunizations with every mother being screened for PPD by using the EPDS.

The efficacy of health care services using telephone support had mixed reviews. Two participants expressed negative views toward telephone support based on their PPD experiences. In contrast several other participants expressed positive views about how telephone based services could be a beneficial way to provide accessible and flexible support services. More about these views are offered in the last chapter on social support strategies.

Lily was convinced that telephone support made it more difficult for her family. She also questioned the sincerity of the nurse’s actions. She expressed these concerns:

Professional nurses follow me for a long, long time. Almost every day they call us and ask us to bring the baby to clinic or somewhere, so no time for rest. My husband would say, ‘We don’t need to always listen to them even if they are professional’... because it doesn’t help us... makes it harder... I think in their heart maybe they want to help, but they just want their job and they need something to do, but [they don’t] really think about our situation here...
Dana, too, was not satisfied with telephone support and the frequent telephone calls. She articulated further concerns about telling the same story every day. She was already greatly stressed and frustrated because she perceived she was not getting anywhere with expressing her difficulties to the nurse. It was clear to her that her circumstances had not changed since the initial phone call and any requests for assistance had gone unheeded, so the calls were of no use to her.

Dana felt very frustrated with the formal support, given not only by nurses, but by other community agencies, and maintained: “I was thinking ‘oh this is a waste of time’ I was getting calls from two [community agencies]… they asked the same questions… I need somebody who can come, and connect me to the psychiatrist.” As a result Dana experienced a very long route to obtaining the services she felt were appropriate for her and further described the fragmentation of health care delivery:

We can’t do that... because it’s not in your area. We are going to send you some documents and if you want to get help from any of these agencies, you can do that. Finally I got a pamphlet and there were referrals I called. They arranged the social worker and nurse to come to my house. I talked to them about everything. So... it took me to somewhere. Rather than those phone calls...

Fragmented health care delivery therefore may contribute to poor service delivery for immigrant and refugee women seeking appropriate PPD care. Another participant voiced her beliefs: “I don’t like the way the system is. You must speak with the nurse first and explain the symptoms to her [then she] explains to the doctor...at the end the doctor doesn’t have any communication with the patient. I think it’s lost in between...” Carmel also noted this repetition and articulated her experience with health care delivery:
It happened in the ER... then came one doctor and one nurse and asks you a question, then they change shift and the nurse asked you exactly the same question, I said, ‘I told this to another person, twenty minutes ago and you’re asking me exactly the same...’ seems like there is no communication and they don’t know what they are doing... or who they are talking about...

Fragmented health care delivery and system design may be somewhat responsible for the kind of treatment immigrant and refugee women experienced. Immigrant and refugee women are vulnerable clients because of factors such as limited language skills, poverty, and lack of knowledge of how the system works. However fragmentation of services within the health care system is a frequent observation by Canadian born and immigrant individuals alike.

Along with fragmentation of services participants also had difficulty finding a physician or specialist. In past years the city has experienced rapid growth in population resulting in a shortage of suitable primary health care physicians. This remains a continuous challenge for many individuals who make this city their home. Kelly captured this well: “When I started to look for [a doctor] it was very, very difficult, I call.... almost fifty doctors... and nobody had space for a new patient.”

Pam used a walk-in clinic rather than a family doctor even if wait times were lengthy. She is seven months pregnant, and it’s too late to find a specialist but fortunately the clinic accepted her as a patient. She compared her access to services in China. She pointed out that if you are willing to pay back home you will find a physician very easily compared to here where free access to a physician takes much more perseverance.
Health care relationship. For immigrant and refugee women to manage and negotiate appropriate mental health care services for PPD, the health care relationship is a very critical determinant as to whether these women will seek and accept help or not. Health care providers play an important role in either encouraging help seeking behaviour or impeding their access to treatment. In previous research O’Mahony (2005) found that the relationship between the health care provider and client was very significant, not only because relationships between the physician and client were the critical entry point into the system, but also because the health care provider relationship influenced whether the immigrant woman would access health care services elsewhere or not access services at all.

In this study participants voiced negative and positive views regarding the impact of this often powerful relationship. In this section I will present perspectives on the healthcare relationship challenges while later in this chapter I will look at the positive influences and facilitators of seeking help.

Participants expressed different reasons for poor relationships with their health care providers. These included the health care providers appearing uninterested, asking few questions, and/or probing too intrusively into their often vulnerable situation. Participants spoke of the superficial help received and minimization of feelings, feeling let-down by physician, feeling the physicians were not well informed, physicians having no time to talk, as well feeling mistrust, and the perception of being unsupported. This negative attitude was perceived by these participants as discrimination. This data suggests that the power distribution may be asymmetrical between the health care provider and participant. The participants had perceptions that their physicians normalized their
symptoms and depressive feelings and therefore underplayed the seriousness of the situation.

According to Kleinman (1980) a key component of health care is the interaction between the EMs of patients and healthcare providers. Not uncommonly, EMs conflict along with unacknowledged cultural influences, lead to problems in communication and the health care provider-client relationship. Under the circumstances it is not surprising that some immigrant and refugee women may not pursue additional PPD help or treatment. Drawing on the postcolonial feminist perspective as an analyzing strategy we see how racialization processes are most harmful in situations of unequal power relations whereby immigrant and refugee women are constructed as inferior or subordinate status (Anderson, 2006). These racial assumptions when acted upon have negative implications for these women. At the individual level of care we may see racial discrimination and oppression affecting immigrants as negative attitudes or behaviours within the health care relationship. Misunderstandings and breakdowns in communication further generate negative feelings making it less likely for these women to receive appropriate PPD support and treatment.

Anna puts it plainly: “If I don’t trust you I will not be open with you. Okay, I will talk with you on the surface, but it’s different than talking from inside.” Another participant, Eve, felt the negative attitude of staff in community clinics was discriminatory as she met with great challenges in finding a physician. She noticed a change in attitude when clinic staff found out she was of Mexican descent:

It was difficult, mainly because for the fact of being immigrant it was difficult to find a doctor for the baby, maybe there are a lot of people from different countries
and there might be some racism. When I tried to find a doctor, they asked me where I was from and when I said ‘from Mexico’, I noticed a change from them being from Mexico, I don’t know. I wanted to run. I felt helpless.

Eve’s example portrays the discrimination she felt because of her ethnicity, making her feel inadequate within this health care encounter. A critical inquiry approach allows us to develop a deeper understanding of how hidden power imbalances may have influenced this refugee woman’s access to health care services. Drawing from the postcolonial feminist perspective it is important to identity how race and culture rarely operate in isolation from constructions of race which are laden with social, political, and historical meanings. Thus it leads us to question further about how these unequal social power relations may shape the everyday lives of these women in receiving help for PPD. It is also important to recognize that not all women share the same social reality and that historical positioning, class relations, and racialization may simultaneously intersect with other contextual factors leaving the women vulnerable and disadvantaged in protecting themselves against PPD.

In Jenny’s situation she described how she valued her physician for his medical knowledge but did not have opportunity to share or express her depressed feelings. At first she tried to ask questions with the expectation that the physician would deal with it more in-depth but soon realized he did not encourage that conversation, possibly due to time constraints. Having experienced this first hand she reflected back on her reluctance to be open with her physician:

I felt that it wasn’t my [place] to talk about my feelings. It was not welcome there and not enough time so I just preferred not to say anything. He’s not a
psychologist, he’s a physician... but his job is to identify so maybe there
should be more specific questions... even though the woman is shy, or not
prepared. My physician is knowledgeable and I value him for this.
Coupled with lack of physicians were the time issues that limit the delivery of
care. Carmel reflected about how she felt dissatisfied by her medical care: “I still feel like
a procedure... if they spend more than fifteen minutes with you, they are not productive.
I understand that there are not enough doctors but that you can’t ask more than one or
two questions in one visit!” Dana also echoed the same concerns about time constraints in
the system: “Last time I went to my doctor, she had a note in my file... ‘She’s in
postpartum depression from last delivery’... so she knows but didn’t do anything about it.
They don’t have time. They won’t do what they’re supposed to do...”

Many of the participants commented on the health care provider’s attitude and the
powerful effect it had on the health care relationship. A number of participants noted that
not only was there limited time to talk, but their feelings were being minimized by the
health care provider, which had a negative effect on the relationship. Some women
interpreted the health care provider’s attitude and treatment as uncaring and dismissive.

Two participants reflected on the health care encounters in the hospital after
childbirth and the treatment received. Their narratives express both positive and negative
experiences. Opinions on postpartum care centred on the importance of the health care
provider’s attitude and the willingness to want to help. Eve spoke with great emotion
about her treatment: “I felt a little bit of racism with the nurses because I couldn’t
communicate and understood little English... I put out my hand to the night nurse but she
didn’t give me her hand. It was hard because, when I feel ... (crying.)”
Kate also acknowledged that some nurses gave excellent nursing care but also observed that hospital policies determined postpartum care, and not always in a helpful way:

Some nurses were really good, but they did not allow my husband to stay with me at night. It not only surprised me, but I was very upset. I understand because you have so many patients but at least let my people who love me stay so they can help me. The reason they gave me was 'we want one of the spouses to have a good sleep' they said. Okay, that's understandable. So let my mom stay... They said 'no, the policies won't agree with that.'

These women's narratives signify the discouragement and negative feelings of the women in seeking appropriate care for their mental health needs. It was clearly evident that often all they needed was someone to take time to listen and empathize with them. Ahmed and colleagues (2008) explored new immigrant mother's experiences with symptoms of depression and suggested immigrant women are very sensitive to attitudes that may be interpreted as inattentive or unfeeling. This is consistent with other research studies that found an indifferent attitude of health care providers is a major impediment in seeking health care (Browne et al., 2002; Dennis & Chung-Lee, 2006; Whitley et al., 2006).

Kleinman (1978) asserted that differences are bound to occur between client and health care provider views of health and illness, but to provide effective health care health care providers need to negotiate and treat illness in a way that is socially and culturally acceptable to the client.

The postcolonial feminist lens extends the boundaries of our thinking to further understand the factors shaping their health and access to health care services. The
unequal social relations and structural inequities expressed by these participants may be influenced by the broader socio economic, historical, and political forces which shape their experience. Unequal access to health care resources and unequal power relations between social groups affect how individuals receive health care and cope with illness. Therefore it is important to understand these women’s lived experiences from a wider social and cultural context and to examine the effects of power in the health care relationship. There is a need to engage critically and shift the attention toward looking at how health care institutions and policy affect women’s health instead of viewing each woman as being fully responsible for her health care (Anderson, 2002; Donnelly, 2004). By asking certain questions from a particular epistemological perspective we can take into account the context in which their lives are situated. We can illuminate how power relations, gender, race, and class influence their health care encounter and access to care. We can have deeper understanding that historical forces and structural inequalities may shape the immigrant and refugee women’s social position and hence their experiences.

**Community service agencies.** As part of postpartum care, new mothers who are experiencing some difficulties may be referred by the public health nurse to community support services. This often may be their first connection with these types of services for the mother to access help for herself and family. Two participants described their dissatisfaction and unhappiness with the treatment received. Bonnie felt ambivalent about some of the community help received because they made her feel bad about herself: “I was in the middle of all these problems and she treated me like I was stupid... they were attacking me because they said, ‘You have to do your part. You have to call because I have so many clients and you’re not my only client. I know I’m not stupid but they made
me feel stupid.’”

Carla recalled how she felt about the breast feeding support by the lactation consultant. She sensed the consultant’s uncaring attitude and lack of sensitivity toward her as a new mother struggling with a new experience:

For lactation consultants the emotional part is missing. ‘You will do it... No be patient. No, you have to try every two hours to feed him, if he is sleeping wake him up.’ It makes you stressed... the lactation consultant is not good with the feelings of the mom who is depressed about ‘why’ she can’t feed the baby. They won’t talk about the emotions or caring about your feelings... or how are you? are you alone or not with your mother or family... No. They didn’t ask...

Within the community several participants pointed out that support groups were not always helpful or met their individual needs. Kate reasoned with the idea of attending a support group but felt she needed to talk with someone more than once a week. Because of the severity of her symptoms she needed more time:

Support groups was not very attractive to me, because they would have a meeting once a week for only one hour... my doctor also signed me up for stress relieving classes too, but somehow I didn’t feel relieving from stress was helpful for depression. I didn’t go because I didn’t strongly believe in that.

Dana, who has suffered from PPD twice, also points out that community support groups may not suit every women’s situation. In her case it was detrimental to her recovery. She was firmly convinced that listening to other women’s PPD experiences increased her negative thinking. With strong conviction she explained:

I joined a group for women with babies. They talked about what happened in the
week. Everybody was saying, ‘I’m having this depression and this problem.’ I was taking it all in, inside me. If I’m going to tell you the story, you’re going to tell me the story... we will talk about that negativity for an hour and that stays in you... I want something positive from somebody else, so then I can think that way; rather than thinking[negatively].

Two participants gave examples of how policies within the immigrant community services affected their situations. Jenny received counselling support regularly but after six months was cut off from services abruptly when her baby was registered in day care. She expressed the impact of this change:

   It was a very bad time for us... my husband was working but I still needed the support... [The counsellor] left and was not allowed to see me if my baby is not here with me. I don’t have a problem seeing her somewhere else but wasn’t offered such an option. Our discussions were about mental health and she gave me strategies how to cope... so it wasn’t only about the baby. I think it only makes sense that [community] associations should look over their policies and regulations of how they stop the services.

Cora, too, was affected by policy regulations and was not able to continue the postpartum support program she had been attending for the past year: “I became pregnant and because I cannot receive both assistance at the same time [they] told me not to return... I felt emotionally sad... there are times when I don’t leave the house or take a shower. I just don’t know why this is...”

A critical inquiry approach is important as it addresses issues related to power inequities and structural intersecting oppressions within society. A central tenet of critical
theory is that individual experiences are mediated by institutional processes and related structural barriers. By using reflection to generate strategies for social justice, critical inquiry approaches represent new ways for contributing to knowledge that addresses health inequities and structural constraints. It gives us a way to conduct valid inquiries into the context of these women’s experience and, in particular, provides an interpretive lens to address socio political oppressive conditions influencing their health and health care access (Browne, 2000; Reimer Kirkham & Anderson, 2002). By starting with individual accounts of these participant’s experiences we can collect further data related to policy and practice context so as to gain a deeper understanding of the ways individual experiences are shaped by policy (Lynam et al., 2003). This also means for immigrant and refugee women that this relevant data reveals the factors influencing immigrant and refugee women’s ability to seek help for PPD and accessibility to health care services and in turn contributes to enhancing mental health care for these women.

**Positives of Accessing Formal Support**

Despite all the negative comments, in general the majority of participants expressed great satisfaction with the formal health care services received and held a positive view of most health care providers. When participants were made aware of services and had more knowledge about PPD it helped to break down barriers in accessing help. Providing encouragement and positive reassurance that their baby would be safe was a powerful message for these women.

Roberta observed: “There is a lot of assistance. If you don’t want to take it is another matter, but there is a lot of support going on here.” Maggie, a young refugee mother, also asserted:
In Canada you get lots of support. If you look for support, you can get it. Even from hospital... when they see someone needs help, they helped me a lot. I see the difference from Mexico and Canada, because in Mexico there’s a lot of babies that die because of negligence or even mothers too. So here I was not worried because I knew I would be taken care of as a new mom.

**Health care relationship.** Most participants felt that the relationship between the health care provider and woman was a significant one in either direction, and a powerful one. The health care professional relationship heavily influences how these women seek health care services for support and management of their PPD. Trust and confidence of individual participants’ influences whether or not they would continue to obtain necessary support within the health care provider relationship. The establishment of trust is necessary if the helping relationship is to continue. Feelings of fear may result in a broken trust, which acts as a further barrier for these immigrant and refugee women as we have earlier read.

Carmel validated the importance of trust within the health care relationship:

> I just trust my family doctor and the other ones... I have my reservations. At least I know my family doctor has the whole history. It’s not the medication that’s going to help you but it’s the support. Time is limited too, but you have a relationship with the doctor.

For Kate, too, the relationship was about trust because of her great fear that the physician would report her to the authorities:

> That’s the first thing I asked my doctor. If I open up my mouth, would they take my child away? The doctor gave me a lot of assurance. ‘No one will separate you
and your child’, Both of my doctors, I thought my God... they are goddesses.

Bonnie had awareness and access to services yet felt some reluctance in accepting help. She goes on to explain that the encouragement received from the health care provider made her overcome her shyness:

Filipinos are shy people. We always want to give... it’s so hard to accept that I’m the one asking for help now, not giving. Not that I’m ashamed, but when you’re used to giving and suddenly you’re the one taking.... But I overcome my shyness for my daughter... I was so shy to ask for help even calling the Food Bank. People around me... the social workers and the nurses offered their help... they told me not to be shy because it’s my right.

Many factors may possibly influence one’s attitude to seek professional help, however an important factor is the differences in explanatory models of illness. Several participants expressed the view that accessing formal help was indeed the easiest and sometimes only choice in getting help because of family far away they did not have a support social network to draw on for assistance. These findings are not consistent with Kleinman’s (1978) explanatory model concept whereby much of the decision-making is made in the popular sector (family and social network) where sickness is managed within the family in a more personal manner. In the formal sector the emphasis is on their physical illness with lesser reference to their home environment, personal relationships or religion. However EMs are strongly shaped by context, and explanations may vary with different accounts given for illness by the individual to themselves, their families, and their health care professionals (Helman, 2007). Some participants in this study who used formal support asserted that they were more comfortable with the health care provider’s
meaningful explanations to which they could relate to individually, culturally, and socially. They perceived professional help to be valuable. Moreover while explanatory models may have an impact on attitudes toward seeking formal support, Fung and Wong (2010) suggest it is significant only when support and accessibility are perceived as available.

In Alice’s situation she stated the nurse and physician took the place of informal support because of her family being so far away. She found that:

> In Iran usually there are parents both sides and the family have experience of how to deal with the difficulty. I didn’t have it here, so I tried to get help from nurses to replace my family. I used to ask for help from my friends as well, but when there were serious things I would contact the nurse and doctor.

In Kate’s situation it was about feeling more at ease when talking about her feelings with the physician instead of family members. She felt her partner did not understand what she was going through: “I felt very comfortable with my [physician]... more than my husband. I just stopped talking to him and discussing these things with him.” Dana also felt more at ease sharing her feelings with the psychiatrist over a family member: “Rather than talking to a family member or friends who know me... I feel more comfortable with a psychiatrist doing that. I think every woman will think the same way. They say sometimes you can’t share everything with your husband.” Maria also echoed how formal support was utilized in place of family and commended the care she received:

> When I was pregnant I got very sick. I also got diabetes and I was extremely scared. I was in Canada and so worried that I would die all alone. In Morocco, I had a lot of emotional support from the family, but over here I had a lot of
emotional and psychological support from the doctors. I will never forget and the words ‘thank you’ doesn’t describe how much I feel.

In addition to the physician many participants viewed the community health nurse’s (CHN’s) support as being especially knowledgeable, encouraging and caring. Anna expressed her gratitude for support received from the CHN:

The main thing is that people are so giving, and they help... the first nurse I met after I came from the hospital was so helpful, and very supportive to me because we’re alone. Yes... me, my husband and our new baby and this new experience. I have a lot of things I don’t know, but I am so grateful.

Lana, a participant with limited English skills, was also pleased with the care received: “The community nurse referred me to the [community program]. In Canada... they do a good job with the community and associations. [The nurse] speaks Cantonese... So the first thing she booked time for baby immunizations with a translator.” Carol too a non-English speaking participant and refugee who had experienced health difficulties with her new infant expressed great praise for all with whom she came into contact:

They tried to communicate with me and help me with breastfeeding. At the beginning milk wasn’t coming but they gave me a special machine and when I left hospital I already had milk. People from the Children’s hospital visited and [connected me] with the Cleft Palate Clinic for the next step. The nurse gave me the appointments and doctors that I needed to see. They had interpreters for that.

In Maggie’s view the CHN knowledgeable advice was invaluable:

We were in the basement with no windows. We couldn’t get anything else because we didn’t have money. A nurse visited and said it was illegal and very
bad for the baby... it was a problem too because the baby had jaundice and 
[needed] more sunlight. The nurse explained it was very dangerous... if there was 
a fire we have no place to escape. I never knew this... in Mexico there are no 
basements...

Moreover Kate was appreciative of the breast feeding support offered by the 
CHN: “All these nurses that worked with me did a great job and am grateful because they 
were very patient with me... to teach me how to breastfeed. I think I know enough and 
feel confident with my breastfeeding... it’s from them.” Kate went on to say: “Every 
nurse told me something different from her point of view and that helped me. When the 
nurse visited me, she suggested I turn to the help of an [immigrant agency].”

Additional community supports. Other formal community supports such as 
health promotion and educational programs designed for pregnant women was identified 
by several participants as being a useful support in the prenatal period. Pam used the 
internet to find resources:

My husband searched for information from internet and found a group called Best 
Beginnings... for expecting women. It’s very helpful, because they teach you how 
to delivery and take care of your baby. You feel better and more confident. [The 
instructor] speaks Mandarin, so it’s better for us to understand and feel not as 
alone in this city.

Maggie also found resources via the internet to lead her to the same program: “I 
started reading books and there’s lots of information on the internet if you look for it... 
that’s how I found this [prenatal program]. I think it helped me a lot to know how the 
baby needs to look and how things have to be.” Wendy further pointed out that this
formal support gave her a protective type of support since her family was far away. She attended the prenatal program primarily to obtain information about how to take care of herself during pregnancy. Being an older mother of 40 years of age she was worried if the baby would be healthy. Consequently she felt stressed and anxious with more responsibility than she ever had but without her previous social support network.

 Formal community support was perceived by these participants as being very important. For some participants it meant getting out of the house and connecting with other people to share their feelings while for others it was a life line to move forward from an abusive situation. Immigrant and refugee women in this study challenge oppression by speaking out and sharing their particular experiences of social injustices and unequal social relations. Many participants gained transformative knowledge to support and guide them through some very difficult circumstances. Even though there were multiple barriers to accessing health care, the positive coping abilities of the participants were strong facilitators in supporting them to deal with PPD and the related struggles.

 Immigrant service agencies were viewed by many participants as a very useful community resource. Jenny expanded on this idea: “Actually, my counsellor… the information and suggestions she brought me was very helpful, but it was [the counsellor] herself, because she is very optimistic and we just connected well… the fact that she was coming I just was happy.” Kelly also talked about the many services she found helpful to support her situation:

 When I go to the [immigrant agency], I found the counsellor and information for the English class, immigration services... for my migration situation... better place
for the immigrant woman. I take one parenting [class] to be a better mother. I talked with other women of different countries and you exchange ideas.

Another participant, Eve, found support accidentally while waiting for the C-train. She met a Spanish speaking woman while she was waiting for the train with her kids. The woman heard her speaking Spanish and started speaking Spanish back to Eve. Eve explained that she’d just arrived in Calgary. The woman guessed Eve might need help, and gave her a card for a social worker. Eve explained: “I contacted her… She’s Columbian and helped us get things for the house, find a doctor and school for my children. She helped us feel secure. The social worker sent me to the immigrant agency which gave us more information.”

Two participants and their infants found a ‘safe haven’ through using formal community services by connecting to a safe place and an opportunity to move ahead in their lives. These women experienced very supportive care from an emergency shelter. Abby, a young immigrant mother, told us she initially found help through an immigrant agency with a counsellor of the same language as she. This counsellor advised her to go to any shelter if she needed protective services at any time. After an escalated physical argument with her husband she called the police and they brought her to the emergency shelter. With support and counseling, she soon realized that she must leave her husband to rebuild her life for her own sake and for her son.

Bonnie also a new mother in need reflected on the outstanding community care services received:

It was really hard at first I was at the [short term shelter]. But people were so good and so supportive. I told them everything about [my partner], my status…
my feelings. They’re always so concerned and I can feel that they are really concerned. They helped me to deal with this problem. If not for them I would not know what to do… or where to go. I was supposed to stay there for 21 days, but they let me stay for seven weeks because I really didn’t have any place to go.

**Home visitors.** Many participants expressed the view about how the home visitors provided encouragement and assistance to improve their overall situation, whether it was through offering information or emotional support or teaching skills related to parenting. A collaborative home visiting program is available for families experiencing complex difficulties within the postpartum period. In order to participate in this program, families must meet particular criteria for eligibility. The home visitors provide emotional support for mothers, arrange referrals to community-based PPD support programs and offer educational materials and resources. They focus on infant and child development. Participants had great praise for their home visitors. Lily as a new immigrant commended her home visitor: “[If] I don’t understand something she will talk and help me understand Canadian, how to think… it’s like some culture shock. Sometimes you feel totally different way so she helped me in that way… because she also is an immigrant.”

Anna told us about the indecision of whether to accept home visitor support or not:

I was a new immigrant… she called and I said, ‘Okay, I will meet you today but I will not take this program.’ It’s strange but I wasn’t willing to do this. Maybe because deep inside we are different culture… they will not understand us, or we talk a different way, [because] English is a second language. I feel shy to show
that I’m making mistakes in speaking, so there are hidden things... it ends up
with the result of ‘oh no, I don’t want to be involved or I don’t seek help...’

Much to Anna’s surprise, the first visit was a ‘turning point’ in helping their family move forward. She now waits enthusiastically for the home visitor:

I felt so easy with her. I can talk with someone and she can understand & help me... She can feel my feelings, my fear; my worries... She told us about the Salvation Army, the milk program and the Food Bank to make less stress on us...
Also helped me set goals...the most important thing.

Jenny also had ambivalent feelings regarding talking about her problems with a stranger:

I wasn’t sure that it will help me... or what it was for actually. I didn’t believe that something could be for free. I was having doubts... maybe they will ask me too much questions for their own purposes... and I don’t get anything. I didn’t want people to know... to get too much into me. At least she will come and I will talk to someone. I think when you’re very down and depression is very intense, you don’t believe that anything can help...

Cora had these kind words for the home visitor: “We do so thank her very much. Thank God... He’s put a lot of angels in my way and a lot of people have helped from the community agencies with formula, things for the children, diapers... so that’s been a very, very big help.”

**Informal Social Support**

Receiving support from family, friends, and the community are salient factors in helping women to cope with difficulties after childbirth. Such support may have been omnipresent and available to the immigrants and refugee women in their country of
origin but now for the majority of participants this support is limited due to their isolation. The absence of family members, lack of social relationships, and lack of connectedness within the social network, as well as particular loss of emotional, and informational support is a challenging situation for the new immigrant and refugee mothers in this study. In the following section participants share more of their experience.

**Lack of Informal Support**

**Family members.** Participant perspectives were varied as to how they perceived informal support and whether it was helpful or not for the new mother. Ideas expressed centred on not having family nearby for support and that being a newly immigrated mother without the familiar pre-existing support networks could disadvantage women and predispose them to higher risks for PPD. Women felt that they were more vulnerable because of this lack of family support after childbirth. In contrast two participants found that family support is not always welcome or helpful. Moreover one participant observed in-laws may be part of the mother’s stress and consequently the mothers are reluctant to share their feelings within the family.

The role of informal social support within Asian families is of great importance and many Asian immigrants would rather seek help for mental health problems from family and friends rather than from a health care provider. Help seeking is often a joint family venture and accepting other types of support or services may be seen as a betrayal that may create shame and dishonour within the family. This is congruent with Kleinman’s (1978) framework whereby 70-90% of illness is managed in the popular sector in both Western and non-Western societies. The family plays an essential role in making health care decisions of what to do and whether to comply in certain types of
health care activities. However in Lily’s case she felt a negative relationship with her mother-in-law. In this instance a controlling and powerful mother-in-law created unhappiness for this new mother:

She thinks I should go to work and earn money so she can take care of his two kids. I don’t think so. She complains [about] everything and thinks everybody is not very good except my husband! I know what kind of person she is… never changes a diaper or wash clothes. She just wants to control those things. I told my husband it is not a good idea if she lives with us… we will have a family war.

Many participants commented that a family’s support is a strong influence on how the new mother feels and copes and can protect her from depression. For Anna, being connected is the norm back home: “The family are so big and always supportive. For example I got married and went out from my parent’s house but we’re always in touch… always gathering and someone around you. I think the culture here is different.” Ruth echoes the same reply: “You don’t have any responsibility like everybody is sharing with you; it’s not private life over there like… everybody is involved in your life.” Kate maintained that PPD is more commonly found here because of the lack of familial support and having the stress of being alone. She felt isolation and solitude are the biggest problems in developed countries.

In Jenny’s case she needed her mother’s advice but the time difference was a barrier to gain her mother’s support:

I didn’t know what to do with the baby. I was always thinking ‘am I doing this right?’ or I don’t have anyone to ask, maybe I will call my Mom tomorrow when she is awake, because of the time difference… it’s night in Israel. If I have an
urgent question I cannot get the answer right away but the baby is crying… after two weeks I’m depressed all of a sudden.

Dana was of a different opinion because she didn’t always feel comfortable sharing her feelings or receiving emotional support from family members but rather wanted instrumental (tangible help with child care) and financial support from them:

Even if she’s your Mom, you can’t tell her everything because you know she is already sick and has her own problems. They can’t understand what you are going through… so you need somebody else with whom you can talk to… Not your family members. I can’t tell them everything. Maybe they can help me with the kids, or we need diapers, formulas and clothes. They did help and lend us money.

Review of the literature indicates that lack of partner support and a stable relationship are predictive risk factors associated with PPD (Dennis & Chung Lee, 2006; Letourneau et al., 2007; Morrow et al., 2008). Past studies also place emphasis on how important the role of the mother’s marital relationship in helping to prevent PPD or in providing emotional and instrumental support (Dennis & Letourneau, 2007; Dennis & Ross, 2006; Zelkowitz et al., 2008). Women in this study agreed that a supportive partner could make a significant difference in their ability to cope with PPD and other related difficulties. However for some participants it was a huge challenge because of difficult gender relations and abusive circumstances although for two participants it was about their spouses not sharing the same understanding and acceptance of the seriousness of PPD.

Kate felt her partner didn’t share the same perspective concerning PPD and only confused her further in coming to terms with what she was coping with – in fact, he was the opposite of supportive. He compared the chemical changes in her brain to those of a
pervert’s or criminal’s mind and viewed them to be essentially the same. Dana also struggled with trying to make her partner understand:

My husband would say ‘You stop doing it. Why are you like that? You should not be like that.’ He said you are just behaving like you are an uneducated person. You should not say bad things to your parents, like education didn’t tell you that… It made me feel really, really bad. I start crying and arguing… later I thought maybe he was right. I should not behave like that…

These participants clearly acknowledged that the behaviour of their partner or spouse was a contributing factor to their PPD. Gender hierarchies within the family context may play out as unequal power relationships affecting not only family well being but may aggravate the women’s vulnerable emotional state. This creates unequal social relations between the sexes and put immigrant and refugee women in a socially disadvantaged position. The participants felt that relationship difficulties were strongly implicated in the new mother’s perception of being supported and in her recovery of PPD. In the past, cultural differences may have been used to help rationalize and explicate why partners of immigrant women use behaviours of control and dominance (Jiwani, 2001). This explanation is overly simplistic, however, and diverts attention from other powerful structural barriers and environmental stressors that immigrant and refugee women face.

**Friends.** Friends were also viewed as not always being a source of support to share one’s true feelings. As I described in the past chapter concerning the stigma and cultural beliefs surrounding PPD there are many tensions surrounding peer support. One participant did not trust her so-called friends anymore because they fabricated a story that
the authorities would deport her because of her status to further distress her. Bonnie, already dealing with a Downs Syndrome baby and immigration status issues, shared this:

I believe them [the immigrant friends]… here for five years, ten years and they told me a story like that but it wasn’t true… I was so worried and fearful being deported, especially my baby with some health conditions. Because so many people told me that it was like that. They would just knock on my door and handcuff me and bring me to the airport.

Cora’s view was straightforward when it came to sharing her problems with her friends:

You have to be very careful because sometimes you find good people; [yet] they could be bad people. You know sometimes they’re jealous… you open up to them and explain what’s going on, and the next thing you know they’re really not there for you. They’re making the problem bigger. They usually tell you with negativity which you don’t need, so sometimes you just have to find a professional.

Abby also described her Arab friends as being unsupportive after she left her husband. She felt betrayed by her friends. She asserted that the changes in her lowered economic and social status may have influenced her friend’s behaviours. Eventually she found formal support through a community shelter. She reflected back on her situation:

I don’t need their help, because the government is helping me… [My friends] make the relationship because my husband is architect. I thought they are my best friends. When I lived with my husband, they visited me and helped me, but now, when I left him, nobody called me. My friends don’t care if I am sad. The Arab people here don’t help you if you are not a rich person. [They do] if you
have a good job, or if you are intelligent. I don’t have any family here to help me, so it is very difficult.

Social Isolation

Being separated from family and friends at a most significant time in the immigrant and refugee women’s life’s contributes to social isolation. For most of the participants social isolation was expressed as a significant reason why they felt sad and depressed. Being left alone all day with a new baby and having no one to talk or share their feelings was a recurring theme. For Kelly it meant having less control over her situation and feeling guilty about her son not having any playmates. Moreover feelings of isolation and unequal social relations between the sexes may put immigrant and refugee women in a socially disadvantaged position. Kelly is a new refugee mother with employment challenges, lack of a pre-existing social support network, and limited access to resources which has increased her vulnerability to PPD. She said:

I have too much time alone and my son no stay with other children… is alone with me. He learns English with the TV and me… I wait in the home for my husband, make food, only see people [through] the window. I no have control of the situation… I have too much to carry. My husband is busy everyday… my mind is more small, and only I think of my problems and I don’t have opportunity…

Jenny felt very isolated especially with her husband working from early morning until evening. She wondered about the differences in mind set: “I started to meet people, but, didn’t make real friends here… I don’t want to make these classifications, but here in Canada it’s more difficult to make friends than in Israel.”

Jenny went on to describe further:
People are different and the mentality is different... as an immigrant you have to get used to this. People here are more excluded... maybe they are busier working and making money... they exclude themselves from friends. It was so hard for me... I was thinking ‘oh, the people here are so cold’, and ‘if I was in Israel, people would be warmer. They would ask me more questions and offer more help.’ I was so isolated and wanted advice... like practical advice because I didn’t have enough knowledge. I just wanted people to be there for me, and just maybe laugh with me, or cry with me...

Jenny also noted the strain on her relationship: “It’s only two of us, sometimes I feel I need a friend because now we have misunderstandings between us... both of us are drained and need other people... yet my husband does when he goes to work but I don’t.” In the viewpoint of this participant the reason for her social isolation and diminished contact and caring between her and other people was the cultural differences and change in life style. Foucault’s writing asserts power relations arise when there is difference or conflict when one individual or group is affecting the other in ways of living, group’s interests, and potential political ideology. The postcolonial feminist perspective draws our attention to differences among women without replicating essentialist notions of cultural difference and acknowledges that “the colonial encounter depends on an insistence of ‘Difference;’ that is sharp virtually absolute contrasts between ‘Western culture’ and ‘Other cultures’ (Narayan, 2000, p. 83). Therefore this ‘othering’ process identifies women who are thought to be different from the main stream. This reinforces and reproduces positions of denigration, domination and subordination. In turn this racial
stereotyping projects negative connotations of immigrant and refugee women as being awkward or inferior and situates them in a socially disadvantaged position.

Several other participants commented on their isolation. Maria compared her experience to her country of origin: “In Morocco, usually after one week of the baby is born, we make a big party. Over here I was so lonely because we didn’t have anything and we were mostly in the hospital... So it came like kind of like a routine thing.” Sara expressed the way it is: “I think big problem with the immigrant people is [being] alone here in this country. For no have family support. The family is very important, friends are very important for support.” Cora also captured this idea: “Well, I don’t go out of the house because first of all, I don’t have too many friends... What I do is talk to my mother over the phone every day. I only have my husband and my children.”

Overall participants want to receive help from their family, friends, and other community resources however there are many difficulties after childbirth when informal social support is not accessible. Being a new immigrant or refugee mother and not having emotional or instrumental support increases the vulnerability to health risks such as PPD. In the next section those participants who received support from their family members and friends describe their experiences.

Facilitators in Seeking Help

Family members and friends. Although there were a few participants with differing views most participants described support from their family members and friends as an important factor in helping them cope with PPD and the difficulties after childbirth. Emotional and instrumental support by family and friends were critical factors in helping these participants to cope with depressive symptoms. Anna pointed out: “We
are always have the support from the families and the friends back home, indirectly
without knowing, without going and asking them for support.” Several participants
praised their partners for giving such excellent support. Maggie said: “She was too small
and so I didn’t know how to hold her, change her or bathe her, so my husband helped me
do this… I didn’t know anything and I was too scared I might hurt her.” Maggie noted
that her friends gave boundless instrumental support by cooking, cleaning and providing
transportation to necessary appointments.

Anna described a dual role: “Sometimes my husband used to support me and
sometimes I support him… we are doing the role together…” Eve was very grateful:
“Thank you to God for my husband supported me a lot... If I didn’t have his help... He’s
very intelligent and told me to calm down. We are together, and we are going to
manage.” Carla was experiencing many difficulties and eventually went back home to
Egypt for family support:

I crying all the day, at night I tell him, ‘stay with him, I’m not going to touch him
and I don’t like him, I’m not his Mom’ so [my husband] stay at home. He says ‘I
will be with you all the time, don’t worry about me. I will do everything and take
care of the baby. Because he was studying, I didn’t like him to be overloaded so
after twenty days of support I told him, ‘no, I have to be strong and brave enough
to take him and go back to my Mom.’

Simone expressed her relief over having a family member near to provide support
and help her cope with the overwhelming and often terrifying thoughts. As her husband
was working in South America, she received primary support from her mother in law
who lived close to her place. She felt living alone encouraged depressive thoughts and consequently felt more protection when she was with someone close to her.

Kelly reflected on how her social supports and relationships have changed for the better:

Last time when I talked with you, in my life I had very, very lot of problems with my husband... and almost never talk with him. But when I talk with my friend, all start to change. With time my depression now is almost nothing. I talk more with my husband, my friends and I can talk about other ideas because the depression is almost gone.

In Kate’s situation the family had initially tried to bring her mother-in-law over from India, but her mother-in-law was unable to obtain a visa. Fortunately her own mother was able to come from India to support her: “When Mom came I started feeling much better and more confident because even though I had thoughts, I wasn’t alone with the baby. She’s watched me continuously.”

Although several months back Bonnie expressed her bitterness for how her friends treated her she now has moved on and made new friends. Bonnie explained:

So now my Filipino friends are the ones helping me. They took us from [the shelter]... I’m not paying any rent. I feel better now, especially I’m with friends that I know and they will protect me. I still feel so lucky... so blessed. People around me are so good. I feel like God sent them to me as an angel.

**Summary**

In summary I explored with the immigrant and refugee women how they use their formal and informal social support networks to cope with PPD and other related problems. Relationships within the social support networks were either deemed
supportive or non-supportive in helping these participants. From the immigrant and refugee women’s perspective it is evident that there are negative and positive factors with using both formal and informal support. Most formal supports were highly praised and there were positive benefits of accessing health care services with the appropriate care received. Difficulties accessing services included being unaware of services, lacking information, fragmented health care delivery and finding a family physician. Participants however were divided in viewing whether the health care relationship was supportive for their particular situations. Several participants suggested that some health care providers may lean towards normalizing the women’s symptoms and depressive feelings and therefore giving less attention to the seriousness of their condition. Such lack of empathy may discourage some immigrant and refugee women from pursuing help for their PPD.

As discussed in Kleinman’s (1978) writings there is particular emphasis on these explanations of health and illness that are constructed within the health care provider-client relationship. The meanings given to events within the context of the immigrant and refugee women’s experiences provides an awareness and understanding of how these women may expand their ideas about what is most important in relation to an event and how their ideas may influence their health care practices.

Consistent with critical inquiry, an important goal in understanding PPD is to establish conditions for open communication and to expose hidden power imbalances. Therefore a critical theoretical framework was used to view cultural, social, economic, and political factors within which these immigrant and refugee women are situated. A postcolonial feminist theoretical perspective enabled me to critically examine the relations between these women and their family, community, and the broader social and
cultural milieu that shape immigrant and refugee women’s health and health care practices.

Racial discrimination and oppression can affect immigrants at the individual level of care. Racism may be seen as negative attitudes or behaviour shown by the health care provider towards the immigrant and refugee women. Barriers within the health care relationship, such as differing values and perspectives, may result in misunderstandings that precipitate breakdowns in communication and engender negative feelings.

The participants also noted that informal support was an important influence over whether they sought help for PPD. The participant observations are consistent with the theoretical framework of this study. Kleinman’s (1978) framework describes the family as a strong and controlling influence over the immigrant and refugee women’s health as well as her source of support. Participants agreed that having strong family support was an important factor. The role of the family was extremely important for emotional support during the PPD experience. However, the absence of family members and lack of social relationships within the social support network, in addition to loss of emotional, and informational support is an overwhelming challenge for new immigrant and refugee mothers.

In the next chapter I focus on other factors which influence the immigrant and refugee women in seeking help to cope with PPD.
CHAPTER VII: FINDINGS AND DISCUSSION: OTHER FACTORS IN SEEKING HELP TO COPE WITH POSTPARTUM DEPRESSION

In this chapter I discuss other factors that are part of the immigrant and refugee women's PPD experience. The participants in this study have identified some important influences which have affected their ability to cope and manage their mental health care. Three dominant themes were found: family wellbeing and vulnerability, migration issues, and positive outcomes of migration.

Family wellbeing and vulnerability is about the physical and mental health problems of the mother, father, and infant and how these problems affect the immigrant and refugee women's ability to cope with PPD, either directly or indirectly. Participant narratives tended to include the entire perinatal period rather than just the postpartum. The participants needed to talk about health issues (emotional or physical) in the pregnancy as well as after childbirth during this period of extraordinary change. Analysis of the data revealed sub-themes such as multiple difficulties occurring at the same time, maternal health during pregnancy, maternal health postpartum, partner health, and infant health concerns in the postpartum period.

Effects of migration can produce numerous difficulties and challenges for the new migrant mother and her family. Accompanying stressors were identified as sub-themes: forced migration, loss of family, language barriers, socio-economic disadvantage, and housing issues may negatively impact the perinatal period. Alongside these migration issues are the positive outcomes of migration which participants identified as the benefits
of migration which ultimately improved their socioeconomic status and offered opportunities for a better life for themselves and their families.

The participants were asked open-ended interview questions about what made them seek help and what kinds of problems they experienced as a result of PPD. Further questions were about whether being an immigrant or refugee women affected how they coped with PPD and what would prevent them from seeking help.

**Family Wellbeing and Vulnerability**

**Experiencing Multiple Difficulties**

Most participants spoke of the powerful impact of having multiple difficulties occurring at the same time and consequently feeling overwhelmed. Feeling weighed down by additional responsibilities coupled with moving to Canada created extra pressure and stress for these new mothers. As a result it affected their emotional wellbeing and ability to cope. Participant’s perspectives frequently centred on the conflicting and unexpected responsibilities of motherhood. Drawing on postcolonial feminist perspectives it brings into focus that some immigrant and refugee women face simultaneous difficulties such as their past experiences by the prevailing culture of their home country and other displacement experiences. Lowered socioeconomic status, language barriers, and inadequate social supports may be disempowering for the new mother and as a result leave women vulnerable and disadvantaged in protecting themselves against PPD.

Dana pointed out how increased responsibility and changes in her family had great impact on her life and coping ability:

I think when you don’t get too much time for yourself and have to take care
of a kid, it's a big responsibility... if there are two it's twice the responsibility and then you have other relations. You have to cope with everything, and something else comes into your life... so that makes me depressed. All of a sudden everything changed... and felt I just can't tolerate it.

In broken English, Sara explained the reality of the refugee woman's situation:

"You feel very alone, sad, crazy, you feel a lot responsibility in yourself, because [you are] a single mother, or maybe the baby is safer in this moment because the husband drink or take drugs." Eve clearly captured how a multitude of difficulties occurred simultaneously to produce an unsettling effect within family life and ultimately barriers to improving her situation:

It was difficult because my son was born soon after I arrived in Canada. I didn't speak the language and don't have family here. I couldn't go to school or work because there was no support and daycare is very expensive. My husband was an engineer in Guadalajara but now takes whatever work he can get. Life is more expensive here so it is impossible. Our immigration status is refugee and we don't yet qualify for a lot of benefits.

For Cora, the birth of a second child added to the multiple stresses her family was experiencing at the time:

It's very difficult because you're by yourself and lonely. You don't have anyone that can help, because all three [children] want everything at the same time... that causes me stress. Prior to having my second child I was able to attend school but then everything changed... I just pray to God my mother to be here because
my brother is in danger in Columbia. I have too many things going on in my head; the financial situation is difficult... we don’t have too much money.

**Maternal Health during Pregnancy**

Maternal health in pregnancy includes both physical and emotional states. In the past, the complexity of the interrelationship between subjective experience and socio cultural contexts has been neglected (Kleinman, 1980). The socio cultural context of these women’s lives is important to address as it deepens our understanding about their subjective feelings during pregnancy as well as our understanding of other external factors that may have affected their situation or predisposed them to PPD. When participants were asked about their pregnancies, whether it be physical or mental health problems, women revealed many issues. Some of the problems were the shock of unplanned pregnancy, feeling physically unwell, not recognizing depression, putting education on hold, the challenge of caring for an infant & attending high school, and unrealistic expectations of motherhood. Mia shared these concerns over her physical and mental health while pregnant:

Actually in my early pregnancy I really felt so bad, I could not get up from my bed. I really wanted to just abort the child. I don’t want to keep it, because I felt so bad physically. I told my whole family I wanted to give up on my child. I just have no interest in any communication with people. I just wanted to lie in my bed for the whole day for lack of energy.

Julie, an eighteen year old refugee participant, spoke about how her pregnancy has restricted her activities:

It has affected my youth, having a child so young at eighteen. I can’t really go
out to visit or get to know places because of my child... Because with the cold and having to feed her it becomes very difficult... Like who wants to go out with a child?... so I miss going out dancing, which I like to do. Being a single Mom and having to work makes it difficult...

Jenny, too, maintained the unplanned pregnancy altered her plans to finish her education: “We came here for a two year work permit and receive our permanent residence. All of a sudden this baby is coming so we weren’t planning it... because I have my BA not finished yet, and I was thinking about other things to do.”
Kate reflected back to her pregnancy and experience of PPD and speculated she was depressed before the birth of her child, but didn’t know what she was feeling was depression:

I think I had ante-partum depression too, Because I didn’t realize it myself. So I didn’t tell the doctor. When the doctor asked me ‘how are you, emotionally and physically?’ I said ‘I’m all right...’ But in my sixth or seventh month pregnancy I became very ‘irritated’ about what happened twenty years ago. My husband tried to give me support, but he didn’t know that is was ante-partum depression.

Roberta, a Costa Rican refugee woman also described her confusion and feelings of low self-esteem while pregnant but did not identify these feelings as depression:

When I am pregnant, there are days that I just want to cry and it’s my problem, I do know that. It’s a problem that I have with myself. My husband would say, ‘why do you feel inferior?’, or..., ‘Roberta why are you not secure of yourself?’ I say, ‘There is something that’s been happening to me and I don’t know what it is,
but I do feel bad… very fat and very insecure. I feel like I have abandoned myself. Why? I just don’t know… I don’t like myself in it.’

Two participants noted their unrealistic expectations about their new role as a mother. Kate described her fantasies about motherhood. She did not foresee the great responsibility and felt this lack of foresight may have contributed to PPD: “I’ll play with the baby, his cute little fingers, his cute eyes but I was not anticipating the sleepless nights, baby continuously crying… and getting sick, it is a huge responsibility. So, if the mother is not completely ready it might contribute to PPD.”

Kate recognized her idealistic expectations of motherhood during her pregnancy, but also has learned along the way:

By the time he gets to one year I’ll teach him walking and talking, all these things, but again what I didn’t know was babies have their own pace. [The baby] is not a toy… it’s a human being, so he has his own interest, his own pace, his own way of thinking. We should try to adjust to him, rather than making him adjust to us.

Carla as well spoke of this irrational idea of the new infant being a toy:

He crying a lot and maybe I guess the baby it would be a toy, when I put it away he wouldn’t stop. He didn’t have any effort or patience, I didn’t think about this point. It would be a new baby, and so this new life didn’t know anything and I have to be with him all the time. I didn’t expect that.

**Maternal Health Postpartum**

Many participants pointed out that fatigue, unrealistically high expectations, need for perfection, and the expectation of being able to breast feed were factors that impacted their feelings and the ability to be a good mother postpartum. Consequently this often had
a negative effect on their mood and behaviour. Stress related to the multiplicity of gender roles and high expectations of immigrant and refugee women situate them in a vulnerable high-risk position (O’Mahony & Donnelly, 2007b). Participants were distressed by the gulf between their idealized view of what they felt a mother should be and the way they came to see themselves as mothers. They faced further conflict of when their mood and feelings of depression didn’t match with their expectations that a mother should feel happiness after childbirth.

Lily clearly identified her need for perfection also involved her partner: “You want to make sure everything is right and perfect. Because you try so hard and you can’t get your expectations, you can’t get your goal there... Very upset and sometimes my husband and I have our difference of opinion, so... we argue.”

**Discourse of good mother.** A number of participants acknowledged the high importance of being able to breast feed. However coupled with this idea is the belief that if a woman isn’t successful at breast feeding her baby, she is a bad mother. Breast feeding issues strongly emerged as an important desire in becoming a perfect mother. Fatigue also played a role in how some participants coped with their situation. Jenny strived for exclusive breast feeding which led to struggles with sleep:

I set very high goals for myself. I wanted to breastfeed her and not go to bottles, not to give her to my husband... It took a lot of hours of sleep from me and even when I was tired, I couldn’t fall asleep even if I wanted to... (sigh)

Kate was beset by the demanding schedule, inability to latch the baby, and the exhausting cycle of pumping. She also was influenced by others to breastfeed as the best choice. In hindsight she perceives how she could have done it in a different way to lessen her stress:
I was really overwhelmed because my baby is hungry every two hours and wouldn’t latch properly, so I had to pump and give him the milk. I was in that room alone all the time; either feeding him or pumping, pumping, every two hours for half an hour for five months I did that... Very much overwhelming because I felt like I’m a machine and not a human being. I was particular about not giving him formula and wanted to fully breastfeed him, but that wasn’t possible for me. If I put him on formula, when he wouldn’t latch properly, my stress would have gone much, much down. I was so particular... my Mom, and many older women say that breastfeeding is good.

Women simultaneously participate in their expectations of themselves, and their interpretation of cultural norms and values surrounding motherhood, and the dominant discourse of what it means to be a ‘good mother’ (Varcoe & Hartrick Doane, 2008). However the mothering discourse does not consider the economic and social conditions of women’s lives and ignores the fact that there are differences between mothers. Mother’s experiences and dominant discourses that shape those experiences differ within those women’s social locations especially when they intersect with race, class, sexuality, culture, religion, and ability (Varcoe & Hartrick Doane). Participants expressed many difficulties transitioning into this socially idealized role of ‘good mother’ which in turn created negative feelings of inadequacy, guilt, and their inability to be a ‘good mother’ and thus contribute to PPD.

These mother’s voices need to be valued, respected, and addressed through their everyday experiences as a legitimate source of knowledge. From a feminist perspective the aim is not only to explore and prioritize the immigrant and refugee women’s
perspectives about their experiences but also to communicate new knowledge to change
the oppressive conditions in which they live. Feminist research is politically driven in the
sense that it challenges the dominant forces that shape women’s lives and seeks answers
as to how to address and correct injustices (Anderson, 1991). The process of building an
emancipatory element to knowledge production is through open dialogue of their lives so
that these women can recognize sources of their own oppression and become experts on
their own lives. Emancipatory approaches are important as it enables women deeper
understanding of their situation through self-reflection (Lather, 1991).

Ruth also received the subliminal message that ‘to be a good mother you must
breast feed.’ She also felt pressure from a family member back home to persevere with
breast feeding. In the end Ruth wasn’t able to breast feed and thus felt very disappointed:

...I was crying, I prayed oh my God, what I’m going to do. I phoned back
home... my sister told me, ‘don’t give up.’ Push her, push her. It’s good for her
and for you. So just I try, I try, but it doesn’t work. I was disappointed. I read
different books... everything is about how mother’s breast milk is the best.

Carla was of the same mind and was convinced her difficulties with breast feeding meant
she was a bad mother, which caused her to feel increasingly more depressed:

He didn’t want to latch... and I don’t know how to breastfeed him, so I cannot be
Mom. I’m bad Mom, because I don’t know how... so I become very depressed. I go
to lactation consultant and to talk with her is very good...But when you return
home... you crash was the effect... nobody help you, just you and your husband
[The problem] get bigger and bigger, every time I try to breastfeed and he refused,
I become more depressed.
**Emotions and thought processes.** Some of the participants shared with me how they were tormented by the slow onset of confusing thoughts, depressive and anxious thoughts and bad dreams. Enormous fears were expressed about harming the baby and lack of self control and consequent fears of the baby being taken away. Simone expressed having multiple fears about reoccurring destructive thoughts of harming her baby until one day she couldn’t contain it any longer:

After the baby born, I start come in my mind terrible things about to kill the baby but I’m afraid to tell my husband. I worry about going to the doctor and they come and take the baby. So if I don’t say this to somebody something terrible will happen. Because I want to kill my baby… this is not normal. I tell my husband, for I cannot support this anymore. I went to the doctor… for I know the situation is dangerous for the baby…

Dana’s struggles abruptly started in hospital after her first infant was born:

With my first baby, I just changed. I start thinking negative things, bad things… feeling aggressive. It just persisted in me… I couldn’t concentrate on things and never finish one thing. I was in the hospital for a month and that made me really depressed. I was crying all the time. I didn’t like lights and wanted curtains all the time around me. I was in depression and didn’t feel well until one year.

Carmel reflected on how mood swings made her feel out of control: “I feel really violent crying and screaming… that happened very often. From the beginning it was hard to concentrate… I have to concentrate on the business. I’d get this annoying thing that I just felt that everything had to be clean and perfect.” In broken English, Kelly too spoke of having no control over her life: “In this moment I think I can’t see that because when
you have depression you can’t have all… you can’t see because you feel different, you
think different… but the people don’t have the control, their own control.”
Dana had great fear over the impact of continuous bad dreams which in turn made her not
want to go to sleep. Eventually this made her to seek out help:

I just start screaming, and my husband said there is nothing… It was a bad dream
like something was on me whenever I wake up… Because then I feel afraid and
don’t want to sleep. In the daytime I don’t want a nap, because the dream will
come back and if my husband is not around… so that’s why I seek help.

In Kate’s sequence of events she told us the feelings started slowly with being irritated
with others and at times confused, but the symptoms were not so extreme that she thought
they warranted seeking medical help:

After delivery I was feeling irritated over small, small things, like the plate there is
not clean or when my mom brings the bottle, and she doesn’t shake it properly, I
would get upset. I was so restless and didn’t have sleep at all… I was very over-
concerned about my baby and sterilization of things and did not want any friends to
come over… I kept thinking people are irritating me. It’s not me. When my baby
entered third and fourth month I got some doubt… Maybe I shouldn’t be like this…

About four months postpartum these feelings progressed into more destructive thoughts
and Kate soon began to realize the seriousness of her condition:

If I was feeling low, then I was like ‘okay I’m feeling low, so what? It was not
dangerous.’ When the hurting baby thoughts came, that really triggered… a
tsunami, it just starts very slowly. You start feeling down. It didn’t even manifest
into a thought initially. Some kind of fear but I don’t even know what it was.
During this time Kate’s parents also returned home to India. Thoughts of hurting her baby escalated, bringing confusion and fear of her own actions:

I was holding my baby, and sterilizing his bottle in front of the stove… suddenly the thought came ‘I’m going to put his hand in the boiling water, and a kind of fear came like from down to top… it was like I just could not even see things properly at the time. I don’t know why.’ It came out really like a very sudden thought. My confidence was down and it was just not a thought, it was fear, anxiety, depression and everything together. From that day onwards I never took him into the kitchen.

Furthermore Kate blamed herself while tormenting thoughts of hurting her baby continued. Her powerful narrative demonstrated the seriousness of PPD:

I was so low on my self-esteem and self-respect. [I wanted to] just tear my head off that picture and say my baby has only a father, he doesn’t have a mother, because I’m like a devil. I’m not a mother at all. Another thought I had was being afraid if I take him into the kitchen, I would just stab him with the knife. Because the thoughts that I was getting are criminal, I related myself to a pervert or a criminal… getting sexual thoughts on a baby is perversion. Otherwise why am I getting these feelings?

**Partner Health**

Participants were asked about the health of their partners after childbirth. Some participants felt that their partners were also at risk for depression and showed signs they were feeling down. Recent suggestion in the literature also reports that PPD is a significant problem and may affect some new fathers (Field, 2010; Paulson, 2010; Pinheiro et al., 2006). Thus PPD in both mother and father may have detrimental
implications for family health and well-being. It also points to the importance of having family included in the educational processes of increasing knowledge about PPD. The postcolonial feminist perspective provides deeper analytic depth into understanding the many-sided factors that affect the immigrant and refugee families’ every day experiences. It brings deeper insights into how relationship difficulties and changes within the family influence how these women seek help and manage their PPD.

Behavioural changes by the partner were expressed frequently by the participants. For some mothers these changes were not noticed in the early postpartum period and it wasn’t until later on after they had received support and were feeling stronger and coping better. In retrospection Kate spoke about their situation:

I think he’s going through a little bit of depression, because he was very over-concerned about the baby. He’s usually more relaxed person, than me. He looked depressed too… even now he’s depressed. [But] since I was more depressed than he was I didn’t realize how much he was depressed, but now that I’m not depressed anymore and taking the medication I’m able to clearly see. I’m able to help him now to come out of this.

Ciara also reflected on how her partner’s behaviour changed and his inner struggle to share feelings about their infant’s situation. Their infant had many unexpected health challenges. She noticed his increased use of alcohol and tobacco to cope:

I can tell from what he’s doing, he never drank much, but after this he started to drink more and started to chew tobacco which he never did before... he used to stay more in the home, but now he started to go out more with his friends. I noticed he doesn’t open up at all, with anybody. Sometimes if he’s had a few drinks or if
he couldn’t handle the stress he would just cry. But he wouldn’t tell you anything...

Other participants observed changes in their partners. Jenny explained: “At the beginning I was so down… but he was also having this depression (sigh)... both of us actually, although [the baby] was the one who was holding both of us together.” Carmel too noted behaviour changes: “He doesn’t want to talk about it. I noticed that he gets upset with things that he used to not… like his patience is very low. He gets aggressive with people when he was not like that before, so I try to help.” Dana was not convinced that her husband was depressed about being a father because he didn’t have the same demands of looking after the baby, but rather if he was depressed it would have more to do with practical reasons:

They are not depressed... I don’t know in my case if he’s depressed, but I don’t think he can understand what I’m going through. I think he knows what’s going on, but like for men, they can go outside, they can be social, but you have to stay with your kid, and we have to take care of the baby. I don’t think they would be in depression. For us we had some troubles in finance so for that reason maybe he’s depressed but not as a new Dad.

**Infant Health**

Infants with health challenges were clearly another factor in the complex situations of some participants. Huge stresses voiced by the mothers were about excessive worry for their infant and their feeding problems, the extra responsibility, and the management of the home care of their infant. This often impacted the mother’s health as well. Dana stated it plainly: “There are two lives. Mom and the baby, in the real world
so... Yeah, they are affected by depression, if the mom is not feeling good, how can the baby be taking care of good.”

Several mothers articulated these stresses and unforeseen demands. Bonnie, a first time mother, had an infant with many health problems which was very overwhelming for her:

My first baby and away from family... I was overwhelmed and thinking how will I bring my baby up and support her medical condition. She was in the hospital for seven months. She’s born with Downs Syndrome and had heart surgery already. The problem now is she’s not really eating because she has a NG feeding tube.

Ciara was particularly caught off guard as her expectations of having a birth without any complications disappointed. Due to unforeseen complications and an infant in respiratory distress, an emergency C-section was performed. The baby was born with hypopituitarism and multiple health challenges. Ciara described the tremendous responsibility of caring for her baby’s complex medical needs, and the impact on her own health. Ultimately this led to Ciara’s PPD:

Lack of sleep... I think that’s what happened with me, it made me feel more depressed. I didn’t sleep for one month, because I was worried for her all the time. They sent us home, but it was the same. Even when she was sleeping at night I couldn’t go to sleep if she was having a hard time to breathe. I would stay up... so I can help her whenever she needs my help. I didn’t eat properly or pay attention to me. I started to stay away from everybody... stopped talking or calling people. I just focused on her. I’m the only one who takes care of her all the time...
Migration Issues

The participants in this study all emigrated to seek a better life for themselves and their families. The reasons for leaving their homeland were mixed. For many of the immigrant women it was to seek a better way of life with increased socioeconomic opportunities. For the refugee women it was more about seeking protection and a place of safety. Yet given this, the migration experience does create difficulties and increased vulnerability due to the multiple changes to which these women must adapt. Participants voiced a number of contextual factors that influenced their PPD experience. Factors perceived included 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; yet they sometimes give you the wrong information... because they don’t always know...

Forced Migration

With already facing many challenges a number of refugee participants expressed that being forced to move from their home country, often leaving family members behind in unsettled times was upsetting and detrimental to their emotional health. Roberta attested to this: “I’ve had lots of difficulties in life, and the main one having to leave the three children behind in Costa Rica. That was a main difficulty.” Julie too lamented for
family members: “I am sad because of my family, coming from a country that’s so
violent and not having my family. I am sad about my father because he is back in
Columbia.” Some participants expressed concerns about returning to the unsafe milieu of
corruption, kidnapping, and shootings. Carol was firmly convinced: “I had to leave
Mexico because where I used to live there were lots of kidnappings, lots of problems, I
was afraid and phone calls… people threatened me, so I had to leave before something
worse happened.” Maggie, too, felt there was no option but flee to find a safer place to
live although she worried for friends and family left behind in Mexico:

He got kidnapped, so he came here because he cannot go back… we are not
sure if they are going to find out, so… In our city there are lots of drug dealers and
people just ask for money. If people doesn’t give it to them, they burn the store or
kill them… they start with their guns… shooting a lot of people, so it’s been very
bad. We don’t want to go back because of this situation… I’m still worried because
[my family] can’t go out because it’s dangerous… only to work or buy new food.

Although Gloria would like her family back home to see the new infant, it is not a
possibility. She said:

We came here because they were after me… we had to give them money for our
security… the criminals. If we didn’t give them money, they will kill me, or
somebody from my family. Because now in Mexico, they see you have a car or a
little business they think you have money. So we came here as tourists, escaping…
Later I went back to Mexico to see if we could return but it is still very insecure. I
came back and claimed for refugee status… so that’s the reason why we’re here.
Environmental Changes

Coupled with the unfamiliarity of the new country, several participants noted how extreme climate changes and access to transportation affected their daily life. Most significant was the observation of how these factors affect the immigrant woman’s mood and ability to get out and about with a new baby. Hence two factors which may further predispose these women to PPD.

Lana, a single mother, was concerned the new baby would be unwell from the cold: “I’m worried the baby might get sick and don’t know how to take care of her. In the winter I don’t have a car… so I have to bring the baby out in the cold.” For Roberta too, cold weather & access to the train posed as a barrier: “To be home… that is all we can do because it is extremely cold. It is very hard for me to go out with my two babies. I have a two-year-old and a nine-month… it’s very cold and very far away from the entrance to the train.” Carla also agreed that lack of transportation and inclement weather grounds her at home. Moreover the lack of sun affects the mood of the Arabic immigrant mother:

We have a baby, no car… you have surgery so it’s not easy for I have to go take bus and C-train. Especially because there is snow and no sun, it makes me uncomfortable. For us as Arabic people it’s not easy to go outside and walk. We are afraid to catch cold… [Yet] all the time at home is not easy… I know maybe this point is not a problem for Canadians as a culture, but for Arabic people it is a problem. So change in the weather affect in your life and in your emotion.

Lack of Language Skills

All participants not surprisingly pointed to language barriers as a strong factor in the isolation of the new immigrant or refugee mother. Kelly recalled her anxiety when
she first arrived: “Because you know when the people no speak English, all is difficult. When I come in the first time to Canada, oh my God, really... I don’t go outside all day and was so scary. I don’t like to go to the store the people ask me, and I don’t know what answer... [feel] very panic.” Gloria agreed: “To know the city, to know where to go to grab the train... Simply without knowing the language you don’t go out... I don’t go out anywhere, because of the language, it’s very difficult.” Alice too found it difficult: “In Iran I was working and didn’t have any problem to communicate, but here I’m unable to work, so I feel lonely and it’s affected my feelings... There are many programs but I cannot attend because I don’t understand very well.”

Mia pointed out it is not only about learning English but also the strong pull of other responsibilities: “Right now I find that it is me trying to do everything, including learning English because my husband is not really motivated to learn English... it is me who knows little English and that’s why all the responsibilities are on my shoulders.” Cora also noted that in order to acquire English skills an immigrant mother must have resources such as family support and child care:

It is very hard...you don’t have anybody to take care of the children... maybe you need to go to school. You have to learn the language in this country in order to survive. [It is] a big problem because daycare for three children, its $2,500... I have dreams that I want to accomplish and go back to school. I don’t want to feel like I’m just worth nothing. I want to make sure I do something productive.

Julie, a teenage refugee mom attending school, described the anger and isolation she felt:

Language is a big issue... the most important thing is to know the language. I
haven’t been able to make any friends, because they talk to me but in English and I don’t know how to answer them... I get very angry and I say ‘no, don’t speak a English’... they continue to repeat what they just said and that just makes me furious. I just go home, lock myself in my room with my daughter and sometimes I cry. I don’t have anyone to tell them my sorrows...

For two participants the emphasis is not just about learning language skills but being completely fluent and familiar enough with the new culture to speak like a native. Kate explained: “When I say language, it’s not just speaking English, you know. In India also we do speak a lot of English, but again, the framing of the words, like communicating properly, every country the communication is different. The way we communicate is different.”

Carla also acknowledged this and described the challenge and uneasiness in sharing feelings in a different language:

I’m a new mom, but I don’t know about how to be a mom, because there is no one... So is the same for language... if I feel something it’s not easy to talk in a different language about your feelings. We can talk many things, but in your feelings it may not be as equal as you talk to someone in your native or in the same language.

Carmel pointed out that learning English is not a priority for some immigrants because they rely on family or their community. She has observed that there are several factors involved that prevents them from learning English. First is the issue of money, because women would feel they should not use their limited monetary resources on language classes when it could be spent on family needs. Second is the fear of
embarrassment and not wanting to make a mistake in front of others. The third reason emphasized was that for some there was no pressing need to learn English as they were surrounded by other immigrants who spoke their language.

Monica told us how relying on a family member to do the translating for a health care encounter brought unforeseen difficulties to her family:

After my 2nd baby was born, a nurse came to visit and my husband did the translating... everything was fine and the nurse did not suspect we would need additional support. But in two months my husband was in a very bad accident and almost died. They sent him back home early from hospital because there wasn’t any room. I was alone with a two year old, a newborn baby, and a husband with a wired jaw who couldn’t speak, eat, or help in anyway. In fact it was like looking after three children. I tried to contact the nurse and explain my need for help but because of the language barrier it led to a communication breakdown.

Thus the nurse had no idea what situation Monica was in, and without a translator the family’s desperate needs fell through the cracks of the health care system. Monica’s narrative portrays a situation whereby she did not receive necessary help because of a language barrier and a lack of translation services, despite a well documented need for such services. This example does bring into question that the lack of interpreter services or the health care provider choosing not to use these services is a form of systemic discrimination against non-English speaking immigrant women. Some immigrant women have misunderstandings about health care services, and with the absence of services such as interpreters, a lack of knowledge will continue to exist. Consistent with a postcolonial feminist perspective we need to bring attention to the broader social context and the
critical role of how socio economic and political forces interacting with race, class, and gender may influence and determine the subjective experiences of immigrant women in their encounters with the health care system (Anderson, 1985).

**Housing Challenges**

Some participants reported housing issues were another related factor which contributed to their often precarious situation. Frequent moves due to finances coupled with health issues of the partner and infant, long waiting periods for housing, and negative encounters with landlords affects the integration into the host country. Zelkowitz and colleagues (2004) found that stress associated with migration such as housing problems were more likely among immigrant women who scored 12 or higher on the Edinburgh Postnatal Depression Scale. These multiple difficulties experienced simultaneously during this process of adjustment have a significant impact on the emotional health of immigrant and refugee women.

Maria, a Moroccan immigrant participant, told us that upon arrival her family stayed in a hotel until their money started to run out. They sought refuge at a resettlement centre temporarily: “I don’t have a proper place to stay… when we came from Morocco we had very limited money and this is all that we had to spend. We applied for housing in Calgary and it has been eleven months and not got an answer yet.”

Two participants had negative encounters with their landlords. Bonnie spoke out about her distressing experience with her landlord:

He was threatening to lock me out and put my belongings outside. The judge told him for a month he cannot touch my belongings. He totally evicted me [but] was still asking for the rent. Because I was in the shelter but [my baby] and her dad
both was in the hospital. I talk to the [landlord]... he was talking bad words about me saying I'm a bad person... he didn't want to give me back the damage deposit.

Lily, too, had difficulties with her landlord:

[The landlord] told me we should move out... He says, 'this is an adult building.' At that time lots of people with children so... before is okay, but this time they want more rent [money]... we can't raise the rent immediately, so they think if we move out, they can ask any price...

By employing the postcolonial feminist perspective we examine contextual factors that intersect with race, class, and gender. Embedded within these two narratives are assumptions about race that intersect with other relations of power to disadvantage some individuals and establish hierarchal domination or class position for others (Anderson, 2006). One of the central themes of postcolonialism is power and most commonly thought of as a force against individuals or groups to achieve their interests against the wishes of others (Barker, 2002). Thus it is imperative to pay attention to other powerful barriers and environmental stressors that these immigrant and refugee women face.

**Education Level**

Several participants spoke of how education and social class may influence communication between themselves and other cultures, which impacts help seeking and adapting to the new country. Anna is of this opinion: “Generally speaking if you don’t have a university degree people look to you and deal with you differently.” Carol also thought that the education level and attitude of some Mexican immigrants and refugees is an important element in a positive migration experience:
It depends on their education and how they have been educated. I know lots of Mexicans that come here just to have free money, food, house but they don’t come to work. To be truthful, there are a lot; they don’t have a job...[But there are] real problems in Mexico... so for some people because they need to be here and truly want to work and have a future for their children... that affects the rest of us.

Carmel strongly felt that education plays a strong role in communication and access to knowledge sharing. As an educated immigrant with past experience of working with new immigrants, she has observed that other immigrants don’t always want to share knowledge or help out especially if you are from different classes of society. She said:

We see each other different... because I’ve been working with all levels of society, for example some people won’t talk with others doing the cleaning... people who have more knowledge and access to the information keep their level and they don’t share... they don’t want to but because they don’t mix.

This embedded power which is based on race, class, and gender relations do influence the mental health problems immigrant and refugee women develop, and impact how they manage and seek help for PPD in the resettlement process. We need to consider other mediating factors in the immigrant and refugee women’s life, for example, the multiple forces of class, gender, race, and history. Moreover Carmel pointed out the hidden political agendas and historical issues that prevent communication and mutual support:

...Lots of problems between Latin American cultures... there is Columbians who come here seeking refugee for they were persecuted by the guerrillas. They don’t talk to each other, because they don’t know exactly who’s who... if they
know I’m here and have money, they will kidnap somebody back home from my family... there is a lot of issues and complicated things back in my country. These people have connections there and family there. It’s about culture, even though we speak the same language, we don’t see the same of each other.

**Employment and Socioeconomic Influences**

In this study the majority of participants stayed at home while three participants worked fulltime jobs soon after childbirth. As such many participants largely relied on their partner for financial support. Most participants expressed concerns and worries over job transitions such as job shortages, frustration over not having their professional status or past qualifications recognized, and unemployment of their partner. For some, the difficulty in finding a job was due to limited English language skills. They expressed fears regarding job security and having enough money for the necessities of daily living.

Carmel, a well educated participant, soon understood the challenges she faced. She arrived with positive expectations but quickly realized that her education and past work experience was not fully appreciated. She ran her own business in Mexico and had a good career but her experience did not seem to matter in the Canadian job market. She told us:

You think that everything is going to be better... you realize you have experience and you are a professional with credentials but here this means nothing... you have to start from the beginning and work as a labourer... you need to earn money in order to eat. It was very complicated and difficult. The first year was a hell.

Even though Anna spoke English, she found her immigrant status an impediment to finding work. She was university prepared but found it difficult to find a job because
she did not have the Canadian work experience. Although her family struggled financially Anna spoke of the tremendous pride of the Arabic culture whereby welfare is not an option, and in fact dishonours her culture:

If he didn’t find a job… the money runs out. I don’t know what we’d do. Because from our culture we don’t like the idea of welfare. It’s a shame for us. It would be stressed that we are trying to find work by any means. For other people maybe it’s an easy door to knock on but not for us. If we don’t have money to pay the rent or food for the baby… it will be forced on us but not easy to do.

Bonnie described the effect it had on her: “I was always ashamed to ask for help… I don’t have income so the ticket for every day going to hospital to visit my baby for seven and a half months… I was really so ashamed to ask for the bus tickets.” Similar to Carmel’s experience, Kelly was also well educated back home and had a professional job but her credentials are not fully acknowledged here. She told us: “In my country almost always I feel intelligent. I have a profession… have job. I’m lawyer.” But presently Kelly is forced to work fulltime nights stocking shelves because she could not afford child care during the day:

I can’t work in the day because I don’t have help with him… my work in the night is very heavy… My son have too much energy… when I no stay in my home, he don’t sleep, he don’t eat, and sometimes my husband is very angry. No is not possible now, bring my son for the daycare because is too much expensive. For the immediate situation, I don’t have subsidy for the daycare… because of [my status] this is only for permanent residents.
Maggie could not work because she was waiting for her work permit and her partner struggled with keeping his job. Eventually they received help from the community:

I couldn’t work because I don’t have my work permit yet. My husband [had] trouble getting a job because of his English, so that was hard for us. We asked for help for income support because most of the money goes to the high rent. He had a job in construction, but lost his job two months before the baby was born... so we got help from the church and food bank...

Many immigrant and refugee women in this study experienced structural barriers such as limited financial resources and a lowered socioeconomic status. Limited language skills, no available childcare, and precarious immigration status prevented them from finding employment. As a result some participants experience downward occupational mobility compared to their occupation in the home country. Because of their professional credentials not being recognized, some participants felt great dissatisfaction at not being able to work and be independent. This contributed to their depressive feelings.

Several participants described negative treatment at the workplace as another factor that influenced family well-being and especially the new immigrant mother coping with PPD. In keeping with the theoretical perspectives derived from postcolonialism and feminist theory it is important to examine how social inequity and unequal social power relations may influence these women’s circumstances. Race or culture by itself should not create a barrier for immigrants to enter the labour force, but it is rather the racialized processes which serve to position individuals in different ways by constructing them as inferior or subordinate (Anderson, 2006). Racialized assumptions lead to unequal social relations and when acted upon have negative consequences for immigrant and refugee
women's health and their families. When examining the contextual factors that impact immigrant and refugee women's PPD experiences, one needs to further analyze the social processes that intersect with race, class, and gender that influence the ways in which these women seek help.

Mia told us how discriminatory attitudes at her husband's workplace affected her family. Due to the changing situation in their home country they came to Canada seeking a better life. Her husband was running the family business back home but as a new immigrant had to adjust to the new employer/employee relationship. Based on the theoretical perspectives of this study it is important to pay attention to how the relations of power can permeate different sectors within the Canadian workplace whereby an immigrant from an ethnic minority group with few job opportunities might find themselves in a subordinated position to the mainstream population (Anderson et al., 1993). Mia described her partner as being bitter as he faced unfair treatment in the workplace. Even though Mia, a mother of three, needed support she perceived her partner required more support than herself:

For local workers at the workplace, when they have a gap without an assignment they can have a break... read a newspaper, chat or relax, but for my husband as an overseas worker, they would not give him that break. If you have no work they would just yell and give you some new job. That's why my husband felt really distressed and unhappy. It is really our greatest concern. My husband struggles about whether he should stay here or going back to the Dominican Republic.

Carmel, too, was frustrated by the negative processes and treatment of new immigrants in seeking employment:
I think it's just in a square box and they don't want to [look] beyond... there is no exception or consideration for people like me or other professionals that work and study. I did everything that they needed to do... to be honest I felt sometimes I have more capacity or eagerness to do things than Canadians living here. It is because everything is harder for us, twice or three times... so to go through the process when you have your credentials, it really bothered me, I think it is discrimination...

Jenny felt many financial pressures but wasn't able to work because of her continuing difficulties after childbirth. Her partner felt torn between going to work and staying home to support her, although the consequences of him losing work would be devastating. They both worried about the precarious financial situation but were left with few options. Jenny felt anxious over the lack of control over her situation and began to fear for their survival. Eventually Jenny did decide to find work however unsuitable. She described a negative experience and felt taken advantage of due to her desperate need:

I worked at a fast food restaurant and was working with [another ethnic group]

Everything was fine, but all of a sudden I started to feel very strange... like they treated me as a servant... maybe they felt that I have no choice, other than to work there... these people hardly spoke English yet they actually regarded me as dumb. I don’t know why... so I started to feel discrimination. There was other things... I was told to make a delivery and she didn’t give me the proper address, or she told me how to get there... so I left this place.

Dana described the unpredictable job circumstances too for her partner:

My husband was having good job, but suddenly they give him one week’s notice... and laid off the same week when my daughter born... you know it's a
stress and you think about whether we will buy this, or we will not buy this. He is looking for work, but at the same time we are not getting anything. So [you use] loans, credit cards…

She also pointed out the financial commitment back home: “My husband’s family back home, they want money all the time, and we don’t have money for ourselves, so how could we support them? But most of the families send back home… it’s again an argument, between us, and with them as well.” Lily felt the same way: “The financial stress is so big and my mother in law also wants us every month pay two hundred dollars to them for the house... for twenty years.”

Roberta maintained that in addition to their difficulties, financial problems add further emotional stress and fostered a feeling of helplessness in their situation:

I even owe money to the government because of the two births. My husband right now he has layoff from working… the government is always sending letters that they want me to pay, but how is it that I’m going to pay the hospital? I cannot pay right now. I don’t know why I’ve been feeling so down lately.

The migration experience does create additional layers of complexity resulting in increased vulnerability due to the multiple changes to which immigrant and refugee women must adapt. Employment and socioeconomic independence holds important implications for these women as it is more than just having enough money. For these participants it was about having self respect, being productive, and a sense of contributing to the family. In other ways it contributed to how they felt about themselves, their core identity, and their role in life. Ultimately this may affect how they coped with PPD and the ways in which they sought help. To balance this view in the next section
some participants express how the positive benefits of migration has improved their overall socioeconomic status and created opportunities in seeking a better life for themselves and their families.

**Migration Positive Outcomes**

**Enhanced Socioeconomic Status**

Many of the participants shared similar problems such as employment difficulties, low incomes, and other economic struggles. However, they were optimistic about what the future would hold. For Jenny it was about not only financial rewards but an affirmative future:

> It’s a new beginning… because there are a lot of difficulties when you come to a new country, so it’s like you’re starting a new life and it’s always positive and it brings some sort of positive energy into your being. Financial reward as well…

my husband is working right now, he gets much more money that he could have dreamt about in Israel.

Carmel, through hard work and determination, started her own company: “I started my consulting company which has been on the road for five years. I consider it a great achievement in a foreign country… when you deal with language barrier and several cultures – it’s not just the Canadian. So I’m happy to be here.”

Mia explained that in the beginning it was difficult for her husband as he needed support more than her. But over time their situation improved:

> My husband came from Dominican, and ran a business. Then he came here and had no friends, a new workplace, and did not know English… But since he has
been working in the same place for two years, he has more friends and the boss
could see his work ability... that's why he feels much more satisfaction now...
Part of Cora's motivation was to strive for a better way of living and improving her
partner's employment choices:
I came away to start a better quality of life... money was not a concern in Mexico,
but the quality of life was not the greatest. My husband has been attending the
training, and [being] head of household you need to attend school to become
better. It is going to take him three years to become a policeman. If we only have
eggs and rice to eat at home, we will. I want him to become better.

Multiple Opportunities in Host Country

Without a doubt participants expressed gratitude to be living in a safe and
welcoming country such as Canada. Several participants underscored the importance of
future opportunities for their infants. Anna emigrated from Egypt to pursue a different
lifestyle and improved education choices for her infant: "The future in this country is
better than our country, so this is what made me move. I'm in a good social class... I had
very good income back home maybe better than here... but I know the education here is
much better." For Ruth, too, her main priority was the future of her children's education:
I'm so happy that they're here in Canada. They can do whatever they want to be
here. Especially when you are born and grow up in here... everything is in your
hand. You can be whatever you want to be... but the big thing is their education.
For Carol it meant getting free health care for her infant who required surgery for
her cleft palate: "If he would have been born in Mexico right now, I would have lots of
economic problems... that would have been more difficult because he was born sick. Here he will have a surgery... they are treating him and I pay nothing.”

Julie expressed much gratitude: “We thank God to be here in a country that has welcomed us so much. I fight... for my daughter even though I’m such a young mom to give her a better future.” Sara also felt that the opportunities are numerous in Canada. She told us that her family will become Canadian citizens soon and she is very proud of this. Because of their ambitious drive to succeed they will be moving into their ‘first owned home’ with a yard! Ciara too asserted her ambition: “For us as immigrant moms, we come to Canada after our marriages... Some moms don’t get that opportunity to go to school and study [back home], but here we can still have our career, and be working towards it. Even if you’re starting from the bottom...”

Anna is pleased with the awareness of social rights and the mutual respect she experienced here. She felt that in order to be respected you also need to show respect. Thus it’s not just about always taking from others but keeping a balanced view of how you can reciprocate. To her this meant keeping a positive attitude despite challenges they may have faced as a new immigrant family. Anna is especially appreciative of the openness and positive mindset of people here:

Real thinking makes it more open. I think this is very positive. Because [back home] we are so closed... even you don’t know it.. I always say, we are not in heaven; any place in the world have the good and bad... so we have to seek what is good and get stuck to it. Because if we keep looking at the negatives or the empty glass, okay, it’s empty, so what?

Kelly, despite all the difficulties with PPD and immigration stresses she experienced,
told us that in order survive you cannot give up:

When you change country I leave, my profession, my family, my life, I leave all for coming to this country. You leave all and start from zero here... my husband have possibility here and now I understand I have possibilities here too; Because I think all people have capacity and only you need try; only you need to leave discourage behind you and try every day. If you don’t try... the life is gone.

**Summary**

In this chapter I have identified other factors from the immigrant and refugee women perspective which may predispose these women to greater vulnerability to PPD after child birth. Family well-being and functioning coupled with efforts to overcome physical and mental health problems impact family members and greatly influences the mother’s state of mind after childbirth. Coupled with the multiple demands of new motherhood is the expectation, typical of many cultures, that the mother is expected to care for the entire family. With many difficulties occurring simultaneously throughout the perinatal period, it is important to recognize the context that situates these women in a very vulnerable position to develop depression. We need to account for the changing social contexts in which immigrant and refugee women identify, experience, and manage their special concerns with PPD. All women do not share the same social reality or level of privilege. Through employing the postcolonial feminist perspective lens we may see that contextual factors interact with race, class, and gender to shape the subjective experiences of these women (Anderson, 2002; Donnelly, 2004). Although the mainstream population may suffer from many of the same risk factors for PPD, the immigrant and refugee population are more likely to be coping with a multitude of
financial, employment and family issues due to the nature of the migration experience.

Migration has strongly influenced these women’s lives, in both negative and positive ways. Moreover we need to be more aware of the role contextual factors such as social, cultural, economic, historical, and political can play when we talk about motherhood, migration and the ways in which we address how immigrant and refugee women seek help and cope with PPD.

As we continue on and move forward to the next chapter, the focus now shifts to exploring the role of gender and the immigrant and refugee women’s experiences in seeking help to cope with PPD.
CHAPTER VIII: FINDINGS AND DISCUSSION: THE ROLE OF GENDER

In previous chapters I presented the immigrant and refugee women’s perspective on cultural and social determinants of health that impact their experiences in seeking help to cope with PPD. Language barriers, lower socioeconomic status, discrimination, cultural influence, and inadequate social support often experienced simultaneously cause this population to be more vulnerable to illnesses like PPD than mothers who were born in Canada.

In this dissertation, sex refers to the biological differences between men and women whereas gender is defined as “the array of socially and culturally determined roles, personality traits, attitudes, behaviours, values relative power and influence that society ascribes to the two sexes on a differential basis” (Greaves et al., 1999, p.2). The interaction between sex-linked factors and the gender based factors are critically important as they are coupled to determine what affects health in women and men. Gender influence is particularly relevant in the research of immigrant and refugee women because of the policies that may create partiality against women, and the cultural conflict of gendered roles and expectations (Donnelly & McKellin, 2008) that influences the women’s health care behaviour in seeking help to manage their PPD. As gender is a health determinant and intersects with biological and social determinants, in this chapter I discuss my exploration with the participants on how the role of gender and gender relations may impact their individual situations during the perinatal period.

Several sub-themes were discovered in talking to the participants. These included their unsettled immigration status circumstances, gender relations, dominance and control
of their partner, and influence of role changes within the family. Gender was also described as having a positive role in that traditional roles brought familiarity and comfort to the family unit. For other women it also meant learning their rights, and receiving support as they left abusive relationships.

At the outset I did not ask direct questions about immigration status or about relationship difficulties and changing roles within the family. Rather, participants discussed these negative and positive factors in answer to other interview questions as gender roles were inextricably tied to their changing situation.

**Immigration Status**

Gender is an important determinant of social inequity and influence on health status. This raises important questions about gender disparities across immigration classifications for immigrant and refugee women. As noted in the literature review many women enter Canada under family classification. Some of the participants in this study were without secure immigration status. Coupled with being emotionally and economically dependent on their sponsors this status may leave women extremely vulnerable and disadvantaged in terms of protecting themselves and seeking appropriate help.

Many participants expressed problems with their immigration status. They felt strongly that their status prompted further difficulties in their everyday lives, whether it was inability to work, limited access to health care services, lowered income, no access to language classes, and or housing. It also prompted negative discriminatory feelings which ultimately affected their emotional well-being and personal dignity.
Mia felt insecure and inferior to other Canadians. Living with the knowledge of not having secure immigration status made her more vulnerable and with a perception of less control over her life and sense of belonging. She was reluctant to seek out help, feeling that asking for help would negatively affect her family’s immigration status:

In my heart I always worry that because my husband is still on a work visa and not a Canadian citizen it may affect our immigration application… that’s why I dare not seek any help. I really felt inferior and that’s why I had a feeling that we’re not supposed to get any help without a Canadian citizenship status. My husband faced a lot of unfair kind of treatment in work place. So for the first year our lives were really bitter… we could not see any way out and each day was filled with worries and anxiety fearing that we would be expelled from Canada.

Mia’s feelings are based partly on immigration norms in her home country. She described how the status of overseas workers in Hong Kong is perceived as inferior to those of local workers. She applied this way of thinking to her own experience here and felt the same kind of prejudice with not being entitled to have the same privilege or the same rights. Mia resolutely avoided the subject of her status: “I used to avoid telling people that we are still not a Canadian citizen and not let them know that my husband is on a work permit. Unless they were deeply asking where you come from or how you come here…”

Discrimination is an important element of the resettlement experience in a new country. Inequities begin with entrance requirements (status) and then may progress to further difficulties in finding employment. Meadows and colleagues (2001) found that new immigrants from non-Western countries find themselves in uncomfortable social
situations similar to this participant’s feelings of inferiority as described above.

Hierarchies are formed through non-formal and formal categories of who is a Canadian and who is not. The further reinforcement of hierarchies through social policies leads to lesser opportunities to employment and access to health care services (Krieger, 2000). This discrimination may affect immigrant and refugee women negatively and ultimately may leave women defenceless and disadvantaged in seeking help and protecting themselves against PPD.

Roberta also didn’t have valid immigration papers, resulting in a multitude of problems for her and her family. In her situation gender plays out with other health determinants such as socioeconomic factors, social support networks, and immigration status. This notion of intersectionality implies gender is experienced by women simultaneously as their experiences of class, race, and sexual orientation and any other forms of social difference. Instead of examining gender, race, class, and nation as separate social hierarchies, intersectionality draws attention to how they mutually construct one another (Collins, 2000b). These complex interactions of oppression compound one another and influence the health of migrant women. In social conditions of inequity, and particularly with poverty, barriers are created to obtaining appropriate mental health care for immigrant and refugee women. That is women without financial resources have less choices when it comes to mental health care treatment. Roberta said:

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. I don’t have papers so it’s difficult when you can’t go to school and you can’t learn English… it causes a lot of difficulties. I was very depressed because not working much… right now I don’t have electricity, it

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was disconnected, I don’t have the money to pay for it. I tried to ask for assistance at immigration services, but I don’t have papers.

Some participants talked about negative encounters with the immigration department. Several participants noted that their close family members were denied or had limited access because of the strict regulations on visas. Immigrants often have difficulties getting visas for their relatives. This has an effect on women when they cannot have their mother or other female relatives join them to help and support them after the birth of a baby. Maggie, a refugee, told us that her mother was not allowed to come and help support her after childbirth: “I wanted my Mom to come and she got her visa denied, so I really felt very bad… maybe because I’m refugee and they thought my mom was going to come and stay, overstay, I don’t know.” Carol, too, pointed out the limitations of being a claimant and in a state of uncertainty and how waiting impacted the family well-being:

For those of us still claiming there is lots of restrictions. Something that will help people that are in process is… my Mom wants to come to visit me, she can’t. Because if she comes she will claim refugee status as well, so she’s not allowed to come to Canada. If you’re not accepted you have an appeal, and there are humanitarian reasons. [But] it could be even five years.

Luckily for Kate, her mother was financially well off and was granted a visa so she could help support her in the midst of PPD. Kate pointed out that immigration officials scrutinize the financial background of visa applicants. If you have a stable financial background your chances of obtaining a temporary visa are much higher. However, her mother-in-law’s visa application was rejected. In Kate’s view it was because she had
limited resources and lower income situation possibly deeming her more at risk of remaining in the country illegally or claiming refugee status:

   My mother-in-law didn’t get her visa... Because they fill out a financial background too, so probably the immigration officers were afraid that she would come and settle here. We applied for my mother-in-law two times for her visa and got rejected two times. I took doctor’s notes every time [stating] that I’m suffering from postpartum depression. I need somebody to be with me... my mom already had visa... so she had to come.

   In Bonnie’s situation circumstances led her to Canada to work as a nanny, however her working permit expired and she was not aware that another application was required, creating a series of problems for her. After giving birth to her daughter she was afraid to ask for help because of her precarious immigration status and feared being deported and separated from her new infant. Due to her insecure status Bonnie felt she should minimize her visits to the physician: “Because of the status... really it is the one keeping from doing this... I only see the doctor three times during my pregnancy and she was a preemie at 27 weeks.” Bonnie was informed it would take two to three months to obtain her status, however she has been waiting two years.

   Immigration policies determine the entry status of immigrants and refugees and establish employment rights and other social rights and entitlements often differing by gender. As a structural barrier, gender was clearly implicated through the participant’s testimonies in that it affected how they coped with PPD as well as the ways in which they sought help. Roberta, too, met with real adversity concerning her refugee status after the authorities discovered she had an expired status:
My husband still didn’t have a job and had no money for our kids or the rent. I
told my husband to ask for social help. He said we can have problems with your
immigration status if we go... and they asked for the refugee papers and saw that
my paper was expired. A month later they knocked on our door and arrested me in
my own house in handcuffs. At that time I had a very small baby and was breast
feeding... they treated me like if I was a criminal which made me feel very bad.

Similar to Bonnie, Carol was uninformed of the regulations surrounding ‘work permits’
and therefore had unrealistic expectations and was caught off guard:

I didn’t know that there are temporary workers, and they have a lot of freedom,
more than us. Their families can come here, and mine can’t. If I had known, I
could have done everything to come as a worker and not as a refugee. I thought
would look for a job and have it. But they told me no, here you need a work permit,
until then you cannot even search for a job... the process is long. Somebody told
me that I could work anyway... they will pay by cash, but others say that’s illegal.
So I had to go and ask for help...

Several participants spoke about how irregular (illegal) status created tensions and
multiple barriers and in turn difficulties and negative feelings. Having this precarious
status renders some women dependent on a third party such as a spouse or family
member. This ‘irregular status’ does not give them the right to remain permanently in
Canada as they must undergo another application to obtain a more secure status. This also
increases the women’s vulnerability to being exploited sexually, physically and
economically (Oxman-Martinez et al., 2005).
Deportation and status fears discourage immigrant and refugee mothers from getting the necessary health care services. Carmel expressed it clearly:

There is immigrant women living here underground… they have no papers, they get here and lose their status and somehow then they are too afraid. If they go to the doctor, the doctor might not take them. Or if they have to pay... or the doctor will call immigration.

This delay in getting her papers compromised her ability to apply for a job or apply for housing. Bonnie said it plainly:

My status doesn’t allow you for support from the government. The [Resettlement Centre] let me stay here for free. That’s really the difficulty with me – my status. I want to go back to work and get a job for my daughter, but I cannot find a place for me to live, because there is no help from Alberta Works until I have my status.

(Alberta Works is a government agency that helps unemployed people find and keep jobs, and help Albertans with low incomes cover their basic costs of living.)

Bonnie and Roberta both have irregular status and have been in the process for over three years. ‘Waiting’ in the immigration system for a more permanent status is not an uncommon experience for some participants. Jenny commented on her frustration of waiting coupled with the lack of updates and information concerning their immigration status:

It’s like a bureaucratic system, a very large one. One problem with immigration is lack of information about our status. We applied for our permanent residence but still don’t appear on their database, because they’re not updated on a regular basis. I want to know whether I’m staying here or do I have to prepare my ground
to go back to Israel. We’ve applied for an extension of our visa. It’s supposed to take four to six days and it’s been already a month. My visa has expired so officially I can’t look for work…

Gender affects the power and control men and women have in different ways over their socioeconomic determinants (income, employment, social class) and their status, roles, access to resources, and other treatment in society (WHO, 2010). The main point at issue here is that not only are there socially constructed differences between women and men but that these differences often result in discrimination and inequalities. We must recognize the multiple contextual factors affecting these women’s lives are related to the power relations between the sexes and the structural barriers and class position of immigrant women within society (Anderson & Lynam, 1987). Gender based disparities in access to resources, in power and decision-making, and in roles and responsibilities have repercussions for immigrant and refugee women’s health care practices and access to PPD services.

This raises important questions for gender disparities across immigration classifications for immigrant and refugee women entering Canada to live. Gender based discrimination and inequalities are contributing factors in health differences between women and men. The impact of entry status may influence the ability of how these women assimilate and settle in the host country.

Roberta described very clearly how being a woman with no status has affected her mental health in multiple ways and as a result created barriers in moving forward as a family. With great emotion Roberta expressed her stance:

I am a very hard working woman. I don’t like to be home because I need to work,
like they say — someone that works, provides energy to the life, but if you don’t work, it’s like you’re dead, being alive. In my case they just closed a lot of doors. It’s not because of the pregnancy [or my] kids. It’s [because] they have me as being illegal.

Further she said:

We [want] our papers so we can progress; not so we can leave or cause harm to anyone here, but just to work — not to be a load for anyone. But just to work buy a home and to give our kids a good life. Not a lot of luxury, but just to be a decent family. I do get depressed because I can’t live like normal people because I’m always thinking if I leave or if I stay... it’s just very bad and it does cause me to be depressed. It’s something very ugly.

Several participants also expressed a fear of authority. They were anxious about being separated from their infant and deported. Bonnie remains fearful of what might happen: “When I saw policemen and if he asks for my ID I will... [Be afraid] It’s still now because I don’t have the status, and for my baby’s sake I don’t want to be deported. There’s no peace of mind for me until I get that status.” For Anna it was about the fear and being on your guard about her infant being apprehended: “I have to take care, very carefully, when my infant cries outside. I feel scared. Everyone is watching you and reporting. This is not good, because when the kids are taken from the family they have more problems.” Alice also echoed similar perceptions as it weighed heavily in her mind about what would happen with her infant if she didn’t meet the nurse’s expectations in breast feeding properly and her infant gaining weight. Viewing the nurse as an ‘authority’ she too feared apprehension of her infant if she didn’t comply with the rules. These
participant’s perceptions concerning the fear of authority may influence the inclination of the women to seek help and information from health care providers. Socio cultural factors such as cultural background, experiences with authorities in the country of origin and in the host country, proficiency of language skills, and social isolation interact with race, class and gender and ethnicity (Oxman-Martinez et al., 2005).

Alice further described another past example of the immense anxiety and fear that existed in her family surrounding child abuse and apprehension. She felt her family was accused unfairly of not taking care of their child properly. She reflected:

The fear of police it is a big issue. I feel scared that, oh my God, one day they are come and find some reason to take my child. Once my daughter was just crying because she wants a dog.... we couldn’t bring a dog in a one bedroom apartment... the neighbour would call the police. The police came and were so exaggerated of why my child is crying. For a year we were involved with them... I don’t know how much this destroy our family relationships because it’s the minority who are abusing. You are destroying a very safe relationship between parents and children.

**Gender Relations**

Gender hierarchies within the family context may be played out as power, domination and control over women. This can create unequal social relations between the sexes and put immigrant and refugee women in a socially disadvantaged position. As a result unequal power relationships may affect the family through new economic roles and challenges, a resistance to new tasks and assigned roles and ultimately affect the spousal relationship. On top of dealing with this period of extreme change some participants spoke of the relationship difficulties with their partner such as alcohol and drug
addictions, separations, emotionally abusive behaviour, and involvement with child services and restraining orders. Some women commented that back home domestic violence is accepted as normal and usually issues are dealt with within the family.

Furthermore as new immigrant and refugee mothers they now may find themselves in a powerless and generally dependent position that leaves them vulnerable to abuse. In a previous chapter some participants viewed their partner in a supportive role and an amelioration of their PPD. However a number of participants also clearly identified that the behavior of their partner or spouse was a contributing factor to their PPD and related problems within a very complex situation.

Roberta, now a mother of five children, described the change in her relationship which occurred soon after childbirth. Leaving three children behind in Costa Rica, she arrived as a refugee in Canada. Relationship difficulties were a strong factor in the development of her emotional instability and as a result still struggles with PPD in her current situation:

One week after I was getting better from the birth, he asked for a divorce. I believe that he psychologically destroyed my life; he destroyed my mind. I was depressed for five years; there were some days that I did not take a shower or fix myself in any way. I just felt very bad. I did not want to get a divorce... It's not good for children to grow up without their father. I know that I was a coward. That's why I came over here, so I could escape those problems...

Bonnie described a very complex situation; one in which a tumultuous relationship presented many difficulties. Her partner viewed her immigration status as the root cause
of many of their financial problems. When the emotional and physical abuse began she didn’t speak of it:

I was always having problems with my partner. He was always blaming me for what happened: ‘because of your status you don’t have money, you’re not working, and that’s why we’re so tight with money now.’ At first he was so happy I was pregnant but then he became suspicious that she’s not his... He was mad at my friends and separated me from them. I don’t want people to think he’s a bad guy, because he’s still the father of my baby so I was protecting him. I kept it secret but when things got more difficult he became more abusive.

Bonnie told us she suffered much emotional and physical abuse and feared for her safety. Her partner had addictions to alcohol and drugs like crystal meth. He received money from the government for the infant but spent it all on his addictions. She also reflected about the extra pressure still being applied by his family: “I was emotionally blackmailed by his family. They said he can’t make it without me… It brings me down. If I went back to him, there’d be a place for me and my baby... but I know his addiction, he’s not using drugs anymore but until when…”

Kelly also experienced a volatile relationship as a new immigrant mother. She especially worried about the effects of the turmoil and abuse not only on her as a mother but on her child as well:

My husband was violent with me. Sometimes it’s unpredictable…because when I talk with him, only I fight, fight... and I don’t like this for my son. I see [my son] more angry, more aggressive, he don’t like this... (sigh) oh, this situation is very difficult for me because my son is my big love. I will like one good life for him...
and opportunities for him... because if I'm stay good, my son stay good. If I'm stay bad, my son stay bad.

Kate, too, had many difficulties within her relationship. Adamantly she spoke about the differing standpoint on the causes of PPD between her partner and herself. Her partner viewed it as a lack of control over her behaviour. She felt he didn't understand the seriousness and intensity of her problem: “My husband is very educated and knows what postpartum depression is... but he doesn’t agree. He would attribute it to my family, my parents’ and childhood behaviour. But this is a real problem, and a serious problem, and any person could become a victim of this.”

In the end Kate openly spoke out about her relationship and the magnitude of how vulnerable and powerless she felt and how this negatively affected her ability to cope with PPD. She felt her husband’s unsupportive attitude was the foremost cause of her PPD that exacerbated her depressive symptoms:

When I was very low in self-esteem there was no boosting up. He always said ‘you’re not doing well here’ and tried to put me down and make me curse myself every minute. I wanted my husband to say ‘I’m with you.’ Let’s face this together... But we’re never on the same page, it’s an arranged marriage. My husband is not a bad person; he’s never abusive... But we don’t share that big love relationship. For me one of the major causes for my postpartum depression was the relationship with my husband... because there is no attachment. There is no love. An ‘arranged marriage’ is a union between a man and woman introduced by their parents based on education, caste, and family background (Goyal et al., 2006). In the literature, arranged marriages, restrictive customs, relationship difficulties, and being ‘controlled’
by family members are identified as contributory factors to mental distress in South Asian women (Ahmad et al., 2004; Baldwin & Griffiths, 2009; Bhugra, 2004; Burr, 2002). For this participant in her view, the arranged marriage and lack of a meaningful relationship with poor emotional support was a significant and powerful factor in predisposing her to PPD and in coping with the depressive symptoms.

**Shifting Gender Role in Motherhood**

Participants freely spoke about how role changes affected the whole family after the birth. A common pattern for many immigrant women while adjusting to a new country is to manage family responsibilities, work outside the home, and uphold the cultural norms of the past. It is well known that female gender roles frequently require women to be more responsible for a disproportionate amount of domestic and paid work, as well as balancing child care and housework (Anderson et al., 1993; Anderson & Lynam, 1987; Anderson, & Reimer Kirkham, 1998; Spitzer, 2005). However multiple roles make these women more vulnerable to role conflict and predispose them to mental health issues such as PPD. Gender roles and statuses change and are variable, and together with embedded power relations within the family may also influence the immigrant and refugee woman's access to mental health care services (Greaves et al., 1999; Jiwani, 2001; Kinnon, 1999).

Many of the women in this study were at home but expressed a strong desire to work and contribute to the family's economic well-being, but because of structural inequalities induced by admission criteria, reluctance to recognize educational and professional credentials, and practical barriers issues such as lack of child care, working
outside the home was not possible. Some women described a sense of confusion over role identity and felt dissatisfied with their lives, and thus were more prone to PPD.

Cross culturally women are thought to be the most appropriate as caregivers for children. In this couple’s situation observing the shifting of gender roles and expectations has significantly shifted the new mother and father’s role. The overall process of having a baby brings disruption and change into the family’s lifestyle. This prompts a new father to renegotiate his sense of masculinity and rethink what is a legitimate male role while for women this role may seem a natural progression into fulfilled femininity-motherhood (Nicolson, 1998). Underpinning the social construction of femininity and masculinity we see how the every day practices of child care reinforces the differences between men and women’s life situations.

Ciara described how her partner’s focus was directed more towards his job and less to the infant. He felt more responsible for fulfilling his new career role and therefore felt it was much more his wife’s responsibility to care for their very ill baby:

He was thinking like before... it was just me, who was his responsibility, now he has another one, [his infant] and she has this condition. He started to think that he’s the only one who can go to work and bring money to home. Even in the hospital, he stayed just for a couple of days... I think he just focussed on his job so... he didn’t take a time out for him.

Jenny felt discontented with her new role as a stay at home mother:

My husband works full time so he’s doing all the living and bringing the money home. So now I depend on him financially. I’m doing the woman’s job, staying home but I still don’t agree. It is a negative feeling because it doesn’t suit me. Of
course I will spend more time with my baby but it's not the only thing I want to
do in my life right now. I wasn’t thinking of myself as a stay at home mom but
more about [obtaining] the highest goal possible. My last job in Israel I was a
research assistant at the university… now all of a sudden I’m reading only children
books. It’s frustrating from a professional point of view and very difficult for me.

Jenny felt her discontent is having a negative impact on her marriage. She
attributed these feelings to multiple reasons such as her social isolation, her partner
feeling overworked and fatigued, and numerous arguments with him about their limited
finances. Lately she expressed she is frustrated and feeling less loved by her partner. Her
depressive feelings have not gone away and in fact are getting worse as she tries to adjust
to her new role and her ongoing perception of receiving limited partner support.

In Dana’s case she had to persuade her partner to support her. Although highly educated
he was more concerned about his wife fulfilling her role as primary care giver to their
child than obtaining mental health care treatment:

To make them understand, women can’t tell their husband that ‘oh, I’m having
depression, so I need to go to a psychiatrist’. No. She, she can’t tell that, and I
don’t think a man would support it. I had this with my husband. Even though my
husband is he’s really educated and he knows all that but he won’t allow me. He
thinks it is a bad thing…‘oh, you have to go there; who will take care of the kids?’

Influence of Traditional Gender Role in Motherhood

Traditional gender roles increase vulnerability by stressing submissiveness and
imposing a duty to take on the care of others. These multiple roles and high expectations
position women in a vulnerable, high-risk situation for increasing levels of stress and
stress related illnesses such as PPD. Traditional customs during the postpartum period are
generated towards providing support for the new mother. Lack of cultural traditions could
leave the new mother feeling powerless and unsupported.

In Chinese society, the mother traditionally has the role of looking after the
household and child care (Chan, Levy, Chung, & Lee, 2002). Traditional Chinese
teachings encourage women to observe the ‘three obedience’s and ‘four virtues’ (Chen,
Wang, Chung, Tseng, & Chou, 2006). The ‘three obedience’s are to comply with her
father before marriage, with her husband after marriage, and with her sons when her
husband dies. Virtuous qualities to promote in being a good woman are to improve
personal traits, language, physical appearance, and housework skills. Chen and
colleagues found women experienced excessive distress over the traditional gender role
expectations they faced in new motherhood.
Lily, who is of Chinese descent, experienced many role changes in her family. She
felt she gave up an important and valued role of working outside the home and earning
money:

   Before I’m a manager, I earn okay pay and everything is good, everybody think I’m
   a very good woman. I’m very strong and have everything. But after I went to
   Canada, everything is changed. I have no work. I can’t study or go to school.
   My husband continues his career. But now after having a baby I just stay at home.
   Before my husband totally respect me and gave me space but something changed…

Another core belief she had was the increased responsibility for the stability of the family
and retaining the care-giving role, but at the same time being worried about her
husband’s feelings toward her. This ideology of saving face for one’s self and one’s
family has had a negative impact on her self-esteem and self-confidence. With this shifting of gender roles and extra responsibility she described the risk of losing herself in the process. She still maintained that she should be a confident woman but at the moment she only sees her husband having a very brilliant future here, but she does not see her own future as being brighter:

Your husband and kids, you have a lot of responsibility there. I think the roles totally change. You're not free anymore. So quickly it change your role, so you don't think. He was so proud of me but right now (big sigh), I think is despairing me, just despair. He always thinks I didn't do things right or good. I worry about that he just think I'm not make a contribution for my family too [but] raising kids is very hard job.

Abby spoke out about how traditional gender roles may strongly influence some Middle Eastern women. In her case she went against the norm of her cultural practices. She told us how in her country of origin you are forced to live with your husband. Even if he is mistreating the women in his family they almost always stay. Separation and divorce are uncommon because it makes the woman an outcast. Even for Arab people that live here she maintained that if you are separated or divorced, you are not viewed as a good woman. Thus, we can see how for some cultural groups a key element of their survival strategy is not to reveal relationship problems or mental health difficulties such as PPD, or use health care services which may indicate they have such problems.

Kate maintained that traditional roles are important to Indian culture. She told us how traditional views and expectations of some Indian men and extended family members
may impact the immigrant women’s situation. Cultural norms are powerful and dictate how the Indian mother should raise her family:

According to Indian culture, the men are the wage-earners and the women are to stay at home and take care of their kids. It’s the woman’s responsibility to take care of the baby completely. If I’m going to work and my baby is sick often, it is looked down upon by some elderly people in the household… they expect I quit my job and take care of my baby. They don’t expect my husband to do this. If your husband stays home and the wife goes to work, it’s looked upon as very weird…

Kate asserted how the traditional gender role was a strong influence in her situation.

Receiving limited support from her husband was a detrimental factor in helping her to cope with PPD:

They expect a lot of support from woman but the men don’t give any support to woman. They don’t give anything in return. They just bring the money in, that’s what. So that is what it’s like in many Indian families. My husband comes from that kind of thought process…

Some participants claimed traditional roles conflicted with their own mindset. Rather than viewing traditional roles as having a reassuring familiarity and creating positive balance within their family and extended family unit, several women were more anxious to get out of the home and work. They viewed this as an opportunity to be less depressed and as a way to be more autonomous within their life.

Differing traditional gender roles and expectations also influenced how they viewed their role as mother. One Chinese participant did not concur with her mother’s insistence on career and independence at this point in her life but may be open to it in the future:
In China my mother always told me, you should trust for yourself. You should become very strong, not just to stay at home, take care of your babies, or you will become a nobody... nothing. My mother always thinks I should go outside to get a job or start my career. I shouldn’t just stay at home. Before I think is okay, but I want to study, spend some time with my kids. Recently I, think about maybe my kids grow up a little bit, I should like start something to find myself.

Bonnie described a very traditional role for women in the Philippines, however she felt here it is more about economic necessity for many women: “In my country it’s like that. The mothers stay at home, the husband works. I don’t feel that way anymore. Because if you have to work in order to support and give enough for the family then you have to work. It’s a practicality...” Although traditional roles are important to Indian culture Kate in contrast viewed going back role for to work as a positive her due to her need to be less isolated and be more independent:

I don’t agree with [staying home] because that’s for women who are able to stay alone at home and who don’t have postpartum depression problems. First I should be happy and healthy to teach others. We should make ourselves clean and perfect... So in this stage definitely every woman has to go to work.

Relationship Dominance and Control

Situations of dependency and abuse are very real for many immigrant and refugee women. Many migrant women arrive as the dependent spouse of a male independent immigrant. This subjects them to social isolation, restricted independence, resources, and access to information about their rights. It is evident through these women’s narratives
that it was not simple to remove themselves from emotionally abusive relationships.

Emotional and instrumental support by their partners is important and is needed by mothers in the postpartum. Without this source of support the mother’s maternal health maybe affected and disadvantaged in protecting themselves against PPD. Ciara observed that in some cultures there is a dominant gendering socio cultural influence:

I noticed in a lot of cultures... some men they don’t allow their wives to be independent, or if they’re hitting and beating them. They don’t want the doctors to know what is happening in the house or in their lives. I noticed sometimes they will take their wives to the doctor, but they will say to them ‘if you told anything true to the doctors, you will be in more trouble’. So they kind of threaten their wives.

Several Middle East participants talked about how gender role affected them. Jenny commented on how the role of gender strongly influenced whether women feel free to seek help. She pointed out that Middle Eastern women are very modest and every attempt is made to keep their bodies covered. This modesty could be based on religious beliefs or the beliefs that women should be seen by their husband only. She also suggested using female Muslim health care providers to reach out to these women:

I see how they behave... they don’t want men other than their husbands or sons to be near their wives, or women in their house. They have privacy issues and their husbands don’t want their wives to see anyone. But it’s not only men, it’s also women. For example if we want to get to these women, you have to take mostly Muslim women to get to them and Muslim women who are not Westernized.

Anna’s husband, in line with Muslim tradition, felt women should not visit male doctors, however she viewed this in a positive light:
Our culture, most of the men, doesn’t like his wife to go to men gyne doctor. You can see it as overpowering you, he’s controlling you and doesn’t give you the chance to do what you like or what make you feel happy... Or you can look at it, as he’s protecting you. So it depends how you see things.

Alice, too, gives her perspective on the gender role as it plays out in her Muslim family. She told us about how accessing mental health care services from a psychiatrist could upset her husband. Yet she perceived his behaviour not as controlling her but rather one of honouring his wishes. She sees it as a balancing act in her relationship to maintain peace and harmony: “Just by knowing he’s not happy about me... [I must] honour him or... it is by both sides decision, so one side is not happy. I prefer just not to go. If I do go this a reason for conflict and argument, isn’t it?”

In broken English Abby tried to convey her many troubles and struggles within her relationship:

Because we make argument, sometimes he bit me. I was alone and nobody to help me. Sometimes I was very nervous. I felt I’m his slave not his wife. He wanted everything to his hand and make control for everything in my life. I don’t think this is life. Nobody live my life like me... I won’t live with him.

She told us that her husband, who is 21 years older than she is, sponsored her from a Middle Eastern country. Abby further explained how her husband’s extremely controlling behaviour worsened:

He sponsored me. He refused if I want to find job or work. He said ‘You must stay in the home and help me, care about your son, and house, that’s it.’ Learning English, he refused. I wanted to [go to] school but when they called him... he say
no, he’s not interested now. He wants control on my life. He doesn’t want [me to] go anywhere except with him. Just if I want anything ask him first. For example, if I want to visit my friend or want to walk, I want to ask him before. He refused make TV… he didn’t make telephone, internet.

Lana, a participant, describes a tragic example of how some Chinese women might deal with dominance and controlling behaviour by their husband within the family. A Chinese woman was murdered in this city two or three weeks ago but she didn’t ask for help and no one knew that there was a problem. She didn’t have very many friends to talk to mostly because Chinese people have a saying, ‘problems in the family stay in the family’ so they wouldn’t call the police. In Lana’s experience she maintains that Chinese women won’t call the police on family issues. Lana described the controlling and emotional abusive behaviour by her husband:

I was evicted by my husband. He pushed me out of the house. The police took me to the YWCA. He took away a lot of my things I really treasure. He wouldn’t let me learn new things or let people help me. My husband would teach me a lot of things the wrong way… like wrong ways of thinking and he made me sign papers. Only now I know it’s the wrong way…

Kelly wanted to leave her husband but was fearful of whether she was able to survive financially. She explained how dependant she really was even though she was engaged in full time paid work at night. Her partner demanded full control over her wages and this precipitated further unrest in her family situation. She questioned whether women should accept violence in their life.

Moreover she tries to explain her feelings of powerlessness in asking for help:
Because when the woman’s are scared I think you can’t know. I can feel this power because the men try, I don’t know in English, push, push down... control. But you don’t ask for help. Your mind explodes... I think oh my God ... believe me, my life is very, very heavy. I have a flyer say ‘if you are violent for your partner, call me’ but oh my God, I think too much, I think, I think .... But I can’t call...

It is very evident that some participants experienced gender-based violence. Being socially isolated and financially dependent made it increasingly difficult to leave the situation and in turn they became vulnerable to becoming depressed. However participants also articulated their appreciation for being protected from domestic violence and being offered opportunities to move forward in a positive direction. Through the support services received in Canada these women learned that they do have choices and they don’t have to live with abuse. Kelly had many domestic troubles but she never gave up and eventually received the support and information she needed to cope and manage with her PPD. She pursued different avenues for support and assistance: “I call to the one shelter and... on internet I find all kind information about that because I see this country have a lot of protection for the woman and kids. My life it changes a lot.” She told us that overtime she regained her own control and her perception of the future was transformed:

A few months ago I think I don’t have my own control in my life but now I feel very different, All people can change right. I have the opportunity for change.

When I start to take my own decision, when I start to think for me, when I care more to my son because he is my responsibility... when I take my own control for me I did better in my life... that was very good for me.

Ciara’s viewpoint is that women’s voices need to be heard and noted:
Every woman has a right to speak if they’re in trouble. We are human beings too…we should have freedom to talk, when the men [are abusive]. It doesn’t matter which culture. I noticed in the Canadian culture it happens too, so instead of being scared by our husband we should deal with the situation so it doesn’t happen again. Bonnie also from a troubled past expressed her thankfulness:

We’re so lucky to be here in Canada because abuses… that is not right. Men are really abusive because they think that it’s their right to hit women, so when they come to here in Canada that change because they know the government won’t tolerate it, so… it helps a lot for women from other countries. We like to be here.

Summary

This chapter was about recounting the immigrant and refugee participant’s perspective of how the gender role may influence their PPD care, treatment, and overall management and coping with PPD during this vulnerable and extraordinary period of change in their lives. As identified in the chapter, the role of gender may take on negative or positive influences. The immigrant and refugee women’s immigration status was particularly voiced as a significant yet unsettling factor as it also promotes other difficulties in their every day lives. Jeopardizing family well-being, fears of deportation, insecurities about being able to stay in the new country, and various negative encounters with immigration services were some of the extenuating factors identified by participants.

The multiple changing roles and high expectations of some immigrant and refugee women situate them in a vulnerable high-risk position. Moreover these changes placed increasing levels of stress on the entire family unit. For some participants there is a central belief that they are responsible for the stability of the family and having the
care-giving role. With limited resources and access, immigrant and refugee women want to maintain honour within the family. The traditional gender role exerts negative consequences for some participants by the because of the expectations that they should do all the family caretaking without support. This traditional role is so powerful that it impacts the choices these women make. As in previous chapter findings, for some women accepting mental health care services or treatment maybe viewed as betraying the family, or abandoning their traditional role, further placing stress on the mother.

The participants felt that relationship difficulties were strongly implicated in the new mother’s perception of being supported and in her recovery of PPD. The perception of dominance and control leading to either physical or emotional abuse was also identified by some as a variable in their ability to cope with their new role as mother.

In contrast some participants viewed gender relations positively. As we have read earlier, traditional beliefs and practices may be important sources of strength and support for immigrant and refugee women. Given this background some participants also identified that traditional gender roles may be an important and necessary component in maintaining emotional health and well-being within the family. Through receiving appropriate help and negotiating and working through their difficulties, participants improved their relationships and increased their ability to cope with other family issues. Participants expressed gratitude for being protected and supported in regaining mastery over their life and thus providing opportunity for a more positive future.

In the next chapter, I bring attention towards additional strengths of immigrant and refugee women and their positive attributes in coping with PPD and other related difficulties.
CHAPTER IX: FINDINGS AND DISCUSSION: ADDITIONAL STRENGTHS AND COPING SKILLS OF IMMIGRANT AND REFUGEE WOMEN

This chapter is about the additional strengths and positive attributes that immigrant and refugee women have shown in coping with PPD and its related problems. Truly understanding the participant’s PPD experiences includes learning about the women’s particular strengths in dealing with such adversity. I asked open-ended questions about their perspectives on what kept them strong during a very tough time. A core theme emerged centering on their coping mechanisms for managing PPD, vulnerable and disadvantaged in protecting themselves against PPD. Various sub themes found were instrumental: positive acculturation, medications usage and a responsibility to maintain health. Furthermore, participants identified changes in attitude toward accepting help, community sharing and involvement, and hope for the future.

Positive Acculturation

Acculturation is a process where there are connections between diverse cultural groups resulting in changes for both groups (Berry, 2001). It is also said that resistance to acculturative strategies may result in marginalization. However being able to identify with both the host culture and one’s own ethnic identity is important in fostering positive mental health. Several participants expressed the importance of an optimistic view toward acculturation and how resistance in adapting to the new culture or societal changes may affect mood level and vulnerability towards depression. Wendy expressed her willingness to adapt without fuss: “Usually for Chinese women after first month of baby’s birth they are not supposed to go outside. They can’t take cold things and not to be affected by
the wind... I had no choice. Within the first week I had to take the baby to the family doctor. But as I see everybody experience the same, I accept [the cultural change].” Anna agreed and added being flexible and having openness to the ways of a new culture ameliorates the resettlement process:

They have to be more flexible. Some come and they want to copy their life there, here. If you want to copy your life, stay there. But keep your values, keep your dreams... I think we have to take what we see good and just be away from what you don’t like; just avoid what you consider bad. The values you have to stick with it, but the way of living, you have to adapt with it...

Moreover Anna asserted she has learned to adapt to the new lifestyle and protect herself from future despondency. She recognized that she is more prone to depressive thoughts since migrating because she is used to a different lifestyle and culture. In her country of origin she was used to being in groups and seldom alone. However here in the host country she has taught herself ‘how to be alone and enjoy it.’ She emphasized that finding the positive side of things makes a huge difference and in her view the only way you can survive here.

Kelly too expressed a desire to be open and flexible to new ways:

For my children for example in my food I keep my culture, my personal culture about it, but I have to take care of myself my son, so... I take something from this culture. For example they help me, and the health services I take. Sometime is difficult if it is your culture you grow up with... but you want change...

But as Maggie pointed out: “Sometimes your culture is deeper and you don’t want to change it; and sometimes you think you don’t need the help... and you actually need it.
When you are used to do things your way like in Mexico . . .

These participants’ insights speak to the challenges of acculturation and importance of positive adaptation in a new society. They tell us that it is also salient to maintain their cultural heritage but also work on adopting the new mainstream culture. By maintaining a positive attitude and flexibility to cultural changes, better integration will decrease marginalization and will foster more strength against becoming depressive for these women in the perinatal period.

**Effectiveness of Biomedicine Modality**

Although we have previously read about the negative views by some participants about taking anti-depressants and the side effects, two participants expressed gratitude for this kind of help. Simone put it plainly: “I take the pills for postpartum depression and after I went to Brazil... after I feel happy because I have all my friends... I have my daughter, I have my family and now I’m okay.”

Kate avoided taking medications for many months until one day she had enough of the terrifying thoughts. Taking medications was the first step in keeping her baby safe and towards her own recovery:

I felt like putting his hands in the heater. That was terrible, and I thought tomorrow I’m starting medication, no matter what my cousin is going to say. I am going to be on medication, even if I become crazy. [Then] one day my baby was playing here and I was in the kitchen. Still I got the thought of bringing the knife here, and then stabbing him. I don’t know how I controlled myself, and that thought really made me start medication right away...

Fortunately Kate finally realized that taking medications was better than the destructive
and reoccurring harmful thoughts she was experiencing towards her baby. Kate’s strength showed her ability to recognize that after six months of suffering with PPD she needed professional help and medication to help control her harmful thoughts. In retrospection she reemphasizes the importance of being on medication for PPD as in her view, saved her life and her infant’s life from irremediable harm.

A Responsibility to Maintain Health

A responsibility to maintain health was a reoccurring thought identified by participants. Out of 30 participants, 24 women expressed a desire to improve their situation because of their new role and responsibility as a mother. Many described a strong motivation to look after their physical and emotional health needs. Several participants emphasized how important it was to be aware and keep healthy to prevent depressive feelings from reoccurring. Ciara put it plainly: “The only way is if I’m healthy [then] I can keep my daughter healthy and take care and focus on her for whatever she needs.” Kelly, too, echoed a similar view: “I try my best because I want be happy. Really I want to be happy because when I help myself, by myself you can help the other people especially for my son, for my husband. Because my family are all far away…” Bonnie had many predisposing factors making her vulnerable to PPD but she was a fighter and was resolved to overcome her difficulties:

I don’t think about the problems, I don’t think about her disability. I accept it wholeheartedly. I really accepted her. I’m always negative for a while; Maybe that’s what makes me still standing… you feel that you are fighting; you’re fighting with things but when I think about it, I want to stay positive…

Anna described a proactive stance towards depression:
I’m aware that I may get depressed easily... it’s a kind of inner struggling, ‘no, I have to be stronger... I don’t have to feel weak.’ I always have to encourage myself to be better and try not to make myself alone... Sometimes I feel sad and I want to cry so deeply then after crying for a while, I said ‘no, I shouldn’t be sad.’ I think this is the only way it can help you not to be depressed, plus of course, to seek help. She also used the medium of writing to put her thoughts on paper to ward off lingering negative thoughts. Whenever she felt bad or angry, she would write down her feelings as if she was talking to someone. If there was something very critical or impolite to say she found writing it down caused her to feel lighter and replaced negativity with a happier attitude.

Another participant optimistically advocated for Iranian immigrant women: “If a woman from Iran comes here and had a depression postpartum and if she knows how to get to the psychiatrist, she will do that. There are a lot in Iran giving [support for] mental and physical needs. Now people are very open to it.” This finding is not consistent with Kleinman’s (1978) explanatory model whereby much of the illness and decision-making is managed within the family, and indicates that there may be some awareness and knowledge of professional services to help with mental health problems.

For Roberta increasing her overall knowledge gave her more power and protected her from negative help-seeking interactions: “As you go developing and learning things you can avoid any kind of an embarrassment or to be ashamed as you go ‘being more’ and that [won’t] allow people to do that to you.”

Several women observed that their infant was the motivating factor in their perseverance to find help. Nellie told us her view:
When you were a small child, they brought you up the way you are... you are strong and know you can do it. You are the only one who must do it. When there was not help, you didn’t just cry on the bed and waiting for miracle happen, but you stand up from the bed and you kept going, it is this strongness inside you...

Further she added:

I try and think that I’m strong, I just do it, I can do it today... if I’m feeling sick I no feel... because I can’t stay sick for my daughter. Because more problems always is mine. I am an extremely strong person; very self-disciplined. I will always do it. I am really trying to be very optimistic all the time, because [I had] a very hard time.

Gloria expressed her gratitude and recognized the strength she received from them: “I think only because I have my children. They made me strong. Having them smiling makes me stronger, and I have to do it for them.” Jenny agreed: “She makes us feel more positive and we have a lot of hopes for her and for the future. It’s a new beginning and it’s always brings you positive energy.” Kate, too, had a similar response and is very grateful for the timely support given, because her situation may have had a very different outcome without that support:

Whenever I got a thought I would just look at him once and I hugged him to my heart. I think he gave me a lot of strength. I never thought that depression is an aggressive thing until I experienced it. I always thought depression will make you very dull and sloppy... My mom gave me lots, lots of strength; because moms always do unconditional love so I compared myself with her. I think every mom won’t even care for her life [but] puts her baby’s life first, than her own life.
In Abby’s situation she told us:

[My infant] helped me to continue my life separate from my husband. He helped me too much, to continue my life… I must be strong because my son is young and he needs the help. I’m separated from my husband and so I need to build my life again, and make a good life for me and my son, so I want be strong.

**Determination to Acquire Language Skills**

As part of the responsibility to look to sustain their health, acquiring English skills was frequently mentioned by participants as a tool in coping with PPD and the numerous barriers that new immigrant and refugee women face when adjusting to a new country. Acquiring language skills was critically important to these participants. Without English, they could not communicate with the outside world and as a result faced more challenges with accessing health care services, employment, meeting other immediate needs, and having a social life and network. Sometimes it left them vulnerable to domestic abuse. Moreover, improved language skills and communication was viewed as a means to obtain information to be able to make more informed decisions, be a stronger healthier mother for their new infant, and offer a better life opportunity for them.

Without hesitation Wendy agreed: “The very first thing I think is to learn English.” Mia too agreed: “I try to grab every opportunity for the ESL classes. I didn’t take any ESL class in a registered college, but I go to the church or to some resource organization like Chinese Community Association in China Town.” Lana also noted that not having sufficient English skills placed her in a most vulnerable situation. However after enduring abuse and subsequently receiving help she is now committed to learn as much as she can to provide protection for herself and her infant:
I want only to have a better life and to think about the happy things. My husband used to abuse me because of my bad English and I don’t want that to happen again. I want to learn about problems and how to solve them... Also about the laws here, because the laws here are different from China, I don’t want to cross the line. I need to take care of myself in order to take care of my baby.

Two other participants also agreed that learning English would enable them to become better and healthier mothers. Julie, a teenage refugee participant asserted: “I want to learn English and proceed with my career, that way I can offer a good opportunity for my daughter. I’m at high school right now... but even though I’m such a young mom I fight to give her a better future.” Kelly agreed:

I think all women have problems and if I go for talking about my problems, I think is good, because I try English when I go outside. I try for my son and for me and I feel better. I don’t know in English, but I take out all of my mind, and I come back with a new ideas, new change, new ‘espiritu’ you know?

**Change in Attitude to Accept Help**

Some of the participants recognized that in order to cope with their new situation they needed to change their perception of seeking and accepting help and viewed it as a bridge to receiving appropriate support. They spoke about changes in attitude, and finding ways to increase their knowledge, and improve how best to deal with their circumstances. They also found that by assuming a more optimistic attitude and reframing events in a more positive manner it created feelings of connectedness and a sense of belonging. In Carol’s case through introspection she has come to accept and
develop a deeper understanding of her PPD experience. She thoughtfully reflected about coming to terms with acceptance of the situation after receiving support and talk therapy:

I was wrong. I should have told the doctor that I missed my family, that I was sad. I began [going] to a group, I felt more support. I changed my way of thinking little by little, because I listened to other ladies talking about [their situation]... so I know it’s not okay to have negative thoughts... it’s better to talk about it. Some moments in our life we need help and need the psychologist... somebody to talk to. Not because one is traumatized but when we don’t feel okay...

Dana, too, reflected on how she met resistance from her family when she decided to seek treatment, however she persevered. Despite her family’s beliefs she forged ahead with seeking help and treatment for her PPD. She recognized by seeking help she now has a chance to cope better with her PPD and in turn contribute to the overall family’s well-being:

Now I’m thinking positively after two months, I was not myself... I couldn’t deal with everything, but I know how to do it, so it gives me positive energy when I go and talk to [the psychiatrist]. They give me some ideas and I bring it back. When I have the bad situations, I just think about those things and I stop myself. Because it’s not good for my kids... I don’t want to be like that in front of them or with my family because your home environment is not good then. It really matters in your married life and your family.

Thus in the research of these women’s mental health care experiences, emancipatory knowledge is important as it calls for approaches that allow opportunities to enable individuals to change through self-reflection and a deeper understanding of
their particular circumstances (Lather 1986, 1991). The participants of this study challenge structural barriers by speaking out and wanting to bring attention to their possible social injustices and unequal social relations of their individual experiences. They wanted to contribute to improving PPD health care support and how care is provided for immigrant and refugee women in the postpartum period. This process provides a way of bringing an emancipatory element to knowledge building; one that recognizes social injustices and unequal social relations that disempower individuals, and identifies marginalized voices as legitimate (Ali, 2002; Anderson, 2002). Some participants also gained transformative knowledge; that is new knowledge constructed to guide them from being a passive vulnerable individual with PPD to one that actively advocated for women who are struggling with PPD.

**Goal Setting**

Two participants expressed how goal setting has improved their daily living. In turn this created more positive thinking about their circumstances and promoted emotional well-being. Coping strategies linked to positive mental health include acquiring knowledge, focussing effort to manage problems and therefore feeling a sense of empowerment, and setting realistic goals to solve problems. Setting goals can act as a type of catalyst to force one into action. Lana explained how this strategy has made a positive difference in her life in dealing with the challenges she has faced:

Having experienced this, slowly you get stronger. [With] services from the communities, I learnt about defence for women… then slowly become more strong and being able to solve problems. Slowly your life gets better and you won’t be as
depressed all the time... I used to cry a lot too, but slowly I gained knowledge and setting goals and thinking of things in a positive way. I'm still young and think I can still give to society, like working and giving a good life for the baby...

Cora, too, is grateful for the help received and sees goal setting as a way to move forward:

Sometimes you can help people but you cannot give people all the help. Like my mother used to say when you have children you need to teach them how to fish... not hand them the fish. I think sometimes there are certain things that you need to do and if you have goals in life you have to meet them and make them a reality. I really appreciate the help that I've been getting...

**Spirituality**

For some participants spiritual beliefs and practices offered strong support for some of the darkest days they had experienced. Religious and spiritual practices were viewed as positive and effective ways to cope with health challenges. Religion, identity, and spirituality play particular roles in the immigrant and refugee women’s lives which enhances their abilities to deal with the numerous challenges that surround them. They expressed their spirituality in various ways. These included providing a sense of familiar strength and identity, powerful prayers and beliefs, visions, spiritual healing practices of Reiki, meditation, and breathing exercises. For many immigrant and refugee women who do experience complex issues post migration, spirituality may take on even more meaning in their lives and religious centres may become a source of community support. Bonnie sincerely spoke of how her religious beliefs and visions afforded her steadfast support and strength to care for her new infant born with Downs Syndrome:
I have to be strong for my baby. Because when you pray he’s listening... and sends people to help you. I call them angels. He sends angels to me in disguise. They’re here protecting me, guiding me all my life... like St. Mary always in my dreams telling me what to do. I believe that everything happens for a reason... it has to happen so the good things can come. He won’t put me into that situation if he knows I couldn’t cope. So in my belief I know that he knows I can do it.

For two participants, Muslim prayers are a strong support. Maria described the power of prayer: “In Ramadan it’s very important for Muslims, and I prayed to God a lot during that month for emotional and financial support, for the future plans.” Abby told us that her holy book (the Qur’an) gives her direction: “Because in my religion, if something bad happens to you, you must be strong and maybe tomorrow you will feel better.” For Cora too praying was important: “You don’t really have to go to church to be good with God. You can just do your own praying... you don’t need to be there. I just think that right now I’m still a long way to go but I do get strength...”

Ruth, a refugee from Ethiopia, expressed how her beliefs kept her strong and she is grateful and proud of her strength:

I believe in God, I prayed a lot. Really I proud of myself... I came all the way from Africa and I live here and have family. I keep that successful. So that gives me more strength, so I say ‘wow... I did it,’ I’m thankful for, I didn’t just do it by myself, because all the time God was with me to help me with everything, I never feel like inferior, so every single thing, I counted as success.

Two participants spoke about how spiritual healing practices could provide support. For Jenny it was about energy therapies: “…Meditations and spiritual books. I
became very interested in Reiki... I’ve been always using my hands to heal myself. Even before I knew about Reiki it was something usual for me doing this... and now I’m doing it even more.” Guided by Sri Sri’s philosophy of peace another participant Kate explained how she used this as a complementary therapy:

Art of Living is a course given by Sri Sri Ravi Shankar, who is a very great saint in India. He always believes that most of the depressions and anxieties come because of a lack of responsibility. If we take a hundred percent responsibility on anything and if we give a hundred percent in tasks then we should be able to get out of these things.

(The Art of Living offers several stress-elimination and self-development programs based mainly on breathing techniques, meditation, and yoga. It encourages taking full responsibility of the situation.)

Kate goes on to explain:

I was trying to practice meditation and do sudarśana-kriyā - its breathing exercise. The Guruji, [teacher] says is if we breathe our anger, all of our emotions, they are caused by our breathing cycles too. When we are serious we tend to breathe fast or when we are really cool and calm we tend to breathe deep. We have slow cycles, medium cycles and fast cycles. After the breathing is done, you feel so alert... without doing any unhealthy things. Whenever I was in deep trouble I used to practice but this postpartum depression is such a big monster, such a big devil that still I had to face it.
Community Sharing

Many women in this study found resourceful ways to seek out help. They expressed their desire to share their experiences and help each other and thus making it easier for other immigrant and refugee women and their families in the community. They wanted to share their experiences to give back to the community, group support programs, and volunteering activities.

Pam attested to the usefulness of community programs:

Those programs are very helpful... having a group that you come and see others like you that have the same difficulties, same problems, same loneliness, it helps a lot. I was talking to other mothers [about] some difficulty taking care of baby.

They will answer me because they also have the same experience.

Bonnie, even in her situation, now still tries to give to others out of her gratitude for what she has received. She shares what she has learnt with the other refugees living in the resettlement centre because she knows it’s helpful in adapting to the new environment. Despite a troublesome settlement in the host country initially she draws on her Philippine upbringing and described how this taught her the importance of sharing with others: “I grew up listening to my father and mother that whatever you have you share ... whatever blessing you have, you share... we’re not really rich in the Philippines because everything comes from the family.”

Carol found that there were other people who suffered like her, not knowing there was help available. Now she shares this information as best she can:

When I meet people that don’t have a pediatrician... I provide them help or give the numbers of the doctors. If they’re pregnant I tell them where there is a doctor
that speaks Spanish. Because when I came here it took time to know how to move, where there is help, and it was terrible. It was difficult for me. Why would I not give you this information? I think that is too selfish... if I already know I can ease your way then I will help.

Community sharing was also identified as a facilitating factor in making some participants feel more comfortable, connect with others who speak the same language and provide more support for socially isolated women. The focus may be on food, family gatherings or just offering some practical advice. Eve connected with some others from her own ethnic group while at immigration services: “When we were filling in papers for status, there we met people there and they invited us to a church. We went to a Christian church... then discovered a Spanish speaking church... that’s where we met a lot of Latinos.” Simone, too, reflected on how she met another Brazilian woman in a supermarket and shared her struggles with her. She told her she was alone and was going through some emotional problems after childbirth. She described how a friendship was cultivated which in turn connected her with other families through the community Brazilian church.

Carla, too, observed the meaning of community support:

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If you are surrounded by good community it will make you very calm, very relaxed. You know if you are tired, you can call someone and tell them to come. You trust them with your children to play. You know them well. Because you are in a special time and, very, very sensitive. So if you don’t have a community or family with you it would be a big problem, because your husband can help... but only for so many days.
Several participants also spoke about the importance of volunteering activities which gave them an opportunity to give back to the community. Pam pointed out:

“Maybe you can give some information to help them, or you can do some volunteering... if you help other people, you will feel confident and you will feel your self-esteem would be higher.” Carmel told us of her positive community experience: “I start volunteering with an [immigrant agency] to teach other women how to find a job or prepare their resume. I have the background so... it was a very rewarding job to help somebody because I went through the experience myself.” Another participant was unsure about volunteering but changed her mind, reflecting:

On the idea of volunteer – we don’t have it back home. The first time I said ‘why should I work without paying... it was very strange for me’ but then I said, ‘okay I will try, it’s better than being at home.’ But I actually loved it [because] you’re getting something more precious than the money. You are doing things for others and you are helping others; this is a reward...

Simone agreed too: “Because if you do that, you don’t do for money; you do because you want to do. You can help. You can help a lot. I think some day I will do the same and be a volunteer... makes you better for sure.”

**Hope for the Future**

At the close of the interview, I asked participants about their future. Many women had come to realize that they weren’t alone and that they had survived through their struggles with PPD. It was a proud moment in not only sharing what they had learned but also regaining control of their lives and creating a hopeful future for themselves. In few
words Abby defined it for herself: “I want to be strong... I put my past life in my back, and I want to see my future.”

Recovery happened over time for Kelly due to many integrated activities that made her stronger and created hope in her situation:

I feel my mind, they feel my mind, because I can see difference. I have different activities and ideas... I think it was better when I tried my job because everyday you have time together with other people [from] other countries, you change ideas... when the relationship with the husband is better, I think all change. I feel more energy, more better, more happy I think all these activities, my family, my job...

Kate is proud of how she was able to find her way through the help-seeking process and regained control of her life:

I’m always thinking about ways to improve my situation... it’s not like I didn’t do anything ... that’s the reason why I was able to talk to the doctor. My cousin, my husband, everybody discouraged me to take the medication, except my doctor. But I just made a choice and I went through it, and I’m very happy that I took the right chance. But not everyone will have the same kind of situation.

Carmel agreed that one has to recognize how to help oneself: “I think the fact you have nobody and you have the need to keep going...There is nobody else who can help me. So it’s just me. I came here by myself and so I had to take more effort...”

Eve, too, is of the same mindset. As a woman being helped and growing from this experience she was more confident in protecting and helping her family and children develop and grow too:

...By acquiring more knowledge you know how to protect yourself and protect
your baby... I really believe that self-help is really important; so I do my best.

During the struggle in the first year my husband wanted to give up and go back to the Dominican Republic. I told him that with the kids growing up there they would have a dim prospect because the country does not provide a lot of opportunities for the young people to grow. So I said try to persevere...

Ruth as well reflected on how her experience of living in a refugee camp has strengthened her to cope in the present and future:

When I was in the Sudan, it was desert, it was so hot. There is the dust season from Sahara desert, the dust comes... it looks like cloud, so it goes in your eyes, in your teeth. When you open the shower the first minute, all the dirt it come up with mud, and in the summer when you try to take a shower you have to open the pipe and let it run first few minutes, otherwise you’ll burn yourself... so I lived that kind of situation, so here... it’s a piece of cake for me... When I try I’ll do it...

Lana summarized the optimism she felt toward learning and participating in this study:

There is a lot to learn when you are a new immigrant... about the legal system and the way Canadians live... This research for immigrant women is very important for the next generation and how they grow up. I think this is important for women and the whole family... for the next generation, their health, emotional, spiritual and physical health of the next generation.

Summary

In this chapter we have seen there are many additional strengths and skills of immigrant and refugee women that are positive facilitators in coping with PPD and related problems. Immigrant and refugee women have certain survival and adaptation
strengths. Strong determination to maintain health, a determination to work hard, and resilience were dominant characteristics clearly shown by these participants. It was identified that other positive strengths and coping skills lay in the women’s strong family and community centred values and collective ways of sharing. Spiritual and religious practices were also sources of strength and hope and provided a way to cope with their mental health problems. Lastly participants expressed great hopes and a willingness to move forward into the future.

As this chapter closes we now move to the final chapter where I discuss intervention strategies for PPD care and treatment from the immigrant and refugee women’s perspective. This last section incorporates all significant information from preceding chapters. It also includes recommendations and implications for practice and health care policy in order to bring forward a deeper understanding of what would be helpful in meeting the immigrant and refugee women’s mental health needs in future postpartum care and treatment.
CHAPTER X: INTERVENTION STRATEGIES FOR POSTPARTUM DEPRESSION CARE AND TREATMENT: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

This last chapter is divided into two sections. Consistent with the critical ethnographic approach, my aim is to bring to the forefront the immigrant and refugee women’s voices and their ideas concerning the social support services and strategies that could address PPD care and treatment within this population. Thus, in the first section the theme of intervention strategies for PPD care and treatment is presented from the immigrant and refugee women’s perspective. Participants offered suggestions about what kind of supports they preferred when coping with PPD and other related problems. Furthermore they identified appropriate interventions that would be helpful in the prevention and treatment of PPD to fit their diverse needs. Two sub-themes emerged from the data: strategies to social support and educational health promotion and prevention interventions to assist immigrant and refugee women during the perinatal period.

In the second section I synthesize the information presented in past chapters. Based on the results and a better understanding of what would be helpful in meeting the immigrant and refugee women’s mental health needs in postpartum care and treatment, I make recommendations and explore implications for practice and health care policy.

Initially I asked participants about what kind of information was or would be most helpful in deciding whether or not they would seek help for PPD. In probing this idea further I asked about what other health care services should be available to support
immigrant and refugee women in dealing with PPD. Lastly I asked about preferred ways to offer health promotion and prevention activities to inform the women about PPD.

**Strategies to Social Support**

We have seen the majority of the women in this research experience social isolation which increases their risk for PPD or perpetuating further isolation. The participants expressed an overwhelming feeling of being alone. However, by talking and sharing their thoughts with someone they experienced a release of emotions and tensions in many circumstances. Support for isolation and preferential treatments included: peer support, one-to-one talk therapy (rather than group support), telephone support, in-home respite care and online support.

**Peer Support**

Many of the participants preferred having the opportunity to talk about their feelings with someone who was genuinely compassionate and understanding of their situation. It gave some women more confidence when they were able to converse about their problems. The importance of feeling connected to others, normalizing their problems and hearing that other women also experienced similar feelings was a reassurance that there was hope and they would be well again.

Pam said:

> Just go out and talks to others… join some group or activities. If you talk to each other you will feel more confident and better… because maybe you can give some information to help them... if you help other people, you will feel confident and self-esteem... to know some new parents. Because they have some [of the] same experience [so] we can exchange experiences.
While Kate battled with PPD she eventually realized that she was not alone in her experience and that other women had similar struggles. Normalizing PPD and bringing it out into the open was cathartic for her, and she wanted to assist other mothers:

…Because I always had the feeling that ‘I’m a bad person’ or ‘I’m a bad mother’ but I came to know I was not alone and there are others like me; and they are also good people… after facing what I faced, I want to provide help to any woman with the same depression… that’s the reason I agreed for the research too. For us to know we are not alone is very important. This is normal; they don’t have to be afraid to speak. Speak loudly about it and get support.

**Individual versus Group Support**

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. Letourneau and colleagues (2007) found that their sample of Canadian mothers favoured one to one professional support and also preferred to have emotional, informational, and instrumental support face to face at home visits. Sara stated that talking one-to-one was her preference and ‘groups’ was not something she was comfortable with. This was partly because of her English skills and her uneasiness of opening up to others: “In my case I don’t like a big group, so no... I prefer maybe one person, more confidential.” Mia too was anxious about speaking up in a larger group: “If it’s one on one, I have more time to express. 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.”

Kate compared receiving written materials versus face to face professional support:
I think that giving pamphlets and advertising is not that much of help. I don’t mean to say it’s the wrong thing, but I’m a person who wouldn’t read. I wouldn’t read the pamphlets but I would talk and listen one-on-one. For me, the doctor or nurse talking to me directly was more powerful than reading the pamphlets.

Most participants stated that professionals working with immigrant and refugee women should individualize treatment because they do not all require the same type of support. The point at issue here is because these women want to know that their personal accounts of their experience are being listened to and that the professional has understanding about the extent of their situation. Women in this study wanted recognition given to differences such as the individuality of their childbirth, and perinatal events leading up to their PPD such as difficult labour, lack of support, infant health. The postcolonial perspective has allowed me to examine broader social, political, historical, and economic differences which influence the immigrant and refugee women’s situation and thus shape their PPD experiences. Moreover it provides a means to generate transformative knowledge towards equitable and improved health care for immigrant and refugee women. Dana agreed and maintained:

I think every person is different, not only the women. Males are also different.

Every person has their own personality and their own thinking so they are different, so you have to think different when you talk one to one to understand, rather than just taking it as a whole.

**Telephone Support**

Several participants said providing support through telephone based services was a good way to provide accessible and flexible support services. Kate proposed that having
daily support sessions would have been very beneficial to her recovery especially in the onset of PPD when frequent support is very much needed. She felt this may be a preference for other women experiencing depression. However the delivery of health care services using telephone support was not universally accepted, as we read in a previous chapter with the two participants who expressed negative views toward telephone support based on their PPD experiences. Ciara explained that access can be greatly improved and it is also an opportunity to discuss more in-depth information about PPD care and management.

Similar to Kate, she did not find the written material as effective as a telephone interaction:

Sometimes with pamphlets it's hard... moms get so busy with their babies and it's a new experience for adjusting... so it's hard to read at that time. If English is not your first language it's hard for you to understand too. I think if somebody would talk with Moms on the phone and explain to help them and understand more to handle the situation. This way a Mom can tell if she's having any kind of problem. I think that does more than handing out flyers...

Carla was also of the same mind regarding telephone support, but added language support is an essential component in dealing with immigrant and refugee women. She reflected on the many times that misunderstandings took place because of not having an interpreter. For her telephone support also meant convenience and less preparation for an in-home visitor.

For Pam it's about the language too, but it is also about the privacy and non-stigmatizing nature of the telephone intervention:
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.

**In-home Respite Care**

Several participants suggested that in home respite support was very helpful however was not offered for a long enough period of time. Their recommendation is to provide these supportive services for longer periods. By the time Jenny found out about this supportive service it was too late:

One hour or two hours a week a person comes to your house and just stays with your baby for a while; even if you’re in the same room. It’s up to the age of six months old but when we had time to figure out if we wanted this, she was already six months old, so we didn’t benefit from this...

Cora believed that in-home support is about: “visiting the person at their home, hearing their problems and showing them the right way to solve the problem. Especially we women feel lonely and need someone to visit that can be close to us and talk to us.” However as practical and idealistic as this may sound there are barriers in providing this type of support because in-home respite care is only offered for six months after childbirth. Lana did receive respite services for six months but maintained that sometimes it’s needed even more after this time: “It was really good, but I hoped that it would have been until the baby was one years old. I think sometimes it’s even more needed for after
six months." A home visitor who works closely with this population pointed out:

"Sometimes they don’t have enough workers and families have to wait... for example there was a single mom with two babies and she never got it, because it was such a long waiting list. Once on the list, it was too late."

**Online Access Strategies**

A number of participants identified web-based internet support as a confidential and convenient means of receiving support and information about PPD and management. Some women felt that the prenatal information provided on line was helpful and in one case took the place of attending a prenatal class. Although the internet was identified as a means of support, some participants further suggested there could be more done to provide easier access and more specific information online for women. Two participants pointed out that the internet was an important source to gain knowledge and information about what they were experiencing. Maggie, a young mom, described how this supported her: "Reading and knowing about everything when I knew I was pregnant, I started reading books and there’s lots of information on the internet if you look for it... I just went to the library and it was free."

Kate was sceptical of reading materials but found the internet a suitable way to seek out support and perhaps help answer some of her nagging questions:

Because I saw other parents, they were all happy and pretty relaxed. Why am I not able to relax? Why am I becoming so restless, like this?... then I started reading over the internet and read about postpartum blues, postpartum depression, psychosis... postpartum anxiety.
Two well-educated participants expressed ideas as to how this kind of support could be modified to be more fitting. Carmel proposed making a website that was more straightforward to use, thereby, making it accessible to a larger base of users with varying computer skills: “You don’t know where to go or where to start so... I think to get the information more accessible to them in an easy way... to provide them with information and have a website that is not so complicated... because health care have tons of information...”

Jenny took a prenatal course online because she did not know where to attend prenatal classes and lacked transportation. She recommended giving more education about PPD earlier on in pregnancy so that women felt better prepared:

I also encountered this problem. I did the prenatal course online but there was not enough information about the difficulties that people can encounter after pregnancy... very practical issues that people don’t think about... I think they should emphasize [PPD] and describe it more in how you’re going to feel that everything is climbing on you and give examples... so knowing that you need to prepare emotionally from now on.

**Educational Health Promotion and Prevention Strategies**

The second sub-theme identified by the participants was educational health promotion and prevention strategies. Participants offered a variety of ideas and strategies for how to provide more appropriate and useful information to address immigrant and refugee women's PPD care and treatment. This included improving community out-reach such as utilizing churches, offering information in multiples languages, streamlining
broad ranges of postpartum services, inclusion of partner and family members in educational process, and additional education and strategies for health care providers.

Community Out-reach

**Offer information in multiple languages.** Although this idea is not new or of surprise, the fact that it is still an ongoing issue in the community is of concern. All participants described how the barrier of not speaking English could lead to overwhelming isolation. I raise this point because it is a troubling notion and one that needs more attention despite being a well known issue among this population. It also speaks to the inequality that some marginalized immigrant and refugee women face. Research (O’Mahony, 2005) conducted with health care providers questioned whether lack of interpreter services, or choosing not to use these services was a form of discrimination against these women. A participant with extensive experience with counseling and human rights for women felt that this was a form of systemic discrimination. She clearly stated: “Non-provision of translation services [is discriminating]... people are receiving a different kind of service because things aren’t explained clearly... in order to be expedient.”

In order to reach out to immigrant and refugee women and offer appropriate mental health care services we must continue to address the importance of language translations and using interpreters. The participants spoke about the critical need for the immigrant and refugee woman to have language supports. Anna maintained: “This could help, because sometimes they couldn’t express the feeling they have... so I couldn’t make you know exactly what I want to say or to feel what I’m passing through. So if it’s in your language it will be easier...” Carla agreed: “It’s not easy to talk with a different
language about your feelings. We can talk in many things, but in your feelings it may not be as equal as you talk to someone in your native or in the same language.”

Eve captured how acquiring language skills supported the new immigrant woman’s well-being and mental health:

When an immigrant woman arrives in a new country she should have help in her language at the beginning, so that she would feel safe and that it wasn’t a mistake to leave her country... That she feels supported with information and can manage and study the language and not be afraid to go out to communicate. If you have this help, an interpreter, you would feel safer and be able to explain how you feel and ask for help.

She added: “Because we are afraid we can’t express ourselves... the doctor can’t tell if they are depressed if she can’t speak the language. If there is no interpreter they can’t express themselves well enough for the doctor to know that they are depressed.”

Lack of bilingual health care providers or interpreters may create feelings of misunderstandings and confusion. Lily talked about her feelings of disconnection:

When I was feeling sad, I talk with the instructor, one to one... but I don’t have patience. She couldn’t understand me. We weren’t connecting, only we are different in cultures. So what is a problem [for me] or in my family, is not problem for her... maybe in her eyes, so we are not equal in understanding.

Health care provider participants in past research (O’Mahony, 2005) identified that some immigrant women have misunderstandings about health care services, and with limited interpreting services, these misunderstandings persist. The women in this research also suggested if the health care system does not permit the health care provider provision
of translation then one can argue there is systemic discrimination.

Two recent Canadian studies have examined the factors in the misunderstandings and gaps of using health care services with perinatal women. Reitmanova and Gustafson (2008) found that immigrant Muslim women experienced discrimination, insensitivity, and lack of knowledge about their religious and cultural practices in response to their maternal health and care needs. Health information was limited or lacked the cultural and religious particularities to meet their needs during the perinatal period. There were significant gaps between existing maternity health services and women’s needs for emotional support, and culturally and language appropriate information. In another study, Grewal et al. (2008) examined new immigrant Punjab women’s perinatal experiences and suggested that better communication strategies are required in health promotion and prevention for the mother and her family. Further, the health care system needs to be more open to models of health service delivery which integrate lay outreach workers with cultural and language abilities in fostering more positive relationships.

Several participants had their own ideas about community out-reach. Community churches were suggested as a place to distribute information about community services available to encourage women to seek out support. Dana pointed out the importance of advertizing in various community worship settings: “For different religions you can go to temples and Mosques and you would have to do it in different places.” Simone also supported this idea: “Within the Brazilian community at the church, they have a place on the wall, you can put a paper and they find... because sometimes like me, the woman is here alone and the mother cannot come to help...” Carmel suggested support from church leaders of the community would also help.
Kate suggested that providing centralized community outreach for all moms in an informal and relaxed manner would attract more women than a ‘formal support group setting’:

Maybe instead of having a support group you could bring together moms in one community. To meet together, talk and have a program, like exercises, or ‘how to give a bath to a baby’. People who have these problems will be interested in these kinds of services… even if you know a mom who doesn’t understand the language you have a baby of same age, you’ll automatically get some kind of friendship feeling… like birds flock together. That kind of support groups would be very helpful in my opinion.

Roberta emphasized the importance of community out-reach for all immigrant and refugee women:

Just being part of the community, knowing that she’s going to have a child, and offering her those services, making sure she is aware that they exist and that she can get them. That alone would help a lot. If she is not working she should participate in all the programs that they have.

**Streamline Broad Range of Postpartum Services**

One participant exuberantly offered an idea about providing a broad range of services for women within the same building or agency. Postpartum services for new moms could include help for emotional counselling on site. The participant explained that having diverse types of health care and support services would encourage and attract new mothers because of the convenient access to services and especially help to lower the stigma and normalize visiting a mental health professional. For example most new
mothers want to have more information about diet for themselves and their baby and would utilize consultation from a nutritionist. She also suggested there should be other ways to draw them in such as free diapers, formula, or discount coupons for vegetables. Once there, more information about other services could be offered which enables the mother to make her own decisions about obtaining more holistic health choices for treatment of her depressive symptoms.

Dana was very excited about this idea and she felt very confident that other immigrant women would feel the same:

There should be one organization where we can get everything. There are so many different agencies and numbers you have to contact… many women don’t bother. If they need help they will have more opportunity in one place rather than search around. Somebody can take care of my kids for an hour. In that hour, maybe I can see two people and deal with two things. It’s just a convenience.

**Inclusion of Partner and Family Members in Educational Process**

The women in this study wanted to receive support from their partner and emphasized the importance of this assistance. They suggested that more attention be placed towards educating their partners about PPD, therefore enabling them to provide better support and care. We also have read earlier how family members may be instrumental in whether the women accesses support or not. Therefore extending education about PPD to other family members is a critical element to increasing their understanding and encouraging their participation in the recovery process.

Dana observed that in time her family was accepting because they were more informed:

I told him something which my psychiatrist told me, and my Mom was there and
she listened to it and appreciates that. So sometimes you need education, you need that information, and you have to absorb it and you have to be the first one, so maybe I’m the first one in my family...

Lily agreed and asserted that education for family is very much needed because they can be your advocates in providing instrumental and emotional support. Family support is particularly important with mental health problems and in hindsight she believes in her case 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.”

Kate had an unsupportive husband, and now after regaining her health she is convinced of the importance of education about PPD for all family members. She felt this will help support women who feel they are struggling and often powerless:

Husbands should be supportive. The husband can really help in this care, because if the woman doesn’t have education, has language barriers and is feeling this way, for her to even come out, her husband should seek help... I think husbands need to be educated, especially Indian husbands.

Kate pointed out that her husband was very dominating and initially she was afraid to share her confused feelings with him. She told us that her husband was highly educated and therefore partially understood her experience with depression yet with other families that may have limited knowledge or education about mental health issues; she is convinced this gives rise to major conflicts within the relationship. In her view, she is
quite certain that this is may be the case for many other Indian families and therefore stresses the importance of education about PPD so that family members are better equipped to provide support to the mother and manage depression within the family unit. Consistent with the postcolonial feminist perspective we examine how gender, race, class, and power relations influence the women’s help seeking and support experiences and explore how contextual factors may situate immigrant and refugee women in a socially disadvantaged position. By using a critical inquiry lens we can view the interactions between these women and their families and how the wider socio cultural environment may shape their health and health care practices. Having a deeper understanding of how gender, race, and class influence these women’s health care practices will help to inform and provide more appropriate PPD care and treatment. Through listening to their ideas we can help to empower new immigrant and refugee mothers gain transformative knowledge and enhance access and support for mental health care throughout the perinatal period.

**Provision of Additional Education and Strategies for Health Care Providers**

Participants spoke of the critical need to offer information about PPD at various times to women throughout the perinatal period. They emphasized more in-depth prenatal discussions about PPD and more awareness of the kind of help that may be needed or is available. Jenny, a participant, asserted that the health care provider should not overlook or discount the women’s verbal and non-verbal cues as to how she is feeling after childbirth. She suggested considering more of the socio cultural factors that influence women’s circumstances and to use additional focused questions to ascertain the immigrant and refugee women’s true feelings.
Some participants felt that more could be offered about PPD in prenatal classes, in primary care settings such as community clinics and in the hospital after delivery. Participants also perceived that a good strategy would be including information about PPD at hospital along with other health teaching. Consistent standardized information would be offered to all women. It was suggested that standardizing information about PPD was important so that health care providers could provide the same content within their clinics.

Anna explained why offering PPD information more than once is of value: “You know when you hear about it several times, a lot, then you start to accept the idea, so for example if you already know this, then you can seek help more easily because it’s not your first time [hearing about] this problem.”

Ciara supported this idea about starting the education about PPD early in pregnancy:

For all moms when they’re pregnant and closer to their delivery, it’s better if somebody can talk and explain to them what postpartum depression is. So if they are having any kind of feeling, they can talk and be open to someone instead of closing it to themselves… getting more information during the pregnancy, [let’s] you know how to deal with this situation.

It was suggested by several participants that more training for earlier assessments of PPD and treatment should be considered. Kate responded by drawing from her own experience and gave a scenario of how she would support a new mom:

If I were a doctor or a nurse, I would ask the mom, ‘how are you?’ first. If she would say ‘I’m fine’, then I would say ‘that’s good but just in case you have sad feelings or anything like that, don’t hesitate to tell me, and please also understand
that it’s totally normal to have these feelings, and don’t worry. You can tell
anything to me, I won’t take this to child services.’ That’s just giving trust to that
woman and she can trust me on this.

Dana had a similar view: “Better to ask more questions about PPD to new moms again
and again… without alarming them. When asked ‘are you depressed’… people are
confused. You can ask about symptoms, and screening does helps but besides the
screening… you have to somehow diagnose it.”

Jenny is of similar thinking but emphasized the health care provider’s need for special
training:

   It’s useful that physicians get special training for refugee people here. It’s only
   logical because they deal with these women and address their problems, so...
   because refugee women are different from others, and have layers in themselves
   so… maybe something new for physicians or they don’t get enough training on
   how to deal with depression. Maybe ask more questions… if there is a layer in the
   compilation of special identifiers so he knows how to deal with that...

Recent strategies endorsed by the government of Saskatchewan have made
maternal mental health a priority. An inter-professional initiative created a policy
to address the issue of inconsistent screening, and the identifying and treatment of women
with PPD. Their strategy includes mandatory screening (EPDS), an educational
component to increase public awareness, help seeking encouraged during pregnancy and
in the postpartum, and new treatment options offered. Most salient is that this will occur
at prescribed intervals throughout the perinatal period and not in an unsystematic manner.
Moreover in a recent update from Alberta Health Services (AHS) (2011) a pilot project funded by Alberta Health and Wellness is now underway to implement a perinatal mental health program. The expectations of this pilot project are to enhance PPD screening throughout the perinatal phase and offer intervention programs for families at risk for mental health problems during this period. A needs assessment with key stakeholders within AHS and the community was completed and based on these findings a consultation model of practice has been initiated within physician’s offices which may include perinatal mental health assessments and brief therapy (A. Marshall, personal communication, January 10, 2011).

The participants in this study all had some contact with a health care provider at some point during their PPD experience. 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.

Women’s voices from South Asia had strikingly strong opinions about PPD and their observations about appropriate care and treatment of all women in the postpartum period. It is also evident that these women were educated and had an easier time expressing themselves in the interviews. However in terms of the magnitude of struggling and coping with PPD and other related problems they described many of the same difficulties as the other less educated women in this study. The non-English speaking women in this study found social isolation and access to support the most difficult challenge after childbirth. Language proved to be the biggest barrier in obtaining appropriate care. Reflecting on my observations as a home-visiting community health
nurse to new immigrant and refugee mothers, I would agree that this is a serious continuing problem for these high risk women.

We now move on to the second part of this chapter. All relevant information is brought together from preceding chapters for additional analysis, discussion and conclusion. Implications for practice and future research is also presented to bring forward a better understanding of what would be helpful in meeting immigrant and refugee women’s mental health needs in the postpartum period.

**Conceptualizations of Postpartum Depression**

The literature consistently states that pregnancy and childbirth may be the same globally but how PPD is conceptualized and is experienced by women of different cultures may be quite different (Kumar, 1994; Morrow et al., 2008; Oates et al., 2004; Teng et al., 2007). The data collected from the participants in this study revealed that the understanding of PPD among immigrant and refugee women is incomplete and that more knowledge and awareness about PPD is greatly needed. The participants emphasized that many immigrant and refugee women are unfamiliar with the term PPD. Even those who had heard about PPD were not entirely sure of the ramifications of depression after childbirth.

For many of these women the idea of PPD was non-existent in their former country and therefore they were not able to identify with this ‘Western’ terminology. As Kleinman and Good (1985) point out, sadness, despondency, dysphoria, and lack of pleasure with social relationships have striking differences in meaning and expression in many societies. Moreover some cultures may have no label for depression and may conceive sadness in ways which differ from Western conceptions. Many cases of
depression globally are experienced and expressed in terms of bodily sensations such as head and back aches, fatigue, and many other somatic symptoms, and is therefore viewed as a physical condition and treated as such. But Jenkins, Kleinman, and Good (1991) maintain that only in the contemporary West is depression expressed as occurring or existing within the mind. Some participants were vocal in describing PPD as profound fatigue, sadness, and feeling sick. Kleinman (1988) referred to this phenomenon as ‘somatisation’ which is the expression of interpersonal and individual distress – an expression of bodily complaints. That is, untoward emotional states like depression are expressed by bodily complaints such as ‘being tired’, headaches, dizziness, or ‘pains everywhere.’ Kleinman further pointed out how different cultures and social classes may use somatisation as a culturally specific way of coping with the effects of depression and serves to block self examination of one’s feelings or direct expression. He found in his work of diverse ethno cultural groups that somatisation is more common among poorer social classes or those with more traditional life styles. The important point here is that models of depression in Western psychiatric settings may not match those of non-Western societies. Thus, in many cultures it is difficult for western health care professionals to accurately interpret the symptoms of depression because the patient’s understanding of depression is more of a physical experience rather than expression of acute hopelessness.

It is also important to be aware that cultural backgrounds shape the women’s EMs of illness and disease, and their expectations toward treatments, which in turn influence how they make decisions about coping with illness and health care practices (Kleinman, 1978). Therefore not infrequently EMs conflict along with unacknowledged cultural
influences which lead to problems in communication within the health care encounter. 
The women in this study often choose to express their ‘depression’ through descriptions of physical symptoms and emotional feelings explained as deep sadness within. Kleinman’s explanatory model lens helps us to comprehend that indeed the women’s behaviour and healthcare practices are impacted by cultural factors and that difference in explanatory models of health and illness may influence how they seek help for PPD.

In different cultures there is often an absence of psychological terminology and cultural norms of respect and politeness may constrain emotional expression, or emotion may be expressed in non-verbal artistic ways such as poetry (Jenkins et al., 1991). This Western diagnostic category of depression cross culturally often does not have an equivalent in some non-European languages which makes the assessment of depression difficult (Helman, 2007). This is an important point because of the need to understand the different ways that some immigrant and refugee mothers may conceptualize, describe, and report symptoms of depression. If we do not pay attention to these other modes of how depression may be expressed then we are doing an injustice to these women by allowing them to fall through the cracks untreated without proper screening and assessment of PPD. This is critical to understand because it affects how we provide more culturally sensitive postpartum care and also how we could ensure that the postpartum services are delivered with more accessibility and appropriateness which enables these women to better manage and cope with PPD. It is also important to recognize that cultural factors, along with socioeconomic and political forces intersect with race, class, and gender to influence the ways these women seek help for PPD.
Coupled with the misunderstanding and lack of awareness about PPD is the stigma of mental health problems. The stigma of PPD is not only felt by the mother but extends to discriminatory judgements by family members and ultimately the broader community. Past literature reports that mental illness is extremely stigmatized in some cultures (Dennis & Chung-Lee, 2006; Fung & Wong, 2010; Sheikh & Furnham, 2000). Teng and colleagues (2007) found that the stigma of mental health illness and lack of knowledge and comprehension of postpartum depression was a strong barrier for the immigrant woman and her family. Consistent with the literature, the stigma associated with depression strongly influenced these participants, causing the mothers to hide their feelings from family and friends and prevented their seeking help to manage PPD. Stigma was expressed by participants as a barrier to talk about their feelings to family and health care providers for fear about losing custody of their children and deportation. These strong fears led some of the participants to be less than truthful when being screened for depression.

Immigrant and refugee women are often scrutinized and labelled upon entering the mental health system. This social labelling perspective developed by sociologists generally sees mental illness as a social rather than biological fact (Helman, 2007). When a diagnostic label is applied it is difficult to eliminate it and individuals are largely dependent on the society to de-label them and free them from this sick role. Waxler (1977) noted that in Western society feelings of sadness, withdrawing from social interaction, and lacking energy are frequently labelled as depression whereas the same phenomenon in Sri Lanka receives minimal notice or treatment. Due to the powerful impact of labelling, stigma interferes with successful treatment and recovery from PPD.
The concept of stigma has had important shifts since the initial idea was expressed by Goffman in the 1960’s who viewed stigma as a process based on social construction and identity. This implied that individuals with a stigmatised condition moved from a ‘normal’ status to a discredited social status (Goffman, 1963). Recently a wider sociological understanding of stigma identifies that social processes occur within the socio cultural milieu whose effects can be seen by the individual. This implies viewing the broader structural factors that may contribute to disadvantages placed on stigmatized individuals. It gives us a way to examine the ways power, socioeconomic, and political factors influence stigma processes within a social setting (Kleinman & Hall-Clifford, 2009).

Social inequities that result from racism, sexism, and class relations do influence the mental health problems immigrant and refugee women develop and impact how these problems are understood and treated by health care providers and in society. The participants in this study repeatedly acknowledged their concern about being shunned by others and being labelled with mental illness. Consistent with critical social theory and the postcolonial feminist perspective we strive to understand the relationship between power, thought, and truth claims to uncover systemic societal practices that have oppressed disadvantaged groups. This understanding involves reflexive thinking and questioning of assumptions to expose hidden power imbalances and in the ways we offer care.

Stigma is a well known factor within mental illness yet it continues to pervade and impacts both help seeking behaviour and treatment of PPD for these participants. It is also a serious barrier that exerted control over these women to deny the existence of
depression and prevent the acknowledgment of the often distressing symptoms. Fear of disclosure and shame to their families was clearly evident. So what can we do to raise more awareness of the effect of stigma and PPD? This is not easy to answer for stigma is poorly understood in mental illness such as PPD (Edwards & Timmons, 2005; Pinto-Foltz & Logsdon, 2008).

Based on the perspectives of these women I suggest several ideas to improve access and treatment for PPD. First it is imperative that as health care providers we draw more awareness and attention toward how stigma works and how individuals cope with this type of stigmatizing behaviour. It is often a double edged sword because individuals not only experience devastating symptoms of depression but must also experience undermining prejudice and moral refutation from the stigma. Second a deeper understanding of stigma by the health care provider may also prompt them to examine their own behaviour, beliefs, and values and how this may affect their interactions and delivery of client care. We need to encourage this population to use more community resources through referrals and advocate for more education and information about stigma. Perinatal support groups could offer more about stigma through workshops, presentations, and one to one discussions with these women. Third, educating the woman and her family about stigma attached to PPD leads to empowered decision making and increases understanding that it is a treatable condition with appropriate supports and mental health care treatment. In turn this provides feelings of hope and a greater likelihood of accepting help.

Louise Bradley, a psychiatric nurse and President/CEO for The Mental Health Commission of Canada (MHCC) reported that nurses and other health-care providers are
not above stigmatizing and stereotyping. Sadly, discrimination is found on the frontlines of health care and in all areas of the health care system. In truth people with mental health issues who seek help say they experience some of the most intensely felt prejudice and inequality in these settings. Stigma and discrimination toward individuals with mental illness is strongly evident and is often worse than the illness itself. Based on these facts, the MHCC’s anti-stigma initiative, ‘Opening Minds’ (2010) has targeted health-care professionals in order to help modify their attitudes and behaviours (Canadian Nurse, 2010).

In past research exploring the immigrant woman’s mental health care experiences through the health care provider’s perspective, health care providers suggested the label of “mentally ill” stigmatized people in certain ethnic groups to such an extent that other medical problems were overlooked (O’Mahony, 2005). All health care provider participants felt that the cultural stigma attached to mental illness and help seeking was a strong access barrier for immigrant women. Particularly from a cultural perspective, accessing mental health services was difficult for many immigrant women. Some concerns expressed were: “How do you respect where people are at? It is a scary concept, mental illness...The stigma is great if they think God is punishing them, how can the little mental health care system do something? There are a lot more complicating factors” (O’Mahony, 2005, p. 81).

One health care provider spoke about her encounters with South Asian women:

The accessing of mental health services is a new concept [for them]…, there is this concept of being called “Pheal” which is just... crazy. Any time there is significant mental health issues perceived then they are seen as crazy, they may
not go out and look for specific mental health services... their access is limited because of barriers from their culture and that perspective (p. 81-82).

Thus, the data findings about the strong stigmatizations and overpowering access barriers within the immigrant women’s mental health care experiences from the health care provider’s view corroborates with my findings in this present study.

In order to further understand immigrant and refugee women’s help seeking practices it is important to acknowledge that cultural beliefs, values, and knowledge are strong determinants that may shape their expectations of PPD care and treatment. Kleinman’s Explanatory model lens has helped broaden my analysis that indeed the women’s behaviour and healthcare practices are impacted by cultural factors and that difference in explanatory models of health and illness may influence their attitudes towards seeking help for PPD.

Cultural issues exerted both positive and negative influences that impact how the immigrant and refugee women perceive and make choices in seeking help for PPD. Cultural beliefs can serve in positive and protective ways when the mother and family participate in traditional customs and rituals which bolster the mother’s network of support. Assigning value and respect to the mother’s role can improve the mother’s overall postpartum health. However when cultural expectations and beliefs are not met it may leave the woman vulnerable and susceptible to becoming depressed. In many cultures significant negative feelings surround the concept and stigma of mental illness, as well as the forms of treatment such as counselling and medication.

Many of the immigrant and refugee women were hesitant to access help and identified major limitations to help seeking. They emphasized that the lack of knowledge
and understanding about PPD, the overriding stigma of mental illness and the powerful influence of cultural beliefs both within the mother, family and community were strong determinants in seeking help for PPD. This is a very critical problem among immigrant and refugee women because of the serious consequences that may befall mother and infant. Therefore more awareness about PPD and culturally appropriate care and education is needed to address the complexity of issues faced by immigrant & refugee women.

**Help Seeking and Social Support Network**

The social determinants of health (SDOH) offer a window to view both the micro-level processes (beyond single causal factors of illness) and the macro-level processes (socio-economic, historical, and political forces) which shape the human experience. Viewing the immigrant and refugee women’s situation within a larger social context and exposing social inequities, policies, and practices may be fostered which result in better social justice (Donnelly, 2004; Raphael, 2006; Reimer Kirkham & Anderson, 2002).

Given this, what effect do these health determinants have on the PPD help seeking experiences of immigrant and refugee women? Interacting SDOH such as inadequate social supports, lowered socioeconomic status, language skills and gender roles may be disempowering through their effects on self-esteem and perceived power, especially when some SDOH are experienced together, thus increasing risk for depression (Mawani, 2008). The immigrant and refugee women described very clearly through narrative accounts these interacting determinants, and identified that experiencing simultaneous chronic stressors influenced their vulnerability to PPD and their capacity to seek help.
The following discussion addresses each of those SDOH which have impacted the women in this study.

**Social Supports**

Kleinman’s framework has guided me to explore with the participants their views about their social support network in coping with PPD and moreover has allowed me to examine further and develop a deeper understanding of what it means to provide and negotiate meaningful care and support for these women. Because the participant’s EM’s are strongly shaped by context, the women in this study have expressed both diverse and analogous explanations of their perceptions about their PPD experience and their pathways to seeking help. The wider context of EM’s also includes the particular social and economic circumstances of what individuals currently experience (Helman, 2007) and therefore imperative to use perspectives that broaden understanding of the social, political, historical, and economic influences that shape these women’s health and health care practices. Furthermore through the postcolonial feminist perspective lens we can examine contextual factors such as socioeconomic status, gendered roles and expectations, and social support networks that influence the women’s health care behaviour. Though their socially constructed positions and the inequity that exists within society we can bring attention to how race, gender, and class issues shape how health care support is provided to immigrant and refugee women and in the ways they make decisions about seeking help for PPD.

**Formal support.** Social support can take on many faces and the subject has clearly resonated with the women’s voiced experiences of PPD in this study. For many of the participants, receiving support enhanced their ability to cope and improved their
overall situation. However the participants listed numerous challenges to accessing formal support and appropriate health care services in the postpartum. Participants asserted that practical barriers of accessing health care services such as the unfamiliarity and unawareness of services and lack of information about community support programs were strong deterrents to accessing care. In particular they spoke of lack of awareness about community programs. These women felt strongly that community based resources were exceptionally helpful for prenatal and postnatal care once they found out about the services; however these services were often discovered through chance. Having less perceived control or access to services and resources can translate into inequality and oppression for these women. Moreover two participants gave examples of how policies influenced and constrained their circumstances when they tried to seek additional support. Drawing on the postcolonial feminist lens (Anderson, 2002) it is important to illuminate these social injustices by addressing how inequity (differences that are unfair and preventable) and unequal social power relations contribute to the unequally distributed health care resources and inaccessibility of health care services for immigrant and refugee women. It is also a way to conduct legitimate inquiries into the complex relationship between these participants and their environment. Because these women may already lack a support network due to understandable circumstances (migration), delivery of support and appropriate programs for PPD is of great significance as evidenced in this study.

**Health care relationships.** Participants perceived health care relationships as a significant contributor to the immigrant and refugee women’s social support network and help seeking experience. These contributions were seen as either negative or positive
factors. The participants were divided in their views based on their own experiences.

According to some participants, negative factors were about communication breakdowns in the health care-provider relationship. Many of the participants stated reasons for this: feelings of mistrust, time constraints, minimization of their symptoms, and the attitude of the health care provider. However, other women expressed gratitude and commended their health care providers for the excellent care and support received.

During analysis of the findings it became very evident that conflicts between the professional and popular sectors do occur, resulting in misunderstandings and difficulties between the participants and their health care provider. These conflicts may also be the result of unequal power relations within the health care relationship. By recognizing and placing particular attention to the three structural domains (Kleinman, 1978) I increased my understanding that problems may arise when explanatory models are not shared by others. Congruent to Kleinman’s theory it was found that the explanatory models of health and illness used by the immigrant and refugee women influenced their perspectives and ability in seek help for PPD. It is important to be aware that the meaning and values are not all the same and differ within the health care relationship. The impact of culture on the assumptions between health care providers and immigrant and refugee women may go unrecognized. Negotiation, therefore, is a process that takes place in the context of the health care provider-client encounter and requires mediation between the health care provider and client explanatory models (Kleinman, 1978). Kleinman’s framework had particular emphasis on these explanations of health and illness that are constructed within the health care provider-client relationship.

Bhabha’s (1994) notion of hybridity viewed culture as partial and ambiguous,
constructed in a space of negotiation. His influential writings extend thinking about culture as a negotiated process and an ‘in-between’ ambivalent space where cultural identity and meaning emerge. This concept of cultural hybridity and Bhabha’s notion of the ‘Third Space’ is important in this study because we can view this space as a place for deferral and possibilities of future interpretations of culture. Complex cultural differences and meanings are always changing with emerging multiple identities open to this ambivalent space. It is here we can trouble the fluctuating relationship between the oppressed and their oppressors. This interstitial space opens up the possibility of a cultural hybridity where difference exists without an imposed hierarchy (Bhabha, 1994). It is here that negotiation and cross-cultural interactions of the immigrant and refugee women take place which offers a greater opportunity to negotiate cultural meanings and deepen understanding of their situation.

Consistent findings (O’Mahony, 2005) were found through the health care provider’s perspective concerning the influential health care relationship and immigrant women’s access to health care. Differing values and perspectives between health care provider and client were seen as barriers in the health care relationship. Misunderstandings and communication style differences promoted negative feelings within the relationship. Participants upheld that trust and faith in the health care relationship were essential components to the immigrant women’s continued use of the health care services.

**Informal support.** Participants were strongly united in their opinion that receiving emotional and instrumental support by close family members was an important factor and were their preferred choice in seeking help and treatment. This is consistent
with findings by Kleinman (1978) who reported that 70-90% of health care concerns are managed in the popular sector. However within this study some of the participants did not have accessible family support. Social isolation, coupled with the absence of family, drove some women to look to formal supports to take the place of informal supports. Some women recognized that in order to survive and cope with their new circumstances such formal support was their only option. Consistent with various Canadian studies, the findings of this research suggest that immigrant families rely on both formal and informal social networks, although their preference is to look first to their informal network (Ahmed et al., 2008; Legault, Gravel, Fortin, Heneman, & Cardinal 1997; Lynam, 1985; Neufeld et al., 2002; Teng et al., 2007).

Informal support includes receiving emotional and instrumental support by the partner to show caring, acceptance and protection of their significant other in dealing with PPD. Women in this study agreed that a supportive partner could make a significant difference in their ability to cope with PPD and other difficulties that were troublesome within the family setting. However several women pointed out that their partners many times could not help them because of misunderstandings and confusion about PPD, existing difficulties within the relationship or practical reasons such as working long hours. Past studies also emphasize the importance and role of the mother’s relationship in helping to prevent PPD or in the provision of emotional and practical support (Dennis & Chung Lee, 2006; Morrow et al., 2008). In the event of a poor relationship associations have been reported towards an increased risk for PPD (Dennis & Ross, 2006; Fitch, 2002; Letourneau et al., 2007; Mauthner, 1998; Oates et al., 2004).
Additional Determinants in Help Seeking

Other factors in seeking help that were discussed in chapter seven were about the family’s well-being being integral to the physical and emotional needs of the mother. An important area to further emphasize is the discourse about what it is to be a good mother and the expectations the women placed on themselves. They expressed conflicting expectations within themselves which ultimately revolved around the notion of being a perfect mother. On one hand it was their interpretation and perception of cultural norms and beliefs surrounding motherhood and on the other it was the actual reality and daily experience of being a new mother. The subjective meaning of a certain aspect of motherhood for each participant was individual. For some it was the idealistic notions they fostered in the care and feeding of a newborn; for others it was about having unexpected breast feeding problems or not being able to breastfeed. When they experienced endless crying, extreme fatigue and sleepless nights, or strong desires for perfection of themselves and their partner, a deep sense of failure or inadequacy was created and thus contributing to PPD.

Moreover consistently in the literature it is suggested that low income, unemployment, and financial strain have a predictive relationship to PPD (Ahmed et al., 2008; Beck, 2001; Boyce, 2003; Kurtz Landy et al., 2008; Morrow et al., 2008; Sequin et al., 1999; Sword et al., 2006). Given this important association with PPD it is imperative to pay attention to income and education levels and ask: How does this influence immigrant and refugee women in their PPD help seeking experiences? Why are some immigrant and refugee women more vulnerable to PPD than others?
Persistent socio-economic pressures are acknowledged risks to the mental health of individuals and communities. Mental illness has been clearly associated with poverty indicators and lower levels of education (WHO, 2010). The multiple demands of motherhood, coupled with poverty and low levels of education, combined to predispose the immigrant and refugee mothers to PPD.

Anthropologists (Jenkins et al., 1991) view stressors and supports as being systematically bound together within social structure. These systems may protect individuals or groups from powerful social pressures or conversely render them vulnerable to oppressive forces and deprivation, generating cycles of demoralization, and failure (Kleinman, 1986). This anthropological perspective calls for a methodology that takes into account the changing social contexts in which immigrant and refugee women recognize, experience, and manage their PPD. All women do not share the same social reality or level of privilege. It is here we need to tease out the complex historical and social locations in order to comprehend how they work as social determinants of health (Anderson, 2006).

**Socioeconomic Status**

Dennis Raphael, one of Canada’s top researchers on the SDOH stated:

Income is a determinant of health in itself, but also a determinant of the quality of early life, education, employment, working conditions and food security.

Income is also a determinant of quality housing, the need for a social safety net, the experience of social exclusion and the experience of unemployment and employment across the life span (cited Health Council of Canada Report, 2010). Economic factors and social inequality are reported to be among the most important
causes of poor health because poverty is associated with poor housing, poor nutrition, lower levels of education, and exposure to physical and psychological stresses (Helman, 2007). Research reports that the higher and more successful one is in the social hierarchy, the greater one’s health and life expectancy and the lower the social ranking, the higher the health risks (Evans, Barer, & Marmor, 1994; Marmot, 2004). The social gradient of health is also heavily gendered according to the World Health Organization (WHO) 2010, which assert 70% of the world’s poor are made up of women who earn considerably less than men in paid work. Helman asserted this ‘social gradient of health’ is found in all societies where social inequality is an element. A good example is the famous ‘Whitehall Study’ a 25 year study of the health of government employees where it is reported that lower ranks (income and education level) had higher mortality and morbidity rates, as well as a diminished sense of control over their particular situation. Marmot noted that the diminished sense of control is a key factor because psychological experiences of inequality have powerful effects on the body systems. ‘Low rank’ is a strong predictor of depression and is reinforced through low status jobs, chronic stressors, and reduced social support (WHO, 2010).

The socioeconomic status has widespread health effects on immigrant and refugee women and also impacts the inequalities experienced (Beiser, 2005; Li, 1988). It is also well documented that some immigrant and refugee women are trapped in lower echelon jobs by institutional structures & dominant groups (Anderson et al., 1993; Lynam et al., 2003).

The majority of immigrant and refugee women in this study experienced structural barriers such as limited financial resources, lowered socioeconomic status
coupled with a loss of pre-existing support networks. Low income was a strong and prevailing difficulty for the majority of participants. Most women relied on their partner (if employed) for financial support. Coupled with having lowered financial security was the frustration of not being able to work and be self sufficient. Many had great difficulty securing employment because they lacked language skills, childcare and sometimes a legal immigration status. This prohibited some women from upgrading their skills, going to school, or gaining Canadian work experience. Some women were also disenchanted and despondent because their professional qualifications were not recognized in this country. Participants had varied educational backgrounds with one-third of the women having some secondary level of education and had had careers back in their homeland.

Three women were very well educated professionals prior to migrating to Canada. Four women were employed currently: one as a daycare in-home operator, one as a part time cashier, one as a retail clerk, and one as a business manager with the remaining women as home-makers.

Some women expressed their sense of identity was in jeopardy and not being economically independent meant losing self respect and confidence. Their sense of control over their situation was diminished and contributed to depressive symptoms. Thus being employed is not only about having monetary gains but plays a salient role in these women’s identity and self worth.

In my view by taking into account the everyday context of new immigrant and refugee mothers and the SDOH we can further develop and implement programs and health policy that are more appropriate and culturally sensitive to their needs. As health care providers we need to recognize the multiple factors affecting the lives of immigrant
and refugee women which are related to not only power relations between the sexes but also to key structural issues and the class position of these women in society. Socioeconomic factors coupled with migration issues such as unemployment, lowered incomes, or unexpected job qualification restrictions together with limited language skills and education level had significant impact in predisposing these women to becoming a high risk for PPD and in turn in created difficulties with seeking appropriate help. Past studies with immigrant women have found similar findings (Anderson & Lynam, 1987; Boyd, 1998; Donnelly, 2006; Thurston et al., 2006).

**Role of Gender and Help Seeking**

When examining factors that affect health it is necessary to recognize gender as a key determinant of social inequity and health. The impacts of race, gender, class, sexual orientation, age, and disability influence social support networks, access to education, employment and other resources affecting health. Gender interacts with race, ethnicity and social class, resulting in unequal benefits among certain social groups and between men and women.

Gender as a structural determinant of mental health is particularly important in the immigrant and refugee women’s help seeking experiences. Gender interconnects with and deepens the disparities associated with other health determinants such as socioeconomic factors (income, employment and social position) social support networks, and migration (WHO, 2010). A gender sensitive lens is also more focused on the concept of intersectionality, meaning that gender is one of the many forces women experience simultaneously with their experiences of class, race, sexualities, abilities,
citizenship among others. These categories operate relationally, and gain meaning and power by reinforcing each other (CRIAW, 2006).

With these key concepts in mind I offer further analysis as to how a feminist view of gender as a ‘social construction’ differentially affects these participants within the context of migration through: a) structural processes (national laws and policies) and immigration entry status; b) gender relations and hierarchies of power; c) role multiplicity and conflict (Boyd & Grieco, 2003).

**National Laws and Policies**

A strong theme voiced by the participants was concern over social inequities in immigration laws, and policies that ultimately influenced their health and access to resources. These participants, many without secure immigration status, and who may be financially and emotionally dependent, are extremely vulnerable and disadvantaged in terms of protecting themselves and seeking appropriate help. A brief background highlights some of the policies and laws which are most relevant to this study.

Canada’s immigration system includes laws and policies that not only systematically structure and reinforce sexism and racism against women, but also put immigrant and refugee women at a disadvantaged status, and create barriers that prevent them from accessing certain social supports and resources (Neufeld et al., 2002; Ng, 1988; Thobani, 1999; Thurston et al., 2006). It has been argued that racialised assumptions lead to unequal social relations between the sexes when the dominant group has the power to make decisions and implement social and institutional policy and situate the immigrant and refugee women in a socially deprived position (Abu Laban, 1998; Anderson & Reimer Kirkham, 1998; CRIAW, 2003; Donnelly, 2004).
As described in the literature review, immigrants are organized into categories of family class, economic or business class, refugees and other individuals accepted under humanitarian or compassionate grounds which many scholars have coined as the ‘gendering of immigration’ (Boyd & Grieco, 2003; CRIAW, 2003; Jiwani, 2001; Li, 2003; Spitzer, 2005; Thobani, 1999). Many new migrant women arrive as the dependent spouse of a male independent immigrant. Immigrant and refugee women right from the start are admitted into the country on unequal terms and made subject to a lesser citizenship. This inequality and embedded power based on race, class, gender, and social relations influence the immigrant and refugee women’s experiences and the kind of treatment received. To illustrate how immigration policy context may frame and affect women differently I draw on CRIAW (2003) (2006) and Alaggio and colleagues (2009) for a summary of facts:

1) Point system: Canadian officials determine economic classes according to allocated points for education, official language ability or if financially affluent (paying your way into the system) – this discriminates against many women around the world who have been denied access to education, training and employment opportunities relative to the men of their country. Women represent over half of all immigrants and are more likely to enter the system under the family class (Boyd, 1998). In 2009, it is reported that 32.8% of female migrants were categorized in Alberta as family class (Citizenship & Immigration Canada, 2010).

2) Sponsoring inequalities: Under family class sponsored women are financially dependant on their spouses. The sponsor must sign a three year contract
promising to be responsible for supporting their spouse, common-law or conjugal partner – yet this gives the sponsor enormous power over women. Immigrants are not allowed to receive any social assistance while under sponsorship. In reality many abused women are isolated and do not have access to information or support to leave the situation.

3) Domestic violence and sponsorship: With relationship breakdowns, a humanitarian and compassionate (H&C) assessment and application for permanent residence may be carried out – yet immigration officials are granted discretionary powers when making decisions and are do so with an acknowledged degree of subjectivity. There is no right of appeal in this situation (Statistics Canada, 2007).

4) High Immigration fees: A sponsorship application is $75.00 plus $550.00 per person non-refundable for each application – yet women are less likely able to afford this.

These facts clearly show that the organization of some current immigration policies and regulations affect immigrant and refugee women and subject them to patriarchal control through increased dependency on sponsors. These socially constructed positions result in portraying or constructing these women as less productive, not being able to make economic contributions, and generally undesirable compared to those individuals with greater productivity and higher economic performance (Li, 2003). By allowing women into the country on unequal terms and as a lesser status the interaction of race, class, and gender will continue to be reproduced (Thobani, 1999). Denying immigrant and refugee women their autonomy and independent status perpetuates
unequal conditions and inequities within society and consequently influence women's health care decision making process and behaviour.

The immigrant and refugee women's notions about immigration issues were expressed as a strong and powerful thread throughout many of the women's narratives. Their testimonials are clear evidence in depicting their struggles within the immigration system. Some participants took this opportunity to express constrained emotions, discriminatory beliefs and further disempowerment and frustrations toward the immigration system. Others validated that without a Canadian citizenship they felt great anxiety and inferiority compared to other Canadians. Some women perceived that their status issues were the underlying root cause of many of their difficulties. Some implied that if they were given more permanent and secure status their other issues would disappear. This was especially so for several immigrant women and the eight refugee women. The refugee participants either from Central or South America arrived with similar background circumstances. These women fled their homeland because of insecure living conditions and violence and applied for acceptance as a Convention Refugee or Protected person.

For varying reasons some women did not apply for permanent residence within the required six months, which necessitated application for the H &C assessment and Permanent Resident status. It is here where some refugee women met with numerous difficulties. Seven out of the eight refugee women were non-English speaking. The waiting period for status is a long and frustrating process ranging from seven months to three years. For one refugee participant the process has been eight years and now her status is considered illegal, causing fear of deportation. Several sponsored immigrant
women also experienced domestic abuse. It is very evident how the women’s entry status may affect other rights and entitlements and situate them with less opportunity to access certain social supports and health care resources.

**Gender Relations and Hierarchies of Power**

Gender is a relational concept because it refers to the relations between men and women. Gender hierarchies within the family context may play out as unequal power relationships affecting not only family well being but also creating economic challenges, new responsibilities, and assigned roles and affecting decision making between the mother and father. The participants in this study expressed many hardships and difficulties within their relationships. Resistance to change was a reoccurring notion due to the multiple changes that exist with migrating to a new country coupled with the extraordinary transitions of being new parents.

Many participants described how the behaviour of their partner had contributed to PPD. Five women expressed how their tumultuous relationships with their partners ended in domestic abuse. It was clear 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, fear that their infant will be taken from them and of being deported. Thus a major incentive as part of their decision making process was not to report relationship problems, mental health (emotional) difficulties or access health care services which may reveal such problems.

It is well documented in the literature that abused women suffer from negative mental health effects and face significant depression and post traumatic stress disorders (Ahmad et al., 2004; Alaggia et al., 2009; Bhui, 2003; Guruge & Humphreys, 2009;
Hyman, Forte, Du Mont, Romans, & Cohen, 2009). While all women from diverse cultural backgrounds may experience domestic abuse, women who are new immigrants face additional barriers because of immigration policies. Despite the fact that ten years ago Sheppard’s (2000) analyses concluded certain Canadian immigration laws were a violation of human rights and increased vulnerabilities for immigrant women the conditions remain unchanged (Alaggia et al.).

Gender Role Multiplicity and Conflict

The dual burden of engaging in paid work and having family responsibilities while adjusting to a new country, even while preserving the cultural norms of the old, is a familiar pattern for many immigrant and refugee women. Many of the women in this study were homemakers but expressed a strong desire to work and contribute to the family’s economic well-being. They viewed not being able to work outside the home negatively and with considerable role conflict, but because of multiple barriers working outside the home was not feasible. Because they had been previously engaged in paid work or in a professional occupational rank and were now at home, some women described a sense of confusion over role identity and felt disappointment with their lives, and thus were more susceptible and a higher risk to PPD.

As described in some participant’s narratives, multiple role overload and cultural conflicts make it almost impossible for them to consider reaching out for appropriate mental health care. Traditional gender roles increase vulnerability by stressing passivity and impose a duty to take on the care of others. These multiple roles and high expectations of themselves position them in a vulnerable, high-risk situation for increasing levels of stress and stress related illnesses such as PPD. The shifting of the
gender roles and the underlying power relations within the family greatly influence the immigrant and refugee women’s ability to seek help and access to mental health care services. This has supported my thinking towards a deeper understanding of the significance of gender roles and how this impacts immigrant and refugee women help seeking for PPD. Reflecting on the interconnected influences of race, class, and gender and other social relations, it has allowed me to examine the complexities of how these influences may be played out simultaneously in their lives. The postcolonial feminist perspective has prompted me to look closer at the immigrant and refugee women’s particular circumstances embedded within a larger social context and directed me to recognize that structural inequalities and oppressive forces shape their health and illness experiences and equitable access to appropriate PPD care and treatment (Reimer Kirkham & Anderson, 2002).

**Additional Strengths and Coping Skills**

Lastly, I place emphasis in directing attention toward the positive attributes and strengths of these immigrant and refugee women and how they used their coping skills in dealing with adversity and circumstances related to PPD. The Public Health Agency of Canada (PHAC) (2006) broadly defines mental health as the ability in all of us to experience, believe and act in a manner to enhance our capacity to enjoy life and also deal with the challenges. Having emotional and spiritual well-being is about a positive attitude that values and respects culture, individual dignity, equity, social justice, and interconnections. As a SDOH of mental health, coping skills are identified by PHAC as actions by which individuals can promote self-care, cope with challenges, develop self confidence and make informed choices to enhance their health.
Rather than portraying these women as helpless my intent is to tell their stories, which illustrate both their struggles and their strengths. Feminists posit that analysis begins in everyday experiences and is framed within a language from their perspective. These perspectives are co-created through dialogue and multiple locations. Thus there is a commitment to listen and value the voices of all women. As critical social theory, feminist thought is tied to lived experience and the aim is to ‘better’ these experiences in some way (Collins, 2000a).

I also uphold that how immigrant and refugee women understand their PPD help seeking experiences has important implications both for how they manage PPD and how health care providers can enhance future care and treatment strategies for this population. Feminists believe that not all women share the same experiences and struggles; black feminists theorize that historical positioning, racialization, class relations, or forces intersect at the same time within their experiences. The aim is to expose these sources of oppression (Anderson, 2002; Collins, 2000a; hooks, 1981, 2000).

Further I recognize the importance of representing these women not as ‘other mothers’ who have been positioned through patriarchal beliefs to be seen as different from the mainstream or often looked upon as subordinate, with their experiences being dismissed or insignificant and thus reproducing and reinforcing positions of domination over immigrant and refugee women. Stereotyping discourses have labelled immigrant and refugee women as being passive and without agency. Thus my endeavour is to bring forth more awareness about their values, beliefs, and positive qualities. Listening and sharing though dialogue brings their powerful voices to the forefront.
The participants in this study spoke of what kept them strong and also what enabled them to cope with the many changes and complexities of their circumstances. Acculturation, being responsible for their own health maintenance, change in mindset, spirituality, collective sharing, and a keen sense of hope for the future was expressed as ways to promote positive emotional well-being. Despite having numerous difficulties and challenges many women described their resilience in adapting to their often difficult circumstances. They reframed the stressful events into more positive terms and as a result experienced growth and a stronger sense of control over their situation. Several women told of how exposure to past adversities such as refugee camps, domestic abuse, and violence had strengthened their coping abilities. Through navigating and negotiating with informal and formal support networks for PPD some women found meaningful resources and ways to cope.

Further emphasis on positive emotional well-being is about the relationship with spiritual well-being. Spiritual well-being can be described as feeling connected to something larger than oneself and having purpose and meaning in life. Spirituality may include religious beliefs and practices as well as the broader values and principles which give meaning to life (Canadian Institute for Health Information (CIHI), 2009). For some women in this study spirituality was a positive influence which gave them a source of strength, a sense of connectedness to oneself, and other relationships, and a means for coping with problems. Experiencing many negative emotions, some women found that a new sense of agency was created and that they had more meaning and purpose in their life after having struggled with PPD and related problems.
It is interesting to note that many of the same attributes identified in past research by health care provider participants (O’Mahony, 2005) were acknowledged by the immigrant and refugee women of this study. Health care providers similarly described positive coping strategies for immigrant women as reliance on strong family and community-centred values, resiliency, work ethic, and the intentions of immigrant women to improve their situation, as well as spirituality and religious practices in providing strength and guidance to manage a mental health problem.

The next section is about acknowledging the insights and knowledge by immigrant and refugee women based on their struggles and experience of PPD. It is important to recognize this knowledge and the implications it has for health care providers and practice and how PPD care and treatment is offered to immigrant and refugee women during the perinatal period.

**Implications and Recommendations for Practice**

PPD awareness & information is needed during the perinatal period. It is strongly recommended that awareness and information about PPD be offered numerous times throughout pregnancy and the postpartum so that all women have opportunity to gain knowledge about PPD to recognize symptoms of depression and support interventions that are available. This may also decrease the powerful stigma attached to a treatable condition such as PPD.

Education for PPD must extend to include family members. It is imperative to offer information to all family members because they often don’t 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. Rather, encouragement to utilize mental health services needs to come from the family.

Regular PPD screening is a shared responsibility between obstetrics, primary health and paediatric health care providers. Nurses and other health care providers are well positioned to identify women who may need help during the perinatal period. Public health nurses in particular, who have frequent contact with postpartum women have the opportunities to screen for PPD, make referrals and use their strong communication skills to provide supportive counselling. 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.

Working with immigrant and refugee women to establish connections within community-based services for new mothers and their families is important. This means supporting women through referrals to appropriate sources of help and relevant support programs in the community. It implies addressing language barriers through the use of interpreters or bilingual health care providers, providing information to navigate the health care system more easily, and involvement in ethno cultural agencies that provide additional resources for new immigrant and refugee families.

A consideration of how broader 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 labelling their despair as mental illness.

Health professionals should challenge themselves to recognize and question how communication style, attitudes, and beliefs may affect their own practice. The challenge is to develop critical reflective practices and skills to become more aware of the extent in which we hold knowledge, power, and privilege in relation to other groups in society (Browne et al, 2002). Cultural competence may result in less ‘blaming of the victim’ that is, we shift our attention towards the social factors that impact individual choices (Thurston et al., 2006). The question of who to blame or who may be responsible is answered from a different perspective.

Culturally appropriate care suggests being aware of the issues faced by immigrant and refugee women. It is important to understand the factors that cause women to feel powerless, dependent, isolated, and other multiple forms of oppression. A shift is required away from understanding culture as a social characteristic of the client to one that recognizes culture as a fluid and dynamic process, which is important to the everyday situation of immigrant women. Understanding the ways culture can shape the immigrant women’s responses to health and illness will help health care providers to adapt their practices more responsively to immigrant and refugee women.

According to Polaschek (1998), cultural safety is about:

- Recognizing the position of certain groups, and power relationships in nursing service delivery... [to] enable the less powerful to genuinely monitor the attitudes and service of the powerful...ultimately to create useful positive change which can only be of benefit to nursing and to people we serve. (p. 453)
Recommendations for Future Research

Additional research to further our understanding about immigrant and refugee women’s postpartum health, care, and treatment preferences is required because of the complexity of the factors that affect their lives. Qualitative methods are particularly appropriate for accessing this rich and complex data, and will help inform decisions about the appropriateness, the content and the provision of community resources and health care services for this population and be a part of future policies. Research aimed at the positive contributions that immigrant and refugee women have on Canadian society as well as exploring the strengths and positive health attributes of this population would be beneficial in creating greater access for all.

As suggested in recent research and a current finding of this study, PPD in men is a significant problem. The prevalence and risk factors of depression among new fathers are poorly understood (Paulson & Bazemore, 2010). More research is needed to increase our capacity for identification of parental depression thereby facilitating earlier prevention and treatment. Research on paternal PPD needs much more attention because of the high risks to the infant and family health and well being. More efforts need to be put forth to improve screening of fathers particularly because of the substantial emotional, behavioural, and developmental effects on the infant.

As well, women having infants with health challenges require additional support. More research is needed to explore the effects of the responsibility of caring for an infant’s complex medical needs, and the impact on the mother’s own health.

Consistent with the findings of this study, more research focussing on telephone-based peer support interventions would be beneficial in helping to support and prevent
PPD among this population. Past research (Dennis et al., 2009) found that telephone-based peer support interventions provided a means to offer more flexible and non-stigmatizing support, and reduce other health care access barriers in obtaining appropriate PPD care and treatment.

Future plans should include research directed at working with multiple levels such as government and community health sectors to design intervention programs to support this population. At present there is a lack of evidenced-based information on the efficacy of mental health promotion programs and interventions, making policy decisions difficult.

Limitations

The findings of this study cannot be generalized to all immigrant and refugee women or other contexts due to the small sample size and nature of qualitative research. The scope of future investigations could be broadened by using a larger sample and a mixed methodology with inclusion of the health care provider's perspectives that provide direct postpartum care for this population. My decision to interview women between 18-46 years of age was to gain deeper insights and diversity regarding the women's PPD help seeking experiences, although some scholars might view this as a limitation. Because of the language barrier, an additional limitation was the utilization of interpreters. While it is imperative to hear the views of non-English speaking immigrant and refugee women, there is also the potential that different language and cultural perspectives and meanings attributed to these experiences may be altered through the translation process. Despite these limitations, the results of this study contribute significantly to raise awareness and
understanding of what would be helpful in meeting the mental health needs of the immigrant and refugee women within the postpartum period.

**Conclusion**

The number of immigrants and refugees coming to Canada from non-European countries has increased significantly over the past several decades. How best to assist the escalating numbers of immigrant and refugee women to adapt to their new environment and to cope with PPD is a legitimate concern for both the women who are seeking help and for health care providers who are providing PPD care and treatment. Thus, the purpose of my study was to explore how contextual factors intersect with race, class, and gender to influence how immigrant and refugee women seek help for PPD.

Kleinman's explanatory model, postcolonialism, and feminism provided the theoretical foundations for this research and helped me to address my research questions. 1) How do immigrants and refugee women conceptualize postpartum depression? 2) How do immigrant and refugee women utilize the available health care services and social support networks to cope with their postpartum depression related problems? 3) How do contextual factors such as social, cultural, political, historical, and economic influence immigrant and refugee women's mental health care experiences? 4) What services or strategies could address postpartum depression care and treatment among immigrant and refugee women?

Applying Kleinman's (1978) conceptual framework enabled me to explore how explanatory models of illness and disease used by immigrant and refugee women influence their perspectives and ability to seek mental health care services. The meanings assigned to events within the context of the immigrant and refugee women’s PPD
experiences provided awareness and understanding of how they may develop their ideas about what is most important in relation to an event and how their ideas influence their actions. As stressed by Kleinman, negotiation in each health care provider client encounter is of great importance to provide effective health care, and to ensure the women’s cooperation, health care providers need to negotiate and treat illness in a way that is socially and culturally acceptable to them. This was prominently expressed in many of the women’s narratives. The health care relationship was a key factor and an important determinant in whether health care services were found to be of value, acceptable or to be accessed in the future again. Trust and faith in the health care relationship were found to be essential components to the immigrant and refugee women’s continued use of the service. It is also revealed that immigrant and refugee women’s conceptualizations of health and illness, their decision making and health care behaviours and social support networks were greatly influenced by cultural knowledge and values. Cultural knowledge, beliefs and values exerted both negative and positive influences toward their help seeking experiences within the postpartum period.

Through a postcolonial feminist perspective, analysis was raised to a broader level of conceptualization, one which is required to understand how multifaceted socioeconomic, historical, and political factors interact with race, class and gender to influence these women’s PPD help seeking experiences. The relationship and complexities between the effect of historical forces, together with the present socioeconomic, political, and environmental factors may influence the immigrant and refugee women’s health and health care behaviours. Accordingly we must work towards taking into account the wider context of these women’s everyday lives and the SDOH
that influence these marginalized women’s experiences. That means asking more questions about how power relationships and politics and economy perspectives shape the organization of social structures and to what effect has ideologies of individualism and egalitarianism have had on health care providers to observe the socioeconomic barriers that prevent women from taking responsibility for their health (Anderson & Reimer-Kirkham, 1998; Raphael, 2006).

Harding (1998) encourages us to think of postcolonialism and feminism as ‘thinking spaces’ that open up by transformations in social relations and in the ways we think about them. Changes in discourse can stimulate the articulation of new questions and debate within these spaces. Analysis begins in everyday experiences and is framed within a language from the women’s perspective and co-created through dialogue and multiple locations. As critical social theory, feminist thought is tied to lived experience and the aim is to ‘better’ these experiences in some way. Therefore there is a commitment to listen and value the voices of these participants in creating more social justice. In this way we can honour and validate these voices that have been isolated and silenced in the past through these research findings. The knowledge gained from this study will contribute to develop health care services that address PPD for immigrant and refugee women living in Alberta that are understandable, accessible, and culturally appropriate for women. This will help to ensure these women can access health care services and resources in a timely manner to promote their mental health and quality of life.

By exploring social factors such as economic insecurity, care giving, family responsibilities, and experiences of domestic abuse we may see how they in turn influence the women’s ability to access and utilize appropriate services as well as the way
health care providers respond to the women. Gender as a systemic structural determinant runs a fault line interacting with and deepening inequities associated with other socioeconomic determinants (WHO, 2010) which influence the immigrant and refugee women’s PPD help seeking and may make it inaccessible for many women. By examining the structural constraints we may get a clearer portrayal of what is happening in their lives which ultimately affects their health care behaviour. We may be able to discern why or why not they choose to participate in health care promotion or prevention programs for mental health issues.

At the societal (population) level promoting positive mental health is about building healthy public policy, and creating supportive environments for better mental health. Interventions must involve multiple sectors to address the determinants of health and mental health. Efforts at the community level are well positioned to play a central role in strengthening the promotion of mental health as governments and non-governments agencies are situated on one hand and families and individuals are on the other. Promoting positive mental health at the individual level it is about developing and building on personal skills and strengths. This perspective advocates personal and social development by means of information, education, and improved life skills (Jané-Llopis, Barry, Hosman, & Patel, 2005).

With this recognition we must work towards changes through adjustments of policy and program with the aim of improving health for immigrant and refugee women. Training and organizational change programs would be effective in preventing inequities if they focused more on cultural competence and increased understanding of how stereotypes and discrimination is manifested in health care systems. The implementation
of programs to reduce inequalities is complex and requires both 'bottom up' actions by
the community and participating citizens as well as the 'top down' commitment by policy
makers. Commitment and collaboration from stakeholders is required with strategies
coming from all levels of government, academic institutions, communities and health
care providers. Only then will we be able to move forward in reducing and eliminating
inequities between and among all people in society.
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Appendix A

EDINBURGH POSTNATAL DEPRESSION SCALE


Date: ___________________ PHN: ___________________ Client ID# ___________________

As you have recently had a baby, we would like to know how you are feeling. Please answer which comes closest to how you have felt IN THE PAST SEVEN DAYS, not just how you feel today.

1. I have been able to laugh and see the funny side of things.
   - As much as I always could (0)
   - Not quite so much now (1)
   - Definitely not so much now (2)
   - Not at all (3)

2. I have looked forward with enjoyment to things.
   - As much as I ever did (0)
   - Rather less than I used to (1)
   - Definitely less than I used to (2)
   - Hardly at all (3)

3. I have blamed myself unnecessarily when things went wrong.
   - Yes, most of the time (3)
   - Yes, some of the time (2)
   - Not very often (1)
   - No, never (0)

4. I have been anxious or worried for no good reason.
   - Not at all (0)
   - Hardly ever (1)
   - Yes, sometimes (2)
   - Yes, very often (3)

5. I have felt scared or panicky for no good reason.
   - Yes, quite a lot (3)
   - Yes, sometimes (2)
   - No, not much (1)
   - No, not at all (0)

6. Things have been getting on top of me.
   - Yes, most of the time I haven’t been able to cope at all (3)
   - Yes, sometimes I haven’t been coping as well as usual (2)
   - No, most of the time I have coped quite well (1)
   - No, I have been coping as well as ever (0)

7. I have been so unhappy that I have had difficulty sleeping.
   - Yes, most of the time (3)
   - Yes, sometimes (2)
   - No, not very often (1)
   - No, not at all (0)

8. I have felt sad or miserable.
   - Yes, most of the time (3)
   - Yes, quite often (2)
   - No, not very often (1)
   - No, not at all (0)

9. I have been so unhappy that I have been crying.
   - Yes, most of the time (3)
   - Yes, quite often (2)
   - No, only occasionally (1)
   - No, never (0)

10. The thought of harming myself has occurred to me.
    - Yes, quite often (3)
    - Sometimes (2)
    - Hardly ever (1)
    - Never (0)

Total Score ________

Note:
- The Edinburgh Postnatal Depression Scale is a screening tool only and is administered to all mothers in the Calgary Health region at 3-4 weeks postnatally.
- The screen itself does not indicate a diagnosis.
- The screen itself does not indicate treatment.

Scoring:
Score <10: Regular PHN and Physician follow-up
Score 10-11 (English/Punjabi): Refer to Postpartum Support Services for re-screening.
Score 12+ (English/Punjabi) / 10+ (Chinese, Vietnamese, Arabic, and Spanish): Refer to Postpartum Support Services and Physician
Question #10: If yes, Suicide Risk Assessment (refer to Appendix B)
### Appendix B

#### Participant Profile

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Birth-place/ Yrs in Canada</th>
<th>PPD status</th>
<th>Occupation 1st language spoken</th>
<th>Marital Status</th>
<th>Migration Status/ Other info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isabel 001</td>
<td>36</td>
<td>Eritrea East Africa; 9 yrs</td>
<td>Screened high risk for PPD</td>
<td>homemaker</td>
<td>separated</td>
<td>Immigrant 2 children, 7yrs &amp; 7mths Declined audio taping/ field notes only</td>
</tr>
<tr>
<td>Jenny 002</td>
<td>27</td>
<td>Russia Federation (lived in Israel since age 9); 1.5 yrs</td>
<td>Screened high risk for PPD</td>
<td>part time cashier Russian English Hebrew</td>
<td>married</td>
<td>Immigrant 1 child 9 months 2nd IV done</td>
</tr>
<tr>
<td>Julie 003</td>
<td>18</td>
<td>Colombia; 7 mths</td>
<td>Screened high risk for PPD</td>
<td>student Spanish (interpreter required)</td>
<td>single</td>
<td>Refugee 1 child; lives with mother</td>
</tr>
<tr>
<td>Bonnie 004</td>
<td>46</td>
<td>Philippine 5 yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>Nanny (past) homemaker Tagalog English</td>
<td>Common-law</td>
<td>Immigrant 1 child, 16 months with Downs Syndrome domestic abuse 2nd IV done</td>
</tr>
<tr>
<td>Cora 005</td>
<td>30</td>
<td>Colombia; 2.5 yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>homemaker</td>
<td>married</td>
<td>Refugee 3 children, 5yrs, 1½ yrs, 5mths 2nd IV done</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Pseudo-nym</th>
<th>Age</th>
<th>Birth-place/ Yrs in Canada</th>
<th>PPD status</th>
<th>Occupation 1st language spoken</th>
<th>Marital Status</th>
<th>Migration Status/ Other info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria 006</td>
<td>37</td>
<td>Morocco; 11 mths</td>
<td>Screened high risk for PPD</td>
<td>homemaker</td>
<td>married</td>
<td>Immigrant 2 children, 2 yrs, 7 months</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Arabic French (interpreter required)</td>
<td></td>
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</tr>
<tr>
<td>Sara 007</td>
<td>42</td>
<td>Colombia; 5 yrs (3 yrs in Calgary)</td>
<td>Confirmed diagnosis of PPD</td>
<td>Daycare in home, Spanish English</td>
<td>married</td>
<td>Refugee 2 children, 8 yrs, 2 yrs 2nd IV done</td>
</tr>
<tr>
<td>Lois 008</td>
<td>36</td>
<td>Mexico; 2.5 yrs</td>
<td>Screened high risk for PPD</td>
<td>worked dry-cleaners (past), Spanish (interpreter required)</td>
<td>common-law</td>
<td>Immigrant 1 child, 12 months; 7 months pregnant</td>
</tr>
<tr>
<td>Roberta 009</td>
<td>39</td>
<td>Costa Rica; 8 yrs (3 yrs in Calgary)</td>
<td>Confirmed diagnosis of PPD</td>
<td>Warehouse worker (past) homemaker Spanish (interpreter required)</td>
<td>married</td>
<td>Refugee Illegal status; 5 children, 20 yrs, 12 yrs, 11 yrs, 2 yrs, 9 months migration issues 2nd IV done</td>
</tr>
<tr>
<td>Kelly 010</td>
<td>28</td>
<td>Mexico; 1 yr</td>
<td>Screened high risk for PPD</td>
<td>Lawyer in Mexico (past) shelf stocker at Wal-Mart night shift Spanish English</td>
<td>married</td>
<td>Immigrant 1 child 3 yrs old Complex domestic abuse 2nd IV done</td>
</tr>
<tr>
<td>Pseudo-nym</td>
<td>Age</td>
<td>Birth-place/ Yrs in Canada</td>
<td>PPD status</td>
<td>Occupation</td>
<td>Marital Status</td>
<td>Migration Status</td>
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<td>Lily 011</td>
<td>37</td>
<td>China; 5.5 yrs (5yrs in Calgary)</td>
<td>Screened high risk for PPD</td>
<td>Manager in China (past) cashier</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Carla 012</td>
<td>30</td>
<td>Egypt; 5 yrs (3yrs in Calgary)</td>
<td>Screened high risk for PPD</td>
<td>Chemical Sciences (past) homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Nellie 013</td>
<td>41</td>
<td>Mexico; 8 yrs</td>
<td>Screened high risk for PPD</td>
<td>Secretary (past) homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Anna 014</td>
<td>43</td>
<td>Egypt; 2 yrs</td>
<td>Screened high risk for PPD</td>
<td>Secretary (past) homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Lana 015</td>
<td>36</td>
<td>China; 3 yrs</td>
<td>Screened high risk for PPD</td>
<td>Kitchen help; shelf stocker</td>
<td>separated</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Pam 016</td>
<td>24</td>
<td>China; 1 yr</td>
<td>Screened high risk for PPD</td>
<td>Accountant (past) homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Simone 017</td>
<td>33</td>
<td>Brazil; 3yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>Restaurant server (past) homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Age</td>
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<td>PPD status</td>
<td>Occupation</td>
<td>Marital Status</td>
<td>Migration Status</td>
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</tr>
<tr>
<td>Alice 018</td>
<td>32</td>
<td>Iran; 2 yrs</td>
<td>Screened high risk for PPD</td>
<td>Engineer (past) Homemaker Farsi (interpreter required)</td>
<td>married</td>
<td>Immigrant 1 child 13 months</td>
</tr>
<tr>
<td>Dana 019</td>
<td>27</td>
<td>Pakistan; 6.5 yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>Science degree/ worked as lab tech (past) homemaker Urdu English</td>
<td>married</td>
<td>Immigrant 2 children, 4yrs, 4 months, Strong interview 2nd IV done</td>
</tr>
<tr>
<td>Abby 020</td>
<td>27</td>
<td>Yemen; 2 yrs</td>
<td>Screened high risk for PPD</td>
<td>Computer programmer (past) homemaker Arabic English</td>
<td>separated</td>
<td>Immigrant 1 child 17 months; past hx of domestic abuse Lives in shelter housing</td>
</tr>
<tr>
<td>Mia 021</td>
<td>30</td>
<td>China; 2 yrs</td>
<td>Screened high risk for PPD</td>
<td>Small business (past) homemaker Cantonese (interpreter required) Spanish English</td>
<td>married</td>
<td>Immigrant 3 children, 6yrs, 4yrs, 8mths; issue with status; Lived in Dominica before Canada</td>
</tr>
<tr>
<td>Ciara 022</td>
<td>27</td>
<td>India; 10 yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>Child care educator (past) homemaker Punjabi Hindi English</td>
<td>married</td>
<td>Immigrant 1 child 2yrs with complex health issues 2nd IV done</td>
</tr>
<tr>
<td>Pseudo-nym</td>
<td>Age</td>
<td>Birth-place/Yrs in Canada</td>
<td>PPD status</td>
<td>Occupation</td>
<td>Marital Status</td>
<td>Migration Status</td>
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</tr>
<tr>
<td>Eve 023</td>
<td>31</td>
<td>Mexico; 2yrs, 7mths</td>
<td>Screened high risk for PPD</td>
<td>Secretary (past) homemaker</td>
<td>Common-law</td>
<td>Refugee</td>
</tr>
<tr>
<td>Wendy 024</td>
<td>40</td>
<td>China; 1yr, 9mths</td>
<td>Screened high risk for PPD</td>
<td>Accountant (past) homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Gloria 025</td>
<td>24</td>
<td>Mexico; 1 yr</td>
<td>Screened high risk for PPD</td>
<td>Hostess (past) homemaker</td>
<td>separated</td>
<td>Refugee</td>
</tr>
<tr>
<td>Carol 026</td>
<td>36</td>
<td>Mexico; 17 mths</td>
<td>Screened high risk for PPD</td>
<td>Small business owner (past)</td>
<td>common-law</td>
<td>Refugee</td>
</tr>
<tr>
<td>Ruth 027</td>
<td>35</td>
<td>Ethiopia; 10 yrs</td>
<td>Screened high risk for PPD</td>
<td>Factory/Hotel work homemaker</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Age</td>
<td>Birth-place</td>
<td>Yrs in Canada</td>
<td>Occupation</td>
<td>Marital Status</td>
<td>Migration Status</td>
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</tr>
<tr>
<td>Carmel 028</td>
<td>33</td>
<td>Mexico; 7 yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>MBA degree; HR Consulting Business</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Kate 029</td>
<td>29</td>
<td>India; 1 ½ yrs</td>
<td>Confirmed diagnosis of PPD</td>
<td>Masters degree Business Intelligence Specialist (past) homemaker Telugu English Hindi</td>
<td>married</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Maggie 030</td>
<td>21</td>
<td>Mexico; 2 yrs</td>
<td>Screened high risk for PPD</td>
<td>Assistant Accountant (past) homemaker Spanish English</td>
<td>married</td>
<td>Refugee</td>
</tr>
</tbody>
</table>
An Invitation

Did you?

- Have a baby in the past five years in Canada?
- Feel low in mood or deep sadness that didn’t go away?

Are you?

- An immigrant or refugee woman living in Canada less than 10 years

IF YES, Please call
Joyce (403) 801-5678
for more information
Appendix D
Information Letter

Dear Prospective Participant:

This letter is to provide you with some information on the forthcoming research study. First, my name is Joyce O’Mahony. My varied nursing background consists of 30 years of experience in acute and community-based care. Currently, I am a Doctoral nursing student at the University of Calgary and this research is part of my PhD nursing degree. My supervisor is Dr. Tam Truong Donnelly, Associate Professor in the Faculty of Nursing at the University of Calgary.

The purpose of this research project is to explore with immigrant and refugee women their understanding of how they make decisions about postpartum care; what factors may influence their health-seeking behaviour and what kind of strategies would they find helpful in postpartum depression prevention and treatment. I am interested in learning about your past and present postpartum health care experiences, the health care services that you use, and the supports that you draw upon to foster your health care practices. The study will involve interviews about these experiences. To increase the understanding of what would be most helpful in meeting the immigrant and refugee women’s mental health needs is an essential goal of this study.

The participant will have two semi-structured interviews (with approximately two months in between) and duration of 60-90 minutes. The second interview will permit me to return the data to the participant along with my interpretations. This enables further clarification and to discuss with the participant emergent ideas and concepts. A questionnaire consisting of open-ended questions will be utilized for
data collection. These questions explore the immigrant women’s mental health care help-seeking experiences in the community. Interviews will occur from November, 2009 to approximately April, 2010. The participant will determine interview location. Possible interview settings are the participant’s residence, community library, Families Matter (community agency) and nearby Community Health Centers. At anytime you may withdraw from the study, should you decide not to participate. Participants are not obliged to respond to any questions they may feel uncomfortable answering during the interview. Through interviewing immigrant and refugee women I may uncover sensitive issues which may be distressing, thus counselling service contacts will be available if you experience any level of distress.

Thank you for your interest and potential participation in this relevant research study of immigrant and refugee women. If further information is required you may contact me by phone at (403) 801-5678, email: jmomahon@ucalgary.ca or contact my supervisor Dr. Tam Donnelly, email: tdonnell@ucalgary.ca

Sincerely,
Joyce O’Mahony RN, PhD (c)
Appendix E
Guiding interview questions for immigrant and refugee participants

Introduction: Thank you for taking time today to speak with me. I am very interested in hearing about your thoughts on how a person manages with postpartum depression (PPD) in the community. The knowledge gained from this study will contribute to the development of healthcare services that are effective and culturally appropriate to address PPD amongst immigrant and refugee women. I will discuss some information that is personal to you, how you have dealt with your depression and the best way to help other immigrant and refugee women experiencing PPD. I want to ensure you that all information is kept confidential. For any question you don’t feel comfortable answering please let me know. You have the right to withdraw at any time throughout this project. If during our conversation you feel upset I will stop the interview. Counselling services can be arranged if you think this would be helpful.

Firstly, I would like you to tell me a little about yourself and your experience with postpartum depression

Prompt questions:
• Are you familiar with the term postpartum depression?
• If not I will describe this to you…
• Firstly, is there something in particular you would like to tell me about your experience with PPD?
• How did you find out that you had PPD?
• How long ago did you experience PPD?
• What do you think caused your PPD?
• What kinds of problems did you experience as a result of PPD?

Next I would like to find out how you seek help and who do you ask for help when you have a mental health care problem?

Prompt questions:
• Do you have family & or friends living in Calgary?
• What made you seek help?
• Who did you ask for help?
• Was it easy to get help to manage your PPD? If it was, what made it easy for you to obtain help?
• If it was not easy what made it difficult?
• Was it hard to acknowledge that you have mental illness? If yes, why was it difficult?
• Were mental health care services appropriate and suitable for you?
• In what way were they?

Next I would like to find out what your beliefs and values are concerning PPD and other factors which may influence your mental health care practices?
Prompt questions:

- What kinds of cultural beliefs and values influence the ways you seek help for PPD and its related problems?
- Has being an immigrant or refugee living in Calgary influenced how you have dealt with PPD? If yes, Why?
- What would prevent immigrant & refugee women from seeking help for their PPD?
- Has being a woman influenced how you have dealt with PPD?
- Dealing with mental illness such as PPD takes a lot of strength… what do you see as your strengths, & your family, community?
- What is your experience with utilizing Alberta Mental Health Care Services?
- What kinds of supports and services were available or not?

Lastly, I would like to find out about your thoughts, based on your PPD experience... what is needed to help other immigrant and refugee women in similar situations?

Prompt questions:

- What kind of services would be most helpful?
- If you required information about deciding whether or not you would seek help for PPD, what kind of information would be most helpful to you?
- What other health care services should be available to help support immigrant & refugee women in dealing with PPD?
- What would be the best way to offer health promotion & prevention activities to inform immigrant & refugee women about PPD?
- Based on your experience what recommendations could you give to other immigrant & refugee women in the same situation?
- Is there anything else you would like to tell me today?
# Appendix F

## Purpose, Questions and Interview Guide for Immigrant and Refugee Women

<p>| To find out what their knowledge &amp; beliefs about PPD are &amp; what does this concept mean to them | 1) How do immigrants &amp; refugee women conceptualize PPD? | Are you familiar with the term postpartum depression? If not I will describe this to you… Firstly, is there something in particular you would like to tell me about your experience with PPD? How did you find out that you had PPD? What do you think caused your PPD? What kinds of problems did you experience as a result of PPD? |
| To gather information about how immigrant &amp; refugee women seek formal &amp; informal help to cope with their PPD | 2) How do immigrants &amp; refugee women utilize the available HC services &amp; social support networks to manage their PPD? | Do you have family &amp; or friends living in Calgary? What made you seek help? Who did you ask for help? Was it easy to get help to manage your PPD? If it was, what made it easy for you to obtain help? If it was not easy what made it difficult? Was it hard to acknowledge that you have mental illness? If yes, why was it difficult? Were mental health care services appropriate and suitable for you? In what way were they? |
| To gather information about the factors (facilitators &amp; barriers) that influence their mental health care practices | 3) How do contextual factors such as social, cultural, political, historical and economic intersect with race, class &amp; gender to influence their mental health care experiences? | What kinds of cultural beliefs and values influence the ways you seek help for PPD and its related problems? Has being an immigrant or refugee living in Calgary influenced how you have dealt with PPD? If yes, Why? What would prevent immigrant &amp; refugee women from seeking help for their PPD? Has being a woman influenced |</p>
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<tr>
<th>To identify effective services &amp; intervention strategies that will effectively meet the needs of immigrant &amp; refugee women with PPD</th>
<th>4) What services &amp; strategies could address PPD care &amp; treatment among immigrant &amp; refugee women?</th>
<th>Immigrant &amp; refugee women who have experienced PPD</th>
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<td>how you have dealt with PPD? Dealing with mental illness such as PPD takes a lot of strength… what do you see as your strengths, your family and your community? What is your experience with utilizing Alberta Mental Health Care Services? What kinds of supports and services were available or not?</td>
<td>What kind of services would be most helpful? If you required information about deciding whether or not you would seek help for PPD, what kind of information would be most helpful to you? What other health care services should be available to help support immigrant &amp; refugee women in dealing with PPD? What would be the best way to offer health promotion &amp; prevention activities to inform immigrant &amp; refugee women about PPD? Based on your experience what recommendations could you give to other immigrant &amp; refugee women in the same situation? Is there anything else you would like to tell me today?</td>
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Appendix G
Socio-demographic Questionnaire

Age: (years) _______

Birthplace: ____________________________________________

Marital Status: Married _____

Single _____

Divorced/Separated/ Widowed_______

Common-law _______ Other _______

Parity: _______

Number & age of children: ____________________________________________

Extended family members in Calgary:__________

Years lived in Canada: __________

Years lived in Calgary: __________

Did you come to Canada as a refugee _____ or as an immigrant _____?

Languages spoke: First language: ________________

Second language: ________________

Others: ________________

Religion: ____________________________________________

Education: University/college graduate: ________________

Some university or college: ________________

High school graduate: ________________

Some high school education (grade level): ____

Less than high school education (grade level): ________
Others: ________

Occupation: _______________________

Employment: _______________________

Full time: ________ Part time: ________

Full time homemaker: ________ Student: ________

Unemployed: ________ Maternity leave: ________ Others: ________

Family income yearly before tax:
- Less than $10,000 ________
- $11,000- $20,000 ________
- $21,000- $30,000 ________
- $31,000- $40,000 ________
- $41,000- $50,000 ________
- $51,000- $60,000 ________
- $61,000- $70,000 ________
- $71,000- $80,000 ________
- Greater than $80,000 ________

Do you participate in:

Your ethnic community activities or events __________________________

Other community events (nearby where you live) __________________________

Are your friends:

Mainly within your ethnic group __________

Mainly from another ethnic group __________

Both from your ethnic group and other groups __________

Does not have any friends __________

Do you have extended family in Calgary? __________

Do they live with you? __________

Health Care:

Do you use: Mainly traditional medicine: __________

Both traditional and Western medicine: __________

Mainly Western medicine: __________
Type of health insurance:

Public: ________ Private: ________ No health insurance: ________

Do you have a family doctor?

If yes: Male: ________ or Female: ________

If no, do you have a regular place of medical care: ________________

Do you have a doctor who speaks your language? ________

Date of last visit to doctor: ________________

Do you see other health care providers? ________

Have you used other sources of formal support?

Community Health Nurse ________ Health Link ________

Healthy Beginnings ________ Baby and You classes ________

Others not listed ________________
Appendix H

CONSENT FORM

TITLE:
Immigrant and Refugee Women's Voices: Exploring Postpartum Depression Help Seeking Experiences and Access to Mental Health Care

SPONSORS:
AHFMR; CIHR

INVESTIGATORS: Principal Investigator: Tam Truong Donnelly RN PhD (403) 220-8377; Fax: (403) 284-4803

Co-Investigator: Joyce O'Mahony RN PhD (c) (403) 801-5678; Fax: (403) 284-4803

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND:
The number of immigrants and refugees coming to Canada from non-European countries has increased significantly over the past several decades. There are over 31 million people living in Canada. Among them, over six million are immigrants. According to the 2006 Census of Canada, Alberta has a population of over 3 million
people, of which 16.2% are immigrants. In Calgary, immigrants make up 23.4% of the total population.

Postpartum depression (PPD) may be the most common complication of pregnancy. It is major depressive disorder and serious illness that can have long lasting traumatic effects on the mother, child and family. Fortunately, PPD is treatable. This would point to the importance and value for early detection and treatment of the problem. Yet, immigrant and refugee women may be at risk for lack of early detection and treatment of this illness.

Immigrant and refugee women may be particularly vulnerable following childbirth because of language difficulties, cultural beliefs and practices, and socioeconomic factors that shape their postpartum experiences. A pressing issue for health care providers is how to assist these immigrant and refugee women to adapt to new environment and to cope with mental illness such as PPD.

Little research has been done to date that have examined immigrant and refugee women’s perspectives about their social support needs, the barriers they experience and the kind of preferred help required after childbirth. Intervention strategies continue to be underdeveloped and more research is essential. Through examining cultural, social political, historical, and economic circumstances we can better understand factors that influence immigrant and refugee women's mental health care experiences. To decrease the severity of mental illness we must address these issues. An understanding of access barriers through this research will help to raise awareness and understanding of what would be helpful in meeting the mental health needs of the immigrant and refugee women within the postpartum period.

In this study approximately 30 immigrant and refugee women will be interviewed. Through semi-structured interviews we will investigate and explore how immigrant and refugee women experience and access mental health care services.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this qualitative study is to explore how immigrant and refugee women seek help to manage their postpartum depression. The objectives are to increase the understanding of how immigrant and refugee women make decisions about postpartum care; what factors may influence their health seeking behaviour and what kind of strategies would they find helpful in PPD prevention and treatment.

WHAT WOULD I HAVE TO DO?

Interested participants must meet the inclusion criteria. All participants will be asked to complete a socio demographic questionnaire. Female interpreters will be hired to assist with translations as needed. The in-depth interview is conducted in the language
that is preferred by the woman participant. Each participant will be individually interviewed twice for 60-90 minutes in their preferred location (home, community health centre, community agency) with approximately 3 months between interviews. All the interviews will be audio taped. An interview guide with open-ended questions will be designed for the study. These interviews will begin November, 2009. Data analysis will be ongoing with completion of the project approximately by June, 2011.

WHAT ARE THE RISKS?

Every effort will be made to ensure participants are aware they may withdraw from the study voluntarily and are not obliged to respond to any questions they may feel uncomfortable answering during the interview. Sensitivity and careful explanation of the research project will be conducted by the researcher. Recognizing that social, economic, and perhaps political difficulties may exist, careful attention will be paid to the ways in which interaction is carried out with the participants. I will be attentive to the fact that by interviewing immigrant and refugee women I may uncover sensitive issues which may be distressing for them. Counselling service contacts will be available if the participant experiences any level of distress.

WILL I BENEFIT IF I TAKE PART?

Further research investigating barriers and facilitating factors would be beneficial in providing a clearer picture of service usage by immigrant and refugee women with mental health problems such as PPD. Investigating the reasons for differences in health care utilization may prove useful for developing mental health care programs that are culturally acceptable and appropriate to immigrant women. Furthermore, future research needs to focus on intervention strategies that listen to the immigrant and refugee women’s perspective. This will further the understanding about PPD care; provide significant information about the immigrant and refugee women’s support needs and their preferences.

We also need to recognize that difficulties immigrant and refugee women face in accessing and utilizing mental health services may not be due to culture but historical processes that have produced systemic inequities and oppression. A better understanding of how race, gender and class influence immigrant and refugee women’s PPD experiences is necessary in order to provide more appropriate and accessible mental health care to these women. The information we get from this study may help us to provide better treatments in the future for patients with postpartum depression. There will be no direct benefits to you, yet you may enjoy contributing your expertise and experience to this research, as the eventual results will inform practice. You also may request a copy of the final report that includes suggestions for practice.

DO I HAVE TO PARTICIPATE?

This study is voluntary and you may withdraw from the study at any time.

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WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

There are no costs involved with participating in this research study. Parking and childcare costs up to $50.00 will be paid for the period of time during interviews. Please provide a receipt to claim these costs.

WILL MY RECORDS BE KEPT PRIVATE?

Yes, the data collected will be kept confidential and in a locked environment. Only the researchers and the University of Calgary Conjoint Health Research Ethics Board may have access to the records. Freedom from identification will be protected by 1) data will be identified by pseudonym and code only; 2) all information stored will be kept confidential in a locked cabinet, and locked environment; 3) consent forms will be stored in a locked cabinet separate from the interview tapes and transcribed data. Computers will be password protected. To maintain confidentiality, code numbers will be used with no identifiable information on transcripts and interview questionnaires. At the close of the study, all final reports and publications will not include any identifying information. Audiotapes will be destroyed seven years after the completion of the study. Electronic and paper versions of interview transcripts and field notes, with no identifiable information will be kept for educational and other research purposes, subject to ethic approval and according to standard procedure. After project completion the transcripts will be kept for seven years and then destroyed.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights or release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Joyce O’Mahony RN PhD (c) (403) 801-5678

Or

Tam Truong Donnelly RN PhD (403) 220-8377

If you have any questions concerning your rights as a possible participant in this research, please contact The Director of the Office of Medical Bioethics, (403) 220-7990.
<table>
<thead>
<tr>
<th>Participant's Name</th>
<th>Signature and Date</th>
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<tbody>
<tr>
<td>Investigator/Delegate’s Name</td>
<td>Signature and Date</td>
</tr>
<tr>
<td>Witness' Name</td>
<td>Signature and Date</td>
</tr>
</tbody>
</table>

The University of Calgary Conjoint Health Research Ethics Board has approved this research study. A signed copy of this consent form has been given to you to keep for your records and references.