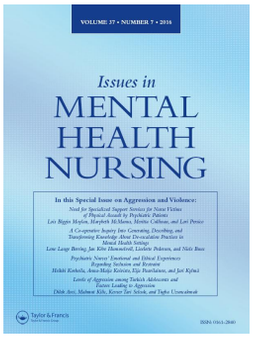

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# Understanding Experiences of Social Support as Coping Resources among Immigrant and Refugee Women with Postpartum Depression: An Integrative Literature Review

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# Understanding Experiences of Social Support as Coping Resources among Immigrant and Refugee Women with Postpartum Depression: An Integrative Literature Review

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**ABSTRACT**

Lack of social support increases the risk of postpartum depression (PPD), especially among immigrant and refugee women. In this integrative literature review, I aim to synthesize the current state of knowledge on social support experiences among immigrant and refugee women with PPD. Conceptualization of social support as coping resources occurs through Stewart's coping theory. Eleven primary sources were located using Whittemore and Knafl's review methods. These methods are philosophically underpinned by Racine's postcolonial feminist lens. In synthesizing literature located, themes were generated and include the following: maintaining cultural identity, connecting with a community, connecting with spirit (subtheme), relational space imparted by health care providers, and seeking and exchanging knowledge. Co-existing issues emerged from this review and capture broad determinants influential in shaping immigrant and refugee experiences of social support. These included: experience of poverty, connecting to maintain gender-driven roles, and experience of trauma and abuse. Interconnectedness of these themes and issues are depicted in a data display to demonstrate complexity. Drawing on these findings, I propose practice implications for nurses working in psychiatric and public health facilities. I also offer future research ideas and policy development recommendations based on the generated findings of this review.

## Introduction

Intentions of this review include summarizing the current state of knowledge on how immigrant and refugee women with postpartum depression (PPD) experience social support. Miriam Stewart's (1989) coping theory conceptualizes social support as coping resources. In harmonizing this conceptualization with Whittemore and Knafl's (2005) integrative review methodology, pragmatic intentions emerge where I offer implications within mental health nursing practice, policy development, and future research endeavors. The following question guided this review: What current knowledge explores experiences of social support as a coping resource among immigrant and refugee women with PPD?

Global migration is increasing at a profound rate. In fact, the current number of people migrating around the world reached 258 million in 2017, the highest number in history (United Nations [UN], Department of Economic and Social Affairs, Population Division, 2017). Within migrant discourse lie several categorizations which influence health trajectory. Those who are categorized as immigrants and refugees will be focused on within this review. From a gendered perspective, a closer look at migration statistics reveals half of all immigrants and refugees are women (United Nations High Commissioner for Refugees (UNHCR), 2018; United Nations Population Fund (UNFPA), 2016)). Most of these women have been identified as childbearing age, pregnant, or mothering (Ahmed, Bowen, & Feng, 2017; Brown-Bowers, McShane, Wilson-Mitchell, & Gurevich, 2015). Although health issues faced by this population are numerous, these women have a higher likelihood of suffering from PPD (Alvi, Zaidi, Ammar, & Culbert, 2012; Ardiles, Dennis, & Ross, 2008).

### *Philosophical and theoretical situatedness*

In situating myself within a postcolonial feminist (PCF) lens as seen by Racine (2003), I bring assumptions when approaching my data search and analyses. A primary assumption includes power imbalances being embedded in broad structural forces due to hegemonic influences of colonialism. In defining structural forces, I turn to Metzl and Hansen's (2014) articulation centering on paying attention to what happens beyond working with individuals. Therefore, I am guided by PCF to ensure integration of what social, economic, and cultural issues lay beneath experiences of social support as coping resources. Racine (2003) highlights PCF as a lens one can use to uncover knowledge that has been unnoticed. Examples of this application of

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PCF in my review include digging deeper into the broad concept of social support to hone in on coping resources as well as shedding light on experiences of immigrant and refugee women with PPD.

Theoretical guidance through Miriam Stewart's (1989) coping theory helped refine and conceptualize the broad arena of social support into definite coping resources. As a result, I offer nurses working in psychiatric and mental health fields a review of thematic findings that are concrete and tangible. These findings are intended to provide transformative knowledge to inform nursing practice and policy development related to caring for immigrant and refugee women with PPD.

## Background

### *Immigrant and refugee women*

Fragile global issues have led to yearly growth in the immigrant and refugee population. In fact, the number of immigrants and refugees is growing faster than the worldwide population (UN Department of Economic & Social Affairs, Population Division, 2017). Notably, a continuous, yearly rise in the number of female immigrant and refugees has been trending. Over half of all immigrants and refugees that have moved into countries within Europe, North America, Oceania, Latin America, and the Caribbean identify as female (UN Department of Economic & Social Affairs, Population Division, 2017). Africa and Asia see between 42% and 47% of female immigrants and refugees every year (UN Department of Economic & Social Affairs, Population Division, 2017). Immigrant and refugee women frequently come from countries where gendered roles are defined differently from their host country. For example, Ardiles, Dennis and Ross (2008) describe diversity in perinatal rituals and practices that commonly occur in various communities around the world. These customs are meant to support women in successfully transitioning into motherhood and typically involve female relatives. Immigrant and refugee women draw on these sources of social support to buffer multifactorial stressors that occur during transitioning into motherhood (World Health Organization (WHO), 2009). However, migration experiences contribute to loss of social support and increased chances of mental health concerns (Ardiles et al., 2008; Kirmayer et al., 2011). With migration impacting social support experiences, immigrant, and refugee women are more at risk for mental health concerns.

### *Mental health among postpartum immigrant and refugee women*

Childbirth and postpartum are times where vulnerability can surface (Ardiles et al., 2008). Postpartum depression (PPD) is a health concern that impacts maternal outcomes as well as infant health and well-being. Effects of PPD include long term infant development concerns as well as maternal health issues ranging from decreased self-care to suicide (Grace & Sansom, 2003; Dennis, Merry & Gagnon, 2017; WHO, 2019). Over the last decade, researchers have identified immigrant and refugee women as being at high risk for experiencing PPD (Alvi et al., 2012; Ardiles et al., 2008; Dennis et al., 2017; O'Mahony, Donnelly, Este, & Bouchal, 2012; O'Mahony, Donnelly, Bouchal, & Este, 2013; Stewart et al., 2008; Sword, Watt & Krueger, 2006; WHO, 2009; Zelkowitz et al., 2008). Among many complex reasons contributing to this high risk, lack of social support has been cited as one of the most prevalent reasons for development of PPD among immigrant and refugee mothers (Alvi et al., 2012; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony et al., 2013; Stewart et al., 2008; Sword et al., 2006; Zelkowitz et al., 2004; Zelkowitz et al., 2008). With social support being a broad domain, I sought tangible understandings through Stewart's (1989) coping theory to guide my integrative literature search.

### *Conceptualizing social support*

Social support is a broad social determinant of health that is conceptualized in many ways within mental health and social science literature. Miriam Stewart's (1989) coping theory facilitates deeper understandings of social support through directing attention to the relationship between a person and their environment. Within this relationship are processes of social support which Stewart (1989) conceptualizes as coping resources. These resources are defined as "interactions with the natural network of spouses, family, and friends, and with peers and professionals … that communicate information, emotional alliance, practical aid, and affirmation," (p. 192). Intersecting this definition of coping resources with the experiences of immigrant and refugee women with PPD has potential for more in-depth understandings of social support needs. Using Stewart's (1989) coping theory provided me with a lens that magnified coping resources within eligible studies for this review.

## Methodology

Five methods of Whittemore and Knafl's (2005) methodology were applied in this integrative literature review: problem identification, literature search, data evaluation, data analysis, and presentation of conclusions. Problem identification consisted of developing the following research question: "What current knowledge explores experiences of social support as a coping resource among immigrant and refugee women with PPD?"

### *Search strategy*

The second method of this integrative review was the literature search. Through consultation with a university research librarian (University of Victoria, British Columbia), a search strategy was developed. Three search approaches were used to locate primary sources of research: computer-assisted approach, ancestry approach to help locate earlier relevant literature, and location-of-central-thinkers approach, where publications of central thinkers in the field of immigrant

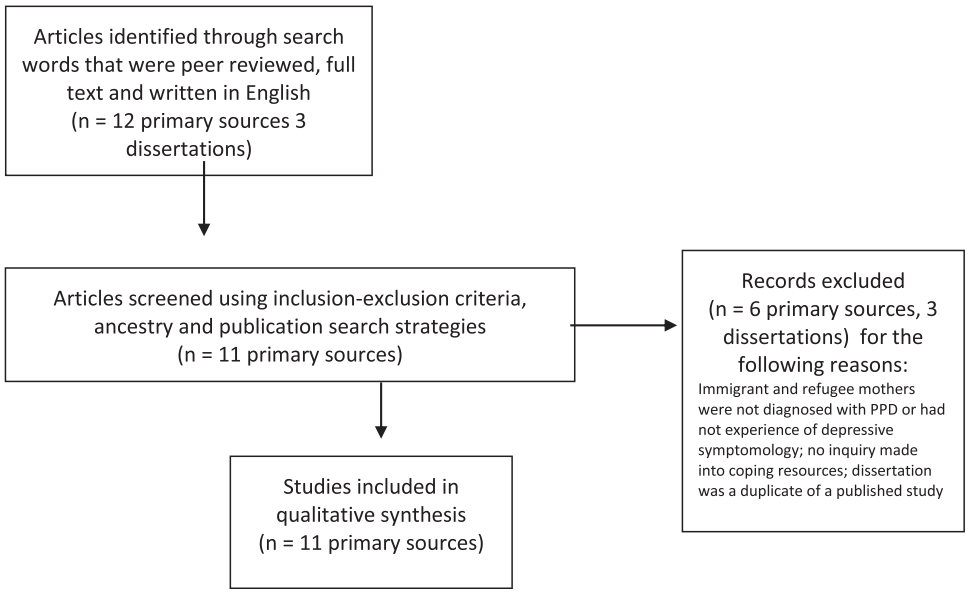


**Figure 1.** Flowchart of literature search.

and refugee women with PPD were located and searched. Ancestry and location-of-central-thinkers approaches were applied after the computer-assisted approach was completed and eligibility criteria were applied.

Databases searched within the computer-assisted approach, and relevant to the research question included: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), and Psyc Info. Three dissertation databases included in the computer-assisted search were ProQuest Dissertations & Theses, Dissertations & Theses at the University of Victoria, and ProQuest Dissertations & Theses: UK & Ireland. Search words used included: "immigra*", "refugee", "wom*", "postpartum depression" OR "perinatal depression" OR "postnatal depression", "social support" OR "coping", and "experienc*". Interestingly, excluding the word 'refugee' from the computer-assisted search did not make a difference in the number of articles generated. This was a concerning discovery that supports the lack of knowledge related specifically to refugee women with PPD. A historical look at PPD discourse generated words such as "blues", "psychoses" and "psychiatric" (Held & Rutherford, 2012). Applying these words to my search strategy, however, did not generate further literature. Peer-reviewed sources that were written in English and published in full text were included in this computer-assisted search strategy. A total of 12 studies and three dissertations were generated before the inclusion and exclusion criteria were applied.

### Eligibility criteria

Inclusion criteria included: (a) peer-reviewed; (b) written in the English language; (c) available in full text; (d) primary source; (e) qualitative methodology capturing voices of immigrant and refugee women with PPD; (f) immigrant and refugee mothers either formally diagnosed with PPD or enduring postpartum depressive symptoms at any point after giving birth, and (g) considered how immigrant or refugee women with PPD experienced social support as a coping resource. No limits on publication dates were applied. Exclusion criteria included dissertations where the researcher's findings were reflected in other primary sources published by the same author. Applying the inclusion–exclusion criteria refined the 12 primary sources and three dissertations to a total of six primary sources. These sources were then searched for additional relevant sources through the ancestry approach and location-of-central-thinker approach. These approaches revealed five more sources. A total of 11 primary sources were generated. This search process is depicted in Figure 1 through a PRISMA flow chart.

### Data evaluation

This third step to Whittemore and Knafl's (2005) integrative literature review process entailed development of a critical appraisal tool to determine credibility, auditability, and fittingness of the 11 studies. Table 1 is an example of the appraisal tool used for data analysis that draws on Fossey, Harvey, Mcdermott, and Davidson (2002) method of quality evaluation in qualitative research as well as Joanna Briggs Institute's (JBI) (Joanna Briggs Institute, 2011) template for data evaluation scoring. Four criteria were assessed within each article: congruency, permeability, authenticity, and findings. Assessing for congruency included focusing on alignment of philosophical underpinnings with theoretical approaches, methodologies applied, and methods used in each study (Fossey et al., 2002). Permeability was assessed for presence of researchers' awareness of their influence on data collected. This included addressing self-reflexivity as well as locating themselves philosophically, theoretically, and/or culturally (Fossey et al., 2002). Authenticity dealt with staying close to participants' words. This criterion also guided focus on how researchers considered power relations

**Table 1.** Qualitative research appraisal tool[1].
Article Title: _____
Author(s): _____Year of publication_____
Journal title: _____

| Criteria | Considerations<br>Scoring | Yes<br>(2) | No<br>(1) | Unclear<br>(0) | Not Applicable<br>(0) | Comment |
|---|---|---|---|---|---|---|
| Congruency | There is congruity between the stated philosophical perspective and the research methodology | | | | | |
| | There is congruity between the research methodology and the research question or objectives | | | | | |
| | There is congruity between the research methodology and the methods used to sample and collect data | | | | | |
| | There is congruity between the research methodology and the representation and analysis of data | | | | | |
| | There is congruity between the research methodology and the interpretation of results | | | | | |
| | The sampling strategies were context-driven and suitable to identify participants and sources to inform the research question being addressed | | | | | |
| Permeability | There is a statement locating the researcher culturally or theoretically | | | | | |
| | The influence of the researcher on the research, and vice-versa, is addressed | | | | | |
| Authenticity | Were methods of gathering and recording/documenting data sensitive to participants' language and views? | | | | | |
| | Were power relations taken into account (e.g.: were participants involved in documenting, checking or analyzing data, reviewing the analysis or presenting the study? Were interpretations shared with participants?) | | | | | |
| | Participants, and their voices, are adequately represented | | | | | |
| | The research is ethical according to current criteria, or for recent studies, there is evidence of ethical approval by an appropriate body | | | | | |
| Findings | Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data | | | | | |
| | Themes are drawn and transformed to reconceptualise phenomenon being studied | | | | | |
| | Depth is achieved through explaining experiences rather than through listing and labeling themes | | | | | |
| | Summary of findings: _____ _____ _____ _____ | | | | | |

within their research designs. In addition, authenticity assessment validated evidence of ethical approval within each article. Last, findings were considered for criteria that ensured integration of experiences within conclusions. As Table 1 depicts, each criterion had specific areas to look for and scored as either yes, no, unclear, or not applicable. A score of "yes" meant presence of the assessed criteria. "No" indicated the criteria was not present. To quantify these scores, a number was assigned with "yes" being the highest number, and unclear or not applicable being the lowest. Quantifying the scores was drawn from JBI (Joanna Briggs Institute, 2011) and eased understanding of study credibility and fittingness for this review. In scoring articles, I followed Sandelowski and Barroso's (2003) contention that excluding articles based on inadequate reporting risks excluding potentially valuable knowledge. Consequently, all studies were included.

## Data analysis

This step included data reduction and extraction through subgrouping, predetermined conceptual classification and constant comparison (Whittemore & Knafl, 2005). In reading the 11 studies, the data reduction process started with categorization into the following subgroups: methodology used, theoretical standing, study setting, participant characteristics, method used, geographical context, cultural context, and phenomena of interest. Data within these subgroups were then compared using predetermined questions. These questions conceptualized the data extraction process ensuring focus and organization was attained (Whittemore & Knafl, 2005). The questions included: (1) how do participants experience social support as a coping resource to interact "with the natural network of spouses, family, and friends, and with peers and professionals … that communicate information, emotional alliance, practical aid, and affirmation," (Stewart, 1989), and (2) what co-existing issues are apparent within participants' experiences of social support as a coping resource? Applying these questions to the data extraction process allowed magnification of embedded issues that influenced the experience of social support as a coping resource.

## Extraction of data through coding

Data extraction continued using Cameron's (2013) coding approach involving descriptive, topic, and analytic coding. Descriptive coding assisted with keeping track of knowledge that was factual. Topic coding reduced descriptive data into topics and revealed patterns (Cameron, 2013). Analytic

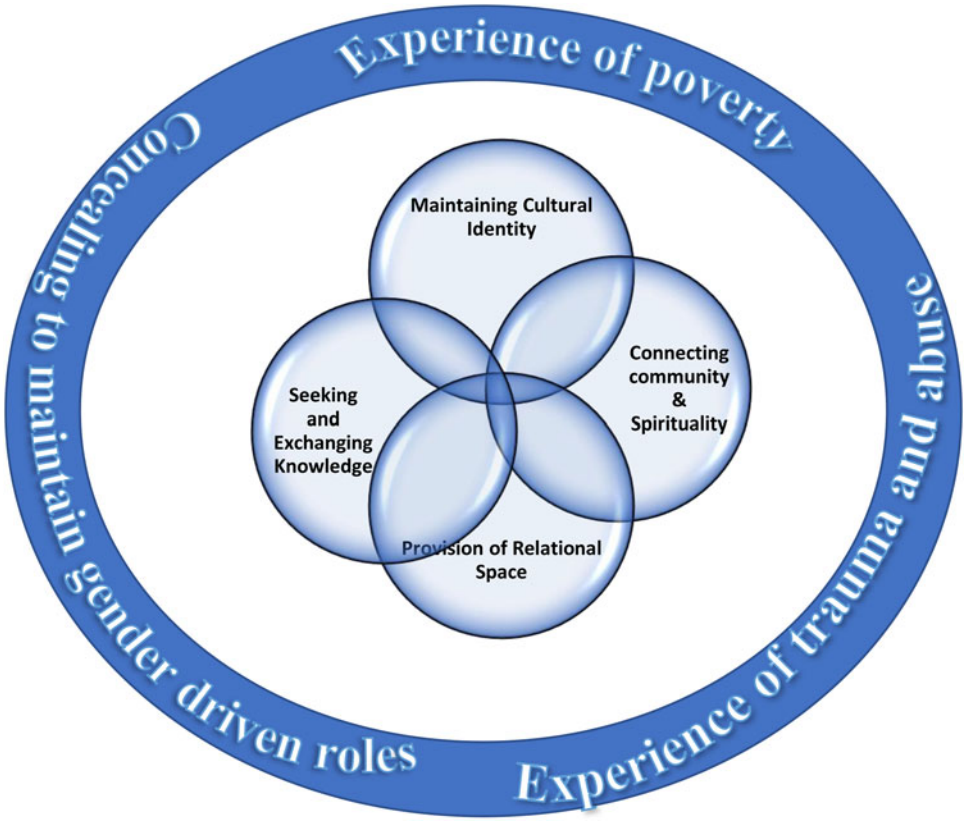


**Figure 2.** Data display: Conceptualizing themes.

coding followed topic coding and facilitated theme development through conceptualization of the data (Cameron, 2013). Theme development emerged centering on immigrant and refugee women with PPD and their social support as coping resource experiences. Remaining close to words used within the data while discerning thematic words was essential to avoiding bias in my decision-making.

### *Presentation of conclusions*

A visual presentation of findings through a data display was developed to appreciate the synthesized findings of this review (see Figure 2). These findings emerged as themes and co-existing issues. Themes reflect the experiences of social support as coping resources among immigrant and refugee women with PPD. They include: maintaining cultural identity, connecting with a community, connecting with spirit (subtheme), relational space imparted by health care providers, and seeking and exchanging knowledge.

Co-existing issues emerged as a result of my PCF orientation which created sensitivity to embedded power imbalance and influences on social support experiences. The following co-existing issues captured contextual determinants that shaped participants' experiences: experience of poverty, connecting to maintain gender-driven roles, and experience of trauma and abuse. These co-existing issues are integrated into the data display as an encircling construct and represent structural forces embedded within study findings.

The data display facilitated conceptualization of relationships amongst themes generated. These are depicted as interconnected systems to convey complexity and encourage intersectional thinking. The interlocking nature of the generated themes is further described later in the discussion of this review. This conceptualization process was the final step in data analysis where integrating data into conclusions took place.

## Results

In this section, a review of geographical contexts, publication dates and methodological approaches used in all 11 articles will be described. Articles that had the most influence within generation of themes due to the data evaluation process will also be highlighted. These articles scored high in critical appraisal of quality and thus had more relevance and credibility to this review.

Geographically, seven of the eleven articles analyzed in this integrative review were conducted in Canada. Two studies were carried out in Australia. One study was located in the United States, and one other was conducted in Malaysia. The date of publication for all eleven studies ranged between 1999 and 2013. Qualitative methodologies used within the eleven studies varied with most using varying forms of ethnographic approaches. Four studies used critical ethnographies, one study used narrative ethnography, and one used an "ethnonursing" approach. One study used a case study approach and one used a phenomenology approach. The remaining two studies were unclear in which qualitative methodology they assumed. A brief review of the 11 articles (see Table 2) outlines author(s), title, theoretical stance,

**Table 2.** Summary of selected articles.

| Author(s) and Title | Theoretical Stance, Methodology/Method | Participant Characteristics | Key Findings |
|---|---|---|---|
| O'Mahony, Donnelly, Raffin Bouchal, & Este. (2013). Cultural background and socioeconomic influence of immigrant and refugee women coping with PPD. | Postcolonial feminism<br>Critical ethnography<br>In depth interviews/semistructured questionnaires influenced by Kleinman's explanatory model | 30 non-European women living in Canada for <10 years, 22 were immigrants and 8 were refugees<br>>18 years of age<br>EPDS[1] screening high risk for PPD within past 5 years PPD by physician | Immigrant and refugee women are influenced by culture and socioeconomics within their experiences of social support.<br>Spirituality was also located within women's experiences.<br>Exposure to violence and domestic abuse was revealed as an issue within women's experiences of social support. |
| [1]EPDS stands for the Edinburgh Postnatal Depression Scale which is a screening tool for health professionals to determine symptoms of depressions and/or anxiety in perinatal women (Perinatal Services BC, 2013). | | | |
| O'Mahony, Donnelly, Bouchal, et al. (2012). Barriers and facilitators of social support for immigrants and refugee women coping with PPD. | Postcolonial feminism<br>Critical ethnography<br>In depth interviews/semi-structured questionnaires influenced by Kleinman's explanatory model | 30 non-European women living in Canada for <10 years, 22 were immigrants and 8 were refugees<br>>18 years of age<br>EPDS screening high risk for PPD within past 5 years | Social support networks influence well-being and can be either supportive or non-supportive.<br>Culture and socioeconomics influence the experience of social support.<br>Relationships with health care providers are essential within the experience of social support. |
| O'Mahony and Donnelly (2013). How does gender influence immigrant and refugee women's PPD help-seeking experiences? | Postcolonial feminism<br>Critical ethnography<br>In-depth interviews/semi-structured questionnaires, and field notes | 30 non-European women living in Canada for <10 years, 22 were immigrants and 8 were refugees<br>>18 years of age<br>EPDS screening high risk for PPD within past 5 years PPD by physician | Immigrant and refugee women were found to experience many complex gender-related issues.<br>Poverty, immigration status, discrimination, and poor spousal relationships influence women's experience of support.<br>This study reveals the complexities of social, economic, and political influences on women's experiences of social support in coping with PPD. |
| Gagnon et al. (2013). Developing population interventions with migrant women for maternal-child health: A focused ethnography. | Critical social justice<br>Focused ethnography<br>In-depth interviews and participant observation, and field notes<br>Influenced by the Population Health Promotion Model developed by Public Health Agency of Canada | 16 international migrant women living in Canada for <8 years<br>>27 years of age<br>High psychosocial risk profile (low income, experienced violence, war or trauma from home country or abuse (physical or sexual) in last year)<br>vulnerable = 4 months postpartum scored high on EPDS, and/or presented symptoms of depression/ anxiety/ somatization and/or symptoms of post-traumatic stress disorder | Migrant women drew on a range of coping resources experiencing a need for more education, creation of supportive environments and building healthy public policy.<br>This study highlighted women experiencing social support through helping others, seeking information and advice, and withdrawing. |
| Morrow et al. (2008). Shifting landscapes: immigrant women and PPD. | "Feminism"<br>Ethnographic narrative<br>Semi structured interviews, and open-ended questions | 18 immigrant women who have lived in Canada for 7–29 years<br>>27 years of age<br>Experienced PPD during perinatal period up to 1 year postpartum<br>Either diagnosed with PPD or self-identified as having experienced depression after birth | Women's experiences and expressions of PPD involved psychosocial stresses of migration experience, and adherence to societal and culturally influenced gender roles.<br>The role of family and community within PPD experiences was salient.<br>Help seeking found community health nurse and family members as key to support networks, however lack of information and awareness about PPD was experienced.<br>The role of interpersonal relationships was significant within women's experiences with social support in coping with PPD. Support for women needs t |
| Nahas, Hillege, & Amasheh. (1999). Postpartum depression: The lived experiences of Middle Eastern migrant women in Australia. | Not made explicit<br>Phenomenology – drawn from Colaizzi (1978) and Spiegelberg<br>In-depth, unstructured interviews | 45 immigrant women from Middle East living in Australia for last 5 years<br>>19 years of age<br>PPD experience and ability to articulate experience | Experience of loneliness due to feelings of isolation and lack of social support. Migration was a contributing factor to feeling separated from community.<br>Feelings of helplessness due to overwhelming task of fulfilling her traditional role as mother and wife.<br>Endured fear of failure and being labeled a "bad mother" by in-laws. |

(*continued*)

**Table 2.** Continued.

| Author(s) and Title | Theoretical Stance, Methodology/Method | Participant Characteristics | Key Findings |
|---|---|---|---|
| | | | Having insufficient knowledge about PPD and available support services.<br>Coming to terms with PPD by undertaking diversional activities and learning new skills.<br>This study raised awareness of culturally influenced gender issues within experience of social support. |
| Nahas and Amasheh (1999).<br>Culture care meanings and experiences of PPD among Jordanian Australian women: A transcultural study. | Leninger's theory of culture care diversity and universality was used as a conceptual and theoretical guide<br>Ethnonursing<br>OPR: observing, participating, reflecting: observing, interviewing and listening to women's experiences and reflecting on them | 22 immigrant women from Jordan living in Australia;<br>Diagnosed as suffering from PPD | Preserving cultural identity and culturally influenced gender issues are revealed within this study.<br>Family support and sense of community are also within the women's experiences of social support. |
| Ahmed et al. (2008).<br>Experiences of immigrant new mothers with symptoms of depression. | Theoretical stance not made explicit<br>"Qualitative"<br>Semi-structured, open-ended Interviews views | 10 immigrant mothers<br>>early 20s of age<br>"Scored highly on [EPDS] at a 2–3 week postnatal visit"<br>all had permanent relationships with fathers | Social support as a coping resource was experienced through being with friends, partners, family, and community support groups.<br>Experienced social support through a good relationship with a health care provider where space was given to discuss emotions facilitated coping.<br>Experienced a need for advice and knowledge sharing on supports within community. |
| Khan et al. (2009).<br>Role of the husband's knowledge and behavior in postnatal depression: A case study of an immigrant Pakistani woman | Theoretical stance not made explicit<br>Case study<br>Face-to-face interview | Immigrant woman from Pakistan living in Penang (an island off of Malaysia)<br>32 years old and married<br>Symptoms self-reported of PPD on postpartum day 4<br>Low income | Care and support traditionally received from family was not available due to migration.<br>Husband had poor understanding and knowledge of PPD.<br>This study emphasized the need for knowledge and information focused on the woman's partner and/or family. |
| O'Mahony, Donnelly, Este, et al. (2012).<br>Using critical ethnography to explore issues among immigrant &refugee women seeking help for PPD. | Critical social justice<br>Critical ethnography<br>In-depth critical ethnographic interviews, dialogic data generation, and field notes | 30 immigrant and refugee women<br>Have experience(d) PPD | Migration contributed to separation for sense of community.<br>This study found that conceptualization of PPD and the need for social support to cope was influenced by culture where stigma against mental illness was found.<br>Experiences of social support was located within the need for information, within women's family values and within spiritual practices.<br>Domestic abuse, immigration status, and poverty, influenced experiences with social support. |
| Callister et al. (2011)<br>PPD and help-seeking behaviors in immigrant Hispanic women. | No theoretical stance made explicit<br>Qualitative descriptive study<br>Semi structured interview, and field notes | 20 immigrant Hispanic women<br>>17 years of age<br>Scored positive for symptoms of PPD within one year postpartum | Some women did not recognize and/or denied their PPD symptoms attributing their sadness to financial concerns, family relationships, and/or work stressors.<br>Experiences included cultural beliefs about emotional health, the perceived stigma of mental illness, and cultural beliefs about motherhood.<br>Experiences with inadequate social support, lack of information, immigration causing separation, and low income were also found.<br>Gender, culture and poverty issues were located within the experiences of social support. |

methodology/methods used, participant characteristics, and key findings.

Based on data evaluation where quality appraisal was implemented, the following five articles demonstrated rigorous data and had the most influence on themes generated in this integrated literature review: O'Mahony, Donnelly, Este, et al. (2012), O'Mahony and Donnelly (2013), O'Mahony et al. (2013), Gagnon, Carnevale, Mehta, Rousseau, and Stewart (2013), and Nahas and Amasheh (1999). Although Ahmed, Stewart, Teng, Wahoush, and Gagnon (2008), Callister, Beckstrand, and Corbett (2011), Khan, Hayati, Tahir, and Anwar (2009), O'Mahony, Donnelly, Bouchal, and Este (2012), Morrow, Smith, Lai, and Jaswal (2008), Nahas, Hillege, and Amasheh (1999) and Khan et al. (2009) scored lower in critical appraisal, findings related to experiencing social support as a coping resource were not discarded. This aligns with Sandelowski and Barroso's (2003) earlier discussed caution in eliminating studies and risking loss of valuable knowledge.

## Emergent themes

The following section is a description of salient themes that emerged through the integrative literature review process. Although I present them in list format, the data display seen in Figure 2, demonstrates the interlocking nature of my findings. The overlapping intersections are intended to portray complexity in the experience of social support as coping resources among immigrant and refugee women with PPD. Moreover, presence of coexisting issues demonstrated broader structural forces that existed within the literature and shaped women's experiences.

### *Maintaining cultural identity*

In seeking social support, researchers found immigrant and refugee women with PPD experienced practical and emotional help by leaning on their cultural traditions and beliefs (Nahas & Amasheh, 1999; O'Mahony et al., 2013). For example, traditions such as resting for many days in the house without leaving are seen as a valuable coping resource for some immigrant and refugee mothers with PPD. A few studies also found that cultural centers set up for immigrant and refugee women with PPD created a network of women with similar cultural beliefs, facilitating emotional, and practical support (Callister et al., 2011; Nahas & Amasheh, 1999; Nahas et al., 1999). The necessity of such networking was supported by studies indicating how migration policies disrupt family connections. Such disruptions led to challenges for immigrant and refugee women with PPD in sustaining coping resources embedded in cultural identity (O'Mahony & Donnelly, 2013). Interestingly, this theme also revealed how stigma is embedded within cultural identity (O'Mahony, Donnelly, Este, et al., 2012; O'Mahony et al., 2013). These studies advised having increased awareness on how to address the intersection of stigma and cultural beliefs when working with immigrant and refugee mothers with PPD.

### *Connecting with a community*

Many researchers in this integrative literature review found having connection to a community as a significant coping resource among immigrant and refugee women with PPD. This community consisted of a woman's partner and/or her family (Ahmed et al., 2008; Callister et al., 2011; Khan et al., 2009; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony, Donnelly, Bouchal, et al., 2012; O'Mahony & Donnelly, 2013; O'Mahony et al., 2013; Gagnon et al., 2013; Nahas & Amasheh, 1999). Researchers found immigrant and refugee women depended on practical, emotional, and financial support provided by partners and/or families as their significant coping resources (Callister et al., 2011; O'Mahony & Donnelly, 2013; Nahas & Amasheh, 1999). Dependence is significant to highlight from a PCF perspective. Researchers revealed how dependence was underpinned by power imbalances that rendered immigrant and refugee women vulnerable to suppression, exploitation, abuse, and decreased self-esteem (Morrow et al., 2008; O'Mahony et al., 2013). The origins and complexities of dependency were briefly described within the literature. These included the political discourse of migrations status (O'Mahony & Donnelly, 2013), the economic roots of spousal dependency (O'Mahony & Donnelly, 2013; O'Mahony et al., 2013), and the psychosocial underpinnings of depending on spouses for social support (Morrow et al., 2008). Having support outside of spousal relationships was discussed within the reviewed literature. Immigrant and refugee women with PPD had limited connections to a sense of family (Ahmed et al., 2008; Callister et al., 2011; Nahas & Amasheh, 1999). This diminished sense of connectedness was influenced by separation from family due to migration as well as spouses being driven away to seek employment due to living in poverty. A salient finding within the literature was how connecting with a female support system was a significant coping resource among immigrant and refugee mothers with PPD (O'Mahony & Donnelly, 2013).

### *Connecting with spirit*

Within connecting with community was the presence of immigrant and refugee women connecting with themselves and others through spiritual and religious beliefs. Researchers identified faith and spirituality as coping resources among immigrant and refugee women with PPD (Gagnon et al., 2013; O'Mahony, Donnelly, Bouchal, et al., 2012; O'Mahony et al., 2013). Although literature is sparse within this subtheme, the notion of spirituality has been raised by researchers as a coping resource that facilitates relationship building within their community (O'Mahony et al., 2013).

### *Relational space imparted by health care providers*

Forming trusting relationships was a significant coping resource among immigrant and refugee women with PPD. Ahmed et al. (2008) identified how immigrant women with

PPD appreciated experiencing the opportunity of being "able to talk to someone" (p. 299) about their experience. O'Mahony and Donnelly (2013) developed the idea of "talking to someone" in their finding that public health nurses are a valuable coping resource for immigrant and refugee women with PPD. However, many researchers also found that space was not adequately given by healthcare providers (Ahmed et al., 2008; Callister et al., 2011; Morrow et al., 2008; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony & Donnelly, 2013). These researchers also revealed instances where immigrant and refugee women with PPD were not provided with opportunities to voice their emotional concerns. Moreover, the experience of "fear and mistrust" occurred often within interactions with healthcare providers (O'Mahony et al., 2013).

### Seeking and exchanging knowledge

Acquiring information and knowledge was a consistent theme that emerged in this literature review. Access to information and advice were viewed as valuable coping resources. For example, researchers found information affirming an immigrant or refugee mother's role was empowering (Ahmed et al., 2008; Callister et al., 2011; Gagnon et al., 2013; Nahas & Amasheh, 1999; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony et al., 2013). Although researchers found perinatal well-being is attended to by healthcare providers, Callister et al. (2011) identified how most information given to immigrant women does not address perinatal *mental health*.

## Co-existing issues

Ever-present within the analysis of literature were broad structural forces rooted within sociopolitical, economic, and cultural contexts of study participants. Importantly, these forces influenced how coping resources were experienced. As a result, co-existing issues within this review shaped the experience of mental health among immigrant and refugee women with PPD.

### Experience of poverty

Poverty and low socioeconomic positioning were significant influences on the experience of social support among immigrant and refugee women with PPD. O'Mahony, Donnelly, Este, et al. (2012) found how poverty was induced by precarious immigration status and contributed to diminished access to coping resources. Thus immigrant and refugee women experienced *limited support* and influenced experiences of PPD. Morrow et al. (2008) also found poverty resulting specifically from insecure employment and immigration status influenced experiences of social support among immigrant and refugee women with PPD. These specific factors contributed to increased fear of partners losing income if they requested parental leave. This fear left women with unmet emotional needs and limited choices in accessing social support (Callister, Beckstrand & Corbett, 2011; Morrow et al., 2008; O'Mahony, Donnelly, Este, et al., 2012).

### Experience of trauma and abuse

Embedded within many of the eleven studies reviewed was the experience of trauma and abuse among immigrant and refugee women (Gagnon et al., 2013; O'Mahony & Donnelly, 2013; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony, Donnelly, Bouchal, et al., 2012; O'Mahony et al., 2013). O'Mahony et al. (2013) highlight how the experience of trauma can be positively reframed. Many of their study participants reflected on their experiences as allowing "growth and a stronger sense of control of their situation," (p. 309). This finding builds on how strength-based approaches facilitate resilience. Gagnon et al. (2013) findings support this claim where fostering inner strength contributes to enhanced resiliency among immigrant and refugee women with PPD who have experienced conflict and/or war-induced trauma.

Consequences of migration on immigrant and refugee women with PPD coming from war-ridden countries were addressed within the literature (O'Mahony & Donnelly, 2013). These consequences had effects on how coping resources were experienced. Leaving family behind was a central consequence of migration discussed that fostered continued experiences of trauma and uncertainty (O'Mahony & Donnelly, 2013). The authors found this increased trauma resulting from family fragmentation diminished women's coping resources and contributed to the experience of fear and anxiety. Being forced to depend on abusive spouses was another consequence of migration among immigrant and refugee women. Spousal abuse dampened immigrant and refugee women's experiences of support and further limited access to coping resources (O'Mahony, Donnelly, Este, et al., 2012; O'Mahony, Donnelly, Bouchal, et al., 2012). Moreover, experience of abuse by a domineering partner contributed to the experience of fear and depression (O'Mahony & Donnelly, 2013).

### Experience of concealing to maintain gender-driven role expectations

O'Mahony and Donnelly (2013) found that immigrant and refugee women with PPD masked true feelings while taking on the motherhood role. Concealment of mental health concerns to maintain gender-driven expectations influenced experiences of accessing coping resources. Morrow et al. (2008) and Callister et al. (2011) generated similar results where immigrant and refugee women were hesitant to seek social support due to feeling guilty and embarrassed about depressive symptoms. Other studies also reported immigrant and refugee women with PPD endured fear of failure in their mothering role. To cope with this fear, women suppressed challenges they were facing (Nahas & Amasheh, 1999; Nahas et al., 1999). Moreover, Gagnon et al. (2013) discovered immigrant and refugee women

cope through socially withdrawing and deal with difficulties on their own.

## Discussion and clinical implications

Findings of this review described through themes and co-existing issues revealed underexplored areas that affect the experience of social support among immigrant and refugee women with PPD. In this discussion, valuing migration status as a determinant of social support, appreciating resiliency, considering intersections of migration policy, gender and culture on social support, acknowledging spiritual well-being as well as creating relational space are areas that will be focused on.

### *Valuing migration status as a social support determinant*

This review revealed the intersection of experiencing poverty with the experience of social support among immigrant and refugee women. Within this intersection, the notion of precarious migration status was a consistent determinant influencing the experience of coping resources. Several studies found precarious immigration status was linked to living in poverty and having limited access to coping resources (Callister, Beckstrand & Corbett, 2011; Morrow et al., 2008; O'Mahony, Donnelly, Este, et al., 2012).

Awareness of how migration status affects socioeconomic positioning can influence nursing assessment of access to coping resources among postpartum immigrant and refugee women. As a result, migration status needs to be considered as a determinant of how social support is experienced. For instance, disentangling migration discourse and the health impacts of migrant categories can be integrated into nursing professional practice. Doing so can increase understanding of how to assess for migrant categories and how immigrant and refugee mothers with PPD are being affected. This increased knowledge among mental health nurses can assist in navigating these women toward enhanced access to relevant coping resources and health services.

### *Appreciating resiliency*

Resiliency was a second underexplored notion revealed within this review (Gagnon et al., 2013). This strength-based characteristic honors the capacity of immigrant and refugee mothers to endure strife and focus on hope. For example, Gagnon et al. (2013) identified the concept of "inner strength" that fostered resiliency. In addition, O'Mahony et al. (2013) framed the experience of trauma among immigrant and refugee women as an opportunity to grow stronger and regain control of their circumstances.

In understanding how resiliency enhances capacity, nurses are well-positioned to create strategies on harnessing inner strength of immigrant and refugee women with PPD. Moreover, nurses can focus on positively framing circumstances to facilitate hope among a population that is traditionally constructed as suffering and dependent. In addition, appreciating resiliency among immigrant and refugee women can occur through nurses challenging mental health discourse that is dominated by illness-orientation and biomedical narratives (Malcoe & Morrow, 2017).

### *Considering intersections of migration policy, gender and culture on social support*

Exploring intersecting determinants to understand experiences of social support among immigrant and refugee women with PPD remains underexplored (Callister et al., 2011; Morrow et al., 2008; O'Mahony & Donnelly, 2013). Honing in on the intersection of migration policy, gender and culture reveals how the idea of family is a critical coping resource among immigrant and refugee women with PPD. However, migration policies have fragmented family units and devalued cultural traditions of drawing on family for support (Morrow et al., 2008; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony & Donnelly, 2013). Thus, migration policy implications have led to diminished coping resources among immigrant and refugee mothers (O'Mahony & Donnelly, 2013). Migration policies have consequently been constructed to ignore the importance of cultural traditions and women's needs for family to enhance their coping skills. Forcing immigrant and refugee mothers to create alternate coping strategies and move away from their cultural supports is a form of structural violence. Choiniere, MacDonnell, Campbell, and Smele (2014) describe structural violence as embedded factors that contribute to removal of basic needs and hinder well-being.

Questioning policies that hinder the well-being of immigrant and refugee women has potential to unearth structural violations that are going unnoticed. Therefore, nurses working with immigrant and refugee women with PPD are situated to explore cultural traditions that foster social support. Suck knowledge can equip nurses to challenge structures that are forcing these mothers to forsake their traditional coping resources. These structures could range from operational processes to program and policy development.

### *Acknowledging spiritual well-being*

Little attention has been placed on the relationship between spirituality and well-being (Gagnon et al., 2013; O'Mahony, Donnelly, Bouchal, et al., 2012; O'Mahony et al., 2013). This is supported by limited generation of literature within this integrative review that addressed spirituality. As a result, how do nurses approach spiritual health within their work with immigrant and refugee women with PPD? Understanding how to address spirituality could potentially enhance and strengthen relationship building with immigrant and refugee mothers with PPD. This relational approach can facilitate creating space to communicate emotional help (Ahmed et al., 2008; O'Mahony & Donnelly, 2013). Creating this space empowers immigrant and refugee women enduring PPD with information and knowledge (Ahmed et al., 2008; Callister et al., 2011; Gagnon et al., 2013; Nahas & Amasheh, 1999;

O'Mahony, Donnelly, Este, et al., 2012; O'Mahony et al., 2013).

Nurses can support immigrant and refugee women with PPD in their spiritual well-being through continuous dialog with peers and self-reflection on assumptions regarding spirituality as a coping resource. Questioning how spirituality is assessed within practice and program development needs to be integrated into nursing practice to enhance social support needs. For example, how do nurses' current practices acknowledge and explore spiritual well-being among immigrant and refugee women with PPD?

### *Creating relational space*

Creating space for relational practice was another theme found in this review. Relational work within this review meant to create trusting relationships with immigrant and refugee women that fostered nurses being viewed as someone to talk with regarding their mental well-being (Ahmed et al., 2008; O'Mahony & Donnelly, 2013). However, with many researchers in this review identifying inadequate provision of space to voice emotional concerns, questioning current relational practice is imperative (Ahmed et al., 2008; Callister et al., 2011; Morrow et al., 2008; O'Mahony, Donnelly, Este, et al., 2012; O'Mahony & Donnelly, 2013).

Reflecting on how such space is currently provided for relational practice should raise questions such as "What does relational practice mean to me, to my colleagues, and to decision-makers?" and "How do current structures shaping operations of my clinical practice prioritize relational care provision?". Shifting the gaze toward how current systems support clinical practice in fostering relational work has potential to disrupt processes that unintentionally perpetuate asymmetrical power relations. Moreover, focus on questioning operational and structural influences on clinical practice can lead to changes that support immigrant and refugee women's social support needs.

## Further research and policy implications

An unexpected finding within this review included a homogenous view of migrant women. Few articles explicitly recognized categorizations of immigrants or articulated migrant status as a determinant of health experience. For example, many studies did not articulate refugees and asylum seekers as having unique mental health needs due to forced displacement. Conflating the circumstances of refugees and asylum seekers with immigrants who choose to migrate dilutes experiences of social support needs. Thus, I recommend more inquiries that specifically focus on the refugee experience of maternal women with mental health concerns. Inquiries into refugees or any migrant category needs clear articulation of migrant discourse to clarify health impacts. Moreover, policy development needs to appreciate heterogeneity of migrant status and health impacts of these heterogeneities on various migrant groups.

Research methodologies applied within immigrant and refugee research focused on women with PPD can include those underpinned by a critical lens. Institutional ethnography is one example that can facilitate magnifying power relations embedded within organizational structures and clinical activities (Rankin, 2015). Taking up IE can allow researchers to link taken-for-granted practices and processes with specific problematic experiences of coping resources as revealed within this integrative literature review (Rankin, 2013). Constructive grounded theory (CGT) is another example that can be used in various ways including theory construction out of nursing perspectives. CGT holds a promise of highlighting power imbalances embedded in broader sociopolitical structures (Charmaz, 2014; Marcellus, 2017).

Applying an equity-oriented intersectionality lens as proposed by Hankivsky and Cormier (2009) within future research inquiries to explore interplay of determinants is also recommended. For example, exploring gender, culture, migration status, and socioeconomic status affect experience of mental well-being among immigrants and refugees could reveal underexplored issues for further inquiry (Hankivsky et al., 2010). Such explorations could also attend to integrating perinatal mental health with migrant policy development. This upstream approach has capacity to trickle into the practice realm where Callister et al. (2011) identified a gap in addressing perinatal mental health with immigrant and refugee women.

Further research exploring intersections of stigma and experience of intimate partner violence and abuse from other family relationships can deepen experiences of PPD and foster questioning current practice and policies. Such analysis can inquire into how existing structures such as policies and operational practices are perpetuating powerlessness and dependency among immigrant and refugee mothers with PPD. Focus on systemic influencers that steer practice and professional development can uproot inequities going unnoticed (Pauly, MacKinnon & Varcoe, 2009).

## Conclusion

This integrative literature review contributes to understanding current knowledge of immigrant and refugee mothers with PPD and their experiences of social support. Applying PCF tenets (Racine, 2003) and Miriam Stewart's (1989) coping theory provides a deeper understanding of social support among an underexplored population vulnerable to PPD. After an extensive search strategy and critical appraisal process, data analysis revealed interconnected themes and coexisting issues. The intersectional nature of these themes and issues illuminated the complexity of experiencing social support as a coping resource. Drawing on these themes, clinical practice recommendations for nurses working within psychiatric and mental health domains of care were made within underexplored areas. These areas included valuing migration status as a determinant of social support, appreciating resiliency, considering intersections of migration policy, gender, and culture on social support, acknowledging spiritual well-being as well as creating relational space. Questioning current practices, programs, policies, and processes is necessary to enhance the quality of care provided to immigrant and

refugee women with PPD. Future research and policy development recommendations were also made with focus on an equity-oriented intersectionality lens (Hankivsky & Cormier, 2009). In doing so, current attempts at fostering social support as coping resources can be appreciated and structural violations going unnoticed can surface and be challenged.

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I, the author, report no conflicts of interest. I alone am responsible for the content and writing of this paper.

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## Compliance with ethical standards

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