

PUNJABI IMMIGRANT MOTHERS' EXPERIENCES  
OF POSTPARTUM DEPRESSION: A NARRATIVE INQUIRY

by

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## **AUTHOR'S DECLARATION**

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**ABSTRACT**

Postpartum depression can adversely affect not only a woman's health and well-being, but also the health and development of her infant, as well as her family relationships. Research reveals immigrant women have higher risk factors for postpartum depression. The purpose of this Narrative Inquiry is to give voice, to Punjabi immigrant mothers who have experienced symptoms of postpartum depression. Connelly and Clandinin's Narrative Inquiry approach was used to explore the experiences of two Punjabi immigrant mothers with self-identified symptoms of postpartum depression. Participants engaged in a narrative interview and an adaptation of the Narrative Reflective Process, a data collection tool that allows creative self-expression and reflection. Womens' stories were re-constructed and analyzed using Narrative Inquiry's three levels of justification (personal, practical and social). Findings reveal three key narrative patterns: motherhood, relationships and loneliness, each informed by the narrative thread of immigration. The outcomes of this inquiry suggest that, as healthcare professionals and policy makers, we need to broaden and deepen our understanding of postpartum depression from the immigrant mothers' perspective, so that we can provide them with a more effective support during this significant time in their lives. Such sensitive and thoughtful care has the ability to improve their well-being and the health of their infant, as well as that of the whole family.

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## **DEDICATION**

I dedicate this thesis to my loving parents, who always provide me with unconditional support, wisdom and encouragement to fulfill my aspirations. Your devotion to education provided me with the inspiration to complete graduate studies. Thank you for believing in me and standing by my side along this journey. I will always be grateful for everything you have done for me.

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## PROLOGUE

### “The Journey of a Thousand Miles Begins With One Step”

Lao Tzu (Brainy Quotes, n.d.)

Dear Reader, I invite you to join me on my thesis journey, along a road less travelled in nursing research, Narrative Inquiry (Connelly & Clandinin, 1990, 2006). When we engage in conversations with friends, families and colleagues we share stories of our experiences. In doing so, we listen, comment and ask questions to better understand these accounts. In similar fashion, Narrative Inquiry is a qualitative research method, where participants, in relationship with the researcher, tell their stories of experience, which happen over time and in a place (the three-dimensional narrative inquiry space, further described in Chapter 3). Following a rigorous analysis of the stories, this process allows an in-depth understanding of the phenomenon under investigation.

This prologue serves to introduce you to the eight design elements of Narrative Inquiry (Clandinin, Pushor, & Orr, 2007).

#### **First Element: Justification**

The first design element identifies the reasons for this inquiry. In Narrative Inquiry these are explored at the three levels of justification: personal, practical and social (described in greater detail in Chapter 3). The introductory chapter begins with my own story, the personal justification for the choice of the topic. The literature review (Chapter 2) explains the practical and the social justifications for this inquiry.

## **Second Element: Phenomenon**

The second design element states what the inquiry is about by naming the phenomenon of interest (Clandinin et al., 2007). This is identified in Chapter 2 in form of the inquiry puzzle, traditionally referred to as the research question. The stories of the phenomenon under investigation, as shared by the participants, are presented in Chapters 5 and 6.

## **Third Element: Methods**

The third design element describes the Narrative Inquiry methodology (Clandinin, et al., 2007). In Chapter 3, I define Narrative Inquiry and provide its historical background, and the three-dimensional narrative inquiry space. The specific process of participant recruitment and data collection methods is addressed in Chapter 4.

## **Fourth Element: Data Analysis**

The fourth design element describes and explains the process of analysis and interpretation of the research text using the three levels of justification. In Narrative Inquiry, the three levels of justification for choice of phenomenon are also used for its analysis. The steps involved in this process are detailed in Chapter 3.

## **Fifth Element: Personal Justification**

The fifth design element refers to the positioning of the narrative inquirer in relation to the inquiry. My researcher voice, as well as my reflections and interjections, are threaded throughout the participants' stories (first level of justification: the personal) in Chapters 5 and 6.

### **Sixth Element: Practical and Social Justifications**

The sixth design element of design explains this Narrative Inquiry and the resulting knowledge gained from the analysis process. As the narrative patterns emerge, these threads are reflected upon and further explored, using the Narrative Inquiry three-dimensional space as the theoretical lens and scholarly literature. Thus, in this second level of analysis, the practical justification (Chapter 7), I explore the knowledge gained in relation to the greater professional context: the nursing profession.

In the third level of analysis, the social justification (Chapter 7), I broaden the significance of the told stories to the greater healthcare context and society at large. The inquiry is further contextualized within existing research literature, answering the questions “So what?” and “Who cares?”

### **Seventh Element: Ethical Considerations**

The seventh design element in Narrative Inquiry is the ethical considerations that must be followed throughout the research process (Clandinin et al., 2007). Since the inquirer (researcher) becomes involved with participants in the field, listening to their stories, the inquirer-participant relationship develops and requires special consideration from an ethical standpoint. Ethics considerations, including rigour and reflexivity, are discussed in Chapter 4.

### **Eighth Element: Representation of Findings**

The eighth design element to consider in Narrative Inquiry involves the researcher’s conscious representation of the research text into narratives (Clandinin, et al., 2007). The reconstructed stories (narrative texts) can be re-presented in various forms, such as drawing, poetry, and letters, to share research findings (Chapter 8).

In the next chapter, I introduce you to my personal story for conducting this inquiry.

## CHAPTER ONE

### **My Story: Personal Justification**

I was born in the United Kingdom, into a Punjabi family. I immigrated to Canada in the mid 1970's with my parents and two younger brothers. I was six years old. I recall feeling sad as I said good-bye to my auntie who would remain in England. She and I were very close. To this day, I still miss her warm hugs and smiles.

Canada was a country of growth in the mid 1970's. Many families immigrated from all over the world to settle in Canada. My dad's brother moved from India to live in Toronto during this time. He encouraged my dad to join him in Canada with our family. So we did. My mom was pregnant with her fourth child during the transition from England to Canada. Looking back, I wonder how she was able to manage packing belongings for the entire family while being pregnant and caring for three children on her own. My dad was supportive when he was with her at home, but he had to work long hours during the day. We did not have a lot of family close by to lessen our family's burdens. But, my mother was strong and resilient, and to this day, she always seems to manage it all.

My family settled in the west end of Toronto, known as the Junction. Memories of my childhood are filled with images of warm summers riding our bikes all day long and playing in the community parks. Both of my parents worked diligently to provide a good life for us. Here in Toronto, our extended family lived close by, which allowed me to build strong bonds with my cousins, I still treasure today.

Time passed quickly. I was the first in my family to be married. I was a young Punjabi woman in my early twenties preparing for a new family life once more; this time

with my in-law family. After the wedding festivities passed, life set in. I was expected to reside in the same home with my in-laws. I had no choice! My husband was adamant we live with his parents. I felt overwhelmed with new family responsibilities as a wife and daughter-in-law; cooking, cleaning and daily household chores. As I integrated into this new life, time with my parents and siblings became restricted. My husband was not keen on me visiting my family. I felt isolated. However, I did not speak up. I pretended to be happy, but deep down I felt like I was losing my independence, and my family of origin.

When we returned from our honeymoon, my husband lost his job. He decided to return to school for two years to pursue a new career. It was a challenging time for me. As I was adjusting to the new role as a married woman, I became pregnant. Although my pregnancy came sooner than anticipated, it was a special feeling of excitement for me. Since my husband was still in school, I attended many of my doctor's appointments on my own. At times, I felt lonely. I wished I had someone with me for support and reassurance. My family lived more than one hour away and I did not want to bother them, so I did the best I could to manage on my own. Ten months passed by quickly. I still recall the day I felt my first contraction:

It is a bitterly cold December day. I wake early. The snow is falling. The winds are strong and the roads are covered in a white blanket of snowflakes. As I walk to the washroom, I feel a mild contraction in my lower back and abdomen. I wonder if this is the start of early labour. An hour later the contractions begin to get stronger. I am in labour! I am feeling nervous and excited, all at the same time. My water breaks. I need to get to the hospital. I call my husband in a panic. Feeling worried, he grabs the hospital bag and we

drive to the hospital. The roads are icy and the driving is treacherous. The hospital is only five minutes from our house, but it feels like it is taking forever to get there. As contractions get stronger my pain becomes more extreme. I tell my husband, "I can't do this". He gives me encouragement and reminds me to breathe. I remember the deep breathing technique I learned in prenatal class. I purse my lips and take a deep breath and then slowly exhale. Breathing helps to momentarily distract my attention. Finally we reach the hospital emergency department. What transpires next is a bit of a blur.

After several hours of labour, I was told that the baby's heart rate is compromised and I would need an emergency cesarean section delivery. I remember feeling confused and scared. This was not at all how I had envisioned my labour journey. But, I had to accept the reality. My husband called my parents and brothers to let them know I was in the hospital. Everyone came to the hospital and waited with anticipation. I felt fortunate to have my husband and family around for moral support during this time.

Later that day my son was born. I remember feeling so happy that I wanted to cry. It was a day filled with many emotions. There must have been over twenty family members who came that day to visit and meet my son. Although, I was grateful, I was exhausted from the labour and just wanted to rest. My nurse, who could see my fatigue, advocated for me and asked everyone to leave my hospital room so that I could rest. After everyone left, I began to cry. I was confused as to why I felt so emotional. I tried to make sense of the sadness I was feeling: "Maybe I'm just tired? Maybe it's the change in hormones?" I thought to myself: "I should be happy. But I am not! What is going on?"

I remained in the hospital for one week with my baby. I had a high fever and the baby required monitoring in the neonatal intensive care unit. During this time, my emotions continued to fluctuate. One day my nurse noticed I had been crying. She sat beside me and began to explain:

Sometimes the postpartum period can be a really emotional time. When things don't go the way you plan, you may feel disappointed and overwhelmed. I see that you have been crying. Don't worry. This emotional rollercoaster will eventually slow down. You are going through what is called postpartum blues. Many new moms experience these feelings for the first few days after giving birth. However, if these feelings of sadness continue past two weeks, then I want you to tell your doctor or nurse to get some support. Will you do that Poonam? "Yes, I will. Thank you so much for telling me. I wasn't sure what was happening." I gratefully reply. She continued to explain that not many people know that postpartum blues can progress into postpartum depression. That is why it is so important to follow up with your family doctor for your postpartum check-up.

To this day, I still recall the wonderful nurse who sat with me and provided me with the information and the reassurance I needed. Thankfully, the feelings of sadness eventually disappeared. However, my life with my new baby was challenging. After I was discharged from the hospital, I went to my mom's house for forty days. In India it is a common tradition for new mothers to stay with their own mother for support and guidance in caring for the newborn. I was fortunate my mom lived relatively close by. She not only helped me to care for my baby but also encouraged me to get lots of rest and

eat healthy. My husband came periodically to visit me. After forty days, I returned to my in-laws' home. At first, it was difficult to care for my baby on my own. Even though my husband was consumed with his studies, he reserved time to play with our son in the evenings. This allowed me time to catch-up on my household chores. However, it felt like the work would never end. Although I lived with my in-law family, during the day I was alone with my son. We shared wonderful moments together, and yet I often felt lonely. Before I realized it, six months were up and I returned to work in the dental clinic. Then, a year and half later I gave birth to my daughter. I was a busy mother working full time outside the home, while caring for my two very young children at home. Although it was my joy to look after my children, the home care and outside work obligations were taxing.

As the seasons changed year by year so did my life. I became a single parent and I returned to school to pursue my nursing degree. Today, many years later, in the role of a registered nurse, I provide prenatal and postpartum education to women from diverse ethnocultural backgrounds, many of whom are Punjabi immigrant women. My personal experience of postpartum blues makes me more aware of how isolating such a feeling may be for a new mother. And, I can only imagine how more difficult postpartum depression could be for women, their children and families. I was fortunate to have the support of my family of origin. But, what about new immigrant women who do not have their family close by? How do they manage?

As a community nurse who supports women's postpartum health, and as a Punjabi woman who experienced postpartum blues, I want to hear the stories from Punjabi immigrant mothers on how they experience, what they define for themselves as,

postpartum depression. Using Narrative Inquiry (Connelly & Clandinin, 1990), I explore two women's storied experiences of life after childbirth. It is my hope that this inquiry will provide a greater understanding of Punjabi immigrant women's postpartum experience with depression, and shed light on how we, as healthcare providers, could better support them.

In the next chapter, the literature review, I explain the practical and the social justifications for this inquiry.

## **CHAPTER TWO**

### **Literature Review and Synthesis: Practical and Social Justifications**

This chapter further expands on the Narrative Inquiry's first design element, the practical and the social justifications for investigating my chosen phenomenon: Punjabi immigrant mothers' experience of postpartum depression. I reviewed literature in the area of nursing and social sciences to learn what is already known about this topic.

Throughout the chapter I identify the gaps in the literature and how my inquiry may contribute to deepen the understanding of postpartum depression from the perspective of Punjabi immigrant mothers.

When I began exploring research literature for this study, I soon realized the numerous definitions and names that exist for postpartum depression. Within this literature review section, I first introduce and define postpartum depression and how it is used in my thesis, and then review the relevant research literature to discuss the prevalence, consequences and risk factors related to postpartum depression. Following, I explore the social cultural context and screening for postpartum depression in South Asian immigrant women. I address the existing gaps in the literature and consider how my inquiry may inform the profession of nursing (practical justification), as well as the community organizations in the broader healthcare context (social justification), in developing more effective approaches to support Punjabi immigrant women with postpartum depression.

### **Definitional Perspectives**

Childbirth is a significant life event and usually an exciting time for a first time mother and her family. However, for some mothers, the period following childbirth

(postpartum period) brings with it both physical and unexpected emotional changes. According to the Centre for Addiction and Mental Health (CAMH, 2012) postpartum baby blues is a term used to describe the first few days after delivery when mothers may experience tearfulness, fatigue, irritability, difficulty sleeping and mood swings. The baby blues often disappear on their own or with support and reassurance. Sometimes, when the feelings of sadness persist for more than two weeks, mothers may experience a form of non-psychotic depression, postpartum depression (CAMH, 2012). Postpartum depression is a form of depression that may start during pregnancy or anytime within the first few weeks, months or even up to a year after childbirth (CAMH, 2012; Canadian Mental Health Association, 2015; Ross, Dennis, Blackmore, & Stewart, 2005).

According to the latest Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) from the American Psychiatric Association (APA, 2013) the diagnosis of depression now includes an onset specifier called “peripartum onset” which recognizes onset of a mood disturbance can occur during pregnancy and up to four weeks following childbirth.

Within the literature, there are many terms to describe depression after the birth of a baby: antenatal depression (Miszkurka, Goulet, & Zunzunegui, 2010) postnatal depressive symptoms (Mechakra-Tahiri, Zunzunegui, & Seguin, 2007), postpartum depression (Morrow, Smith, Lai, & Jaswal, 2008; O’Mahony, Donnelly, Bouchal, & Este, 2013; Sword, Watt, & Krueger, 2006; Teng, Robertson-Blackmore, & Stewart, 2007; Van Lieshout, Cleverley, Jenkins, & Georgiades, 2011) and postpartum mood problems (Mamisachvili, Ardiles, Mancewicz, Thompson, Rabin, & Ross, 2013).

For the purposes of my inquiry, I use the term postpartum depression and allow participants to self-identify as individuals who experience it. Inclusion criteria for this inquiry was any participant of Punjabi origin who experienced any of the following: overwhelming feelings of sadness, tearfulness, frustration, continued lack of sleep, changes in eating patterns, feeling guilty and/or a lack of bond with their baby within the first year after childbirth.

## **Literature Review**

### **Prevalence**

A growing body of literature (Kingston et al., 2011; Mamisachvili et al., 2013; Miskurka et al., 2010; O'Mahony, Donnelly, Bouchal & Este, 2012; Teng et al., 2007; Sword et al., 2006; Zelkowitz, Saucier, Wang, Katofsky, Valenzuela, & Westreich, 2008) suggests immigrant women are more likely to experience postpartum depression as compared to Canadian born women. Data collected from three surveys; Canadian Maternity Experiences Survey (CMES) 2006-2007, Quebec Longitudinal Study of Child Development (QLSCD) 1998-2002 and The Ontario Maternal Infant Survey (TOMIS) 2001-2002, provide a snap shot of the prevalence of postpartum depression in Canadian immigrant women. Many other studies (Kingston et al., 2011; Mechakra-Tahiri et al., 2007; Sword et al., 2006) have analyzed the data from these three large-scale surveys and reported secondary findings.

The CMES from the Public Health Agency of Canada (PHAC) was a national telephone based survey of 6421 women that provided insight into Canadian women's experiences, knowledge and practices from preconception to the postpartum period (PHAC, 2014). Kingston et al. (2011) analyzed the data from the CMES and reported, 13.2% of recent immigrant women (living in Canada less than five years) scored above

the cut off on a postpartum depression screening tool, the Edinburgh Postnatal Depression Scale (EPDS), compared to 6% of Canadian born women. Immigrant women had higher rates of postpartum depression symptoms, less access to support, less likely to have support available and less likely to access support (Kingston et al., 2011). Findings from other studies (Ganann, Sword, Black, & Carpio, 2012; Miskurka et al., 2010; Stewart, Gagnon, Saucier, Wahoush, & Dougherty; 2008; Sword et al., 2006; Teng et al., 2007; Van Lieshout et al., 2011) also confirm immigrant women have higher rates of postpartum depression than non-immigrant women.

The QLSCD provides baseline data from a sample of 2224 mothers from different ethnocultural backgrounds who completed a questionnaire to examine factors associated with postpartum depression according to immigration status, using the Center for Epidemiologic Studies Depression Scale (CES-D). Mechakra-Tahiri, Zunzunegui and Seguin (2007) analyzed data from the QLSCD and reported the prevalence of depressive symptomology was twice as high (24.7%) among immigrant women from minority groups (country of birth: Europe, United States, Australia and New Zealand) as apposed to Canadian born women (11.2%). The findings from Mechakra-Tahiri et al. (2007) were confirmed by Zelkowitz et al. (2004) that suggested, 42% of immigrant women had maternal depression. Both these studies (Mechakra-Tahiri et al., 2007; Zelkowitz et al., 2004) provide evidence that confirms the prevalence of postpartum depression is higher among immigrant women (Kingston et al., 2011; Mamisachvili et al., 2013; Miskurka et al., 2010; O'Mahony, Donnelly, Bouchal & Este, 2012; Teng et al., 2007; Sword et al., 2006; Zelkowitz, Saucier, Wang, Katofsky, Valenzuela, & Westreich, 2008).

The Ontario Maternal Infant Survey (TOMIS) was a self-administered questionnaire with a total of 1250 Canadian born and immigrant women, of which 31.4 % were born outside of Canada (Sword et al., 2006). The survey describes the postpartum health and service needs in the first four weeks following hospital discharge in Ontario, Canada. Using the Edinburgh Postnatal Depression Scale screening tool, Sword and colleagues (2006) found that immigrant women were (15.1%) more likely than Canadian women (7.3%) to have depressive symptoms. Additionally, they had unmet learning needs related to difficulty accessing culturally appropriate health information in their own language.

The findings from these three large-scale Canadian surveys (CMES, QLSCD and TOMIS) cannot be generalized to South Asian women. The CMES and QLSCD was conducted in only English and French and the cross-cultural validity of these surveys have not been evaluated to date. TOMIS was conducted in English, French, Spanish and Chinese languages with immigrant women from different minority groups. No South Asian women participated in any of the surveys. However what we do know is, the prevalence of postpartum depression among immigrant women is significantly higher when compared with Canadian born women.

### **Consequences**

Depression is a common complication following childbirth that can adversely affect not only a woman's health, but also the health and development of her infant and family relationships (Morrow et al., 2008; Mechakra-Tahiri et al., 2007; O'Mahony & Donnelly, 2013; O'Mahony et al., 2013). Postpartum depression can disrupt the maternal attachment bond, stemming from mothers who are withdrawn with minimal verbal

interaction, expression of less positive facial emotions and decreased physical affection; resulting in an insecure infant attachment (Boyd, Zayas, & McKee, 2006; Hatton et al., 2005; Righette-Veltema, Conne-Perreard, Bousquet, & Manzano, 2002). Mothers who are depressed are less likely to utilize services such as age appropriate infant medical visits and have poor up take of preventive safety measures (using an infant car seat, smoke detectors, electric plug covers) subsequently, putting the infant at risk for harm (McLellan & Kotelchuk, 2000; Minkovitz et al., 2005). An insecure maternal infant attachment relationship results in poor physical growth (Rahman, Isbal, Bunn, Lovel, & Harrington, 2004) with possible long-term consequences on the cognitive, behavioural and emotional development of the infant (Righette-Veltema et al., 2002).

Negative emotions such as deep sadness, anxiety, and at times aggression (Righette-Veltema et al., 2002) cause a strain on the marital relationship and the transition into the role of a new parent. O'Mahony et al. (2013) conducted a critical ethnographic study of 30 Canadian immigrant women (including three South Asian women) which revealed immigrant mothers face challenges related to mental health stigma. Women reported hiding depression from their family and doctor, which prevented them from seeking help and support for postpartum depression. Furthermore, if symptoms of postpartum depression are left untreated, it may lead to thoughts of harming the infant and or possible suicide (CAMH, 2012; Collins, Zimmerman, & Howard, 2011). It is evident that postpartum depression may have serious consequences for the mother, baby and her family; for this reason it is important for nurses and other healthcare professionals who work with immigrants to gain a better understanding of how immigrant mothers experience postpartum depression in order to provide appropriate support.

## **Risk Factors**

The literature suggests immigrant women may be at increased risk for postpartum depression due to the interconnected risk factors relating to the social determinants of health and migration to a new country (Collins et al., 2011; Dennis, Heaman, & Vigod, 2012; Dennis, Janssen, & Singer, 2004; Fung & Dennis, 2010; Sword et al., 2006; Zelkowitz et al., 2004). These risk factors include previous history of depression, lack of social support, cultural factors, low socioeconomic status, and recent stressful life events.

**Past history of depression.** History of depression may serve as an independent risk factor for postpartum depression (CAMH, 2012; Dennis et al., 2012; Dennis et al., 2004; Morrow et al., 2008). Data from the CMES representing a national Canadian sample from the 2006 Census identified a previous history of depression as one of the predictors for symptoms of postpartum depression (Dennis et al., 2012). My inquiry provides an opportunity for Punjabi immigrant mothers to tell stories of their experiences with postpartum depression.

**Immigration.** Although immigrants may generally arrive to Canada healthy, they often experience a decline in their health over time; this is known as the “healthy immigrant effect” (Gagon et al., 2013). The transition to a new country brings with it stressors that present unique challenges. Several articles discussed the immigration experience as a risk factor for postpartum depression (Collins et al., 2011; Dennis et al., 2004; Miskurka et al., 2010; O’Mahoney & Donnelly, 2013; Van Lieshout et al., 2011; Zelkowitz et al., 2008). The process of moving from a country with established social supports to an unfamiliar environment with a limited family support may lead to social isolation, which can increase the risk for postpartum depression (Ahmed, Stewart, Teng,

Wahoush, & Gagnon, 2008; Miskurka et al., 2010). Other risk factors for postpartum depression in the literature include financial difficulties (Ahmed et al., 2008; O'Mahoney & Donnelly, 2013; Miskurka et al., 2010; Sword et al., 2006) possibly from limited recognition of foreign professional credentials, discrimination (Fung & Dennis, 2010; Zelkowitz et al., 2004) and limited language proficiency (Ahmed et al., 2008; Brar, Tang, Drummond, Palacios-Derflinger, Clark, John & Ross, 2009; O'Mahony et al., 2012) which may contribute to a lack of knowledge and decreased access to support services to treat postpartum depression.

Women sponsored by their husbands to immigrate, reported concerns of feeling powerless because they were dependent on their spouse, thereby increasing marital strain and vulnerability in developing symptoms of postpartum depression (O'Mahoney & Donnelly, 2013; Zelkowitz et al., 2008). Research reveals poor spousal relationships (Morrow et al., 2008; O'Mahoney & Donnelly, 2013; Zelkowitz et al., 2008) and intimate partner violence (Dennis et al., 2012) was also a risk factor for depression in the postpartum period. Miskurka et al. (2010) reported immigrant women from the Caribbean, South Asia, Maghreb, Sub-Saharan Africa and Latin America had an increased risk for postpartum depression than Canadian born women, independent of their length of stay in Canada. These studies confirm the immigration experience and determinants of health including low socioeconomic status; education and personal health practices are strong determinants for postpartum depression.

**Lack of social support.** Grewal, Bhagat and Balneaves (2008) conducted a qualitative study with 15 Punjabi immigrant women, which highlights the vital role of family members in providing instrumental support and advice on caregiving in the

postpartum period. The birth of an infant was described as a celebrated event for these Punjabi families. Childbirth was recognized as a family experience where female elders often provided advice on diet and lifestyle. Immigrant women who do not have the social support from family living in close proximity, may become isolated and at greater risk for losing their postpartum rituals, which adds to the maternal stress of caring for a newborn. Bhagat, Johnson, Grewal, Oandher, Quong and Triolet (2002) share findings from a community mobilization project, which was conducted to explore strategies in order to improve the health needs of immigrant Punjabi women in British Columbia. A team of public health nurses from the South Asian community, program managers, community outreach workers, women from the Punjabi community and an academic formed a team to lead the community mobilization project (Bhagat et al., 2002). The project conducted focus groups with Punjabi immigrant women and consultations with representatives from social service agencies and community groups. The article did not indicate the number of participants involved in the focus groups. The topic of postpartum depression was identified as a health issue in the Punjabi community. Since Punjabi immigrant women were often isolated from the mainstream culture due to limited language proficiency, they did not seek healthcare services for their postpartum depression. Findings from Grewal et al. (2008) and Bhagat et al. (2002) reveal most Punjabi immigrant women do not attend prenatal classes. Participation in a prenatal class would not only provide health teaching related to labour/delivery, infant care and what to expect in the postpartum period (signs and symptoms of postpartum depression) but it would also promote social connectivity for immigrant women to meet other immigrant women in the community and possibly build a social support network. Bhagat et al.'s and Grewal et al.'s studies were the only

two in this literature review that investigated Punjabi immigrant women, and that discuss prenatal care and education. Lacking is research that explores the experiences of Punjabi immigrant mothers in the postpartum period from their perspective. In my Narrative Inquiry, I listen to stories of Punjabi immigrant mothers to gain insight into how they experience postpartum depression.

### **Socio-Cultural Context**

Morrow et al. (2008) explored the meaning of postpartum depression among three groups (Mandarin, Cantonese and Punjabi) immigrant women in British Columbia with narrative interviews. The research findings suggest a lack of terminology for the word depression in the three different immigrant groups. One South Asian woman explained her feelings of depression as follows, “I thought I was anxious because it was very hot in India and because I was in an enclosed house, with no light. This is what I thought was causing my anxiety. I didn’t think it was a disease, but here [in Canada] the doctors are saying it is a disease” (Morrow et al., 2008, p. 602). The personal stories provide descriptions of how immigrant women understand and experience depression after childbirth. The narrative interviews in the study highlight psychosocial stressors resulting from difficult interpersonal relationships and those associated with the immigration experience as a significant contributor to depressive symptomology in the sample of eighteen participants (Morrow et al.).

Grewal et al. (2008) discuss the importance placed on Punjabi health beliefs and practices (diet, lifestyle, rituals) in the prenatal and postpartum period in Canada. The traditional beliefs and practices influenced how Punjabi mothers responded to postpartum depression and the seeking of mental health services for support (Grewal et al., 2008).

Mothers reported both positive and negative interactions with healthcare professionals in Canada (Grewal et al., 2008), which is confirmed in other studies (Bhagat et al., 2002; Morrow et al., 2008). In the Punjabi culture, since direct questioning by an unfamiliar person regarding personal matters is considered inappropriate, face-to-face interviews with a mature female research assistant who was fluent in the Punjabi and English language were conducted in Grewal et al. The findings were further validated through interviews with five healthcare professionals in the community. What the study lacked was an exploration into emotional feelings in the postpartum period. Family members may not recognize or, refuse to accept the existence of postpartum depression due to the barriers of stigma and shame associated with a mental health illness (Ahmed et al., 2008; Morrow et al., 2008; O'Mahony et al., 2013; Teng et al., 2007). Punjabi immigrant women's stories of experiencing postpartum depression is lacking in the existing research literature in Canada.

### **Screening in South Asian immigrant women**

In the healthcare field, screening tools provide a measure of risk factors for conditions such as postpartum depression. In studies that included immigrant women as part of the sample population, there was a common theme: women were more likely to express symptoms of postpartum depression in a complex inter-relationship of physical, emotional and sociocultural contexts (Morrow et al., 2008; O'Mahony et al., 2013; Zelkowitz et al., 2008). In Morrow et al. (2008), South Asian immigrant mothers attributed depressive symptoms to situational stressors resulting from a lack of emotional support from their husbands and family members, in addition to personal physical health problems. Zelkowitz et al. (2008) conducted a survey in Canada with 106 immigrant

women from 44 different countries, and 29 languages. The study suggests psychological distress had a negative impact on marital relationship quality. Immigrant mothers were more likely to experience postpartum depression and express their mental distress through somatic symptoms which included: abdominal pain, limb pain, chest pain, nausea, vomiting, loose bowels, excessive gas/bloating, dizziness, fainting, weakness, sickly feeling and fatigue (Zelkowitz et al., 2008). Furthermore in O'Mahony et al. (2013) interviews with 30 immigrant mothers revealed there was an absence of psychological terminology and, some of their cultural norms of respect may prevent them from expressing their emotions, or emotions may be expressed in nonverbal artistic ways such as poetry. Postpartum depressive symptoms were also often expressed through descriptions of non-specified physical symptoms and internal feelings of deep sadness. However, these feelings were not shared with family or healthcare professionals, posing a barrier to screening. Many of the tools used by healthcare professionals to screen for postpartum depression do not include symptoms that are expressed by Punjabi immigrant mothers such as anxiety, irritability and somatic complaints (O'Mahoney et al., 2013). Hence, screening tools may not be reflective of Punjabi immigrant women, who often express emotional distress through physical descriptions. My inquiry provides the much-needed insight into how Punjabi immigrant mothers, living in southern Ontario, understand and experience postpartum depression.

### **Literature with Punjabi Immigrant Women**

Research focusing on Punjabi immigrant mothers' experience of postpartum depression is lacking. In Canada, South Asians are the largest racialized group with a total of 1,567,400 individuals, residing mostly in Ontario, British Columbia, Quebec and

Alberta (Statistics Canada, 2011). Punjabi was one of the top immigrant mother tongue languages reported in the 2011 Census in Canada (Statistics Canada, 2011). In this literature review, there were only three Canadian articles (Bhagat et al., 2002; Grewal et al., 2008; Morrow et al., 2008) that explored the prenatal or postpartum experiences with Punjabi immigrant mothers. Bhagat et al. describes how community mobilization strategies were used to improve the health of pregnant immigrant women in British Columbia's Punjabi community. A collaborative approach was implemented with representatives from community service agencies. Although postpartum depression was recognized as a health issue in the prenatal period, the emphasis of this project was on creating awareness of prenatal care. The article affirms prenatal education is lacking in the Punjabi community, which means first time parents might not be aware of symptoms of depression in the postpartum period, and as a result may not seek support.

In a descriptive qualitative study, Grewal et al. (2008) interviewed 15 Punjabi immigrant women living in British Columbia, to explore their prenatal experiences. The study provides valuable insight into the emphasis placed on the cultural context of Punjabi postpartum rituals as a source of resiliency. First time mothers valued advice from female elders, but felt overwhelmed when this advice conflicted with that of Canadian healthcare professionals. Considering the importance placed on family involvement, Punjabi immigrant mothers may be reluctant to seek advice for symptoms of depression from family or their doctor due to fear of stigma.

Lastly, Morrow et al. (2008) used an ethnographic narrative approach in their research with three groups; seven Mandarin, eight Cantonese and three Punjabi, first generation immigrant women. Morrow et al. was the only in-depth study in this literature

review that reported on Punjabi immigrant mother's experiences of postpartum depression. Findings revealed the importance of the sociocultural context of childbirth in understanding postpartum depression (Morrow et al., 2008). The narratives provide insight into mothers' experiences through the use of metaphors; which described depression in the context of their relationships and social networks (Morrow et al., 2008).

### **Gaps in the Literature**

From the Canadian literature presented in this chapter, it remains difficult to gain an understanding of the personal experiences of Punjabi immigrant women with postpartum depression. The literature confirms immigrant women are at higher risk for postpartum depression than Canadian born women. In order to provide effective support for immigrant mothers, it is vital that Canadian research is conducted to understand the experiences of postpartum depression from the immigrant women's perspective; such as those emigrating from Punjab, India. As a starting point, in my inquiry I invite two Punjabi immigrant mothers to tell stories of how they experience postpartum depression. Conducting a Narrative Inquiry (Clandinin & Connelly, 2000) allows for personal stories to be told, heard and critically reflected upon, opening the door for a deeper understanding of their experiences with postpartum depression. Furthermore, existing Canadian studies with Punjabi immigrant women have all been conducted in British Columbia. To date, no studies with Punjabi immigrant women have been conducted in Ontario, and specifically using the Narrative Inquiry (Clandinin & Connelly, 2000) approach.

The second design element of Narrative Inquiry is to name the phenomenon of interest (Clandinin et al., 2007). Based on my personal and professional experience and

the literature review (personal, practical and social justifications), the purpose of this Narrative Inquiry is to give voice to Punjabi immigrant mothers who self-identify with symptoms of postpartum depression, and to thereby learn from these women's stories how they experience and understand that significant part of their life. In the context of this inquiry, the term 'Punjabi immigrant mothers' refers to women who have immigrated to Canada from Punjab, India and are of Punjabi decent.

### **Inquiry Puzzle**

How do Punjabi immigrant mothers experience and understand postpartum depression? In this chapter, I have discussed the literature in the areas of nursing (practical justification), as well as community organizations in the broader healthcare context (social justification), and identified the inquiry purpose and inquiry puzzle. In the next chapter, I describe the third design element of Narrative Inquiry, the method used for the inquiry into the phenomenon (Clandinin et al., 2007).

## **CHAPTER THREE**

### **Methods**

In this chapter I review the Narrative Inquiry approach (third design element) and discuss the starting point for this inquiry. For clarity, I explain Clandinin and Connelly's (2000) three-dimensional narrative inquiry space, the research framework through which participant stories are explored. Following, I describe the three levels of analysis in this Narrative Inquiry.

### **Narrative Inquiry**

#### **Historical Beginnings**

Narrative research began in the 1960's with its intellectual roots in the humanities and other fields, including literary theory, history, anthropology, drama, philosophy, psychology, linguistics and education. Narrative research has been commonly referred to as narratology, which is the theory and the inquiry of narrative (Connelly & Clandinin, 1990). Since the late 1980s and early 1990s, the decline in thinking from an exclusively positivist paradigm in social science research promoted a narrative turn to studying experience (Clandinin, 2013; Clandinin & Rosiek, 2007).

Educational researchers, Connelly and Clandinin (1990) first coined the idea of Narrative Inquiry as a methodology, which would be used to understand human experience narratively. As the developers of Narrative Inquiry, Connelly and Clandinin provide the following definition for this research approach:

Narrative inquiry is a way of understanding experience. It is collaboration between a researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving

and retelling, the stories of the experiences that made up people's lives, both individual and social (Clandinin & Connelly, 2000, p. 20).

### **Philosophical Underpinnings**

During their inquiry into the lives of children and teachers, Clandinin and Connelly (2000) developed their narrative understandings of experience, largely building on John Dewey's pragmatic philosophy of experience (Dewey, 1938). Dewey postulated two criteria for experience, interaction and continuity. For *interaction*, he stated, "an experience is always what it is because of a transaction taking place between an individual and what, at the time, constitutes his environment" (Dewey & Skilbeck, 1970, p. 43). For *continuity*, Dewey suggested that an experience develops from other experiences. That is, any point along the continuum, there is a past experience, which may lead to the present or future experiences (Dewey & Skilbeck, 1970).

### **A Starting Point**

Narrative Inquiry begins with a researcher interested in exploring and understanding an experience or phenomenon. The terms "living, telling, retelling and reliving" are often used to describe the process of self-narration in Narrative Inquiry (Clandinin & Connelly, 2006, p. 71). Inquirers (researchers) ask people to tell stories about their lived experience through narrative interviews, personal journals, family interviews, metaphors, photographs, drawings, artifacts and so on (Connelly & Clandinin, 2006). These *tellings* are gathered as field text (data) to detail the participant's life stories. The narrative inquirer and the participant co-construct rich descriptions of the lived experience to *retell*, through a collaborative relationship, the narrative of the person's *living* (Clandinin & Connelly, 2000). As this process unfolds, the inquirer and the participant engage in relational narrative inquiry. This means, by listening closely to

participant stories as they are told, the narrative inquirers also remain reflexive by considering their own lived experiences. In doing so, the narrative inquirers change as they retell lived and told stories, thereby reliving their own personal experiences in the process (Clandinin, 2013). Following, the narrative inquirer critically reviews and analyzes the told stories using the three levels of justification (personal, practical and social), all along considering the three-dimensional Narrative Inquiry space, described below (Clandinin & Connelly, 2000).

### **Conceptual Framework: Three Dimensional Narrative Inquiry Space**

Participants' experiences are revealed by the way they live and tell their stories. In telling stories, the participant reflects back on an event or situation that occurred in a particular place. By going back in time, the participant may elicit personal emotions, thoughts and insights related to the situation. As the stories are being shared the narrative inquirer observes, listens and lives along side the participant (Clandinin & Connelly, 2000). This allows the narrative inquirer to gain a deeper understanding of the participant's experience of the phenomenon. Clandinin and Connelly thus believe experience can be explored through the three dimensional space of Narrative Inquiry: temporality, personal-social and place. This serves as the conceptual framework of the Narrative Inquiry research approach used in this inquiry, as described below.

**Temporality.** Temporality (past, present and future) refers to time. People have a past that informs their present situation, which in turn may impact their choices for the anticipated future. As narrative inquirers, we reflect "backward and forward" on our own past, present and future and on that of the life of our participants to gain deeper understanding of the phenomenon under inquiry (Clandinin & Connelly, 2000, p. 50). As

we do this, we are simultaneously considering the other two dimensions (personal-social and place).

**Personal-Social.** This second dimension relates to both personal and the social conditions. Personal conditions refer to interactions, such as internal feelings, hopes, desires, aesthetic reactions, thoughts and moral outlooks, which may originate from the narrative inquirer or the participant (Clandinin & Connelly, 2000). Social refers to the external conditions or surrounding factors under which participants' experiences unfold. This may include cultural, social, institutional and linguistic narratives, as shared by participants (Clandinin, 2013). Another aspect of the personal-social condition is researchers' awareness of their own position in the Narrative Inquiry and in relation to participants. As narrative inquirers listen to their participants' stories they remain reflexive, which, in Narrative Inquiry, makes them *co-participants* (Clandinin & Connelly, 2000). This added quality allows narrative inquirers to inquire more deeply, and thereby gain greater insight into the phenomenon under inquiry.

**Place.** The third dimension, place, is the location or environment where the experience unfolds, or as Clandinin & Connelly (2000) describe, the concrete and physical place or "landscapes" where the inquiry occurs (p. 51). As the inquiry moves forward and backward in temporal space, the place may change. At some point during the process, the narrative inquirer leaves the field (place) with participants' story, and then at another time, meets them again in another place to review the reconstructed stories. As these spaces are explored they are continuously open to revision and change (Clandinin, 2013).

### **Three Levels of Analysis**

In order for participants' stories (field text) and interim text to be transformed to research text, the interim text needs to be examined using the three levels of justification: the personal, the practical and the social (Clandinin & Connelly, 2000; Clandinin et al., 2007). Each level of justification serves to shed light on how participants' storied experiences inform the inquiry puzzle.

#### **Personal Justification**

The first level of analysis is the personal justification, where I am prompted by fragments of the participant's story to enter into my own inquiry (Clandinin et al., 2007; J. K. Schwind, email communication, February 2, 2015). This is achieved by reading and re-reading participants' stories, listening to the audio recordings and reviewing the field notes, as I reflect on my own personal life experiences, thoughts, feelings, tensions, observations and insights related to the narrative interview. Such insights, along with my personal experiences, are threaded into participants' stories. This allows me, as the inquirer to understand who I am in the inquiry and so remain awake to how I attend to the experiences of participants (Clandinin, 2013). In my thesis, personal justification is represented in the form of a dialogue on paper using different font for the participant's words, thereby demonstrating the personal-social dimension of Narrative Inquiry.

#### **Practical Justification**

The second level of analysis is the practical justification where I, as the narrative inquirer, reflect on the emerging narrative threads within the stories, and consider them within the professional context of nursing (Clandinin, 2013; Clandinin & Connelly, 2000; Clandinin et al., 2007). This may involve the possibility of shifting, or changing practice

for me and possibly for other healthcare professionals who work with immigrant women. As narrative patterns are revealed and narrative threads emerge, I integrate relevant literature and the Narrative Inquiry theoretical framework needed to gain a deeper understanding of the potential significance of the stories within the broader context of the nursing profession (J. K. Schwind, email communication February 2, 2015). During this time, I continue to simultaneously keep in mind the three-dimensional inquiry space (temporality, personal and social, and place).

### **Social Justification**

The third level of analysis is the social justification of Narrative Inquiry, where I, as the inquirer, further consider the stories, while asking “So what? and Who cares?” (Clandinin et al., 2007, p. 25). The narrative is now viewed with a broader lens in the greater social context. Since Narrative Inquiries begin with an inquiry puzzle (a particular wonder), as the researcher, it is my hope the readers feel invited to enter into their own inquiry and reflect on their own practice.

At this level, I discuss the significance of participants’ stories, further expanding on the narrative threads in light of the greater social context (social action and policy justifications), and situate them within existing scholarly literature that expands beyond the immediate, while exploring how the phenomenon contributes to the expansion of inter-professional knowledge (J. K. Schwind, email communication, February 2, 2015).

Following the three levels of analysis, the re-constructed stories (narratives) are then re-presented in a relevant form to discuss the knowledge gained from this Narrative Inquiry. In this way participants’ stories are given voice, and have the potential to inform

care practices provided to postpartum Punjabi mothers in the community sector of the healthcare system.

In the next chapter, I describe the participant recruitment methods, the data collection process and the ethical considerations (design elements 3 and 7) in this Narrative Inquiry.

## **CHAPTER FOUR**

### **Inquiry Design**

In this chapter I present the design for my inquiry. I begin with a description of the participant recruitment process. Next, I describe how field text was collected through the narrative interview, metaphor selection and drawing activity. I conclude the chapter by explicating how ethical considerations, rigour and reflexivity are maintained in this inquiry.

### **Recruitment Process**

The recruitment process began after Research Ethics Board approval (Appendix A) was granted from the University. A recruitment poster (Appendix B) to participate in this inquiry was displayed with permission in locations where Punjabi immigrant women gather in the community: public health unit waiting room, local community centers and doctors' offices. Interested participants left me a message on a confidential telephone line. During the initial telephone contact, I used a telephone script (Appendix C) with questions to determine the eligibility of those interested to participate in this inquiry. The first two participants who fit the eligibility requirements for the inquiry were selected and the recruitment process ended.

Two Punjabi immigrant mothers who self-identified with symptoms of postpartum depression were voluntarily recruited for this inquiry. These mothers, who speak, read and understand English, are over the age of 18, with a child less than two years old.

According to Creswell (2013) a narrative researcher uses a small sample size to allow an in-depth exploration of participant's stories. Therefore, for this Narrative

Inquiry, the recruitment of two participants is ideal. As a researcher, I become immersed in the process of gathering field text, constructing the interim and research texts, and together with the participants, co-create knowledge through the telling, retelling and reliving of stories (Clandinin et al., 2007).

Participants were provided with the option of having the first meeting in their respective homes, without the presence of family members, or at a private space at a local community centre. One participant requested to meet in a private community room and the other participant in her home. During the first meeting, I explained the research process and provided a study information letter (Appendix D) explaining the risks and benefits of participating in this inquiry. Once the participant agreed to participate in the inquiry and signed the consent form (Appendix E), I began the narrative interview.

### **Data Collection Process**

Data collection steps in Narrative Inquiry occur in an iterative fashion. I describe each step of the process in a linear style, although in reality, the three dimensional space of Narrative Inquiry calls for an emergent and iterative path (Clandinin, 2013). In this inquiry, I use narrative interview and an adaption of the Narrative Reflective Process (Schwind, 2008), specifically, metaphor selection and drawing.

### **Narrative Interview**

I provided each participant with the choice of having one interview for two hours or two one-hour interviews. Both participants decided to have one longer two-hour session. This longer session was divided into two parts; the narrative interview and the metaphor selection with a drawing activity. A follow-up telephone conversation occurred two months later.

Each interview lasted approximately ninety minutes in length and was audio recorded with participant's permission and later transcribed verbatim. I met with participants on different mutually agreed upon days and times.

Narrative Inquiry begins with participants telling their stories through a one-to-one conversation by responding to open ended questions. I used a narrative interview guide (Appendix F) to encourage dialogue as needed. To begin this narrative interview, I used the following statement: *Tell me about your life after having your baby.*

During the telling of the stories, participants went back and forth between the questions to add details to their stories of experience. This demonstrates the personal-social dimension of experiences (Connelly & Clandinin, 2006).

### **Narrative Reflective Process**

The Narrative Reflective Process (NRP) (Schwind, 2008) is a data collection tool that includes creative self-expressions, such as storytelling, metaphor, drawing and creative writing. In this inquiry I adapt NRP, specifically using metaphor selection and drawing. These activities guide participants to a deeper level of self-reflection, self-discovery and co-construction of knowledge (Schwind, Cameron, Franks, Graham & Robinson, 2011). Schwind (2003) explains how the activity of drawing “will elicit the depths of our being unreachable by words [...] it is an excellent tool that teases out, to a deeper level, the reflective process necessary for meaning making of life events” (p. 25). A drawing exercise removes language barriers and allows participants to share experiences that are sometimes difficult to express in words. In this inquiry, drawing is an effective data collection tool for Punjabi immigrant mothers, as it allows freedom to express feelings, they may not be ready to express through words alone. Additionally,

Schwind (2009) articulates that metaphors “wring the experience for its essence” in order to gain new learning and to make sense of overwhelming situations (p. 17). In this inquiry, the topic of postpartum depression is a sensitive and a difficult one to address, which may prompt uncomfortable feelings for participants. Metaphor allows participants to creatively make connections between a concept that may be too difficult to talk about, such as postpartum depression, to a similar one that may be more comfortable to consider, thereby allowing the possibility for individual’s increased self-awareness and sense-making of the situation (Schwind, 2003, p. 24; Schwind, 2009).

### **Metaphor and Drawing Activity**

After our conversation, I introduced the metaphor and drawing activity, part of the NRP (Schwind, 2008). As mentioned earlier, I used this creative approach in order to encourage participants to creatively explore their experience of postpartum depression, and to consider what it may mean for them. Each participant was invited to take a moment to reflect and select a symbolic image (metaphor) that best represents for her how she experienced postpartum depression, and how she understands it now. I supported participants by explaining the symbolic image was their own expression of personal feelings and experiences of postpartum depression, and therefore there was no right or wrong answer for this activity. After the metaphor selection, I asked the participants to draw the image. In order to provide further encouragement, I mentioned the drawing does not have to be a “masterpiece”, it can be in any shape, form or colour desired. This part of the data collection took approximately 20 to 30 minutes. After the drawing was completed, I provided the option to share a description of the drawing verbally or to write a brief description. Both participants decided to provide a verbal description and

reflection of their metaphor drawing. One participant decided to sketch two drawings and the other participant created one detailed drawing. The participant who created two drawings required more time to reflect on her feelings before expressing her experience of postpartum depression through a metaphoric image.

### **Field Notes**

I documented my observations (physical environment, body language, gestures and cues) as my field notes during the interview to retain the context of the conversation and enrich my understanding during the construction of interim and research texts.

### **Follow-up**

Approximately two months after my initial meeting, I had one 30 to 40 minute follow-up telephone conversation with each participant to share my understanding of the story described during our narrative interview. This telephone meeting also provided the opportunity for the participant to change or add comments to the story. After reading the story in its entirety, I asked the following questions:

- Is this constructed story an accurate representation of your experience and understanding of postpartum depression? Can you further explain?
- Is there anything else you would like to add to your story in order for me to get a more accurate understanding of your experiences with and feelings about postpartum depression?
- Is there anything that I should remove from your story in order for me to get a more accurate understanding of your experiences with and feelings about postpartum depression?

- Is there anything that I should focus on in greater detail in order for me to get a better understanding of your experiences with and feelings about postpartum depression?

Each participant was satisfied and confirmed accuracy of the presented story. However, one participant added one sentence to further explain her story. Next, I asked each participant to select a name (pseudonym) to represent her in the story to ensure confidentiality and anonymity. After the name selection, I provided the opportunity for the participant to choose any font to represent her story. Once the font was selected, I inquired about the reason for her choice. This allowed me to gain deeper insight into the participant as a person, an individual outside of her story of postpartum depression.

### **Emerging Stories: Moving From the Field to the Research Text**

Immediately after each narrative interview, I listened twice to the audio recordings alongside the field notes to ensure I captured the participant's words and then transcribed the interview verbatim in a word document. Identifying features, such as name of the participant, her family members or health agency, were removed. I read and re-read the story and then arranged the field text in chronological sequence. According to Clandinin and Connelly (2000) this point denotes the change in text from field to *interim text*. The composing of interim text allows me to continue thinking narratively by reflecting on the field text within the three-dimensional inquiry space. I shared this story (interim text) with the participant during the follow-up telephone conversation to ensure accuracy of her story. This follow-up conversation provided an opportunity for us to co-construct the story together by making changes, clarifying and confirming the accuracy of the story. After the participant approved the story, I proceeded to the data analysis

phase using the three stages of Narrative Inquiry analysis (personal, practical and social), which converted my interim text into *research text* (Clandinin & Connelly, 2000).

### **Ethical Considerations**

Before the start of the narrative conversation participants were given a study information letter (Appendix D) that explained the research inquiry details and possible side effects such as uncomfortable feelings resulting from our discussions on postpartum depression. Participants were informed of their right to pause during the interview session or withdraw permanently from the inquiry without any penalty or consequences if they experienced any distress. It was also explained that the participant would be given an honorarium as a thank you for their time, regardless of whether they finished the interview or not. I provided the participants, should they experience uncomfortable emotions, with a community resource pamphlet on support services and encouraged them to seek assistance from their health care provider. The narrative interview began after the participants signed the consent form (Appendix E) without any undue influence.

The privacy and confidentiality of the participants was maintained throughout the research process. Each participant selected a pseudonym of her choice to conceal her true identity and maintain privacy in the research text (Creswell, 2013). The audio-recordings, interview transcripts and scanned drawings are saved on an encrypted password protected USB key and stored inside a locked cabinet in a home office. The signed participant consent forms are stored in a separate locked filing cabinet at the university.

The relational ethics of Narrative Inquiry need to be carefully considered from the beginning, as the participant-inquirer relationship unfolds and as participants are represented in the research text (Clandinin & Connelly, 2000). In other words, it is vital

that I, as the inquirer, understand, clarify and negotiate the participant's story to ensure it is represented accurately at every stage of the inquiry process.

### **Rigour and Reflexivity**

In Narrative Inquiry, the inquirer is involved in ongoing reflection during the entire research process. In this inquiry, reflexivity occurs as I consider my thoughts and feelings before, during and after each narrative interview. Since the topic of postpartum depression is a sensitive topic related to mental health, a topic often associated with stigma and uncomfortable emotions, I take time to write a reflexive journal as a tool to express my feelings and enhance self-awareness into how the stories affect me on a personal and professional level. Journaling allowed me to record my innermost responses to clarify my thoughts, understand my feelings and consider these in the writing of my thesis.

Reflexivity involves not only being self-aware, but also recognizes the unique relationship that exists between the inquirer and the participants and the resulting stories (Clandinin, 2013). I am conscious of my own position as a Punjabi speaking South Asian Canadian mother and my own perspectives of race, culture, class and gender, and how these qualities may contribute to the co-construction of knowledge in this Narrative Inquiry. Writing in a reflexive journal during the research process also ensures the rigour in the inquiry by allowing me to recall my initial feelings and thoughts and differentiate these from the ideas and comments of my participants' (Clandinin & Connelly, 2000; Rolfe, 2006; Streubert & Carpenter, 2011).

According to Clandinin and Connelly (2000), rigour in a Narrative Inquiry is maintained when the inquiry has an explanatory and an invitational quality, and when it

is authentic, adequate and plausible (p.185). In other words, my inquiry has an *explanatory quality* when I adequately and logically explain every step of the inquiry process. By sharing my own, and my participants' stories, I invite the readers to engage in their own inquiry of personal reflections and professional practice, satisfying the *invitational quality*. *Adequacy* is apparent as I describe, reflect upon and analyze the storied experiences, to sufficiently address the inquiry puzzle. The *plausibility* in my inquiry is met when my research text flows logically out of participants' stories.

In the next chapter, I introduce my first participant, Amar. I share her story integrated with my personal reflections (personal justification: design element 5).

## CHAPTER FIVE

### **Amar's Story**

I begin this chapter by setting the stage and illustrating the progression of each of the two sessions with my participant, Amar. The first session includes the in-person narrative interview, followed by a metaphor activity. The second session represents the follow-up telephone conversation two months later. The description of this process offers an understanding of how Amar's personal narrative began to unfold over the course of the interview.

#### **Narrative Interview**

Date: November 7, 2014

Time: 1000 to 1130

Place: Community Centre in a private classroom

It is a cold autumn morning in November. I look outside my bedroom window, and notice the grass has transformed from lush green to a shaggy brown colour, resembling uncombed hair. The squirrels scurry about, gathering food for winter. I recollect myself and check the time. Feeling a bit anxious and excited, I look in my bag to ensure I have all the necessary supplies (audio recorder, forms, note pad, pens and coloured pencils) for my first interview. I decide to leave early. As I drive to the interview, I admire the freshly fallen autumn leaves on the roadside. The buttery yellow and crimson red maple leaves paint a beautiful autumn scene. It's cold outside, but the warmth of the sun through the car window draws in the beauty of the season. I instantly become more relaxed about the upcoming meeting with my first participant, Amar.

I arrive at the community centre and set up the private room. I reflect on the Narrative Inquiry term *place*. Conscious of the location that my participant and I have decided to meet for our first interview, I think about how she will recognize me in the lobby of the building. I hope she will be open to sharing with me her experience of postpartum depression. My anxiety returns. I take three deep breaths. The time has come. I walk over to the lobby to wait for her arrival.

After waiting 15 minutes, I begin to worry that she has changed her mind and decided not to come. Just then, I see a woman rushing through the door with a toddler in a stroller. She looks over to me and asks, “Are you Poonam?” With a sigh of relief, I smile and say, “Yes I am. It is so wonderful to meet with you”. As we walk over to the interview room, we engage in conversation. She explains the bus was late arriving at her stop. I notice her son is bundled in a warm hat and coat. We approach the classroom and I enter the security code to unlock the door. I hold the door open for Amar as she pushes the stroller into the spacious room. We take a few minutes to settle her son in the room, and provide some toys for him to play with while we begin our conversation, the narrative interview.

During the next two hours we are seated at a small rectangular table in the front of the classroom. As I approach the table to sit down, I recall the acronym SOLER from my nursing class. SOLER means, sit squarely, open posture, lean forward, eye contact and relax. It describes a framework for behavior that shows to another person that you are engaged and paying attention to them. I am conscious of being SOLER with Amar. I choose not to sit directly in front of her, for this may be perceived as intimidating. However, I am cognizant of cultural norms so I ask Amar if she is comfortable with me

sitting with her at the table to her right side. Amar nods “yes” and we settle into the first part of the narrative interview.

I remind Amar that she may stop at any point if she feels uncomfortable for any reason. I begin by asking the first question. To my surprise, Amar is very open to sharing. She initiates conversation immediately by telling me about her labour and delivery story. As I listen to Amar’s story, I allow moments of pause and reflection. By asking open-ended questions I am able to promote deeper conversation on this often-sensitive topic.

Next, we explore the meaning of postpartum depression for Amar. In her own words she explains “it’s when you feel alone, you want to sit and cry...you can’t understand anything, you can’t sleep, you feel tired all the time.” Amar continues to share more of her intimate personal experiences with postpartum depression. As our conversation delves deeper, I ask Amar to explore the reason(s) she felt alone, sad, guilty and depressed after the birth of her son. She takes a moment to think and provides some examples by referring to her personal experiences. We end this part of the interview with Amar looking over to check on her son as he plays with his toys. She smiles and turns to me to continue the second part of our narrative interview, the metaphor activity.

### **Metaphor Activity**

After our discussion about Amar’s experiences with postpartum depression, I invite her to take a moment and think about a symbolic image (metaphor) that best represents the meaning of postpartum depression for her. I provide her a few minutes to collect her thoughts. I place a few sheets of white sketch paper and a colourful array of pencil crayons on the table and ask Amar to draw the image that she has envisioned in her mind. She quickly tells me that her drawing ability is poor and the drawing will not

look good. I provide positive encouragement and we both laugh about our artistic abilities. She decides to make an attempt at drawing. I provide Amar with some privacy at the table. As I play with her son in the same room, Amar draws two pictures and later provides a description of each drawing. After we discuss her drawings our interview comes to a close.

We decide to connect again by telephone for the follow-up meeting. I smile and wave good-bye to Amar and her son as they leave the building towards the bus stop. I feel relieved and excited at the thought of completing my first narrative interview.

### **Follow Up**

Date: January 9, 2015

Time: 1900 to 1945

Place: Telephone conversation

Two months later, I connect with Amar by telephone to set up a time for our follow up conversation. She states that she is very busy with her son at the moment and would prefer to talk later in the day at 1900. I call Amar later that evening. She apologizes for being blunt on the phone earlier in the day. I accept her warm apology and we begin our conversation.

I invite Amar to listen to the story that I have composed from our first meeting in November. I encourage her to interrupt me, if my account of her story is inaccurate. As I read the story, from time to time, she interjects “yes, that is right.” This provides me with reassurance, as I continue to read the story in its entirety. I ask her if there is anything she wishes to add or change. She tells me “no that was exactly right.” I express my gratitude

to her for taking time once again to participate in the inquiry. We end our telephone conversation by wishing each other a happy and healthy start to the New Year (Diwali).

In the following section I present Amar's story based on our narrative interview. To visually represent this story, Amar selected Chalkduster regular, font size 12. She said, it reminded her of "writing on the chalkboard" when she was living in India. For me, Amar's choice of font represents a link to her cultural identity as an educated Indian woman. Amar's childhood and education as a nurse took place in India. Although she now lives in Canada, she still longingly speaks of her life in India. From our conversation, it sounds like she truly misses her life back home. We co-constructed the following story with our words interweaved: Amar's own words with my own reflections and thoughts interjected in between. For my reflective researcher voice, I use Times New Roman regular, font 12 and indent the passage 0.7 cm.

### **First Level of Analysis: Personal Justification**

#### **Amar's Story**

I was so excited to have a baby. But, I had a difficult time right from the beginning. My son, he was born one month premature on December 26 with a cesarean section birth. I felt sad that I couldn't even deliver the baby the normal way. I was not expecting a cesarean delivery. I was not ready for him or the recovery time after the surgery. Because I had stitches; I couldn't even get up immediately in the night time to breastfeed him, so I would sit in a chair all night.

Was Amar all by herself? Where was her family? Where were the nurses? How could she have sat in the chair all night? Yet, in some way, I can relate to Amar's mixed feelings of excitement and sadness. Thinking back twenty-one years, I still remember the anticipation and delight of welcoming my baby, like it was yesterday. Like Amar, I too was not prepared psychologically for an unplanned surgical delivery. However, I count my blessings that at least my family was nearby.

*Since this was my first baby, I didn't know how to interact or be with him.*

Similar to Amar, I too recall feeling lost after the birth of my son. I am not sure why? Perhaps it was the trauma of the surgery, the pain and postpartum recovery that contributed to these feelings.

*It was a depressing time for me because I was alone, and did not have anyone to help me.*

Listening to Amar talk about being alone reminds me of my nursing practice and my interactions with immigrant mothers in similar situations. I recall one first-time mother who shared her story of being alone in Canada, because her husband was still back home in India. She had no help from her family. Her feelings of sadness and frustration seem to be similar to what Amar is describing. Was Amar missing the traditional forty-day postpartum support she would have had in India?

*My husband spent one week with our baby and me. But then he had to go back to work. He was working nights as a security man. Shortly after our baby was born, he started a trucking job. Sometimes, he traveled to Winnipeg and would*

come back after four days! This was the most challenging time for me. While he was away, I was busy taking care of my baby all on my own. I often wondered, how could I do this all alone? I felt helpless because I didn't even know how to give him a bath.

Listening to Amar, I can sense the loneliness in her soft trembling voice. She was socially isolated. With limited knowledge of infant care and no support system, she felt helpless. Seems like her husband was working long hours to provide financial support for the family. But at this time, Amar seemed to be longing for hands on practical and emotional support. I wonder if a home visiting public health nurse could have provided support to Amar during this difficult time. Did she even know that could have been an option for her?

I was still recovering from my surgery. What I really wanted was someone to take care of me. I felt weak physically and emotionally.

Although Amar seems to have a deep insight into her experience after the surgery, I feel sadness for her being all-alone at such a crucial time. How could there have been no one to provide her with support during this difficult time?

My relationship with my husband was okay, not bad. He would try to help me out but he was already tired when he came home from work, so it was not easy for him. He also felt guilty that I was alone with no help. But we had to manage.

There was no other choice. I think it was my faith in God that helped me get through the difficult times.

I am curious how other fathers understand the challenges that come with caring for a newborn. Do they also feel “guilty” when they return from work, seeing that the mother has been with the baby all day? How do they learn their fatherly role? Who teaches and supports them?

I often hear how, like Amar, people find their strength, during difficult time, in their spiritual faith. How else can our society support new immigrant mothers during the postpartum period?

I had one auntie that was in Canada. However she lived far away. I often called her and she would explain how to do things for my baby on the phone. But it was not the same as having someone come to my house. My parents were living in India. I wished my mom lived in Canada. I really needed her support when my baby was born.

Listening to Amar speak about her aunt and mother, reminds me of the importance of having support in the postpartum period. After the birth of my son, I went to live with my mom for forty days. This is a Punjabi tradition called “sawa maheena”.

Translated it means, the month of support. The forty-day postpartum period allows the new mother to recover from childbirth and provides practical hands on help and advice, usually from a female relative. Reflecting on my postpartum period makes me think of how lonely Amar must have felt. Amar’s parents were in India. With no other family close by, Amar was isolated. I empathize with Punjabi immigrant

women who are not able to participate in their rich cultural traditions while living in Canada.

I wonder how Amar's postpartum experience would have been different if her mom was able to visit her in Canada during this time. Interestingly, she does not speak of her husband's family as possible source of support during this time.

My depression after the birth of my baby began with feelings of loneliness. I wanted to sit and cry most of the time. I would sit by myself and think: What am I going to do? How can I manage everything? I couldn't sleep. I felt tired all the time. I think the first two to three weeks of being a new mother are really difficult and depressing.

Amar's description of her feelings of loneliness and sadness are often seen in women during the immediate postpartum period, referred to as the "baby blues". I wonder if Amar knew that other women sometimes also experience these feelings in the first few weeks after having a baby. It seems like Amar was so overwhelmed by her feelings of sadness that she was unable to see a way out of them.

It's even more depressing if you are new to the country. I think if I had some help from my family, it would have been easier to cope. My sister in law had a baby a few months after me. Her mother came from Vancouver to spend three weeks with her after her baby was born. Mothers can understand a woman's feelings more. My sister in law did

not have any problems because her mother was there to give her support. I feel if my mother had been here, maybe I would not have gone through these feelings of depression. Sometimes, I think I made a mistake by not sponsoring my family to come to Canada.

I hear longing, and even a sense of guilt, in Amar's words. Connecting with female relatives at the time of childbirth, and immediate time after, is a practice lived and shared by women in many cultures. I wonder again, what can be done to provide immigrant women, whose family support is not accessible, with emotional support in the postpartum period.

The Punjabi culture is different from the Canadian way. In my culture, the husband wants to eat food at home. Punjabi men don't like outside food. They can manage with eating outside food once a week but not every day. So as a Punjabi woman, I want to make sure food is ready for my husband and the house is clean.

I am reminded of my family. Eating fresh cooked meals is certainly an integral part of our Punjabi culture. It seems that aspects of this Punjabi culture may be contributing to Amar's feelings of postpartum depression. Once again, how can we as a society alleviate some of these stressors on new immigrant mothers?

But there are problems in the Punjabi culture too. The expectations are different. The husband has to work to

provide for the family otherwise the expenses cannot be managed.

Amar's words, again, refer to the Punjabi culture, where the financial burden is placed on the husband to be the breadwinner. I wonder if other immigrant families struggle with the same expectations and issues?

The husband's family has an impact on what happens in the Punjabi culture. My sister in law had her baby and then returned to work shortly afterwards. My husband's family lives close by and they always compare me to her. They wanted me to leave my baby in daycare and go to work to earn money. I want to work. I want to earn money. I want to help my husband with the expenses but I can't leave my baby alone. I want to wait until he goes to school, another one and half years. I feel all they care about is making money. I just don't feel comfortable leaving my son with anyone right now.

Amar's reluctance to leave her son with anyone makes me wonder about her relationship with her husband's family. They are within reach, yet she feels alone and lonely. Amar's words suggest that they are pressuring her to go out to work. Perhaps family dynamics have further contributed to Amar's feelings of sadness? Or, is it Amar's upbringing in India that is influencing her decision to stay at home with her son?

My husband listens to his family especially his mother and brother and sometimes he begins to think like them. This bothers me. I feel every baby is unique. Every lady is unique. Every husband is unique. I can't leave him [baby]. I don't know why I'm like that. But when I think about my husband working so hard, I feel depressed that I can't work and help him.

Amar seems to feel alone with her baby, as her husband sometimes sides with his family of origin. She appears to be torn with the decision whether to stay at home with her baby or to go out to work to help her husband with the finances. Her sadness is visible in her face and audible in her voice.

I was educated as a nurse back home in India. When I came to Canada, I wrote the board exams three times and did not pass. I felt sad. I really wanted to do something in the field of nursing. Now I feel stuck. Thinking about my career situation contributes to my feelings of depression too.

Listening to Amar talk about her nursing education in India and struggles in Canada, makes me realize the extent of educational challenges for immigrant women. I ponder how we as a society can best support immigrant women to help them secure employment in their field of study.

I didn't like leaving my house. However, I noticed that my son was not mixing with other kids. I began to worry about

his development. So I started to bring him to programs at the library. Now we both get out of the house.

From my experience of working with women who experience symptoms of postpartum depression, getting out of the house is a significant step in recovery. For the love of her child, Amar did just that. I wonder if other immigrant mothers have the insight and the ability to become involved with programs in the community, to foster their child's development, or is it that Amar was a nurse in India and so she understands the importance of socialization for children. How can those women who are isolated, but don't have the knowledge or the energy to access community supports be helped? What other barriers exist that we, as a society, are not aware of? Hearing Amar's story, I see her as a woman of inner strength and determination, despite the challenges she experienced during her postpartum period. And, at the same time I realize there is still so much to learn and to understand in order to best support Punjabi immigrant mothers, like Amar, with symptoms of postpartum depression.

### **Amar's Metaphor Drawing**

After our narrative interview, I invite Amar to select a metaphor that best represents her experience with postpartum depression, and then I ask her to draw it. After a moment of pause, Amar begins to sketch. She creates two drawings.

**Figure 1. Amar's Metaphor Drawing of Postpartum Depression: Self**



This picture is of me. When my baby was sleeping, I just wanted to be alone. I didn't want to talk to anyone. I didn't want to call anyone. I was sitting in a chair and thinking how I can get through this situation? In the picture, I have my hand on my head to show that I am sitting alone and thinking about my life. How will I handle the baby? How will I do my household chores and manage my life? It was a very difficult situation for me. Postpartum depression is

when you are down, most of the time crying, feeling alone.  
That's depression.

I am beginning to realize the intensity of Amar's feelings of sadness. The natural maternal instinct to interact with her baby, while experiencing family conflict, financial strain and career challenges, is overwhelmingly difficult. For Amar, her life situation seems to express itself through her feelings of deep sadness and loneliness.

**Figure 2. Amar's Metaphor Drawing of Postpartum Depression: A Tree**



I ask Amar, the reason she drew two pictures. She explains, the first picture of herself allowed her to think deeply about the feelings she experienced. After feeling those

emotions in her mind she then was able to engage in the metaphor activity more freely. A few minutes later she creates another drawing. Below, Amar describes the second drawing.

This second picture is of a tree. When the tree doesn't have the green leaves, they are not seen as fresh. They are yellowish brown and dull leaves. The dull leaves show my feelings of sadness. I was feeling like this tree. I was alone [pointing to tree]. This tree is alone. The leaves are very dull, not fresh and green like in the summer time. In the wintertime, it is so depressing. You can't go outside when it is very cold. In the summertime, you can go to the park.

Listening to Amar's description of the tree standing alone reminds me of her first picture of herself, sitting alone at home with her hands on her head.

I want to be able to work and get out of the house instead of doing the same thing every day. All I do is take care of my baby and do household chores. But I don't know what to do to get out of this situation.

Amar turns to her son and smiles. Our interview comes to an end. I thank Amar for taking the time from her day to participate in the interview. She tells me the drawing exercise allowed her to express thoughts that had been hidden in her mind, and that she was happy to share her experiences with me. Amar begins to dress her son in his winter coat and mentions she may explore the possibility of working in the healthcare field when

the time is right. I smile and provide her with a community pamphlet and review with her the list of organizations that offer assistance for immigrant families. We walk together down the hallway towards the front door. We are both on our separate ways home.

As I drive home I think back to Amar's story, our rich conversation and I begin to wonder more about her story. She continues to express her frustration of being isolated and alone in her house. Amar wants to go out and work, but does not know how to go about doing this because she does not want to leave her baby with anyone. The situation is complex: Is it due to the poor relationship with her in-laws without much support from her husband? Is it the question of finding a safe and trustworthy place and person with whom to leave the baby so she can go out and work? Does her husband want her to work or does he want her to remain at home to care for the baby, clean the house and have home cooked meals on the table every day? Is Amar worried about the financial expense associated with daycare? What role does her husband play in all this? In addition to the family dynamics, hormonal changes in the postpartum period may also be contributing to Amar's challenges. How lonely it must be for Amar to not have anyone from her own family, or a trusted friend, with whom to share her most inner thoughts. I am amazed at how Amar is able to cope in this situation at all. I see her as a strong and determined woman and a dedicated mother.

My thoughts return to my research process. I feel excited that I have finally completed my first interview. I am looking forward to meeting my next participant and hearing her story.

## **CHAPTER SIX**

### **Anu's Story**

In this chapter, I describe how my meeting unfolds with my second participant, Anu. I share the in-person narrative interview and present Anu's story that I create with her own words along with my own reflections and thoughts. I then present the piece of artwork that Anu draws to represent her experience with symptoms of postpartum depression. I finish this chapter by sharing my follow up telephone conversation with Anu.

#### **Narrative Interview**

Date: November 13, 2014

Time: 1000 to 1200

Place: Anu's apartment

It is snowing on the morning of my interview with Anu, who requested to be interviewed in her apartment. Before I get on my way, I write down the driving directions to her home to ensure I don't get lost. After parking my car in the visitor lot, I make my way to the main entrance of the building. I enter the buzzer code for her apartment number and wait for her reply to unlock the main door to the lobby area. After a few seconds, a male voice answers, "hello?" Surprised to hear a male voice, I pause and reply, "I'm here to meet with Anu?" The door unlocks and I walk into the lobby towards the elevator. I feel a bit uncomfortable. Anu said no one would be at home on this day. I want to ensure the confidentiality of my participant. If someone else is present in the home, I will not be able to conduct the interview. I stand stiff in front of the elevator, wondering if I should continue or reschedule the interview. The elevator door opens. I

take that as a sign and decide to visit Anu. I knock on the door and Anu opens it with a smile. She welcomes me inside. I step inside and ask her if anyone else is at home. She explains her husband's voice is recorded on the speaker but he is not at home. I take a deep breath and feel relieved.

Anu asks if we could sit at her dining table for the interview. I take a seat at the table and organize my papers. As I wait for Anu to check on her son, I observe the living room with clothes and crumbs of food on the red carpet. The television is playing loudly. Anu returns and tells me her son is being a bit cranky today. She sits down at the table with me, turns down the volume on the television and we begin to settle into the interview.

I remind Anu that she may stop or pause the interview for any reason at any time. She nods her head and I begin by asking her about her experience after having her baby, as a Punjabi immigrant woman. Anu is excited to share her experience and begins with her story in India and then shares her labour and delivery experience. As I listen to Anu's words, I am reminded of the challenges of sharing stories of a sensitive nature such as postpartum depression. After we are engaged in our conversation, Anu tells me about the relationship difficulties with her husband and his family. Anu's eyes begin to fill with tears and she begins to cry. I pass her a tissue and tell her that we do not need to finish this interview. However, Anu is adamant to have her story heard. She takes a sip of water and we continue with the interview. Anu shares more intimate personal experiences that she attributes to her symptoms of postpartum depression.

Next, we discuss the meaning of postpartum depression for Anu. She explains, it is "the feeling of loneliness up till and even after baby is born. It's when you are worried

about your baby and feel alone.” Some of Anu’s words remind me of Amar’s description of postpartum depression. This part of the interview comes to an end with the sound of Anu’s son crying. She quickly attends to him and gives him a snack. After a few minutes she returns to the dining table and we continue the second part of our narrative interview, the metaphor activity.

### **Metaphor Activity**

After our conversation about her experiences with symptoms of postpartum depression, I invite Anu to select a metaphor (symbolic image) that best represents the meaning of postpartum depression for her. Anu comments that drawing comes naturally to her because of her experience in fashion design. I provide her with paper and a pack of colourful pencil crayons. She closes her eyes for a moment and then begins to draw her metaphor. She takes time to use colour in her drawing and provides a detailed description of the image and why she selected that particular metaphor. After this conversation, our interview ends. We decide to reconnect by telephone to discuss the follow-up meeting. I gather my papers and head towards the door. I say good-bye to Anu and her son as I put on my boots. I leave the apartment and walk towards the elevator reflecting on the rich stories that I have just heard.

### **Follow Up**

Date: January 12, 2015

Time: 1100 to 1140

Place: Telephone conversation

Two months after my initial interview with Anu, I reconnect with her on the telephone to ask her about setting up a date for the follow up meeting. She asks if we

could have the meeting over the telephone at the time of my call. I begin sharing the story I have composed from our first meeting in November and ask Anu to interrupt me at any time if she has any feedback to share. Just like my first participant Amar, I want to be sure that Anu has the opportunity to add or change any part of her story that she feels is not accurate. She listens to the story in its entirety and tells me that it is well written and exactly as she shared. She continues by adding in a bit more information to explain the family dynamics of being married in a family where relatives from both sides (husband and wife) know each other in India. Anu tells me, women in the Punjabi culture must compromise a lot or risk being blamed if the marriage is unsuccessful. She ends the discussion by thanking me for taking time to write her story.

In the following section I present Anu's story based on our narrative interview. To visually illustrate her story, Anu selected the Apple Chancery font size 12. She said, it reminded her of "writing in cursive" when she was studying fashion design in India. For me, Anu's choice of this font style depicts her artistic expression (as a fashion designer) and creativity with the unique flowing style of the letters, similar to her free flowing thoughts expressed in the telling of her story. The story that follows is co-constructed with Amar's words and my reflective interjections interwoven in her story. For my reflective researcher voice, I continue to use Times New Roman regular, font 12 and indent the passage 0.7 cm.

### **First Level of Analysis: Personal Justification**

#### **Anu's Story**

*I was a confident girl when I lived in India. I studied fashion design in school and had a good job. In 2009, I came to Canada as a student and lived with my aunt. This is*

*the same aunt who was the middle person (match maker) that introduced my family to my husband. I had an arranged marriage. After I was married I looked for a job. But there is not much scope for fashion here in Canada. When I was not able to find a job, I continued my studies in College.*

Is Anu's lack of confidence linked to her inability to find a job in the fashion industry? Her frustration reminds me of the same struggle Amar shared in her story when she too could not find a suitable job in her field. Moving to a new country is a big challenge at so many levels, cultural, economic, personal and professional. Then to add to all that, is her arranged marriage. Getting married to someone she doesn't know may have been somewhat scary for her. Is Anu happy with her new life in Canada and with her relatively new marriage?

*Then I became pregnant and remained at home. Since my husband worked long hours I was always alone at home. It was kind of depressing, staying alone at home and here (in Canada) because of weather too, it was cold and I could not go out. And I don't drive, so it was a hard time for me.*

I wonder what feelings Anu experienced when she became pregnant. Was she happy? How did her husband react? Why did Anu stay at home alone and stop attending school during her pregnancy? I wonder if her husband did not want her to go out and work. Together with the hormonal changes in pregnancy, being stuck alone at home in an unfamiliar country during the cold winter without transportation could make

most people feel lonely and depressed. I can certainly empathize with Anu's frustration, as I too felt this loneliness when I remained at home after the birth of my son.

*My mother came from India to visit me during my pregnancy. She was a really big support for me. Even though she had knee problems and couldn't do much work, she was able to help out a little. She was a big mental support for me.*

Hearing Anu talk about her mother's "mental support" makes me feel relieved that she had someone to talk with and discuss her inner most feelings. Amar did not have that kind of support during her pregnancy. Would that have made a difference in Amar's feelings during her postpartum period? Emotional support for any woman who does not have a relative or friend close by is important, let alone if she is an immigrant and her own family of origin is not easily accessible. How do we, as a society, ensure such support is available when we don't even know if immigrant mothers are in need? Unless they connect with a health care professional or a community organization we often seem to be at a loss of how to most effectively reach out to them.

*My baby boy was born with a normal delivery but had to stay in the hospital for three to four days due to other medical problems. My mom accompanied me in the hospital but it was difficult for her to communicate with the nurses because she did not speak English. But together we were able to manage.*

Once again Anu speaks of her mother's support during the immediate postpartum period. This reminds me of how important it is in the Punjabi culture to have support from female kin. I wonder how other immigrant women manage with the stress of being in the hospital, having a new baby, and especially if they do not speak English. How do they communicate their needs?

*My mom helped me to care for my newborn baby at home too. She provided me with lots of support and advice. But when my baby was four months old, my mom returned back home to India. She was crying when she left. She left with a heavy heart (voice becomes softer). She will never come back here to Canada. It was really depressing after she left. I was alone at home with my baby. What made it worse was that we had just moved to a new apartment and I didn't know anyone.*

I can hear the sadness in Anu's voice as she talks about her mother. Why will she not return to Canada? Why did she have to leave, in the first place? Anu spoke earlier about her aunt (the match maker) in Canada. How is their relationship? I also wonder about the quality of the relationship with her in-law family. Does her husband's family live close by? Are they supportive towards Anu and her baby? Is she welcomed in her in-law family? Anu's feelings of being alone in her home, reminds me of Amar's story of loneliness after she gave birth. Anu's husband, like Amar's, has long work hours. I wonder if Anu's husband is able to provide the emotional and physical support that Anu needs during this difficult time. Or, is it that he chooses not to, or that he is disinterested in his role of being a husband and a father?

*My husband is uncooperative, and unsupportive. He always wants his own comforts.*

*He was (soft voice, with tears in eyes) physically and verbally abusive to me in the past*

*(pause). He did not want my mom to stay in Canada (tears dripping down Anu's face).*

*My mom called his mom to tell her that he was mistreating me (wipes tears). This*

*caused a quarrel in my family. It was hard because I had to balance everything.*

Anu is crying. She has been through so much. Listening to her story upsets me.

Questions are flying through my mind: What happened? Did she try to get help? Is

that still happening? I am conflicted. What to do? It must be so difficult for her to

share this upsetting story with me. Yet, I want to know more. I am speaking with her

as a researcher not as a nurse. I want to stop the interview but Anu is determined to

continue sharing her story. Maybe telling me her story is allowing her to release the

emotions that have been building up. I wonder if this is the first time she has shared

with anyone this story of her life. I am curious to find out if Anu is still experiencing

violence in her marital relationship. I ask her how things are going with her

relationship at the present time.

*He does not bother me anymore. He works as a truck driver and has the weekends off.*

*At night, he does not come home right away because he doesn't want to care for the*

*baby. When he is at home, he only wants to sleep. As long as I stay out of his way, he is*

*fine.*

I am relieved to hear that Anu is no longer experiencing violence in her relationship. But for some reason, I still have a sense that that she still feels trapped in her marriage. Being at home with a baby all day without any adult contact can become very lonely. Similar to Anu and Amar, I still remember the challenges of being a first time mother at home with my son. By the end of the day, I too was anxious like Anu to talk with another adult. It is disappointing that Anu is not getting support from her husband. I wonder if he is tired from work and needs time alone before going home. Or, is he as Anu puts it, not wanting to care for his son? This also makes me wonder about the relationship between her husband and the baby. What is her husband's fatherly role in his son's life? How will this baby develop a bond with his father? I think about Anu and how she can remain in this unhappy relationship? And yet, I reflect back on my own life and how it was for me, and how difficult it was to leave. Despite the ongoing abuse, I prayed it would get better, but it never did.

*I think motherhood is the loveliest experience of life. I kind of enjoy it, but on the other side it was a struggle because I didn't know anything about caring for a new baby. For my mother it had been a long time since she took care of such a small baby.*

In the midst of Anu's relationship difficulties, her baby is a source of great joy in her life. It seems like her symptoms of depression are compounded by her feelings of loneliness and isolation within her marriage. Thinking back to Amar's story, she also had a source of inner strength that centered on the love for her son, allowing her to cope with the challenging times. However, both Anu and Amar exhibited symptoms of postpartum depression, which may have been augmented by a lack of social

support after the birth of their baby. A source of social support in the postpartum period has been known to decrease the risk of postpartum depression, neither of which of these two women seem to have.

*My husband gives me a hard time ever since my baby was born. My baby was constipated and had gas problems. At night he cried a lot. I was scared when my baby cried because he was so young and couldn't tell me what was bothering him.*

It sounds like Anu is afraid her husband could hurt the baby. What a burden of fear! She worries for her son's safety. She fears her husband's anger. This kind of living condition would be so difficult for anyone, let alone for a new mom, whose own physiological body changes call for increased support and care from those around her.

*I feel sad also due to my family problems. It was hard to handle my baby because I didn't have anyone to help me out after my mother left. I was feeling very lonely. I was wondering why I came to this country. It was more difficult to cope because my husband did not cooperate. I also needed some time for myself. So I joined the gym. But I didn't go to the gym because I didn't have anyone to watch my baby.*

Anu, like Amar, is neither supported by her in-laws nor her husband. From my personal experience, and from interactions with other Punjabi immigrant women, I often notice how unhealthy relationships with in-laws contribute to symptoms of postpartum depression. In addition to the stress of being a new immigrant to Canada,

motherhood brings with it a period of vulnerability, especially for mothers like Anu and Amar who lack a social support network. As health professionals we must support immigrant women during this important time period. However, the challenge seems to be, how do we identify and reach those women who suffer alone in their homes.

*Before I was married, I was working. After the baby, I received maternity leave benefits but then it ended. So now, I have no source of income and he does not want to support me financially. Because, I had never asked him for money since we got married. He's the kind of person that prefers his own luxuries. He wants the best of everything for himself. But he does not want to spend for me or for his baby. For me, I'll be okay, but if he doesn't want to spend anything for baby, it makes me angry. My baby needs a new car seat but he does not want to spend money on the car seat. But he has his own new car and latest model mobile. He wants everything the best for himself, but not his family.*

Listening to Anu talk about her lack of income and financial stress, I begin to think this is another form of power and control imposed by her husband. Now I am getting a better understanding of why she did not go out to work during her pregnancy. It most likely was her husband, who did not allow it. He is now denying financial support to care for their baby. This is not humane!

This story reminds me of a practice situation when I was visiting with a Punjabi immigrant woman. During the home visit, my client's mother-in-law was listening to our conversation. My instinct told me something was just not right. When her mother-in-law left the house, I was able to inquire further. I looked at my client and said, "tell me how you are really feeling." Her eyes quickly filled with tears. She told me, her mother-in-law pushed her down the stairs during her pregnancy and continues to verbally insult her. After the baby was born, her husband refused to provide her with any money. His income was spent on a cocaine addiction. I was overwhelmed when I heard this story. Thinking about this and listening to Anu makes me wonder why these stories remain silent? Why are we so reluctant to reach out for help? I recall my earlier life situation, not too different from that of Anu and Amar. I had a strong desire to leave my unhealthy marriage, but felt afraid of what others in the community might say. I needed to protect my family name and in doing so, I was obliged to protect my husband, at that time, from any shame. So like Anu's and Amar's, my story also remained silenced for a long time.

*We had fights over money. He has a bunk in his truck. So he tries to sleep overnight sometimes and then come home late. This is why I feel so lonely.*

It seems like Anu's husband is avoiding being at home. Why is he in this marriage, if he clearly does not want to be involved in Anu's or his baby's life?

*I had a cyst in my ear and needed to see the doctor. My husband came home to stay with my baby. I walked to the medical clinic close to my home. The appointment took around two and half hours. While I was in the office, my cell phone was on silent and I*

*forgot to turn it back on. I missed ten phone calls from my husband. I walked back home with two bags of heavy milk. When I arrived home my husband was really angry. I tried to explain, that I had stuff in my hands and I forgot to turn on the volume for the phone. He was so angry. He left my baby in a stroller in the living room and shut the door to his room and went to sleep. He (husband) does not sleep with me. He sleeps in the other room. I guess he doesn't want to be disturbed because my baby wakes up so many times.*

Hearing this, I feel her husband has no sense of compassion for Anu or their baby. I want to understand why he is so angry and distant. Did his family force him into this arranged marriage with Anu? How long can Anu tolerate this toxic relationship? I feel deep sadness and compassion for Anu. I can only imagine how difficult it must be for her.

*He did not even ask about dinner. I took care of my baby and put him to bed. After this long day, I cooked dinner for myself and my husband's food for the next day. I am so frustrated to have a messy home at the end of each day. It is so hard to clean with the baby.*

Anu's comment about dinner makes me think of Amar when she also talks about the importance of food in the Punjabi culture. Although Anu is frustrated with her

marital relationship and the untidy home, she still perseveres to cook fresh food for her husband.

*I feel that sometimes I have memory loss because of my depression. My life has changed from being a confident working girl in India to being in depression day by day and losing my self-confidence (crying). I feel like I am not the same person anymore.*

I feel sadness for her sense of loss of who she was in India. Once again, Anu's tears roll down along the side of her cheeks. I pass her a tissue. I reach out my hand and gently place it on her arm and ask, if we should end this conversation. She looks at me and nods her head to continue.

*I want to find a job now and work, but I feel I don't have the qualifications. I can't go to work in a factory. I have never worked there like that. I even thought about starting my own business at home. But my husband didn't want to support me. He's so negative. He said, I couldn't do it because I have a small baby. In the same way, he doesn't want me to take driving lessons. Here, if you can't drive, you can't do anything. He doesn't want me to drive. He just puts negative thoughts in my mind.*

Hearing Anu discuss her employment challenges reminds me again of Amar and other immigrant women, who are clients in my nursing practice. Many immigrant women with an education from India still encounter frustration in securing employment in their field of study after immigration to Canada. It sounds like Anu is eager to regain her sense of confidence, similar to when she was living in India. But

her husband continues to exert his control and deny her the support she requires to develop her career and gain independence. It seems like Anu is afraid her husband will harm her if she went ahead and pursued her desires. She is stuck ... at least for now.

*I regret coming to Canada. This is known as a country of great opportunity. But I didn't find any. I believe because my husband is so unsupportive of me. He lived in Canada for over 20 years and has a group of friends from his school days that he spends a lot of time with. They are his soul mates. When he leaves work, he spends time with them.*

I can hear disappointment and longing in Anu's voice. Immigration to Canada was not the hopeful experience she expected. I wonder how her postpartum experience would have differed if her husband was supportive. Was he ready for family life when they got married? Was he even interested in having a family? Is he also a victim of his family's expectations for an arranged marriage?

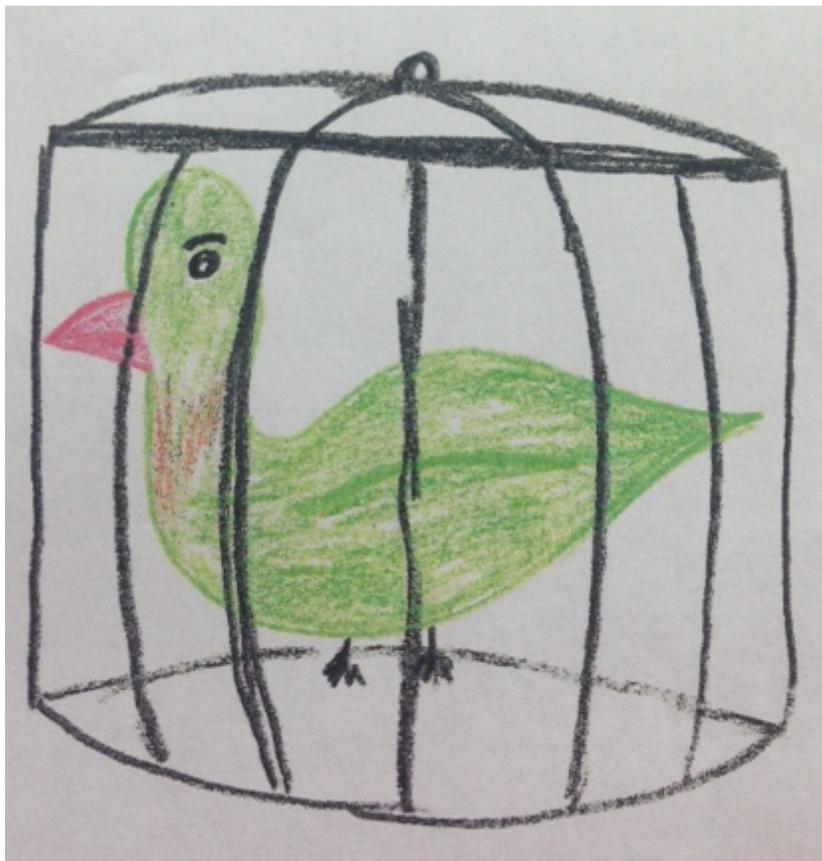
*For me, postpartum depression is the feeling of loneliness up till and even after baby is born. It's when you worry about your baby and feel alone. I don't know what to do. I feel often alone and worry about everything. Like how I'm going to manage everything. I want to see my parents but he (husband) is not willing to buy tickets for me to go to India. I feel financially insecure. I never used to write things down for myself. I had a sharp memory. But, now it's worse. I don't remember things. My life is not easy.*

Anu's words, *loneliness, worry, feel alone and not knowing what to do* make me think of Amar's description of postpartum depression. In Anu's story, she has the additional pressures of an overtly abusive husband. She shares her emotional trauma and spousal abuse of power throughout our conversation. Her life drastically changed after the birth of her son.

### **Anu's Metaphor Drawing**

After our narrative interview, I ask Anu to draw a metaphor to represent her experience with postpartum depression. I provide her with a colourful array of pencil crayons and paper. Anu begins to sketch.

**Figure 3. Anu's Metaphor Drawing of Postpartum Depression: Bird in a Cage**



Once Anu finishes her drawing, she tells me that she drew a bird sitting inside a cage because:

*This is how I feel. I can't do anything. I am trapped like this bird in a cage. I used colours to draw a parrot. A lonely parrot stuck in a cage. (pause) It is not easy to talk about difficult subjects.*

After drawing the picture of the parrot in a cage and giving the above description, Anu sits in silence. As she continues to look at her drawing, she further elaborates on her feelings:

*Sometimes I feel I should break my marriage. You know, there's no point staying with a person who doesn't love you. But I have to think about my baby first, then my parents. Here (in Canada) no one bothers about anyone. But in India, people are related to each other. It will be hard for my husband to answer to everyone. I don't want to make my family face any problem because of me. Just like this parrot I am stuck.*

I think of her life, alone at home, like the parrot inside the cage. The parrot may talk, but sometimes no one really listens. Today, Anu talks with me. I listen as she shares her story. But, for the most part her story remains silenced. Like Anu, I too felt stuck in my marriage relationship many years ago. I too was very much aware of the grief a broken marriage could bring to my family, and his. I stayed silenced until I gathered the strength and determination to begin a new life on my own.

The interview comes to a close. I provide Anu with an information pamphlet and resources for community services and support in both English and Punjabi. We review counseling and financial services, multicultural organizations, housing and shelters in the community. I thank Anu for inviting me to her home and for her participation in the interview. I gather my papers and wave good-bye to her son as I walk towards the door. Anu expresses her gratitude for providing her with an opportunity to tell her story. I smile and thank her for taking the time to share her story with me. I leave the apartment building. I step outside and take a deep breath. It is snowing. Each snowflake is different and unique. Similar to the snowflakes, I am feeling different. Hearing this story makes me wonder about the implications of emotional and physical abuse during the postpartum period, not only for Punjabi immigrant women, but for all women whose family life is filled with fear and tension. These family dynamics are worsened when women do not have connection with extended family and community supports, which is oftentimes the case for new immigrants.

### **Anu's Additions to the Story**

I call Anu a few weeks later to tell her that I have composed her story from our narrative interview and would like to share it with her to ensure that I accurately captured her experience. I encourage her to interrupt me at any time, if there is anything she would like to add or change to the story, as I read it to her. Anu listens to the story and does not interrupt. At the end, she comments that the story is just as she described. However, she adds the following statement to the story to further elaborate on her marital situation:

*My family in India knows his family. If I walk away from this marriage, in the Indian culture it is a big thing. I would be blamed. Our women have to compromise a lot.*

Listening to Anu reminds me again, that we both experienced similar family pressures to remain in the marriage. Why must so many women compromise their happiness in order to avoid cultural stigma of not remaining in a marriage?

Unfortunately, this story still continues to be far too common.

I am beginning to notice the narrative threads within Anu and Amar's stories, and surprisingly, my own. My mind is filled with excitement with having completed my last narrative interview. I now turn my thoughts towards the next step in the research process, the second level of analysis: the practical justification.

## CHAPTER SEVEN

### **Interpretation of Text: Data Analysis**

Over four months have passed since my last follow-up interview with Anu, my second participant. The seasons have changed from the cold winter weather to warm summer days. Since then, I have been reading and re-reading Amar's and Anu's stories, and reflecting upon them. All along I have been keeping a journal of my thoughts and feelings about their postpartum experiences. During this time I have also completed the first level of analysis, the personal justification (Chapters 5 and 6). It is now time to move forward to the next levels of analysis, the practical justification (Chapter 7) and then the social justification (Chapter 8).

#### **Second Level of Analysis: Practical Justification**

In order to prepare for the second level of analysis, the practical justification, I take a step back and listen to the audio recordings and read my field notes again to become immersed in both Amar's and Anu's stories. In this level, my researcher voice becomes stronger, as I critically reflect on the stories from my professional role as a public health nurse. As narrative threads emerge and narrative patterns are revealed, using the Narrative Inquiry three-dimensional space (temporality, personal-social and place), I integrate relevant literature to make meaning of participants' stories and so to situate them within the broader context of the nursing profession.

#### **Theoretical Lens: Three Dimensional Narrative Inquiry Space**

The three dimensional Narrative Inquiry space: temporality, personal-social and place form the conceptual research framework for this Narrative Inquiry. The first dimension, temporality refers to time. Participants under inquiry have a past, present and

future. In Narrative Inquiry we try to understand people in temporal transition (Clandinin et al., 2007). The second dimension relates to both, the personal and the social conditions. Personal refers to feelings, hopes, desires, aesthetic reactions, and moral dispositions of the participants (Clandinin & Connelly, 2000). The social aspect of this dimension refers to the existential conditions, the environment or surrounding factors under which the participants' experiences unfold (Clandinin & Rosiek, 2007). Within this dimension we also recognize the relational quality of told experiences. The last dimension of the Narrative Inquiry space is place. This refers to the physical place, location where the storied events occur (Clandinin et al., 2007). The three dimensional Narrative Inquiry space invites us to travel, backward and forward (past, present and future), inward (internal feelings and emotions) and outward (external conditions) situated within a place (Clandinin & Connelly, 2000).

Narrative Inquiry is a way to understand experience. As discussed earlier, the philosophical underpinning of Narrative Inquiry is Dewey's theory of experience (1938). As such, in this inquiry *experience* is a key term that allows an exploration of how Punjabi immigrant mothers understand and experience self-identified postpartum depression. According to Dewey, in experience both the personal and the social contexts are present. People are individuals and need to be understood not only as human beings but also in relation to a social context, the environment, life, community or the world (Clandinin & Connelly, 2000; Clandinin & Rosiek, 2007). Several features of the ontology of experience make it well suited to explore Amar's and Anu's stories through the three-dimensional space of Narrative Inquiry. First, the *temporality* (past, present and future) of knowledge generation is emphasized (Clandinin & Rosiek, 2007). Since the

narrative allows human experiences to unfold through time, the inquirer can reflect “backward and forward” on her/his past, present and future and on the life of the participant to delve deeper into the phenomenon under inquiry. Secondly, a realistic ontology of experience emphasizes Dewey’s criterion of experience, *continuity* (Clandinin & Connelly, 2000). Meaning experiences grow out of other experiences, which eventually lead to other experiences (Clandinin & Connelly, 2000). From any starting point, there is an imagined past or future that leads to another future experience. Continuity in this sense is ontological (Clandinin & Rosiek, 2007). According to Clandinin & Rosiek, the stories shared by participants are based on their own personal life history, external conditions and social influences, emphasizing the social context of experience. Critically examining Amar’s and Anu’s accounts of postpartum depression through the three dimensional Narrative Inquiry space, allows me, as the inquirer, to gain a greater insight into this phenomenon, and thus to consider the potential significance of these stories within nursing and the greater social sphere (the third level of justification, the social, is addressed in Chapter 8).

### **Narrative Patterns**

As I read and re-read Amar’s and Anu’s stories, I become aware of the emergent narrative patterns: transition to motherhood, relationships and loneliness, which permeate both of their accounts. Upon closer examination, I notice a conspicuous common narrative thread, the immigration context, which interconnects these patterns. Although both participants endure different degrees of hardship in their life, as immigrant mothers with postpartum depression, the three narrative patterns remain prominent in their stories. Using the three dimensional Narrative Inquiry space and accessing relevant research

literature, I examine more closely each of the narrative threads. I first begin by discussing the immigration context.

*“It’s even more depressing when you are new to the country”*

(Amar sharing her feelings as a new immigrant to Canada)

Moving to a new country is often accompanied by the added stress of living in unfamiliar surroundings, adjusting to different socio-cultural practices and changes in support networks (Guruge, Thomson, George, & Chaze, 2015; Lanes, Kuk & Tamim, 2011). For many immigrant women, adjustment to a new life in the host country can be stressful, especially when immigration status is pending or uncertain (Collins, Zimmerman & Howard, 2011; Handa, 2013). The stressors that accompany immigration are compounded when a new immigrant woman is transitioning to motherhood. Studies show immigrant women maybe twice as likely to develop postpartum depression symptomology as Canadian born women (Kingston et al., 2011; Lanes et al., 2011; Mechakra-Tahiri et al., 2007). Immigrant mothers attribute their depressive symptoms in the postpartum period to social isolation, physical changes, feeling overwhelmed and financial concerns (Ahmed et al., Gagnon, 2008; Collins et al., 2011; Ganann et al., 2012; Ornelas, Perreira, Beeber, & Maxwell, 2009). In Amar’s and Anu’s stories, immigration is a central narrative thread. Both Amar and Anu immigrated to Canada for the purpose of marriage, leaving their family of origin back home in India, the main source of their social support. Both participants share the physical and intense emotional impact of losing their extended family support network and cultural practices after the birth of their baby. Research with immigrant mothers commonly refers to the importance given to a

female support person in providing emotional and physical support after the birth of the baby (Jain & Levy, 2013; O'Mahony & Donnelly, 2010; Tsai et al., 2011).

In addition to the anxiety of social separation from the family of origin, both Anu and Amar have financial struggles. It is not uncommon for immigrant women, who are sponsored by their spouse, to experience financial strain because of a lack of or limited recognition of international educational credentials (Zelkowitz et al., 2008). This results in loss of independence, reliance on their spouse and, in some cases, marital strain and even domestic violence (Guruge, Shirpak, Hyman, Zancheta, Gastaldo & Sidani, 2010; Zelkowitz et al., 2008). Unfortunately, both Anu and Amar experience challenges with their spousal and in-law family relationships. In fact, from my nursing practice with immigrant mothers, I have come to understand that, rooted within the social structure of many immigrant families, the husband and the in-law family have the final decision-making power for the wife. In some arranged marriages, similar to the story shared by Anu, women lose trust in their relationship when they have no power and become dependent on others to survive (Tsai et al., 2011). Immigrant mothers in the postpartum period are particularly vulnerable, if they experience the additional stress of unhealthy spousal and in-law family relationship, which increases anxiety and risk for domestic violence, this is evident in Anu's story (Zelkowitz et al., 2008). Immigrant women who are exposed to forms of violence may experience a range of physical and mental health problems (Guruge, Roche & Catallo, 2012). In order to support both the physical and the mental health needs of immigrant mothers, healthcare professionals in all areas of practice (hospital, community, social services) need to work together to implement strategies for health promotion and primary prevention of violence (Guruge, 2012).

As a public health nurse I am aware of programs available to support immigrant mothers during the transition to motherhood in the postpartum period. However, studies still continue to show that immigrant mothers experience challenges accessing health services (Ganann et al., 2012; Jain & Levy, 2013; O'Mahony & Donnelly, 2010; da Conceição & Figueiredo, 2015; Thomson, Chaze, George & Guruge, 2015). There is a need for healthcare professionals to explore creative ways to empower ethnic communities to become partners in program development, in order to ensure these programs are more culturally appropriate and provide effective mental healthcare and support. The immigrant context is the common thread that is weaved through both Amar's and Anu's stories, connecting the narrative patterns: transition to motherhood, relationships and loneliness.

### **Transition to Motherhood**

*"I had a difficult time right from the beginning."*

(Amar shares her experience after becoming a first-time mother)

The transition to motherhood is a significant time in a woman's life, marked with changes in physical and emotional health with added responsibilities and a new role as a mother. Although many women embrace motherhood, others may embrace but also feel overwhelmed, anxious and alone with the changes, and become depressed in the postpartum period. In both Amar's and Anu's stories, they express frustrations of this difficult shift to motherhood.

*“I kind of enjoy it, but on the other side it was a struggle because I didn’t know anything about caring for a new baby.”* (Anu speaks of her

experience of motherhood without the support of her cultural practices)

In my nursing practice, immigrant mothers often express frustration with the Canadian media’s portrayal of Canadian born mothers who are always joyful and confident. This societal expectation of the perfect motherhood experience poses pressure on mothers who are not able to conform to this cultural norm. In fact, the nursing profession needs to open up dialogue with all mothers to talk about the realities of the motherhood experience.

This would promote broader awareness among immigrant families and other healthcare professionals to ensure the appropriate supports are available to ease this important life transition. Literature reveals a woman’s postpartum care experience is an important determinant of how she transitions to her new role as a mother (Jain & Levey, 2013). For this reason the prominent threads: postpartum care, and postpartum rituals are explored in greater detail.

### **Postpartum Care: Support Services**

The provision of appropriate supportive healthcare services would provide the much-needed physical and emotional support required during this turbulent transition period. Ganann et al. (2012) conducted a secondary analysis of data gathered for a longitudinal cross-sectional survey of postpartum health and service use with 1045 participants in Canada. Findings reveal immigrant mothers were more likely to rate postpartum health services fair to poor, and less likely to get support for their emotional health problems than Canadian born women (Ganann et al., 2012). As a result, these researchers found that immigrant women had unmet health and service needs related to

their physical and emotional health. There is a gap in meeting the health and service support needs of postpartum immigrant mothers (Ganann et al., 2012; da Conceição & Figueiredo, 2015). The common barriers to accessing care services for immigrant mothers may include, stigma attached to mental health (Ahmed et al., 2008; Jain & Levey, 2013; Kirmayer et al., 2011; Mawani, 2008), lack of linguistically appropriate services (Ahmed et al., 2008; Brar et al., 2009; Guruge & Humphreys, 2009; O'Mahony et al., 2012; Teng et al., 2007), discrimination and lack of culturally appropriate services (Ahmed et al., 2008; Almeida, Casanova, Caldas, Ayres-de-Campos, & Dias, 2014; Grewal et al., 2008; Reitmanova & Gustafson, 2008; Guruge & Humphreys, 2009), and lack of awareness of available mental health services and discomfort in asking for formal support (Kirmayer et al., 2011; Mawani, 2008). In a literature review, Jain and Levey (2013) explored questions regarding normal and abnormal postnatal experiences of Indian women with consideration to cross-cultural perspectives. Findings reveal postpartum sadness is recognized across most cultures, but in some cultures it is classified as a disease, while in others it is a normal feeling in the postpartum period (Jain & Levy, 2013). For this reason, there may be unwillingness for some immigrant mothers to use medical services when they feel sad in the postpartum period as sadness may be seen as a normal response to childbirth and not a mental illness requiring medical support (Brown-Bowers, McShane, Wilson-Mitchell & Gurevich, 2014; Jain & Levy, 2013). This poses challenges for healthcare professionals to screen and provide culturally appropriate care for immigrant women who are experiencing sadness in the postpartum period.

Despite great advances over the past decades, nurses still practice predominantly in a medical model of care in which emphasis is placed on physical health and testing

procedures rather than holistic care. The cultural context is important to explore because immigrant mothers may conceptualize, describe and report depressive symptoms in different ways than healthcare professionals may expect (O'Mahony, Donnelly, Bouchal & Este, 2013). Also, since some immigrant mothers rely heavily on familiar postpartum rituals for support, disregarding the social-cultural poses a barrier in the availability of culturally appropriate services to support immigrant mothers with postpartum depression. In order to provide postpartum care in multicultural communities, nurses and other health professionals need to better understand the barriers immigrant mothers experience to seeking help. For example, midwives work closely over a long time frame with women during pregnancy and the postpartum period, they are in an ideal position to notice changes in mental health and hence empower women with health teaching, referrals and support.

However, in my nursing practice with new immigrant mothers, many women do not know about the role of midwives or how to access care with a midwife. More awareness is required to educate the public and especially immigrant families about the diverse healthcare services available in Canada including care with a midwife. Another innovative example of providing care to immigrant women is the use of a mobile health clinic. A Canadian research study used this model of care delivery with a mobile clinic to provide reproductive health needs with language and culture-specific care for seven Portuguese-speaking immigrant women (Guruge, Hunter, Barker, McNally, & Magalhaes, 2009). Findings from Guruge et al. (2009) reveal the transportable health clinic addresses barriers by providing access to holistic, linguistically and culturally appropriate care for immigrant women. Alternative models of health delivery, such as the

mobile health clinic, can be considered for postpartum care and mental health support to improve accessibility for immigrant women. Thus, it is important for nurses to develop strong partnerships with social service, settlement agencies and immigrant groups to ensure services are timely, culturally appropriate, coordinated and accessible for immigrant mothers (Thomson, Chaze, George, & Guruge, 2015).

### **Postpartum Rituals**

Postpartum rituals are practiced in many ethnic communities with the belief these customs provide support to protect the physical, mental and spiritual health of the mother and infant during the important time of transitioning to motherhood. Posmontier and Horowitz (2004) reviewed literature related to international postpartum practices and found that social support rituals, such as a mandated rest period, special foods for healing or keeping the mother warm to prevent illness provided by family support networks, are the main focus of care for the new mother during the postpartum period. For example, some Chinese mothers practice “doing the month” or “*Zuo Yue*”, some Mexican mothers observe “*La Cuarenta*” a forty day rest period, while some Nigerian practices include providing support for one month during pregnancy and the postpartum period (Posmontier & Horowitz, 2004).

According to many Punjabi immigrant mothers I work with, and based on my own understanding of the Punjabi culture, the postpartum time is embraced with the health beliefs of providing hot foods, in terms of properties (not temperature) for healing, during the forty day “*chilia*” rest period to regain strength and recovery from childbirth. Postpartum rituals are also supported in the research conducted by Grewal et al. (2008), who found that the first-time mother usually stays with her own mother during the first forty-days to rest and learn how to care for the newborn, after which she returns to her

husband and the marital home. The addition of a new baby is considered a family experience in the Punjabi culture, where family members provide advice, emotional and instrumental support. The extended family participates in ceremonies and prayers to create positive energy in the home (Grewal et al., 2008).

Literature reveals immigrant mothers most often rely on the support of female relatives during the postpartum period (O'Mahoney & Donnelly, 2010; Zelkowitz et al., 2008). The loss of such support and the deep frustration of not having the necessary knowledge and physical assistance to provide infant care, exasperate these mothers' feelings of social-cultural separation. The loss of cultural practices causes anxiety and may increase the risk for emotional problems (Liamputtong, 2001; O'Mahony & Donnelly, 2010; Zelkowitz et al., 2008).

Both Amar and Anu share their feelings of sadness after immigration to Canada without the proximity of their extended family for support in the postpartum period. Maintaining postpartum cultural practices becomes even more complicated with immigration to a country that imposes different beliefs and approaches to postpartum support (Jain & Levey, 2013). From my nursing practice, the emphasis of postpartum care in the hospital setting is placed on the physical health of the first-time mother and infant. Hence, immigrant mothers accustomed to postpartum rituals from their country of origin may feel deprived of their cultural practice during this transition period to motherhood (Ahmed et al., 2008). Nurses can support immigrant mothers to regain some of their postpartum rituals by inquiring about their customary practices, and then advocating to allow customs be integrated, if possible, into hospital and community care. In Anu's story, having her mother by her side in hospital for the first few days did not

require additional work on part of the nurse, but for Anu it was an incredible source of support. However, in my practice setting, many immigrant mothers have shared their dismay when the healthcare providers during the immediate postpartum period tell them what to do without offering any explanation. This is an opportunity for nurses to advocate for immigrant mothers by listening to their stories and discussing their desires for postpartum support, followed by integrating practices into their plan of care.

### **Relationships**

The relationships with: spouse, extended in-law family, the family of origin and infant is the second emerging pattern in both Amar's and Anu's stories of experience with postpartum depression.

#### **Spousal Relationship**

*“If I walk away from this marriage, in the Indian culture it is a big thing.”*

(Anu voices her feelings of being trapped in an unhappy marriage)

Changes experienced post-immigration have the potential to affect marital relationships (Guruge et al., 2010). A meta-synthesis of nine ethnic communities and one book chapter reveals three major changes that result after migration to a new country: changes in gender roles, inadequate social supports and loss of professional credentials (Guruge et al., 2010; Hyman, Guruge, Mason, Gould, Stuckless, Tang et al., 2004; Hyman et al., 2008; Morrison, Guruge, & Snarr, 1999). Both Amar's and Anu's stories also highlight these changes with transition to new motherhood: de-professionalization of their educational credentials and loss of their postpartum supports. These challenges accompanied by stress, disappointment and feelings of helplessness, spark negative outcomes in spousal relationships. Literature focused on immigrant mothers reveals the

quality of the spousal relationship to be an important predictor of postpartum depression (Miszkurka et al., 2010; Zelkowitz et al., 2008).

**Arranged Marriage.** Tension in an unstable arranged marriage can interfere with an immigrant woman's multiple roles: mother, wife and individual in society (Tsai, Chen, & Huang, 2011; Zelkowitz et al., 2008). Immigrant women who had difficulties in their arranged marriage often felt betrayal by the institution of marriage and lost faith in the process of moving to a new country to live a new life with an unknown partner (Kallivayalil, 2010). In my experience as a public health nurse working with immigrant mothers in the postpartum period, I also hear stories from mothers who express frustration from their experience of immigrating to Canada to marry a partner in hopes for a comfortable life, only to endure difficulties with securing employment and financial strain. Due to these challenges, immigrant mothers are often in a vulnerable position, relying on their spouse for financial support to survive.

**Social Support.** An important factor protecting immigrant mothers from depression is social support in the form of companionship, emotional and instrumental care, such as assistance with household chores (Miszurka et al., 2012). Immigrant mothers, who do not have their family of origin living in the host country, rely mostly on their spouse for social support. Guruge and Humphreys (2009) in their study with 16 first-generation Tamil immigrant community leaders reveal that, since immigrant women's social networks are limited after immigration to Canada, both spouses rely on each other for support, which may often result in the increase of family stress and conflict. When immigrant mothers lack their family social support network, they may seek assistance from a formal support service, such as a healthcare professional, social

worker or settlement workers (Guruge & Humphreys, 2009). As discussed earlier, there are many barriers associated with the access to social support services in the community.

In my practice setting I notice when an immigrant mother has female family support, the father of the baby often plays a secondary role in caregiving. However, it is important for fathers to also be involved with their infant, in order to build a bond and foster a positive attachment relationship. In the hospital, nurses can empower new fathers by involving them in the teaching of baby care skills. When fathers are involved with providing care for their baby, it not only builds a positive attachment relationship with their baby but also allows the mother time to concentrate on her own self-care. Nurses can also ensure fathers are able to recognize the signs and symptoms of postpartum blues and postpartum depression. Quite often, it is the father who may notice the first signs and symptoms of postpartum mood changes and so can encourage the first-time mother to seek medical support. Lija, Edhborg and Nissen (2011) in their research with 419 first time mothers in Sweden, found women with depressive symptoms revealed less closeness, warmth and confidence with their infant and partner relationships over the first year. First-time fathers may also experience strain in their marriage relationship due to demands and burdens of having a new baby (Lija et al., 2011). If the spousal relationship is unstable, the added stress of becoming a first-time mother increases the strain on the marriage and risk for a toxic relationship with the potential for intimate partner violence.

**Intimate Partner Violence.** Violence associated with pregnancy and the postpartum period is a major public and social health concern. Statistics Canada (2007) reports 21 percent of abused women are assaulted during pregnancy. The process involved with immigration and settlement in a new country, may result in a loss of

informal social support networks, which can contribute to shifts in power dynamics, resulting in immigrant women becoming vulnerable in their marital relationship, thus increasing the risk for intimate partner violence (Guruge & Humphreys, 2009; Guruge et al., 2012; Morrow et al., 2008). Immigrant women experience various forms of violence in the hands of their spouse. A Canadian study with 60 immigrant women from Iranian and Sri Lankan Tamil communities, conducted by Guruge et al. (2012), reveals that participants experienced various types of violence with psychological abuse (insulting, criticizing and intimidation) by a spouse occurring most frequently, followed by physical (slapping, hitting, shoving) and sexual (forced sexual intercourse and sexually degrading acts) abuse. Intimate partner violence affects the mental and the physical health conditions of women leading to depression, anxiety, sleep disturbances, chronic pain and suicide attempts (Stewart, Gagnon, Merry, & Dennis, 2011). However, as pointed out by Guruge et al. (2012) violence affects immigrant women in different ways. Some immigrant women may report physical health symptoms instead of emotional symptoms (Guruge et al., 2012; Morrow et al., 2008; O'Mahony et al., 2013; Zelkowitz et al., 2008). Since research with immigrant women reveals there are considerable differences in how violence and trauma are expressed, it is important for healthcare professionals to routinely assess for both physical and mental health symptoms.

Anu's narrative reveals episodes of emotional and financial abuse in her troubled marital relationship. During our conversation Anu makes reference to her physical health concern with her ears, in addition to her intermittent loss of memory. Unfortunately Anu's family is not close by hence she cannot rely on her family support network, so she

tolerates the abuse of power and control in her spousal relationship. Deep down she finds the inner strength to endure a life of hardship in her arranged marriage.

*“Sometimes I feel I should break my marriage. You know, there’s no point staying with a person who doesn’t love you. But I have to think about my baby first, then my parents.”*

(Anu expresses her feelings of an unhappy marriage. Her love for her baby and family allow her to persevere)

In addition to the role nurses already provide through immediate care, safety and support for women affected by intimate partner violence, Guruge et al. (2012) make practice recommendations for nurses to enhance their role to that of advocacy for affordable housing, long-term transitional housing, linguistically and culturally appropriate support services that are coordinated in a centralized area, addressing the barrier of eligibility requirements to access services and assisting in affordable child care and employment opportunities. It is vital that all immigrant women have access to appropriate support services if they choose to leave their toxic relationship. But for some women, such as Anu, leaving the marriage is not an option.

### **In-law Family**

*“My husband listens to his family, especially his mother and brother, and sometimes he begins to think like them.”*

(Amar voices her frustration with her in-law family relationship)

Although family support would be welcomed as a source of assistance in the postpartum period, studies with immigrant women reveal conflict with their in-law family

(Mamisachvili et al., 2013; Kallivayalil, 2010; Raj et al., 2011). Relationship difficulties with the in-law family can create stress, feelings of anxiety, sadness and pressure, making it more difficult to cope with the role as a first-time mother. Immigrant women who have their spouse selected by their family in an arranged marriage usually have an intimate connection between the woman's natal family and the in-law parents (Kallivayalil, 2010). Such is the situation for my participant, Anu. She talks about a sense of responsibility to her own family back home in making her marriage successful, even though she continues to suffer emotional abuse by her husband. Healthcare professionals can work together with immigrant families to understand family dynamics and involve family members to support the first time mother to achieve a sense of balance after the body's physiological and psychological transition into motherhood. As health professionals, nurses can build capacity within the community to empower immigrant women. Guruge (2012) suggests nurses can take on the role of health promotion and primary prevention of violence by providing early education about healthy relationships, becoming involved with the promotion of public awareness about the effects of violence for women and children, involving men in violence prevention programs, developing life skills and safety support programming.

### **Family of Origin**

*"I really needed her [mother] support when my baby was born."* (Amar tells us about the importance of her family relationships)

In most cultures women rely on their own mothers and families for social support after childbirth. As discussed in greater detail earlier in this chapter, first time mothers will often live with their own family in their home country to allow time for rest and

recovery. However, when women's parents are unable to come, immigrant mothers are left on their own to deal with the challenges motherhood brings. The postpartum period can be a time of frustration and anxiety related to social isolation and pressure to demonstrate good mothering to the spouse and the in-law family (Morrow, Smith, Lai, & Jaswal, 2008). By connecting immigrant mothers to health and social programs, they become empowered to advocate for the social supports they require, strengthening their postpartum health.

### **Infant Relationship**

*"I didn't know how to interact or be with him (infant)."*

(Amar speaks of her challenges of bonding with her baby)

Immigrant mothers often become overwhelmed with the burden of infant care, while maintaining responsibilities of household duties, without the support of their family and postpartum rituals (Ngai, Chan, & Holroyd, 2011; Zelkowitz et al., 2008). Both Amar's story and Anu's story reveal their emotional liability after the difficult birth of their infants.

*"I felt sad that I couldn't even deliver the baby the normal way. I was not expecting a cesarean delivery. I was not ready for him [baby] or the recovery time after the surgery."* (Amar communicates her sadness after a difficult birthing experience)

Although some mothers have feelings of happiness towards their infant, they may still experience anger and irritability during the transition to motherhood, hence having a negative effect on their relationship with their infant (Jain & Levy, 2013).

A stressful birth with medical interventions may hinder mother-infant interaction and delay maternal feelings and bonding with the infant (Lilja et al., 2011). Postpartum depression impairs a mother's ability to interact with her infant in a healthy way to develop an attachment bond. A positive attachment relationship enables an infant to feel nurtured and lay a solid foundation for social, emotional, intellectual and physical development later in life. Immigrant mothers with postpartum depression often have problems with the infant attachment relationship, which may result in negative implications for the infant's future cognitive and socio-emotional development (Lilja et al., 2011; Ross et al., 2005).

The insecure attachment relationship with the infant is one of the invisible traumas experienced by immigrant mothers with postpartum depression and emphasizes the need for health professionals to implement effective screening and interventions to identify postpartum depression to improve the quality of this attachment relationship. However, nurses working with mothers who have been diagnosed with postpartum depression need to be cognizant that overemphasis on the attachment relationship may exacerbate the mother's feelings of guilt and inadequacy (Ross et al., 2005).

Since a strong attachment relationship between the spouse and the infant may help to promote the infant's development, more attention should be invested in educating fathers and other family members to take an active role with the infant when the mother has symptoms of postpartum depression or difficulty transitioning to motherhood.

As a nurse I notice immigrant mothers have so much more on their plate than we can image. As I listen to Amar's and Anu's stories, I realize that loneliness is another

narrative pattern that clearly emerges in both stories and especially in their metaphor drawings.

### **Loneliness**

*"I often wondered, How could I do this all alone?"*

(Amar shares her feelings of loneliness after the birth of her infant)

Loneliness is a complex, subjective experience that can be related to social isolation or a lack of companionship. Loneliness is not the same as being alone. Anyone can choose to be alone and yet be happy without contact with other people. On the other hand, a person may have many social interactions and be surrounded by people, and still experience loneliness. Research shows that loneliness can have a significant impact on mental health particularly that of immigrant women (Ahmed et al., 2008; Bhagat et al., 2002; A V Pramuditha, Guruge, Schwind, & Schindel-Martin, 2014; Sword et al., 2006).

Immigration to a new country is a stressful experience, especially for women who leave their countries of origin to settle into a new life in an unfamiliar environment without their social support network and familiar cultural practices. In Amar's and Anu's stories, they both had difficulty expressing in words their feelings of loneliness. The adapted Narrative Reflective Process (Schwind, 2008) of choosing a metaphor to represent their feelings, and then drawing it, allowed both participants to illustrate their loneliness experience on paper. In this way they were able to then talk about their feelings by engaging in reflective dialogue with me, as the inquirer.

The Theory of Relational Loneliness developed by Weiss (1973) describes an attachment theory of loneliness in which deficiencies in social relationships that serve a function (social integration or attachment) may contribute to feelings of loneliness.

According to the work of Weiss (1973) the experience of loneliness can be that of social or emotional isolation. Both of these forms of loneliness are evident in Amar's and Anu's stories. The narrative pattern of loneliness is explored through the narrative threads of social isolation and emotional isolation.

### **Social Isolation**

Weiss (1973) identifies social isolation by the absence of engagement in a societal network. He postulates this can be remedied with a satisfying social network, which is also referred to as the provision of social integration (Weiss, 1973). In other words, this aspect of loneliness can be seen in Amar's story of feeling socially isolated from her family in India and emotional disconnection from her in-law family living in Canada. In order to address this social aspect of her loneliness, Amar may benefit from connecting with a satisfying social-support network, such as a community of new immigrant mothers, for example.

Nurses can be the necessary link to fostering the development of social support systems by listening to immigrant mothers' stories, including larger community groups, and then advocating the creation of culturally appropriate programs that foster the development of social networks in settings that immigrant mothers feel comfortable. Furthermore, healthcare professionals can be attentive and ask questions to learn more about immigrant mothers' stories to gain an in-depth understanding of the social determinants of health that impact their feelings of loneliness. We must not assume that all immigrant mothers have postpartum depression if they are experiencing social loneliness after the birth of their baby.

In my inquiry, it is apparent that the creative activity of Narrative Reflective Process (Schwind, 2014), metaphor drawing, is the vehicle that allowed the two Punjabi immigrant mothers to explore their deep inner feelings. Such metaphor drawing activity can be incorporated into nursing practice to allow expression of hidden feelings that are difficult to express in words alone (Schwind, 2003).

*"When the tree doesn't have the green leaves, they are not seen as fresh. They are yellowish brown and dull leaves. The dull leaves show my feelings of sadness. I was feeling like this tree. I was alone. This tree is alone."*

(Amar describes her experience of loneliness and social isolation through her metaphor drawing)

Research literature shows immigrant women who experience social isolation may not feel comfortable to elaborate on their loneliness and seek support from a healthcare professional (Ganann et al., 2012; Mamisachvili et al., 2013; O'Mahony et al., 2012; Waugh, 2011). For this reason, health professionals, who work with immigrant women, need to, with every interaction, inquire and explore women's feelings of loneliness and experiences related to social isolation, both in the hospital and in the community settings.

Women who immigrate to Canada face many challenges some of which are: learning a new language, adapting to different healthcare practices, accepting new policies and laws, unfamiliar Western customs and adjusting to different social interactions (Ross et al., 2005) employment and low socioeconomic status, loss of social networks and social isolation (Guruge et al., 2015; Thomson, Chaze, George, & Guruge, 2015). Thomson and colleagues (2015) conducted a scoping review of 486 articles with

more than two decades of relevant Canadian literature with participants from diverse religious and cultural backgrounds, revealing three major barriers that influence immigrants' access to mental healthcare: the uptake of health information and services, the settlement experience and a lack of culturally and linguistically appropriate services. The challenges with the settlement experience are compounded by the stressful experience of social isolation and barriers in accessing mental healthcare, which may contribute to an increased risk for mental health problems (Fung & Dennis, 2010; Guruge et al., 2015).

Immigrant mothers, who experience violence, are often socially isolated. Stewart et al. (2012) found that pregnant new immigrants to Canada, who experienced violence, also had limited levels of social support and reported more depression, anxiety, somatization, and posttraumatic stress disorder. Inadequate social support can have a profound effect on immigrant women's mental health, especially if they are experiencing intimate partner violence. A scoping review of 34 Canadian research articles, conducted by Guruge, Thomson, George and Chaze (2015), reveals that social support can have a positive influence by helping women adapt to a new country, prevent depression and psychological distress, in addition to improving access to care and services. However, sometimes immigrant mothers may still have significant difficulties in dealing with the second pattern of loneliness: emotional isolation.

### **Emotional Isolation**

*"I am trapped like this bird in a cage[...] A lonely parrot stuck in a cage. It is not easy to talk about difficult subjects [...] Just like this parrot I am stuck."*

(Anu points to her metaphor drawing to explain her feelings of emotional isolation that are difficult for her to express in words)

According to Weiss (1973) the loneliness of emotional isolation stems from the absence of a close attachment relationship. This type of loneliness is only alleviated by the provision of a satisfactory attachment relationship or replacement of one that is missing (Weiss, 1973). Different relationships may require different needs. However, the intimate relationship with a spouse has the potential to satisfy many of the needs to displace emotional isolation (DiTommaso & Spinner, 1997). Emotional loneliness is associated with aloneness, anxiety, feelings of abandonment, vigilance to threat and a constant focusing on solutions to the problem (DiTommaso & Spinner, 1997).

In Anu's story, she expresses deep feelings of sadness (evident in her tears) as she shares examples of her toxic relationship with her spouse. Her emotional loneliness is characterized by the longing for an intimate relationship with her husband that is supportive and free of abuse.

*“My husband is uncooperative, and unsupportive. He always wants his own comforts. He was (soft voice, with tears in her eyes) physically and verbally abusive to me in the past.”* (Anu expresses her emotional experience of her spousal relationship)

The distressing feelings of emotional loneliness can be linked to mental health problems such as depression, increased anxiety, lower self-esteem and psychosomatic symptoms (DiTommaso & Spinner, 1997). For nurses it is important to assess for and consider psychosomatic symptoms such as headaches or other aches and pains. Ample literature discusses how immigrant women often express their feelings of depression

through somatic symptoms (Fung & Dennis, 2010; Dorheim Ho-Yen, Bondevik, Eberhard-Gran, & Bjorvatn, 2006; Morrow et al., 2008; O'Mahony et al., 2013; Zelkowitz et al., 2008). Mothers experiencing social and emotional isolation coupled with symptoms of postpartum depression often feel alone in dealing with their struggles in the postpartum period (Wardrop & Popadiuk, 2013). For this reason, it is important for nurses and other healthcare professionals to use screening techniques that are culturally appropriate for immigrant mothers. At present, the Edinburgh Post-Natal Depression Scale (EPDS) is a screening tool developed in Edinburgh, Scotland and widely in Canada to screen for postpartum depression. Since the English version of the EPDS has a high level of validity and reliability, it has been translated into many different languages, validated and adopted for use in many countries (Clifford, Day, Cox, & Werrett, 1999). In my public health practice, the EPDS is often used during home visits with mothers in the postpartum period to screen for postpartum depression. The concern with using the EPDS is that it is not inclusive of screening for physical symptoms, which are often used by immigrant women to express distress. Also, the EPDS in many other languages including Punjabi has not yet been validated (Werrett & Clifford, 2006). Policies at most organizations do not permit using a screening tool in a language that is not validated. Hence, Punjabi immigrant mothers who cannot read in the English language are not screened for postpartum depression with the EPDS. This raises concerns since many ethnic communities will not be adequately screened for their postpartum mental health. Nurses working in the area of policy and research have an opportunity to work with different ethnic communities to validate the EPDS or explore use of a more culturally

appropriate screening tool that integrates somatic physical symptoms and considers the perspective of immigrant mothers and their families.

The two participant stories represent their own personal experiences with loneliness, entwined with the narrative thread of immigration. Loneliness in Amar's story is triggered by feelings of frustration, anxiety and sadness in her transition to motherhood without a support network, her family of origin. Her spouse is supportive but due to financial constraints works long hours away from home, creating additional social isolation in her experience of loneliness. In Anu's story, her deep feelings of emotional isolation are shaped by the unstable relationship with her spouse and in-law family. She feels vulnerable, trapped in an unhappy arranged marriage with no way out, as depicted in her drawing of a bird stuck in a cage. Despite Anu's significant challenges in life, she demonstrates an inner strength that gives her the ability to accept her life circumstances and care for her baby. In order to support Punjabi immigrant mothers with postpartum depression, nurses and other health professionals can take on a vital advocacy role in the area of policy, practice and research.

In this second level of justification, I have analyzed the revealed narrative thread and narrative patterns using the Narrative Inquiry three-dimensional space and relevant research literature to gain a deeper and broader understanding of Amar's and Anu's experiences with postpartum depression. The following is a literary representation, in form of poetic prose, where I write, using Amar's and Anu's words, the intense feelings of their respective postpartum experiences.

## Literary Representation of Narrative Inquiry

### A New Life, Yet I am Lonely

*It is a beautiful autumn day, as I travel over the deep blue sea, from my motherland.  
I am scared.*

*Leaving my family for the first time is frightening.  
This new land is so different from my own.  
Where have I come? How will I fit into this new life of mine?  
I have no choice now but to stay.*

*One year passes so quickly.  
My husband works long hours away from home.  
It is a struggle in every way. I still can't find work in my field.  
And now I am expecting a baby!  
I should be happy but I am not. I feel so alone.  
I have no choice. I must stay.*

*It's a baby boy! My husband is happy.  
But, I am not. I should be, but I am not.  
Childbirth was not what I imagined.  
I am alone. My family is in India. I need my mother now more than ever.  
Motherhood is such a difficult time.  
How do women do it all on their own? I feel so lost.  
Care is so different in this country. No one understands my customs here.  
Sometimes, I wish someone would care for me.*

*My husband is not here by my side.  
In fact, he is the cause of much of my misery.  
He listens to his family and not me.  
I am like a bird in the cage.  
Why must I endure this turbulent life? Each day I cry in silence.*

*My baby is with me in my lap. I do not feel close to him.  
What kind of mother am I?  
I want to be happy, but I am not.  
I love my baby. I need to be happy for him.  
But, I feel so lonely.*

*It is another autumn day and the bright crisp tree leaves have become brown and dull.  
Each one falls slowly down to the ground.*

*I feel naked. Like the tree, I am alone.  
Standing in the forest on my own with no branches of support.  
Sad and lonely.*

*This life is a trap. Why am I in this cage?  
I feel stuck!  
Let me out. I want to fly back to my home, to my family.  
Here no one hears my cries.  
Why doesn't anyone understand?  
Please let me be free once more.*

In the next chapter, I further explore the wider social context of the stories: the third level of justification, and position this inquiry within the broader research literature on immigrant mothers who experience postpartum depression.

## **CHAPTER EIGHT**

### **Considerations for Education, Practice, Policy and Research**

As I near the end of my thesis journey, I pause for a moment to look back on my initial inquiry puzzle: to give voice, through storytelling and creative self-expression activity, to Punjabi immigrant mothers on how they experience and make sense of postpartum depression. The narrative patterns: transition to motherhood, relationships and loneliness, reveal the outcomes of this Narrative Inquiry. By listening to, and analyzing, Amar's and Anu's stories in the context of immigration, I gain a deeper awareness of the struggles and the complexity that accompany their experiences of postpartum depression. Yet, I recognize there is more to this puzzle than meets the eye. This realization prompts me to step back to look at this Narrative Inquiry from a broader perspective.

#### **Third Level of Analysis: Social Justification**

It is time to delve deeper into the analysis process, beyond the immediacy of Amar's and Anu's stories, and to examine their told experiences from a broader perspective of social justification (the third level of analysis). At this stage of the process I make explicit, the social significance and the contribution this inquiry makes to the larger body of literature (Connelly & Clandinin, 2006). I do this by answering the questions "So what? and Who cares?" (Clandinin et al., 2007, p. 25). Using the three dimensional space of Narrative Inquiry: temporality, personal-social and place (Clandinin & Connelly, 2000), I move backward and forward between conversations with my participants, while simultaneously considering the social significance of the three narrative patterns: transition to motherhood, relationships and loneliness. In this section I

provide future considerations for education, practice, policy and research while situating this inquiry within the extant research literature.

## **Education**

It is important that healthcare providers and those who work with immigrants understand the challenges immigrant mothers experience after having a baby. But how can we understand if the response from immigrant mothers cannot always be communicated in words? Such was the case in my study. Although both participants spoke English, they experienced difficulty verbalizing their inner feelings and experiences with postpartum depression. The introduction of the adapted Narrative Reflective Process (Schwind, 2014) allowed participants to reflect on their embodied experiences and create, for themselves, meaning of these experiences through a creative metaphor drawing.

The benefit of integrating art into nursing curricula to enrich learning experiences and critical thinking skills has been reported in the literature (Ewing & Hayden-Miles, 2011; Schwind, Beanlands, et al., 2014; Schwind, Lindsay et al., 2014; Thomas & Mulvey, 2008). In the realm of education, we need to consider incorporating metaphor, drawing, poetry and sharing personal experiences in the form of storytelling into curricula. This increases the student learning experience and also gives voice to populations, who are often overlooked. But, how can telling a story deconstruct power relations and cultivate an open and safe learning environment? In Lapum et al. (2012) a nursing professor uses poetical and performative narrative with her students to examine how the use of stories can guide her students to self-reflect on their own experiences of oppression. According to Lapum, through this creative teaching-learning activity,

students become more fully engaged in issues of social justice, and so transform their theoretical learning of Critical Social Theory into praxis.

It is vital that those who work with immigrant women participate in interprofessional education. This is the first step in preparing learners to collaborate in different practice settings in order to understand the complexities of postpartum depression from different view-points. In this way they can then work together to improve the health of immigrant mothers during this significant stage of their life. For example, a public health nurse, a newcomer agency staff and a community outreach worker can all work together to plan and implement a community program designed to support Punjabi men in their new role as a father and support person to a first-time mother. Integrating interprofessional education in different practice settings fosters enhanced learning and culturally appropriate care for immigrant parents.

Couples from different ethnic backgrounds who are expecting a baby would benefit from increased opportunities to learn about postpartum mood disorders: baby blues, postpartum depression and psychosis. This education would provide important information to both partners and family members about the signs and symptoms of depression and how to access help and support recovery (O'Mahony et al., 2012). In order to increase the accessibility of these educational opportunities to the public, teaching can be delivered in different formats (prenatal class with a health professional, online, and peer to peer) in a variety of settings, such as settlement or immigration offices, community centers and religious institutions, with outreach in many languages and without cost to the family. Bhagat et al. (2002) point out that there is a lack of awareness of prenatal care in the Punjabi community. A mobilization strategy was

implemented with the assistance of community members in the form of a cultural festival to share messages about prenatal care within the community (Bhagat et al., 2001).

Members of the public can partner with the social service agencies (settlement workers) and health care agencies, such as public health units to organize health or cultural fairs to increase awareness of prenatal and postpartum care.

### **Practice**

In order to more effectively support immigrant women with postpartum depression, changes need to be made in the practice area. It is evident from my participants' stories along with research literature, immigrant mothers continue to experience challenges with high rates of depression, anxiety and family conflict attributed to the stresses of adaption after migration, loss of cultural traditions, and un- or under-employment (Shirpak, Maticka-Tyndale, & Chinichian, 2011). Reflecting back on the personal and the professional levels of analysis and the knowledge gained from relevant research literature, I examine practice-based issues that have become apparent to me at this time.

**Transition to Motherhood.** From my own practice experience and research literature, it is evident that an immigrant woman's cultural background, beliefs and socioeconomic factors have a strong influence on her transition to motherhood. This transition can be a major life event and for some a vulnerable period in their life. In order to support a first-time mother's physical and emotional health, changes are needed in the delivery of culturally appropriate care for providers who work with immigrant women in the prenatal, perinatal and postpartum periods.

All areas of practice in health, settlement and social work should gain knowledge on the different ways immigrant women use to conceptualize, describe and report symptomology for postpartum depression; such as the description of physical symptoms and emotional feelings (Almeida et al., 2014; Zelkowitz et al., 2008). By understanding postpartum depression from an immigrant woman's perspective, health and social service organizations would be able to provide more culturally appropriate support and care.

Language, spoken and written is one of the most common barriers to receiving perinatal care for immigrant women (Brar et al., 2009; Almeida et al., 2014). Service providers must be skilled to deliver culturally appropriate care with multilingual staff, translating educational materials and sharing information through diverse multi-cultural formats and media (Almeida et al., 2014).

Since there is an absence of psychological terminology in many cultures, and cultural norms of respect may restrain women from expressing their emotions in words (Brar et al., 2009; O'Mahony et al., 2013). For this reason, it is important to allow time to integrate the non-verbal ways of expression such as drawing, metaphor and poetry into the practice setting (Lapum et al., 2012; O'Mahony et al., 2013; Schwind, 2003; Schwind, 2009).

Cultural attitudes and beliefs towards mental health pose a barrier for immigrant women to access help (Mamisachvili et al., 2013; O'Mahony et al., 2012; Teng et al., 2007). We must work together in all levels of practice to alleviate the stigma attached to postpartum depression. This means health and social service sectors should build partnerships to create a supportive network in order to understand the cultural barriers and, work together with immigrant groups in the community to navigate health and social

services to support their mental health needs. Professional organizations can also voice their concerns to the government sector to advocate for increased funding to facilitate access to culturally relevant care for immigrant women with postpartum depression and their families.

Peer support in the early postpartum time can provide valuable support for women who may be at risk for postpartum depression. Dennis (2010) conducted a cross-sectional survey with 701 high-risk women (Edinburgh Postnatal Depression Scale score greater than nine within 2 weeks postpartum) participated in a randomized controlled trial to evaluate the effect of peer support in the prevention of postpartum depression, across seven health regions in Ontario, Canada. The majority of women who participated in this telephone-based peer support, perceived the help positively (Dennis, 2010). It would make sense for organizations to provide a telephone based peer support system with trained volunteers to provide emotional and informational support, especially for women who are socially isolated.

**Relationships.** In addition to peer support, immigrant mothers value spousal and family support in the postpartum period. After immigration to a new country the first priority with immigrant families is most often to establish financial security (Bhagat et al., 2002). For couples this means the husband may work long hours and as a result spend less time at home with his family. Immigrant women rely heavily on their familial support networks, and if socially isolated managing life becomes a struggle (Grewal et al., 2008). In the post-migration context, women face changes with a loss of social networks, de-professionalization and relationship instability (Guruge et al., 2010; Shirpak et al., 2011). By recognizing these challenges, service providers, policy makers and

researchers can find innovative ways to promote a healthy marital relationship and secure attachment relationship for the new baby (Guruge et al., 2010). For example, providing culturally congruent education for couples in a variety of different languages in immigrant communities would enhance prenatal and postpartum knowledge; build confidence and social connectivity through interactions with other immigrant couples.

Many immigrant women experience an unhealthy spousal (Howard, Oram, Galley, Trevillion, & Feder, 2013) and in-law family (Raj et al., 2011) relationships with physical and non-physical abuse during the perinatal and postpartum time. Violence is associated with high rates of depression, anxiety disorders, sleep disorders, psychosomatic disorders, suicide and self-harm (Stewart, MacMillan, & Wathen, 2013). All professionals who work with women need to ensure they provide a private, safe, supportive, confidential environment to consistently inquire about intimate partner violence victimization. From an intersectoral perspective, collaboration between health disciplines, social, education and legal services is vital for advocacy, to reduce violence in all populations including immigrant families (Stewart, Mac Millan & Wathen, 2013).

Studies reveal immigrant women are not satisfied with their interactions with healthcare providers (Ganann et al., 2012; Almeida et al., 2014; da Conceição & Figueiredo, 2015; Waugh, 2011). Health and social service organizations need to foster therapeutic relationships in their practice with immigrant women and their families. All healthcare professionals and social service workers have a responsibility to ensure cultural and language barriers are eliminated so the importance of traditional postpartum rituals can be considered within postpartum care in western countries. By rebuilding social networks to understand and support immigrant women with postpartum

depression, organizations can re-orientate their services to ensure communication is respectful and culturally appropriate with immigrant families.

In addition to women wanting support from their mothers, partners and peers, they also desire professional support tailored to their needs, and delivered with a personal approach from a professional such as a midwife (Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011). Midwives have the ability to provide home visits with individualized physical and psychosocial care from the prenatal to the postpartum period. For women who are socially separated from their families or have limited support from their spouse and peers, midwives can fill the gap and offer the much needed emotional support, as well as reassurance and companionship (Seefat-van Teeffelen et al., 2011). However, from my practice I realize most people are not aware of the breadth of midwifery services (postpartum home visits and prenatal care) or how to access care. Definitely the healthcare sector needs to raise more public awareness at the societal level to educate immigrant communities, especially women about the various healthcare supports including midwifery services.

**Loneliness.** Immigrant women suffer gravely when they are socially and emotionally isolated (A V Pramuditha et al., 2014). Professionals who work with immigrant women should consider the importance of relational connections for psychological health and adjustment during the vulnerable postpartum time (Wardrop & Popadicuk, 2013). A relational-cultural lens perspective provides us with the ability to assess the level and the quality of perceived support and health disparities in a woman's life, so that support services can be delivered in a timely manner (Wardrop & Popadicuk, 2013).

For families who live in isolation of their traditional support systems, it becomes important to offer the type of social support they deem appropriate. Healthcare professionals can create supportive environments by addressing the determinants of health such as income and social status, social support networks, employment, health services and health child development (Public Health Agency of Canada, 2011). For example, Public health programs should advocate for a population-based approach that brings together a community of first-time mothers in the postpartum period to form social connections, which has the ability to increase a woman's self-esteem and confidence and help to build a social network in her own community of peers. Both Amar and Anu express the importance of having female support from a family member, specifically their mother, in the postpartum period. Research studies also reveal immigrant mothers rely on care from a female relative to provide emotional and physical support (Jain & Levy, 2013; O'Mahony & Donnelly, 2010; Tsai et al., 2011). Although there are some possibilities for family members to leave their home country to visit Canada, in order to provide assistance in caring for a new baby, there are immigration stipulations in the process that make this a tall hurdle to overcome. The sponsoring family is required to purchase health insurance for the visiting relative, which may not be feasible if the immigrant family is already experiencing financial hardship. This issue needs to be addressed with immigration policy work.

### **Considerations for practice**

Understanding the experiences of immigrant mothers is integral to addressing postpartum depression in relation to the transition to motherhood, relationships and loneliness in diverse practice settings. Health professionals need to collaborate with a

variety of community and social service agencies to involve immigrant mothers in developing programs, services and policies. To implement effective programs and to expedite constructive changes, we need to use both, the “bottom up” approach with citizens and community agencies, and the “top down” commitment from government agencies. Broader action in all practice areas would improve and support mental health by creating supportive environments for immigrant women with postpartum depression.

### **Policy**

Education and practice considerations begin to open the door for change. In order to implement change in these areas, policy action must be taken at multiple levels, individual, family, community, organizational and societal (Public Health Agency of Canada, 2001). Immigrant women need to be empowered to find their own voice to advocate and raise awareness, breaking the silence of postpartum depression. Handa (2013) shares the struggles of pregnant immigrant women who come to Canada expecting health care coverage but sadly in Ontario and British Columbia must wait three months. Many immigrant women seek the assistance from a midwife or a community health centre, both funded by the government to provide services to all residents. However, funding is limited to these services and as a result many immigrant women are left stranded, without knowledge of navigating the health care system (Handa, 2013). Women and their families require partnerships with organizations (health, social, education and legal services) to become actively involved in developing and evaluating programs and services in the community. In order to fill the immigration service gap for the three-month waiting period, it would be necessary to increase the funding allocated for midwifery and community health centres. A systemic problem exists when immigration

and settlement policies have resulted in more women without insurance in Canada (Handa, 2013).

The government sector should be solicited along with experts in the field to write a position paper for a comprehensive review and analysis of immigration policies and support needs related to mental health including postpartum depression in high risk populations, such as immigrant mothers and their families. The resulting policy recommendations would provide direction for government decision makers, organizations and the public to advocate on behalf of immigrant families. However, the implementation of policies also requires evidence informed decision making to underpin the population health strategies. Evidence informed decision-making is the integration of best research evidence together with clinical expertise, which takes into consideration client values, to facilitate decisions. In order to move forward to support policy recommendations, both experiential knowledge from the practice setting and research studies is required (Public Health Agency of Canada, 2001).

## **Research**

This Narrative Inquiry gives voice to Punjabi immigrant mothers to share their life experiences with postpartum depression. However, this study is just the beginning. Further research is required in the Canadian context to better understand how other immigrant groups experience postpartum depression and what interventions from their perspective would be most effective for prevention and support. Narrative Inquiry methodology offers an ideal research approach with immigrant populations, since the oral tradition of face-to-face conversation, rather than questionnaire completion, is preferred in many cultures (Downe, Butler & Hinder, 2007). Illness narratives not only provide

logic for explaining the meaning of illness (postpartum depression), but also elicit a deeper understanding of the experience through creative self-expression, such as metaphor and drawing (Schwind, 2003). In the next section, I suggest possibilities for future research.

**Considerations for future research studies.** Since postpartum depression is a topic that requires an in-depth exploration of inner thoughts and experiences, at times unexplainable in spoken words, the Narrative Inquiry (Connelly & Clandinin, 2006) approach with the Narrative Reflective Process (Schwind, 2008, 2014) would allow participants to express their embodied feelings using story telling, metaphor, drawing and poetry (Lapum et al., 2012; Schwind, 2008, 2014; Schwind, Beanlands, et al., 2014; Schwind, Lindsay, et al., 2014). From my experience in this inquiry, I feel the Narrative Reflective Process is an ideal tool to use in the practice setting when working with individuals who have difficulties verbalizing their inner feelings. However, more research is required using Narrative Inquiry (Connelly & Clandinin, 2006) and the Narrative Reflective Process (Schwind, 2008) data collection tool with a variety of healthcare providers (doctors, nurses, midwives, social workers) and clients (from diverse ethnic backgrounds) in different practice settings (hospitals, community clinics, public health) to understand in greater depth how clients experience their illness. For example, studies conducted with a midwife and a settlement worker working with a new immigrant mother would allow exploration of other models of interprofessional care to ensure immigrant mothers have access to a variety of supports. Research studies into exploring different models of postpartum care, such as the use of a mobile health clinic (Guruge et al., 2009) that travels to areas where immigrant mothers live would facilitate access to care. These

researchers provide considerations for a mobile health clinic as an alternative care delivery model for immigrant women who may face barriers in the immigration context. With continued research in this area, health and social service organizations have the potential to work together to provide timely, culturally appropriate services for immigrant women in the postpartum period with a mobile health clinic.

Research is also warranted to determine effective cultural methodological approaches to screen for postpartum depression. Although many assessment tools exist, most have not been rigorously tested and validated (Downe et al., 2007; Werrett & Clifford, 2006). Since there is a lack of empirical evidence on the effectiveness, many healthcare organizations are reluctant to integrate a variety of screening tools into practice. Also, some tools are not reflective of cultures that present emotional distress with somatic symptoms (Fung & Dennis, 2010; Dorheim Ho-Yen et al., 2006; Morrow et al., 2008; O'Mahony et al., 2013; Zelkowitz et al., 2008). For these reasons studies exploring the cultural context in which Punjabi and other immigrant women conceptualize and express depression would provide opportunities for healthcare providers to have more meaningful interactions, promote therapeutic rapport and enhanced communication with their clients.

By listening to immigrant mothers' stories of experience together with research literature, we can begin to understand the reasons why they experience challenges with: the transition to motherhood, relationships and loneliness. Building strong partnerships with families, communities and other sectors of health and social service organizations, is the vital step needed to address the social determinants of health to enhance the mental wellbeing and overall health of immigrant women.

In the next section, I present an advocacy letter addressed to my nursing professional organization, where I write as a healthcare professional working with immigrant mothers.

## Chapter Nine

### Social Significance

In this chapter, I present a letter in response to the issues raised in the third level of analysis (the social justification: Chapter 8). I write this letter to my national and provincial professional nursing associations, the Canadian Nurses Association and the Registered Nurses' Association of Ontario respectively.

#### Advocacy Letter

*Attention: Canadian Nurses Association and Registered Nurses' Association of Ontario*

*Dear President of the Association,*

*The purpose of this letter is to urge you to lobby the government to provide health policy recommendations to support the emotional health of immigrant mothers after the birth of their babies. I write to you as a nurse researcher, public health nurse and as a concerned citizen in our democratic society, and as a mother who is also an immigrant. I am deeply troubled with the inequality and oppression of immigrant families who are new to this country.*

*As a public health nurse, I see first hand the physical and emotional struggles endured by immigrant mothers in the postpartum period. Most of my clients have left their family of origin and cherished cultural practices back in their homeland. The healthcare system here does not fully recognize the diverse cultural needs of immigrant women. From my practice and research, new immigrant mothers tell me the importance of having a female relative by their side to provide emotional and physical support to them after the birth of their baby. However, current immigration policies make it difficult for families to sponsor a relative to visit. As a result, immigrant women become socially isolated and coupled with poverty, low social status and unemployment, their health begins to decline, increasing the risk for postpartum depression. It is important to consider not only the individual burden this causes, but the burden it creates on our health care system. It is well recognized that postpartum depression effects the health of women, entire families and in particular can have long term effects on children.*

*Close to forty-two percent of pregnant immigrant women have elevated levels of depressive symptoms, with thirty-eight percent of symptoms appearing in the postnatal period. Since the majority of healthcare funding is granted to acute care, to support the biomedical model of care, public health programs that address prevention and reduction of health disparities are left out in the cold. My research with immigrant mothers reveals the stressors that accompany migration (living in an unfamiliar country, adjusting to different socio-cultural health practices and changes in support networks) are compounded when a woman is transitioning to motherhood. Healthcare in Canada should be universally accessible to all with a focus on determinants of health and health*

*promotion. But then, why are so many immigrant women suffering hardships without effective support services?*

*I would like the Canadian Nurses Association to lobby the federal government to consider revising the existing immigration policy to allow provisions for a new immigrant woman's mother or family member to visit for a longer period of time so that she is able to get the support she requires as she transitions to motherhood. The policies related to the credentialing process for recognition of international education also needs to be reviewed and revised so that immigrant men and women are able to secure employment in their field of expertise. We also need to advocate for increased funding for public health units, so that culturally appropriate prenatal and postpartum programs can be developed with collaboration from immigrant families, health and social service agencies. The Child Birth Interest Group and Mental Health Nursing Interest Group of the Registered Nurses' Association of Ontario and other inter-professional organizations such as The Association of Ontario Midwives can be the voice for immigrant women, who are silenced due to the stigma attributed to mental illness in the community. It is my hope, revised immigration policies and programming will provide immigrant women with easier access to culturally relevant support networks and lay the foundation for building healthy communities.*

*Please do not hesitate to contact me if you should have further questions or concerns.  
With warm regards,*

*Poonam Sharma*

In the next section (Epilogue), I reflect on my own metaphor of postpartum depression as derived from my thesis journey.

## EPILOGUE

In this section I reflect back to my Narrative Inquiry with Amar and Anu. I have travelled a long distance from my initial narrative interview, telephone follow-up conversations and to the three levels of analysis: personal, professional and social justifications using the Narrative Inquiry three-dimensional space and supported by research literature. The experience of engaging in this Narrative Inquiry opens my mind to a deeper understanding of postpartum depression in first time mothers, who are also Punjabi immigrants. I am inspired by this investigative and creative journey to now draw my own metaphor for postpartum depression and represent my embodied experience through the poem that follows.

Figure 4: My Metaphor Drawing: Turbulent Waters



## Turbulent Waters

*The water is icy cold. I am alone.  
Scared and helpless.  
I am slowly drowning.  
I cannot swim.  
I cry for help! No response.*

*The water becomes angrier, slapping violently against my face.  
A strong current encircles my body, hungry to devour my spirit.  
Fatigued from the struggle. I am ready to let go.  
Yet, I find the inner strength to resist the vortex.  
I fight back!*

*A hand reaches out and pulls me back towards the surface with great force.  
Someone has heard my cries for help!  
I weep with gratitude.  
Thank you! Thank you!  
I begin to feel safe once again.*

After hearing and reviewing Amar's and Anu's stories of postpartum depression, I take the time to reflect anew on my own postpartum experience. This metaphor drawing and poem of turbulent waters is how I image the embodied experience of postpartum depression. During my own postpartum time, I felt alone and helpless. It was my nurse who came to me to extend a helping hand to rescue me from the turbulent waters. I am forever grateful to my nurse for her support and empathy during my immediate postpartum time. Being a mother for the first time was overwhelming. I had this same feeling when I was near a body of water. I always had fear of water. Until recently, I did not know how to swim. When I began writing this thesis, I wanted to overcome my fear so I enrolled in swimming lessons. Now, as an adult, I can swim. I feel empowered by facing my fear and learning to swim. I am inspired to be that helping hand that helps the one who is caught in the turbulent waters of postpartum depression.

As I look back to Amar's and Anu's stories and the stories of so many of my clients, I realize there is so much more work to be done. This thesis provides a beginning understanding of how two Punjabi immigrant mothers understand and experience postpartum depression. And, so many immigrant mothers from different ethnic backgrounds endure similar challenges. Addressing health disparities ultimately is political. A healthy public policy is a policy that increases the health and well-being of individuals and communities that it affects. With continued research, we can provide further evidence to advocate for healthy public policies for education and healthcare practice to improve the health status of immigrant women overall, and especially those with postpartum depression.

## APPENDIX A

### Research Ethics Board Approval



To: Poonam Sharma  
Yeates School of Graduate Studies  
Re: REB 2014-257: Punjabi immigrant mothers' experiences of postpartum depression: A  
Narrative Inquiry  
Date: August 22, 2014

Dear Poonam Sharma,

The review of your protocol REB File REB 2014-257 is now complete. The project has been approved for a one year period. Please note that before proceeding with your project, compliance with other required University approvals/certifications, institutional requirements, or governmental authorizations may be required.

This approval may be extended after one year upon request. Please be advised that if the project is not renewed, approval will expire and no more research involving humans may take place. If this is a funded project, access to research funds may also be affected.

Please note that REB approval policies require that you adhere strictly to the protocol as last reviewed by the REB and that any modifications must be approved by the Board before they can be implemented. Adverse or unexpected events must be reported to the REB as soon as possible with an indication from the Principal Investigator as to how, in the view of the Principal Investigator, these events affect the continuation of the protocol.

Finally, if research subjects are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research.

Please quote your REB file number (REB 2014-257) on future correspondence.

Congratulations and best of luck in conducting your research.

A handwritten signature in black ink, appearing to read "Lynn Lavallée".

Lynn Lavallée, Ph.D.  
Chair, Research Ethics Board

## APPENDIX B

### Recruitment Poster



### Invitation to participate in a study

If you are a **Punjabi immigrant woman**,  
who has a baby 2 years old or less  
and who has experienced the following:

frequent sadness, crying often; loss of energy, can't sleep, not eating;  
feeling guilty or always worried about your baby

And if you are over 18 and can speak, read and understand English  
I would like to hear your story.

My name is Poonam Sharma. I am a graduate student in Ryerson University's Master of Nursing program, in Toronto. As part of my degree requirements, I am conducting a study called, ***Punjabi Immigrant Mothers' Experiences of Postpartum Depression***. Your story will provide me with an understanding of how symptoms of postpartum depression are experienced by Punjabi immigrant mothers.

To participate in this study, you will be asked to meet with me (for either one meeting of approximately 2 hours OR two meetings of approximately 1 hour each) to confidentially share your story and participate in a creative activity about your experiences. There will be one follow up meeting of approximately 30 minutes to share my understanding of your story.

Participation in this study is fully voluntary. Your privacy and confidentiality will be fully protected. You will receive \$25 as a thank you for participation in my study.

If you are interested in participating or have questions about this study, please contact me at [REDACTED] (a confidential telephone line) or by email: [poonam.sharma@ryerson.ca](mailto:poonam.sharma@ryerson.ca)

## APPENDIX C

### Telephone Script: Eligibility to Participate in Study

During the initial telephone contact, I will use the following script to determine if the person volunteering to be in the study qualifies as experiencing postpartum depression:

My name is Poonam Sharma. Thank you for your interest in my research project. As you may be aware, I am conducting a research study to learn more about the experience of immigrant Punjabi mothers with postpartum depression.

In order to participate in this study, I will be asking you some questions in English. May I ask you if you can speak, write and understand English?

If volunteer responds 'yes', I would ask her if she was born in Punjab, India?

If the volunteer responds 'yes', I would ask if she had her baby within the last two years.

If she says 'no' to any of the above, I would thank the volunteer and say 'good bye'.

If she answers 'yes' to the above questions, I would ask the following questions:

Have you experienced any of the following:

- o Frequent sadness
- o Crying often
- o Loss of energy
- o Inability to sleep
- o Not eating
- o Feeling guilty
- o Always worried about your baby

If the volunteer experiences at least 4 out of the 7 symptoms, they would qualify for the study.

## APPENDIX D

### Study Information Letter



#### PUNJABI IMMIGRANT MOTHERS' EXPERIENCES OF POSTPARTUM DEPRESSION: A NARRATIVE INQUIRY

My name is Poonam Sharma and I am a Master of Nursing student at Ryerson University. I am conducting a study as part of my degree requirements entitled *Punjabi immigrant mothers' experiences of postpartum depression: A Narrative Inquiry*. Data collected through this study will not be shared directly with Peel Public Health, The Punjabi Community Centre or health professionals involved directly in your care at the organizations or anyone else outside from my research co-supervisors, Dr. S. Guruge and Dr. J. Schwind, both of Ryerson University. Any data shared with the agencies in the form of a report or publication, will not identify you as the source of a quote or phrase.

**Purpose:** To research the experiences of Punjabi immigrant mothers who have self-identified as experiencing symptoms of postpartum depression. The findings of this research will provide a beginning understanding of the experiences of Punjabi immigrant mothers with postpartum depression.

**Participation Criteria:** You are invited to participate in this study if you are a Punjabi immigrant woman who has had a baby in the last year and have experienced some of the following symptoms (frequent sadness, crying, loss of energy, inability to sleep, inability to eat, feelings of guilt, anxiety or depression) after having your baby. In addition, in order to be in the study you must be over the age of 18, and be able to speak, read and understand English.

**Involvement in Study:** If you choose to participate in this study, you will be asked to share your experiences after the birth to your child. I will meet with you in person for one 2 hour interview. If you prefer, the first meeting can also be divided into two interviews of 1 hour each.

During these sessions, we will talk about your experiences of being a new mother with symptoms of postpartum depression. Our conversation will be audio recorded so I can listen to it for my research. Then, you will be invited to select your own symbolic image for postpartum depression that you can either draw or talk about. Your drawing, if you choose to draw, will be photocopied and the original returned to you. After the interviews are completed and your drawing is returned, we will have your choice of one telephone session (conversation) or in face-to-face meeting of about 30 minutes where you will

have the opportunity to provide feedback on whether or not I accurately captured your story.

**Benefits:** You may not receive any direct benefit from being in this study. The research may provide a beginning understanding of Punjabi immigrant mothers' experiences of postpartum depression.

Participation is completely voluntary. Whether you choose to participate or not, your professional or personal relations with Ryerson University or care from your health professional will not be affected. If you decide to participate, but later change your mind, you are free to withdraw and stop your participation at any time without penalty or loss of benefits to which you are entitled.

As a thank you for your participation, you will be compensated with the amount of \$25 cash.

If you are interested in participating or have questions about the study, please contact me, Poonam Sharma, by telephone [REDACTED]

## APPENDIX E

### Consent Form



#### CONSENT TO PARTICIPATE IN A RESEARCH STUDY

You are being invited to participate in a research study. Please read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure you understand what your participation will involve.

**Title:** Punjabi immigrant mothers' experiences of postpartum depression: A Narrative Inquiry

This research study is being conducted by:

**Principle Investigator**

Poonam Sharma, RN, MN(c)  
Ryerson Master of Nursing Student



**Thesis Co-Supervisors:**

Dr. Sepali Guruge, RN, PhD  
Associate Professor Daphne Cockwell School of Nursing  
Ryerson University



Dr. Jasna K. Schwind, RN, PhD  
Associate Professor Daphne Cockwell School of Nursing  
Ryerson University



**Introduction**

You are being asked to take part in a study, which is being conducted by Poonam Sharma, a Ryerson University graduate student as part of her Master of Nursing degree requirements. Please read this explanation about the study and its risks and benefits before you decide if you would like to take part. You should take as much time as you need to make your decision. You should ask the study investigator (Poonam) or one of her co-supervisors (Dr. S. Guruge or Dr. J. Schwind) to explain anything that you do not

understand and make sure that all of your questions have been answered before signing the consent form. Participation in this study is voluntary.

### **Background and Purpose of the Study**

Research shows that immigrant women have higher risk factors for postpartum depression. However, there is no research on the experiences of Punjabi immigrant women in Canada. The purpose of this study is to understand the experiences of Punjabi immigrant women who have had symptoms of postpartum depression. Symptoms of postpartum depression often include: frequent sadness, crying, reduced interest or pleasure in almost all activities, fatigue (loss of energy), significant weight loss or gain, insomnia (lack of sleep) or hypersomnia (over sleeping), anxiety, sometimes scary thoughts about the safety of the baby or self.

Your stories will provide insight into the experiences of a woman like yourself, and may help to inform the care experiences of other Punjabi immigrant women with postpartum depression.

Two to three participants will be recruited to take part in this study. The researcher (Poonam) will meet with each of you separately. If you agree to participate in this study, all the interview sessions with the researcher (Poonam) will be audio recorded.

### **What You Will Be Asked To Do**

If you volunteer to participate in this study, you will be asked to do the following: one in-person data collection session of approximately 2 hours. Data collection means that the researcher (Poonam) will be audio recording each session, and then listening to your stories and transcribing (typing out the conversation word by word), which will later be reviewed to better understand your experiences of postpartum depression. This session, if you prefer can be separated into two 1-hour sessions. There will be one follow-up session by either telephone or a face-to-face meeting of approximately 30 minutes. These sessions will be private, between you and the researcher only, where you will be asked to talk about your experiences and understanding of postpartum depression. The data collection session will consist of a semi-structured interview, meaning that there will be a few questions to guide your conversation. In addition, you will be asked to draw or explain an image, picture or symbol that you feel represents your experience.

For the follow-up session, you will be provided with a choice of talking with the researcher (Poonam) on the telephone or a face-to-face meeting. During this last meeting with Poonam you will have the opportunity to provide feedback on the accuracy of the story Poonam constructed based on your interview. In other words, the purpose of this last session is to make sure the researcher (Poonam) accurately understands the experiences you shared.

### **Study Visits and Procedures**

**Data Collection Session:** This interview will be audiotaped and is expected to take approximately 2 hours.

**Part 1:** You will be invited to share your experiences and understanding of symptoms of postpartum depression.

The following are possible questions to that you may be asked during the interview to help you share your experience and tell your story:

1. Can you tell me about your life after having your baby?
2. Can you please describe your experiences/feelings after having your baby?
3. What is your understanding of postpartum depression?
4. How would you define postpartum depression it in your own words?
5. What are some reasons you think you felt the way you did after having your baby?

**Part 2:** The selection and description of an image/symbol, which best describes your experiences. You will be invited to select your own symbolic image that you feel best represents your experience and understanding of postpartum depression. Then, you will be asked to either a) draw that symbolic image including a small description or b) talk about that symbolic image that you have selected. There is no right or wrong image to select; you can select absolutely anything you believe will accurately represent your feelings and, or experiences about postpartum depression.

**Note:** As stated above. Data Collection Session can be separated into two meetings, where Part 1 would be done in one meeting and Part 2 could be done in a second meeting. You can let the researcher know what you would prefer.

**Follow-up Session:** The researcher, (Poonam) will contact you by telephone to provide you with a choice of having the follow-up session by telephone or with a face-to-face meeting. The purpose of this meeting is to allow the researcher to read a summary of her interpretation of your story and to ask if she has an accurate understanding of your experiences and feelings. This session will also be audio recorded and is expected to take approximately 30 minutes of your time. This meeting will take place approximately 2 weeks after session two.

### **Risks Related to Being in the Study**

There are no medical risks if you take part in this study. However, being in this study and sharing stories of your experience of postpartum depression may make you feel uncomfortable or bring up uncomfortable feelings for you. If this occurs, or for any other reason, you can refuse to answer any questions or stop the interview all altogether, without penalty.

If you feel uncomfortable, distressed or sad because of participation in the study, the researcher can refer you to talk more about your experience with your public health nurse or other community health professional, this will only be done with your permission, and if you feel it would be helpful for you.

It is important for you to understand that if during the interview, you share a concern related to the imminent harm or abuse to a child or children, the researcher (Poonam) has a legal duty to report the concern to the Children's Aid Society.

### **Benefits to Being in the Study**

You may not receive direct benefit from being in this study. The research may provide a beginning understanding of Punjabi immigrant mothers' experiences of postpartum depression.

### **Voluntary Participation and Withdrawal**

Your participation in this study is completely voluntary. You may decide not to be in this study, or to be in the study now and then change your mind later. Your decision to take part or not to take part in the study will have no effect on any relationship with either Ryerson University and/or your care with the Region of Peel-Public Health or the Punjabi Community Health Centre. Any data shared with the agencies in the form of a report or publication, will not identify any participants as the source of a quote or phrase.

You may refuse to answer any question you do not want to answer during the interview or stop participating at any time.

### **Confidentiality**

#### Personal Health Information

If you agree to join this study, the researcher will collect only the personal health information she needs for the study. Personal health information is any information that could be used to identify you and includes:

- Name
- Contact telephone number
- Email address (if you wish to use email to communicate)
- Year of birth or age

The information that is collected for this study (the personal health information, the audio-recordings of the interviews, transcription and the original and scanned drawings) will be kept in a locked area by the researcher in a secure environment at Ryerson University for 3 years, after which it will be destroyed. The information will be held in strict confidence and only the researcher (Poonam) and her co-supervisors (Drs Guruge and Schwind) will be allowed to look at the study data.

Any information that identifies you will be removed from documents and a pseudonym (another name different than yours) will be assigned for your name on all documents including any future publications, reports or conferences to maintain confidentiality. Members of the agencies from which recruitment has taken place will not be able to determine who participated in the study. Any data shared with the agencies in the form of a report or publication, will not identify any participants as the source of a quote or phrase.

If you decide to withdraw from this study, all of the above personal health information, name, contact telephone number, email address and year of birth or age will be shredded and securely disposed of within two business days of your withdrawal from the study.

The results of this study may be published or presented at conferences or events. The drawings may be used to illustrate your story; however there will be no information that directly or indirectly identifies you. For example, we will not share your real name, or information about your family.

**Reimbursement**

You will be provided with \$25.00 cash at the end of the Data Collection session. Should you choose to leave the study or withdraw your participation at any time, you will still be provided the \$25.00 cash.

**Questions about the Study**

If you have any questions, concerns or would like to speak to the study team for any reason, please call Poonam Sharma, Principle Investigator at [REDACTED]  
[REDACTED] You may also contact the Co-Supervisors: Dr. Sepali Guruge [REDACTED] or Dr. Jasna Schwind [REDACTED]  
[REDACTED]

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study please contact:

Research Ethics Board  
c/o Office of the Vice President, Research and Innovation  
Ryerson University  
350 Victoria Street  
Toronto, ON M5B 2K3  
[REDACTED]

## APPENDIX F

### Narrative Interview Guide

#### First Meeting: Narrative Interview

I will ask the participant for permission to turn on the audiotape before the interview. Participant will be reminded that at any time if she feels uncomfortable or wants to pause, it is okay to do so at anytime.

I invite the participant to share her experiences as a Punjabi immigrant mother.

1. To begin, please tell me about your life after having your baby?  
*Did your life change after the baby? How?*  
*Did you have support to care for the baby?*  
*Did your relationship change with your partner? family?*
2. How would you describe your feelings/experiences after having your baby?  
*How did you feel after your baby was born?*  
*Did those feeling change?*  
*Why do you think you felt that way?*
3. What is your understanding of postpartum depression?  
*Have you heard of the word postpartum depression?*
4. How would you define postpartum depression it in your own words?  
*Can you tell me what postpartum depression means to you, from your own experiences? There is no wrong answer*
5. What are some reasons you think you felt the way you did after having your baby?  
*Why do you think you felt \_\_\_\_\_ after you had your baby?*

#### Symbolic Image Selection and Metaphor Drawing

“Can you think of a picture or an image that describes how you felt?”

“Your description is so powerful. I’d like to use another way to hear your story.”

“Can you please draw it for me?”

“Here is some paper and some pencil crayons. It’s not important how you draw the picture. There is no right or wrong way of doing this.”

*After drawing is complete*

“Can you please tell me about your drawing?” or “Can you describe your picture to me?”

“Your choice of colour \_\_\_\_\_, what does that mean for you?”

### **Ending Interview**

Thank you so much for taking time out today to meet with me and share your stories.

I will be listening to our audio and then making some notes.

I would like to either meet with you personally or I can telephone you so that you can provide me with some feedback and tell me if I understand your story.

What do you prefer, telephone or meeting? It will take 20 to 30 minutes of your time.

Thank you so much. I will contact you to set up a time in two weeks.

### **Second Meeting: Telephone Follow-up**

I will read the re-constructed story to the participant over the telephone. Participant will be encouraged to interrupt or stop me at anytime if she wishes to edit or comment on the story.

Read story.

### **Prompting Questions after Reading Story**

1. Is this new reconstructed story an accurate representation of your experience and understanding of postpartum depression?
2. Can you further explain?
3. Is there anything else you would like to add to your story in order for me to get a more accurate understanding of your experiences with and feelings about postpartum depression?
4. Is there anything that I should remove from your story in order for me to get a more accurate understanding of your experiences with and feelings about postpartum depression?
5. Is there anything that I should focus on in greater detail in order for me to get a better understanding of your experiences with and feelings about postpartum depression?

### **Name Selection**

What “other name” or pseudonym would you like to use to represent yourself in this story?

### **Font Selection**

What font would you like to choose to represent in the writing of this story?

### **Ending Conversation**

Thank participant for her time and sharing story.

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