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## Perceptions of Ghanaian Migrant Mothers Living in London towards Postnatal Depression during Postnatal Periods

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### ABSTRACT

The concept of postnatal depression might be constructed differently by people with different cultures resulting in the adoption of different coping mechanisms. Ghanaian migrant mothers living in London are no exception. The aim of this paper is to examine the perception of Ghanaian migrant mothers living in London towards postnatal depression during the postnatal period. In-depth interviews, augmented with informal conversations, were conducted with 25 Ghanaian migrant mothers who were within the postnatal period in London. Data were thematically analysed and presented. The study found that although Ghanaian migrant mothers reported experiencing stressful situations due to breastfeeding, infant temperament, lack of social support and housing problems, they were reluctant to seek help from maternal mental health services because they did not trust those health professional they encountered. Ghanaian migrant mothers appreciated the support of health visitors but the absence of family support increased their stressful situations. They, therefore, sought help when they are depressed mostly from religious leaders, friends, and distanced relatives while in London. We argue that since the Ghanaian migrant mother is a subsystem of her larger family which consist of individual elements such as the spouse or partner and her child and also relates with the wider UK environment including the health care system and the church, a change in one has an effect on all. Thus, health professionals must clarify their roles to mothers and take measures to assess migrant mothers on all aspects that influence their postnatal experiences. Identifying additional support needs of these mothers by health professionals is also paramount.

**Keywords:** Perceptions; Ghanaian migrant mothers, postnatal depression, postnatal period, in-depth interviews

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## 1.0 Introduction

The postnatal period can be defined as the first twelve months after delivery (Omar and Fattah, 1998; Babatunde and Moreno-Leguizamon, 2012). This period is generally a healthy period for many mothers (Babatunde and Moreno-Leguizamon, 2012). However, in many cultures across the globe, the postnatal period is seen as a time where new mothers are extremely vulnerable to illness and stress. Hence, certain prescribed traditional practices are initiated to help the women cope this period (Dennis et al., 2007).

Globally, people from diverse cultural backgrounds might display different constructions of mental health difficulties with different help-seeking behaviours (Babatunde and Moreno-Leguizamon, 2012). Most migrant mothers in the United Kingdom, who exhibit symptoms or have been diagnosed with Postnatal Depression perceived it differently. A study by Gardner et al. (2014) showed that some West African mothers within the United Kingdom do not perceive Postnatal Depression as a health concern. The women who informed the study used the word 'stress' to describe their experience. Similarly, a study by Edge (2008) noted that Black Caribbean women living in the United Kingdom were relatively unfamiliar with the term Postnatal Depression.

The onset of Postnatal Depression is generally within four to six weeks after childbirth (Robertson et al., 2004) and can persist beyond two years (Goodman, 2004; Beestin et al., 2014). The signs and symptoms of Postnatal Depression include fatigue, low mood, anxiety, insomnia, weight loss or weight gain, and in extreme instances suicidal thoughts or thoughts of harm to the child (Templeton et al., 2003). Postnatal Depression is a serious public health concern (Robertson and Stewart, 2003) because it does not only affect the mother but impacts on the family (Ramchandani et al., 2008). If left untreated, Postnatal Depression can leave mothers with long-lasting mental distress (Robertson and Stewart, 2003).

Mothers experiencing Postnatal Depression exhibit behaviours such as being withdrawn and disengaged with their babies (Weinberg and Tronick, 1998; Roomruanywong and Epperson, 2011). These have a negative impact on their child's cognitive, emotional, behavioural and developmental outcomes (Taylor 1997; Templeton et al., 2003). Furthermore, evidence suggests that partners of women with Postnatal Depression are prone to clinical depression (Ramchandani et al., 2009).

In many Western nations, migrant mothers who accept that they have Postnatal Depression rely less on seeking for help to deal with their problem. A study by Amankwaa (2003) also reveals that some women of African descent in America who have experienced Postnatal Depression in the past have culture-specific ways of dealing with their situation. These include relying on their religious beliefs and the advice of their family members as a means of managing depression. Also, a study in the United Kingdom by Wittowski et al. (2011) found that turning to religion, remaining positive and seeking more family support help them to cope with depression.

McGarry et al. (2009) found that migrant mothers who have experienced Postnatal Depression do not vigorously seek help. Several studies including Gardner et al. (2014) found several barriers which prevent migrant mothers from seeking help for Postnatal Depression. These include the lack of knowledge of the condition, cultural barriers and lack of knowledge on the role of health professionals. These barriers result in differences in the construction of Postnatal Depression among migrant mothers.

The diverse ways in which Ghanaian migrant mothers construct postnatal depression as a mental health problem and their attitudes towards seeking help for maternal mental health issues is worrisome (Babatunde and Moreno-Leguizamon, 2012). Therefore, the aim of this study is to examine perceptions of

Ghanaian migrant mothers living in London towards postnatal depression during postnatal periods.

## **2.0 Methods**

### **2.1 Research design**

This paper was extracted from a larger, original study that examined the postnatal experiences of Ghanaian migrant women living in London. Other aspects of the original research have been reported elsewhere. In the larger study, qualitative research design which falls within the interpretivist ontological paradigm was used. Interpretivism holds the belief that reality does not exist without us knowing it (Grix, 2010), and thus reality can best be understood by how people interpret their experiences in terms of social life in the world. Drawing on the qualitative research approach, the study sought to understand the perception of migrant women as well as their attitudes and help-seeking behaviour towards maternal mental health services in the UK. Therefore, a qualitative research approach was most suited for this study. This is because the researchers gained a deeper understanding of the topic under study (Creswell, 2013). Data for this paper draw on reports and findings from a part of the qualitative section of the original study, examining the postnatal experiences of Ghanaian migrant women living in London. As an inductive approach to research, qualitative research analysis uses a small sample size which enables an in-depth level of exploration of the topic (Grix, 2010). The approach allows understanding of a social phenomenon through the interpretation of the participant (Brymann, 2012). Thus, the qualitative research seeks to interpret the revelations of a phenomenon through the eyes of the participant (Grix, 2010; Brymann, 2012).

### **2.2 Sampling design and data collection**

The original study interviewed 25 Ghanaian women who live in the United Kingdom. This was done to get information which is vital to the postnatal experiences of Ghanaian migrant

women living in London. The participants included women who were born and raised in Ghana and have given birth in the United Kingdom. Hence, women between the ages of 18-45 years were sampled. The study purposively selected Ghanaian migrant women in order to increase the homogeneity of the sample. The non-probability snow-ball sampling method was used to recruit participants for the study. This method involves making contact with a person known to the researchers who fit the research criteria and then making contact with others through the initial contact (Brymann, 2012). Although reports from snow-ball technique are not considered to produce findings that can be generalised for a larger population, nevertheless, the fact that all the participants have experienced childbirth in the UK suggests that their experiences will provide useful insight.

Data for the study was obtained using both primary and secondary data sources. The primary data was obtained using a semi-structured interview guide developed by the researcher and used for the study. The participants were given the opportunity to ask questions and then signed the consent form before the interview commenced. Each interview was tape recorded and notes were taken regarding contents of the interview. The participants were asked to confirm with a yes or no answer their consent for interviews to be recorded before interviews commenced. Brymann (2012) recommends that interviews be tape recorded so that the interviewer can be attentive to the interviewee, follow important points and ask probing questions where necessary. The interview was conducted between the participants and an interviewer at the various homes of the participants. The participants were informed that the interview would take approximately 30-40 minutes and that it would be tape-recorded. To ensure anonymity, no name was assigned to the interviewee and no personal identifying details were recorded. Questions asked included the

participants' knowledge about the help-seeking behaviour of mothers towards mental health services during the postnatal period.

### 2.3 Data Analysis

After the interviews, the audiotapes were transcribed and thematic analysis was used to analyse the written version of the responses. Common themes from the responses through repeated reading of the transcripts were identified. According to Brymann (2012), a theme is a category a researcher identifies within data gathered that relates to research questions. This categorisation provided us with the basis for an understanding of the data collected. We reviewed the emerging themes and developed thematic descriptions to capture each theme. We then returned to the transcriptions to identify quotes and passages that represented each theme. Finally, we synthesised the themes into descriptions of the participant's postnatal experience in the United Kingdom specifically.

### 3.0 Results

The results constitute the generalised views of the sample employed for the study, Ghanaian mothers living in the London. The standpoints of the participants on the perceptions of Ghanaian migrant mothers towards postnatal depression during postnatal periods are the raised categories from the data. The descriptions of the concept identified in the interviews are organised into two themes. These include perceptions of Ghanaian mothers during the postnatal period and the coping strategies to manage stressful situations during the postnatal period.

#### 3.1 Perceptions of Ghanaian mothers during the postnatal period

On the causes of worry, sadness and stress during the postnatal period, several factors such as breastfeeding, infant temperament, lack of social support (marital problems and partner absence) and accommodation problems were identified.

Breastfeeding was noted by many respondents as stressful. The mothers generally had negative perceptions about breastfeeding. Pain and discomfort were notable aspects. Some respondents explained further as showed in the following quotations:

*"I get very stressed up especially when I have to wake up at night to breastfeed the baby. My breast becomes painful as the baby sucks and I get a bit dizzy. After feeding, the baby will refuse to sleep for me to also sleep and recover. Most of the time I will be awake until morning."* [Fieldwork, 2014].

Another respondent also said:

*"Yeah! Breastfeeding is very painful..... Sometimes there would be sore all over the nipples of my breast but the passion and love I have for my baby force me to still feed her"*[Fieldwork, 2014]

In spite of the pain and physical stress, the women perceived breastfeeding as a sign of good motherhood as a respondent said:

*"Yeah, let me say sometimes I feel stressed and physically exhausted especially if it's only me and the baby when the baby is crying and at the same time you need to feed the baby, change the baby, you have to cook your own food and clean up. Oh, it's too much. But I have to breastfeed to have a bond with my baby and make the baby healthy"* [Fieldwork, 2014].

On the issue of infant temperament, infant behaviour such as poor sleeping and being demanding were mentioned by some of the mothers as a cause of postnatal depression. One mother argued:

*"I sometimes get fed up with the constant and persistent cries of my baby. He always needs attention and I can't do anything for myself and my 4-year-old son. It gets me angry at times and I leave him to cry. However, I feel sad when the baby cries especially when I have to take my 4-year-old son to school. I wish my Mum was alive; she would have been here to help me out. I feel more sad and lonely when my baby cries more. It reminds me when I gave*

*birth to my 4-year-old boy in Ghana. My mother-in-law came to live with me and my husband. She bathed the baby, did the cooking, cleaning, and washing while I rest, she only woke me up to either eat or breastfeed the baby. She did that for 6 months before leaving for my father-in-law.” [Fieldwork, 2014].*

We further sought the respondents' views on the issue of lack of social help: marital problems and partner absence, single parenting were also mentioned by some of the mothers as a cause of depression during the postnatal period. The respondents again said:

*“I was depressed before I gave birth. This was caused by my husband abandoning us. He thought I will have another girl. I used to cry and I was always sad. Everybody including my midwife and church members knew my problem. My sadness increased when I remember how my husband and I used to care for my two-year-old daughter” [Fieldwork, 2014].*

In furtherance of the issue of accommodation, Ghanaian migrant women perceived poor accommodation due to limited housing space as one of their main stressors during the postnatal period:

*“We were in a small place, my husband, the baby and I; so I wanted a bigger place. I went to the council and was put on a waiting list. We had to be in the small place and there was no space. I was very frustrated and stressed up” [Fieldwork, 2014].*

A respondent also has this to say:

*“My situation got worse when I gave birth and couldn't pay the rent. My husband who was working and was paying the rent was nowhere to be found. I couldn't get immediate help from the council so I only tried to eat. I couldn't think right and I was very worried when the landlord came to eject us because we had not paid rent for almost two months. I had to call the Reverend Minister of my church who came with another church member to pay the money to the landlord.” [Fieldwork, 2014].*

### **3.2 Coping strategies for dealing with stress during postnatal period**

Generally, the respondents depended on their family and friends for emotional and practical support after being discharged from the hospital. Nonetheless, this help was only available for the initial days of the postnatal period. This is because both friends and family had to return to their jobs or risk not being able to pay their bills. Although the women spoke about being stress and sadness, most of them reported not seeking help from a professional. Majority of the women rather remained positive or sought help and guidance in the form of emotional support from their mothers who were living in their native country.

On the issue of remaining positive, the respondents saw it as their responsibility to deal with postnatal stress because it was part of their motherhood experience. We, however, found that information on how and where to find help when they feel down and depressed was given to them during the antenatal period and immediately after delivery. Notwithstanding this, the majority of them who felt being depressed and stressed considered them to be part of motherhood. Hence, they used strategies including staying positive to help fight stress instead of seeking professional help. Some comments made by the respondents with respect to the above is as follows:

*“I just told myself I can do it after I got advice and support from my cousin's wife who later on during the postnatal period came to live with me. I had nobody so I had to be strong for my children.” [Fieldwork, 2014].*

Moreover, some mothers also resorted to seeking help by calling relatives. Women who could not get practical support in the United Kingdom (UK) tend to find help from family relations living in Ghana. This is because of negative experiences with professionals as they tried to seek help. As one mother expressed below:

*“You know when you have the baby; they will come to the house and visit you for one or two times. They will just tell you, oh if you have any worry, or you are depressed or if you need any advice just call us. But even if you call them, they will not bother, they won’t even help you. They will just tell you, we will help you so come and see us but, I don’t bother. Because I know what they are telling me is not true. Because I have heard a lot of people say don’t call them if you call them, they won’t even come or they won’t do anything to help you. So, I talked to my mum back home, I have to call my mum. I spend a lot of money buying phone cards to talk to my mum. Every day, I am on the phone with my mum 24/7, every sec, every minute, even if my baby is crying too much I have to call my mum and ask for advice.”* [Fieldwork, 2014].

Another respondent also explained:

*“Sometimes I watch movies to take my mind from some of these problems when I feel stressed up.... You know I’m here all alone without any family member. So my only friend left to console me when I’m depressed is the television”* [Fieldwork, 2014]

### 3.3 Discussion

This study employed a qualitative research approach to examine the perceptions of Ghanaian migrant women living in Ghana towards postnatal depression during their postnatal period. Our findings reveal that migrant mothers were appreciative of the support they received from health professionals. However, the support they received lacked the practical and emotional support they would have received in their native country. This perception affected their well-being. This finding corroborates Melender (2002) and Razurel et al. (2011) that help in the form of social resources provided by health care services and health professionals when viewed as adequate and satisfactory has a significant impact on a mother’s postnatal well-being. The above instances may result in stressful situations for the Ghanaian migrant

women if they do not receive resources in the form of social support after giving birth.

The study further found that Ghanaian migrant mothers experienced stressful postnatal period due to problems with breastfeeding, infant temperament, lack of social support and housing problems. However, the migrant mothers were reluctant to seek professional help for postnatal stress and depression mainly due to cultural barriers and lack of trust in professionals. Hence, Ghanaian migrant mothers rather sought help from religious leaders, relatives and friends back home and abroad. Most of the mothers saw breast feeding as a negative aspect of the postnatal period. This finding is consistent with a study by Razurel et al. (2011) who found that women had negative perception of breast feeding. Also, the experiences of respondents seem to support studies like that of Webster et al. (2011) which found that infant temperament caused postnatal stress among mothers. Lack of social support networks including emotional support from husbands or partners does appear to be related to postnatal stress among respondents. Similar findings were reported in studies including Hoang et al. (2009) and Husain et al. (2012).

Ghanaian migrant mothers who accepted that they had postnatal stress relied less on formal support to cope with their problem. This buttresses similar findings of Amankwaa (2003) that some women of African descent in America who had experienced postnatal stress in the past had cultural specific ways of dealing with their situation. These included relying on their religious beliefs and the advice of their family members as a means of managing stress. Generally, the respondents depended on their family and friends for emotional and practical support after being discharged from the hospital. Nonetheless, this support was only available for the initial days of the postnatal period. This is because both friends and family had to return to their jobs or risk not being able to pay their bills. Although the mothers spoke

about being stressed, worried or sad, most of them reported not seeking help from a professional. Majority of the mothers rather remained positive or sought help and guidance in the form of emotional support from their mothers who were living in Ghana. All the women reported that information on how and where to find help when they feel down and stressed was given to them during the antenatal period and immediately after delivery. That notwithstanding, the majority of them felt being stressed was part of motherhood. Hence, they used strategies including staying positive to help fight stress instead of seeking professional help. This finding is not different from Templeton et al. (2003) that Black Minority Ethnic (BME) mothers living in the UK with symptoms of postnatal stress felt their postnatal experience were just challenges that disappear with time.

Although respondents have common views about the help-seeking behaviour of mothers towards postnatal depression services during the postnatal period, the study found a weak link in the help-seeking behaviours between health professionals and the migrant mothers living in the United Kingdom. This relates to the lack of trust between the health professionals and the migrant mothers. There should be an improvement in the maternal mental help-seeking behaviours by the health professionals towards the migrant mothers in their postnatal period.

### **3.4 Conclusion and Policy Implication**

The study has found out the postnatal experiences of Ghanaian migrant mothers living in London, UK. This could be the first study in the UK that looks specifically at the perceptions of Ghanaian migrant women towards postnatal depression during postnatal periods. The findings provide a useful insight into the experiences of Ghanaian migrant mothers and their needs during the postnatal period.

The study has demonstrated that there is a mismatch between the postnatal help offered by health professionals and the needs of

migrant mothers. Although mothers are generally appreciative of the support offered by health visitors, their need for practical and emotional help is not satisfied. As such, Ghanaian migrant mothers experience stressful situations in the absence of family help. However, Ghanaian migrant mothers were reluctant to seek support from professionals because they did not trust them. These mothers rather sought help from family, friends and the church. The study further revealed that health visitors focused mainly on the health of babies during home visits. However, the migrant mothers reported that they required more emotional and practical support during the postnatal period.

The findings from the study have important suggestions for the implementation of postnatal experiences of migrant mothers living in the United Kingdom (UK) policy plan. To mitigate the problem of postnatal depression, health professionals should clarify their roles to mothers and take measures to assess migrant mothers on all aspects that influence their postnatal experience. This will enable professionals to offer help tailored to the needs of migrant mothers.

Again, health visitors should endeavor to identify any additional needs of mothers which will result in proactive steps being taken to avert potential stressful situations for mothers. Social workers can be involved in the postnatal care of migrant mothers at an early stage during the postnatal period. Social workers can provide practical support for mothers such as supporting them to make applications for accommodation among other things. In addition, assistance with daily tasks can be arranged with the help of social workers.

### **Ethical consideration**

The University Research Ethics Committee, Department of Social Work at Lancaster University, UK provided the approval for this study. Regarding the Declaration of Lancaster, the participants received consent prior to the

start of the interview process. The participants signed the consent form.

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**Conflict of Interest**

Authors declare no competing interest

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