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ORIGINAL PAPER

Cultural Background and Socioeconomic Influence of Immigrant and Refugee Women Coping with Postpartum Depression

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Abstract Postpartum depression is a serious condition that can have long lasting traumatic effects on women and their families. Until recently postpartum depression research has focused more on the population as a whole rather than refugee and immigrant women. Informed by Kleinman's explanatory model and the postcolonial feminist perspective, 30 immigrant and refugee women were interviewed to find out what factors influenced them in seeking postpartum care and what strategies would be helpful in prevention and treatment of postpartum depression. We found that the immigrant and refugee women in our sample: (a) were influenced by both cultural background and socioeconomic factors in seeking support and treatment; (b) were influenced by cultural differences and social stigma when making decisions about health care practices; and (c) employed numerous coping strategies to deal with postpartum depression. Recommendations are provided for more culturally appropriate and equitable mental health care services for immigrant and refugee women living in Canada.

Keywords Immigrant · Refugee women · Mental health · Postpartum depression · Culture · Socioeconomic factors · Health care access · Postpartum care

Introduction

New immigrant and refugee mothers in Canada may be especially vulnerable to postpartum depression (PPD) and to less than optimal mental health outcomes following childbirth because of language barriers, as well as cultural and socioeconomic factors that impact their postpartum experiences [1–3]. PPD may be the most common maternal health problem and complication of childbirth [4]. It may have harmful, even fatal, effects on women and their families. However, recovery from PPD is favorable, especially with early detection and treatment. Assisting immigrant and refugee women with PPD is therefore a critical and pressing issue for health care providers [5–7].

Most PPD research focuses on mainstream populations. The perceptions of immigrant and refugee women, their social support needs, the barriers they face, and their preferred support interventions have received little attention.

In this paper "immigrant" is defined as a person who has moved from his or her home country to take up permanent residence in a new country. A "refugee" is an individual who moves to a new country to escape persecution, torture, or cruel and unusual punishment. We elected to embrace both refugee and immigrant women as participants because their voices are equally important, although their individual experiences might be different due to forced immigration, past insecure living conditions, and violence. Although these women's past circumstances differ, they faced similar cultural, language, and economic challenges in seeking help for PPD.

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Background Literature

Risk Factors

The causes of PPD are uncertain; the general consensus suggests that psychological and psychosocial factors predispose some women to this condition [4, 8–10]. Robertson et al. [11] synthesized two meta-analyses, Beck [12] and O'Hara and Swain [13] incorporated more than 70 studies to summarize potential risk factors. The strongest predictors of PPD included depression or anxiety during pregnancy, personal and family history of depression, recent life stress, poor quality of relationships, lack of social support, and stressful life events. There is mounting evidence that PPD affects a cross-section of women; low socioeconomic status or education and being an immigrant are factors associated with higher risk for PPD [1–4].

Moreover, new immigrant and refugee women are exposed to significant risk factors that might affect their mental health. These factors include stressful premigration experiences, language barriers, marginalization and minority status, lowered socioeconomic status, lack of social supports, poor physical health, and difficulty adapting to host cultures [3, 14, 15]. Several studies have reported that these women, who are already at significant risk for mental health issues postpartum, have difficulty accessing appropriate care even when health care is commonly available [2, 5, 16].

Postpartum depression is a universal phenomenon, not an illness restricted to industrialized Western societies or immigrant and refugee women [17, 18]. Affonso et al. [17] 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 EPDS is a 10 item self-report scale used to screen for PPD [19]. The higher the EPDS score, the higher the risk and prevalence of PPD [2, 3, 10].The study revealed that women in western European countries such as Sweden and Australia have the lowest levels of symptoms. While it is unclear why Australian women scored low on the EPDS, Wickberg and Hwang [20] found significant state support for Swedish women after childbirth, including paternity leave. Mid-range levels of risk for PPD were found in the scores of American women. The researchers postulated 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 higher 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.

Culturally Determined Barriers to Help-Seeking

Pregnancy and childbirth might be similar worldwide, but how PPD is conceptualized and experienced by women of diverse cultures might be quite different [6, 7, 21, 22]. How immigrant and refugee women define PPD and their attitudes toward it will be a strong influence in how they utilize and access social support networks and mental health care services. Moreover, lack of knowledge about and understanding of PPD can limit help-seeking behavior. Culturally determined barriers include fear of stigma and lack of validation of depressive symptoms within the family and within the ethnic community. New immigrant mothers suffering from postpartum depression might not have any knowledge of PPD. They might be reluctant to reveal feelings to family and friends and to seek help for their problems [5]. In some cultures it might be perceived that it is inappropriate to seek external help for depressive symptoms. Medical assistance might seem inappropriate if PPD is not understood to be a medical problem. [7, 23–25]. Rodrigues et al. [24] found that Asian Indian mothers suffering from PPD perceived their symptoms to be natural sequelae of childbirth and were therefore unlikely to access health care services. It has been reported that in Asian Indian communities, maternal depression often goes unrecognized, leaving the mother isolated within her own family [26, 27].

Reitmanova and Gustafson [28] suggested that immigrant Muslim women attempting to satisfy maternal health care needs experienced discrimination, insensitivity, and lack of knowledge about their religious and cultural practices. Health information was limited or lacked appropriate cultural and religious particularities to meet the perinatal needs of Muslim women and there were significant gaps between existing maternity health services and women's needs for emotional support and culturally appropriate information. Barclay and Kent [29] pointed out that the difficulties of new immigrant mothers are exacerbated if they come from cultures where women are held in high esteem and valued and supported during the postnatal period. Cultural beliefs can serve in positive and protective ways when the mother and family participate in traditional customs and rituals that bolster the mother's network of support. Assigning value and respect to the mother's role can improve the mother's overall postpartum health. When cultural expectations and beliefs are not met, the woman can be susceptible to depression. Oates et al. [22] found that recent immigrant mothers might find themselves bereft of the emotional and practical social support they would normally expect in their home country.

Differing Forms of Stigma The immigrant mother suffering with PPD can be additionally subjected to the pain of

discrimination by family members and the broader community. Studies of immigrant mothers and their families found that many cultures attach shame to mental illness such as PPD [5, 30]. In several qualitative studies it was found that social stigma can affect help-seeking for PPD particularly when emotional expression is considered inappropriate or atypical in the culture [7, 31, 32]. Fear of disclosure, labeling, stigmatization, and social pressures are consistently reported to discourage immigrant women from seeking help for PPD [5, 33, 34]. Teng et al. [7] found that the stigma of mental illness and lack of knowledge and comprehension of postpartum depression were barriers against seeking help for the immigrant woman and her family.

Socioeconomic Factors

Persistent socioeconomic 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 [35]. It has been proposed that the multiple demands of motherhood, coupled with poverty and low levels of education, combine to predispose immigrant and refugee mothers to PPD. Numerous studies have suggested that limited financial support, unemployment, absence of partner, and lack of social support have predictive relationships to PPD [12, 16, 26, 36, 37]. These risk factors interact and exacerbate each other, contributing to the mother's stress as she transitions to the new maternal role [26]. In a Canadian longitudinal study, Sequin et al. [37] reported that new mothers with low socioeconomic status (SES) were more likely to experience higher depressive symptoms in the second month postpartum than mothers with higher SES. They found that chronic stressors such as lack of money for every day needs, maternal and infant health issues, struggles within social networks, and poor social support were associated with postpartum depression symptoms.

Other longitudinal studies reported associations between low SES and PPD. Segre, O'Hara, Arndt, and Stuart [38] assessed depressive symptoms in a cross sectional sample of 4,332 women to determine the specific role of social status in the development of PPD. They found that 12 % of the women screened positive for PPD with an increased prevalence in younger, low income, unmarried, and less educated women. The authors concluded that depressed women with limited resources are caught in a circular trap with the symptoms of depression making it harder for them to improve their resources. In a randomized clinical trial of 198 women, Goyal et al. [26] found that women with socioeconomic risk factors (unemployed, limited income, less education) were about 11 times more likely to develop PPD symptoms than women with higher socioeconomic status. Dearing et al. [39] examined changes in family income and depressive symptoms of 1,351 mothers during the first 3 years after childbirth. They reported that a decrease in income was associated significantly with an increase in depressive symptoms.

Landy et al. [40] compared socioeconomically disadvantaged women with socioeconomically advantaged women in Canada in terms of their postpartum health, health service needs, and health service utilization patterns. The authors concluded that within this sample of 1,000 postpartum women, socioeconomically disadvantaged women were more likely to be discharged from hospital within 24 h, were less likely to report very good health, and had higher rates of PPD symptoms. Sword et al. [2] found that immigrant women were considerably more likely than Canadian-born women to have low family incomes and less social support; however, the immigrant women were less able to obtain financial support and appropriate social support. An assessment of 1,250 women (one-third born outside Canada) revealed that 15 % scored above the cut-off point on the EPDS, as compared to 7 % of Canadian born women.

Theoretical Framework

Kleinman's Explanatory Model

Culture is the learned and shared knowledge of values and beliefs. The cultural mores of a society influence the thinking, decision making, and actions of individuals and groups and give meaning to people, events, and objects in the society [41–43].

Cultural beliefs, values, and knowledge can be expected to shape the approach to health care of immigrant and refugee women, and will influence their expectations of PPD care and treatment. Kleinman [43] asserts that a person's explanatory model, which is particular to one's social group and culture, explains causes of sickness, onset and timing of symptoms, pathology, natural course and severity of illness, and choice of treatment. An explanatory model can be constructed from the personal beliefs used to identify, interpret, and cope with a particular illness [42]. Explanatory models do not exist in isolation; they are powerfully shaped by a woman's particular context. The social, political, historical, and economic influences that shape the health of a society can also be modeled to elucidate the mechanisms at work.

Kleinman's explanatory model was used as a framework to explore the influence of cultural knowledge and beliefs on the help seeking behavior of immigrant and refugee women with regard to PPD. It was theorized that the

perspectives of these women toward seeking help for PPD was influenced by their beliefs about health and sickness, cultural social norms for seeking help, treatment anticipations, and relationships. As Kleinman's framework did not elaborate on broader social, political, historical, and economic factors and did not illuminate how gender, race, class, and power relations can influence women's help-seeking experiences, we turned to the postcolonial feminist perspective to address these issues.

Postcolonial Feminist Perspective

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. Postcolonialism is a set of theories that shed light on the everyday experiences of marginalization. A focus on disrupting historical racist views and structural inequities that have emerged through the practices of colonization sets postcolonial theory apart from other theories [44, 45]. Postcolonial feminist perspectives are used to give analytic depth to the many-sided factors that affect immigrant and refugee women living in Canada. Postcolonial feminist perspectives provide a theoretical lens through which issues of social stigma, health equity, discrimination, and accessibility to health care services are examined [45–47]. Racism, historical positioning, and gender are important factors to explore for they shape the broad determinants of health [44] and thus will provide insight into the help seeking practices of immigrant and refugee women who seek to manage their PPD.

The postcolonial feminist perspective exhibits several important tenets:

1. Researchers who conduct postcolonial feminist research are critical of the ontological and epistemological underpinnings of traditional social sciences. They argue against the objectivism and value free epistemology of traditional scientific inquiry [48]. Postcolonial feminist researchers theorize that knowledge is socially constructed and value laden, and that the race, class, gender, and culture of the researcher contrives to shape the research process.
2. The postcolonial feminist perspective examines how race, gender, and class relations influence the social, cultural, political, and economic factors that shape the lives of marginalized women living with mental health illness. Instead of viewing each woman as being totally responsible for her health care (behaviors 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 [47].
3. A feminist project is a social justice project that places women's experiences at the center of analysis [47, 49].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" (p. 10) [45]. Mental illness issues are identified and addressed from the perspective of women who have experienced the illness and help define the important issues and problems.

We have studied immigrant and refugee women with a postcolonial feminist perspective to generate an accurate account of the women's health care activities in relation to mental health care. We believe the information acquired will suggest ways to improve the conditions in which these women live and practice health care [45, 47, 50]. A postcolonial feminist perspective helped us to put immigrant and refugee women's marginalized experiences at the focal point of analysis. It helped us analyze the impact of present and historical social and political forces that influence their health and health care behavior. This perspective also helped us understand how the women coped with illness and how their usage of health care services was shaped by past experience in their home country. We have attempted to place our findings in the context of the individual woman's life.

Purpose and Research Questions

This qualitative study explores how race, gender, and class influence the ways in which immigrant and refugee women seek help to manage their PPD. The research questions addressed here are: (1) How do social, cultural, political, historical, and economic factors influence immigrant and refugee women's mental health care experiences? (2) What services or strategies could address PPD care and treatment among immigrant and refugee women? We demonstrate how cultural and socioeconomic factors impact the help seeking behavior of immigrant and refugee women who suffer from PPD. We recommend ways in which more culturally appropriate and equitable mental health care services could be provided for immigrant and refugee women living in Canada. Findings related to additional factors such as the role of social supports, structural barriers, and gender roles that participants identified as challenges in accessing appropriate mental health care services for PPD have been published separately.

Study Design and Methods

According to Thomas [51] critical ethnography is a "style of analysis and discourse embedded within conventional ethnography" (p. 3). 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 [52, 53]. 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 [53].

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" (p. 4) [51].

A critical ethnographic method that utilized in-depth interviewing gave participants an opportunity to describe their experiences and express more detailed contextual information [52]. This critical ethnographic approach [51] was most suitable for the research of immigrant and refugee women; it allowed us to learn how immigrant and refugee women seek help and access health care and what additional external factors influenced their actions. It allowed us to examine not only cultural influences but also broader social, political, historical, and economic factors that shaped the immigrant and refugee women's situation and their PPD help-seeking experiences. The critical inquiry approach illuminated how social injustice and unequal social relations contribute to an unequal distribution of health care resources and make it difficult for immigrant and refugee women to access health care services.

Participants

A purposive 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 [54]. Access to and recruitment of participants was accomplished through referrals and conversations with health care providers in settings where health care services are provided to postpartum immigrant and refugee women. We were able to gain access to immigrant and refugee women that had been screened for PPD. Almost one-third of the participants (9 out of 30 women) had been given a formal diagnosis of PPD by their physician, whereas the remaining participants were considered by the health care provider to be at high risk of PPD. We selected participants based on the following inclusion criteria: (a) non-European women with immigrant or refugee status living in Canada <10 years; (b) more than 18 years of age; (c) EPDS screening indicated a high risk for PPD (score of 10 and above) within the past five years; (d) current stable mental health; (e) ability to converse with the researcher, or with a translator where interviews were conducted in the participant's first language.

Each participant was contacted to arrange a convenient time to meet for the interview once ethical approval was obtained. All participants gave informed consent prior to each interview. To ensure full anonymity, participants were identified by pseudonym and code only. Out of 30 women, there were 8 refugee women and 22 immigrant women. Participants were from diverse ethnocultural backgrounds and included women from Central and South America, China, Middle Eastern countries, and South Asia. Approximately one-third of the participants had left well-paying jobs or a career in their home country. The majority of participants were now homemakers, although three participants were employed full-time shortly after childbirth (Table 1).

Data Collection

Interviews were conducted in the language the women preferred with 12 women requiring an interpreter. Professionally trained women were employed as interpreters. Interpreters were given the same instructions concerning the interview and general information about the participant's circumstances. We would state each open-ended question in English and the interpreter would translate the question in the participant's language. Interviews took place in the participant's home or a community agency. The open-ended questions were chosen to attain a greater understanding of participants' knowledge and beliefs about PPD and what this concept meant to them. Examples were: Are you familiar with the term PPD? Do you know what causes this condition? Is PPD a problem back home? Do you have friends that have experienced PPD?

Particular attention was paid to the ways in which we interacted with participants as we were aware that the act of interviewing might unearth sensitive issues. We were 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. Access to a counseling service was offered if a participant

Table 1 Sociodemographic characteristics of participants

Characteristics (n = 30) Mean age (year) = 32.5	
Country of origin/immigration status	Number/type of participants
Mexico	4 immigrants; 4 refugees
South America (Brazil, Columbia)	1 immigrant; 3 refugees
Central America (Costa Rica)	1 refugee
SE Asia (Philippines)	1 immigrant
South Asia (India, Pakistan)	3 immigrants
China	5 immigrants
Middle East	6 immigrants
Africa	2 immigrants
	Number of participants
Years living in Canada	
<2	14
2–5	9
6–10	7
Level of education	
≤High school	11
Community or technical school	7
University/college degree	12
Annual family income	
<10,000	12
11,000–20,000	10
30,000–40,000	6
≥70,000	2
History of PPD	9

experienced any level of distress. Participants were assured they could withdraw from the study at any time.

Data Analysis

Based on Carspecken [55] Sandelowski [56] and Denzin and Lincoln [57] we proceeded in four steps:

1. Interview data and field notes were taped and transcribed verbatim. (The twelve interviews requiring interpreters were translated, taped, and transcribed with the same method.) To ensure accuracy, transcripts were rechecked against audiotapes and a hard copy was obtained for preliminary analysis. Audiotapes were regularly revisited as listening to the women's narratives helped to increase understanding of their often complicated situations.
2. Transcripts were coded to categorize beginning themes from the data and a list of code categories was created to organize incoming data. Code categories were refined as subsequent data were gathered.
3. The outcome of data from the initial interview was transcribed and preliminary analysis was carried out prior to the second interview. This technique facilitated the identification of emerging themes, ideas, and concepts that required clarification or expansion with the participant during the second interview.
4. Themes and concepts were used to compare within and across transcripts in the dataset and across cases. This generated a higher level of data conceptualization and broader theoretical formulations. Ten participants were asked to do a second interview which permitted the return of the preliminary data back to the participants along with the researcher's analytic interpretations as a type of "member checking." This process enabled us to clarify, expand, converse, and validate with participants about emergent themes, ideas, and concepts. This step also gave us a broader understanding of the data and we gained insight that helped move the analysis from individual experience to an exploration of wider social processes and structures that organize experience.

Data categories were partially based on the meanings participants gave to their narratives; therefore we paid attention to the ways in which meaning was constructed. Meaning reconstruction was performed to help researchers clarify their impressions of the data and observations [55]. The validation of meaning reconstructions was most credible when the participants themselves constructed them when facilitated in an open-ended way by the researcher. This was carried out during the second interview, where we further explored, negotiated, and explained our interpretations with participants. In many instances this led to a better understanding of their experiences. By giving careful attention to interpretations with attained or agreed consensus by participants, the validity of content was established.

Findings

The immigrant and refugee women participating in this research articulated multiple factors that influenced their PPD experiences and help-seeking behavior both positively and negatively.

Cultural Influence in Seeking Support

Cultural background, beliefs, and socioeconomic factors exerted a strong influence on the immigrant and refugee women's ideas about their emotional and physical health and ways to promote and manage their health. In the mothers' home countries, traditional customs or rituals

during the postpartum period were geared toward providing support for the new mother. Lack of these cultural traditions reduced the women's support system and made them more vulnerable to PPD. Participants articulated their ideas about the causation of PPD and gave a multiplicity of meanings and different explanations for this illness; each participant had a concept of PPD that was based on her unique circumstances and experiences.

Barriers related to cultural values were deeply embedded and the most difficult for the women to talk about. Data analysis revealed that three factors dominated participants' views of PPD: meaning and causes of PPD, stigma of mental illness and influence of cultural issues.

Meaning of Postpartum Depression

Generally there was some awareness of PPD within this group of women. Several participants expressed that in their home country PPD was not a common event after childbirth. One woman noted:

> [PPD] is not talked about. They don't feel any of this … in India they live in combined families, and the neighbors are very close to each other … mom isn't isolated. Every woman gets help from her parents or parents-in-law.

Another woman 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.

Furthermore, another participant pointed out that depression isn't always identified and that a specific word for depression might not exist: "In the Philippines PPD exists, but they just don't bother about it. I think there is a lot depression yet they don't call it depression. Because unlike here in Canada, other countries are not so focused about depression." One participant was not fully aware of the devastating impacts of PPD, thinking it was simply 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." Although she was 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 … never went through an episode of depression before this.

Implications of Family Involvement

Particularly from a cultural perspective, accessing mental health services was difficult for many immigrant and refugee women. Most participants felt that a cultural stigma was attached to PPD and the stigma was a barrier to seeking help. It was felt that in many cultures there were significant negative feelings around the concept of mental illness. The stigma associated with mental illness and the possibility they would be shunned by family and community prevented women with PPD from seeking treatment. Therefore, PPD was difficult to acknowledge within the family and seeking treatment such as medication and counseling became problematic.

Participants who recognized they were experiencing some kind of sadness or depression often felt unable to share their feelings. These women attempted to conceal their emotional suffering and downplayed their symptoms to hide their depression from family, friends, and health care providers. These concerns were also expressed during PPD screening and were voiced by some participants and several health care providers we encountered when networking within this population. Informal conversations with the counselors emphasized the fact that many of their immigrant and refugee women clients (a) were in denial about their depressed feelings because the stigma prevented them from acknowledging their situation, and (b) some immigrant or refugee women might not give honest answers in the (EPDS) screening tool because they did not fully understand the seriousness of PPD or were fearful of being alienated or of disrupting family harmony. One mother talked candidly of how 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." Another participant described her fear and mistrust of the PPD screening event: "We can hide it… if we answer that question like this, maybe they will take our baby away…"

The family was seen to exert pressure as to how the mental health problem should be solved. Dominance and control by the partner was seen to contribute to preventing a woman from accessing services. Some participants felt that the partner and other family members' beliefs might differ from that of the depressed mother. Keeping knowledge of

the problem within the family was a strong social pressure. Even if the immigrant or refugee woman wanted to access services, her actions would be subject to familial pressures. One participant bemoaned that she needed her family to listen but not give unwanted advice. She 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." Her husband was of the same mind:

> You will feel like you are depressed for the rest of your life…you will come out of it and not need medication.

Another participant pointed out that some 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 will think they are not strong enough and cannot manage things well. This participant stated that Chinese women find it is easier to hear that their problems are caused by a physical reason rather than a mental reason. There are numerous challenges for these women in trying to explain the nature of their illness.

Implications of Community Beliefs About Mental Illness

Many participants 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 to conceal her problem from her community. This created 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 negatively because of lack of understanding of her situation. She shared this view:

> Back home, 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 something that prevents the immigrant from asking for the help…because back home it's very rare … and we don't have this knowledge.

Some participants strongly believed that problems should be kept within the family. One women was adamant that taboos about revealing emotional problems outside of the family was a key reason preventing Iranian immigrant women from seeking help:

> 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.

Many of the immigrant and refugee women were hesitant to access help and identified major barriers to seeking help. They emphasized that the lack of knowledge and understanding about PPD, the overriding stigma of mental illness, and the powerful influence of cultural beliefs in the mother, the family, and the community discouraged women from seeking help for PPD. This is a very critical problem among immigrant and refugee women because of the risk of serious consequences of untreated PPD. More awareness about PPD and culturally appropriate care and education is needed to address the complexity of issues faced by immigrant and refugee women.

Socioeconomic Influence in Seeking Support

Many immigrant and refugee women in this study experienced structural barriers such as limited financial resources and low socioeconomic status. Practical barriers such as lack of English language skills, no available childcare, and precarious immigration status prevented them from finding employment. As a result, some participants were unemployed or had lower paid employment compared to employment in their country of origin. Because the professional credentials of immigrant and refugee women are not recognized in Canada, the independence of some participants was compromised, leaving them dissatisfied and frustrated. This contributed to their depression.

Challenges in Seeking Employment

Nine participants were homemakers whereas three participants obtained full-time jobs soon after childbirth. Thus, 9 participants relied on their partners for financial support. Most participants expressed concerns about job shortages, frustration that their professional status or qualifications were not recognized, and anxiety about the job security of their partners. Limited English language skills made finding employment difficult for some. They worried that they would not have enough money for the necessities of daily living. One participant could not work because she was waiting for her work permit and her partner struggled with keeping his job. Eventually they got help from the

community: "… My husband had trouble getting a job because of his English, but then he got a construction job, and lost it 2 months before the baby was born … so we asked for help from the church and food bank."

Another woman, too, described the unpredictable job circumstances of her partner:

> Suddenly they gave him one week's notice and laid him off the same week when my daughter born … it's a stress … He is looking for work, but at the same time we are not getting any money. So [you use] loans, credit cards …

One participant was well educated and had a professional job in her native home but her credentials were not fully acknowledged in Canada. She tells us: "In my country almost always I feel intelligent. I have a profession … have job. I'm lawyer." But presently she is forced to work full-time nights stocking shelves because she could not afford childcare 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, eat, and sometimes my husband is very angry. No, is not possible now, bring my son to daycare because is too much expensive. … I don't have subsidy … because of [my status], this is only for permanent residents.

Similar to this woman's experience, another well-educated participant arrived with positive expectations but quickly realized that her education and past work experience were not fully appreciated. She was a business owner 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 laborer … you need to earn money in order to eat. It was very complicated and difficult. The first year was hell.

Even though she 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 Canadian work experience. Although her family struggled financially, she also had a financial commitment back home: "My husband's family back home wants 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 them." 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 20 years."

Another participant maintained that in addition to all their difficulties, financial problems added 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.

Workplace Discrimination

Some participants described negative treatment at the workplace as another factor that influenced family well-being and especially the new immigrant mother coping with PPD. One mother told us how discriminatory attitudes at her husband's workplace affected her family. Because of 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.

Power relations permeate all sectors of the Canadian workplace and can be exacerbated where immigrants and refugees are employed. Immigrants from an ethnic minority group with few job opportunities might find themselves in a subordinated position to the mainstream population [58]. One participant described her partner as being bitter as he faced unfair treatment in the workplace. Even though she, a mother of three, needed support she perceived that 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 go back to the Dominican Republic.

Another participant was frustrated by the negative treatment of new immigrants 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 … 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 going through the process and having your credentials, it really bothered me, I think it is discrimination …

Positive Energy and Coping Skills

In spite of multiple barriers to seeking help for PPD, the positive coping abilities of the participants coupled with spiritual and religious beliefs were strong facilitators in supporting them to deal with PPD and the related problems. In contrast to the difficulties discussed, participants expressed how migration has provided an overall improved socioeconomic status and created better life opportunities for themselves and their families. Although some participants were affected negatively by encountering a low socioeconomic status in their new country, some were motivated to create a more positive outlook for the future. Participants spoke of what kept them strong and also what enabled them to cope with the many changes and complexities of their circumstances. Being responsible for their health maintenance, change in mindset, spirituality, collective sharing, and a keen sense of hope for the future were expressed as ways to promote positive emotional well-being. Coping strategies linked to positive mental health included acquiring knowledge, focusing efforts to manage problems and therefore feeling a sense of empowerment, and setting realistic goals to solve problems. Setting goals can act as a catalyst to force one into action. One woman expressed her gratitude for the help received and saw 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 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 …

Despite having numerous difficulties and challenges many women described their resilience in adapting to their often difficult circumstances. They reframed the stressful events in more positive terms and as a result experienced growth and a stronger sense of control of their situation. Exposure to past adversities such as refugee camps, domestic abuse, and violence had strengthened their coping abilities:

> … Having experienced this, slowly you get more strong … having knowledge, you know how to protect yourself and protect your baby … your life gets better. Whatever blessing you have, you share … we're not really rich back home because everything comes from the family.
> We are strong enough to leave our countries and be here … so if we have that … everything is easy for us.

Spiritual and Religious Beliefs

For some participants spiritual beliefs and practices offered strong support for some of the most difficult days they had experienced. Religious and spiritual practices were viewed as positive and effective ways to cope with health challenges. Religion, identity, and spirituality played particular roles in the immigrant and refugee women's lives and enhanced their abilities to deal with the numerous challenges surrounding them. Their spirituality provided a sense of familiar strength and identity; it was expressed in prayers and beliefs, visions, spiritual healing practices of Reiki, and meditation and breathing exercises. For immigrant and refugee women who experienced complex issues post migration, spirituality might take on more importance and religious meeting places might become a source of community support. One woman spoke of how her religious beliefs and visions afforded her steadfast support and strength to deal with PPD and helped her care for her new infant born with Down syndrome:

> I have to be strong for my baby. Because when you pray he's listening … he sends angels to me in disguise. They're here protecting me, guiding me all my life … like St. Mary. I believe everything happens for a reason … it has to happen so good things can come. God won't put me into that situation if I couldn't cope … So all I ask for is strength to continue.

A refugee from Ethiopia expressed that her beliefs kept her strong and that she was grateful and proud of her strength:

> I believe in God, I prayed a lot. Really I am proud of myself … I came all the way from Africa to live here and have family. I keep that successful. So that gives me more strength, I say "wow … I did it," I'm thankful because all the time God was with me to help me. I never feel inferior, every single thing, I counted as success.

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 struggling with PPD and related problems.

Discussion and Recommendations

The data collected from the participants in this study revealed that the understanding of PPD among immigrant and refugee women is incomplete and that it is imperative that we raise our awareness and obtain more knowledge of PPD. Participants emphasized that many immigrant and refugee women are unfamiliar with the term postpartum depression. The women often chose to express their "depression" through descriptions of physical symptoms and emotional feelings explained as deep sadness within. Even those who had heard about PPD were not completely sure of the ramifications of depression after childbirth.

There is an absence of psychological terminology in many cultures, and cultural norms of respect and politeness may constrain emotional expression, or emotion may be expressed in nonverbal artistic ways such as poetry [59]. The Western diagnostic category of depression often does not have an equivalent in non-European languages; this makes the assessment of depression difficult [60]. It is important to note this cultural distinction because immigrant and refugee mothers might conceptualize, describe, and report symptoms of depression in ways quite different from what we expect. If we do not pay attention to these other modes of expression these women could fail to obtain appropriate screening, assessment, and treatment of PPD.

Because culture has a strong influence on immigrant and refugee women's mental health care experiences, an awareness of the social cultural context is necessary to provide appropriate, quality care for mental health needs during the postpartum period. We used Kleinman's explanatory model to examine the interactions of immigrant and refugee women with their families and social support networks, and their access to health care. We also attempted to enrich understanding of the broader social, political, historical, and economic influences that shape the health of a society.

We found that the women's explanatory models of illness and disease, their expectations of treatment, and their decisions about coping with illness and health care were shaped by their cultural backgrounds [42]. Kleinman's explanatory model helped us to recognize that the women's behavior and healthcare practices were impacted by cultural factors and that differences in explanatory models of health and illness influenced how they sought help for PPD. Cultural beliefs were shown to have both negative and positive effects on the mental health of immigrant and refugee women. On the negative side, cultural attitudes toward mental illness expressed individually and within the family, created a barrier to the access of health care services. The decision to seek help or to struggle alone was influenced significantly by the cultural background of each participant.

Kleinman's framework [42, 43] describes the family as a powerful and governing influence over immigrant and refugee women's health as well as a source of support during illness. Participants agreed that the role of the family was extremely important for emotional support during the PPD experience. Coupled with this prevailing power was the stigma of PPD, felt not only by the mother but also evident in discriminatory judgments of family members and ultimately apparent in the broader community. Our data show that the stigma of mental illness was a serious barrier to help-seeking behavior in immigrant and refugee women suffering from PPD. In several cases participants denied being depressed as they feared disclosure of depression would bring shame to themselves and their families. Alleviating the stigma attached to PPD is a challenge to health providers as the effects of stigma in managing a mental illness such as PPD are poorly understood [61, 62].

Employing the postcolonial feminist perspective we examined how gender, race, class, and power relations influenced the women's help seeking and support experiences and explored how contextual factors situate immigrant and refugee women in socially disadvantaged positions. One of the important functions of postcolonial feminist research is to examine how inequity and unequal power relations influence the distribution of health care resources and accessibility of health care services for women in marginalized social groups [45, 47].The majority of immigrant and refugee women in this study experienced structural barriers to obtaining mental health care in the form of limited financial resources, lowered socioeconomic status, and loss of prenatal support. Low income was a serious difficulty for the majority of participants. Most women relied on their partner (if employed) for financial support. Participants had difficulty securing employment because they lacked English language skills and/or childcare facilities; in some cases a precarious migration status disqualified them from available jobs. This prohibited some women from upgrading their skills, attending school, or gaining Canadian work experience. Some women were also disillusioned and despondent because their professional qualifications were not recognized in Canada.

Anderson [63] identified race and culture as two key concepts relevant to health. Culture rarely operates in isolation from constructions of race which is richly laden with social, political, and historical meanings. These understandings led us to further question and examine the unequal relations of power that have been with us since colonial days. Anderson [63] reminds us, "Racialization

serves to position women in different ways … all women do not share the same social reality and privilege operates along different socially determined axes of power" (p. 12). Anderson further explains that, rather than categorizing people by race, one should examine how racial categories are constructed and used in everyday life to categorize people in order to interpret their behavior. Racializing processes can affect anyone, and they are most detrimental in situations of unequal power relations where individuals are considered inferior or are in some other way disadvantaged. Discrimination is a significant part of relocation to a new country. Inequities begin with immigration requirements (status) and often continue during a search for employment. Hierarchies are shaped through nonformal and formal categories of who is a Canadian and who is not. The further underpinning of hierarchies through social policies leads to reduced opportunities to employment and access to health care services [64]. Racial discrimination led to negative consequences for the mental health of participants and in some cases obstructed their search for PPD help.

Employment and socioeconomic independence is more than just having enough money. For these women it was about having self-respect, being a productive member of society, and being able to contribute materially to the family. Some women expressed a fear that their sense of identity was in jeopardy. Economic dependence meant losing self-esteem and confidence; their sense of control over their situation was diminished. These factors contributed to depressive symptoms and affected how they coped with PPD and the ways in which they sought help. Similar findings have been reported in other studies of immigrant women [26, 65, 66].

Although the mainstream population might suffer from many of the same risk factors for PPD, individuals in the immigrant and refugee population are more likely to succumb to PPD because they are coping with financial, employment, and family issues brought about by the migration experience. However, we found that immigrant and refugee women's courage in facing migration challenges and coping strategies with PPD were substantial. Immigrant and refugee women have particular survival and adaptive strengths. The determination to maintain health, a strong work ethic, and flexibility were characteristics clearly shown by these participants. They reframed the stressful events in more positive terms and as a result experienced growth and a stronger sense of control of their situation. Moreover, participants expressed great aspirations and hopefulness to move forward to a brighter future. Spiritual and religious practices were sources of strength and hope and provided a way to cope with often complex circumstances and mental health vulnerability. Spiritual and religious practices have been cited as sources of support and protection in other studies of immigrant women [67–70], as resettlement and loss of preexisting support networks can create an intolerable level of stress. It is strongly suggested that closer links with community spiritual organizations can help health care services recognize the role of spirituality in the preservation of mental health [71, 72].

Through conversations with the researchers, participants acquired knowledge of the multiple factors that affect postpartum health, and this gave them power over this particular circumstance. The critical ethnography methodology gave the research participants a voice and afforded their active engagement in the research process of discovery and analysis. The immigrant and refugee women also gained transformative knowledge, that is, new knowledge that had the potential to change them from submissive struggling individuals with PPD to experienced and knowledgeable individuals who could actively advocate for women suffering from PPD.

Limitations of this Study

Results of this study cannot be generalized to all immigrant and refugee women or to other contexts because of the small sample size and the nature of qualitative research. By using a larger sample and a mixed methodology in future research the scope could be broadened. Although some scholars might view the wide age range (18 years and over) of participants in this study as a limitation, we believe that the diversity of the sample enriched the findings. Because of the language barrier, an additional limitation was the utilization of interpreters. Even though 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 will be changed through the translation process.

Implications for Practice

Culturally appropriate care for immigrant and refugee women means that health care providers are aware of and sympathetic to the issues faced by these women. As informed researchers, we advocate for more culturally appropriate health care programs and services that meet immigrant and refugee women's mental health needs. Through listening to the women's voices we are beginning to understand the factors that cause women to feel powerless, dependent, isolated, and oppressed. This understanding needs to be applied to social determinants that

impact the mental health and well-being of immigrant and refugee women.

Support of immigrant and refugee women will be established by enabling them to find their own voice and recognize their own strengths and resiliency in problem solving, individually and within their families and their community. New immigrant and refugee mothers and their families need connections with community-based services to take advantage of available supports. These women need to be referred by government agencies and health care workers to appropriate sources of aid and relevant support programs in the community. Culturally appropriate care for immigrant and refugee women means 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.

Nurses and other health care providers are well positioned to identify women who might need help during the perinatal period. Public health nurses in particular have contact with postpartum women, and therefore have opportunities to screen for PPD, make referrals, and use their strong communication skills to provide supportive counseling. Health care providers have the opportunity and responsibility to intervene in promoting mental health by improving access to mental health services. Health care providers also have a role in educating the public and reducing stigma.

Health professionals should challenge themselves to recognize and question how communication style, attitudes and beliefs may affect their own practice. Stereotyping discourses have labelled immigrant and refugee women as being passive and without agency. How immigrant and refugee women understand their PPD seeking help 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. 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 [73]. Cultural competence may result in less 'blaming of the victim' that is, we shift our attention towards the social factors that impact individual choices [66]. The question of who to blame or who may be responsible is answered from a different perspective.

Conclusion

To provide cultural sensitive and appropriate care, health care providers must strive to recognize cultural differences that influence immigrant and refugee women's mental health and health care practices. Account must be taken of these women's everyday lives and the socioeconomic factors that influence their experiences. This means asking more questions about how power relationships, politics, and economic perspectives shape social structures and create economic barriers that prevent women from taking responsibility for their health [74, 75]. 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. Participation of immigrant and refugee women in health care promotion or illness prevention programs will depend on the reduction of these barriers and on efforts of health care providers to encourage these women to surmount these barriers.

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