Midwifery 31 (2015) 671–677

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Immigrant Afghan women's emotional well-being after birth and use of health services in Melbourne, Australia

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ARTICLE INFO

Article history:
Received 22 September 2014
Received in revised form
4 February 2015
Accepted 26 March 2015

Keywords:
Afghan women
Immigrant
Postnatal depression
Help-seeking
Emotional well-being
Health service

ABSTRACT

Objective: to investigate immigrant Afghan women's emotional well-being and experiences of postnatal depression after childbirth and their use of health services.
Design: telephone interviews were conducted at four months after birth, using a semi-structured questionnaire; and a further in-depth face-to-face interview with a small number of women approximately one year after the birth. Women's emotional health was assessed at four months using the Edinburgh Postnatal Depression Scale (EPDS), as well as women's own descriptions of their emotional well-being since the birth.
Setting: women were recruited from four hospital antenatal clinics or postnatal wards in Melbourne, Australia, between October 2006 and May 2007.
Participants: Immigrant women who were born in Afghanistan, spoke Dari/Persian or English, and had given birth to a live and healthy baby.
Findings: Thirty nine women were interviewed at four months after birth; 41% reported feeling depressed or very unhappy since the birth and 31% scored as probably depressed on the EPDS. Ten women participated in further in-depth face-to-face interviews. Isolation, lack of support and being overwhelmed by life events were the most frequently reported contributing factors to women's emotional distress, and for many being a migrant appeared to intensify their experiences. The themes that emerged from both the telephone and face-to-face interviews revealed that some women were reluctant to discuss their emotional difficulties with health professionals and did not expect that health professionals could necessarily provide assistance.
Key conclusions and implications for practice: in this study a significant proportion of immigrant Afghan women experienced emotional distress after childbirth. Women's experiences of emotional distress and help-seeking were at times affected by their status as immigrants and their perceptions of possible causes and treatment for their emotional health problems. Understanding the effects of migration on women's lives and paying careful attention to individual needs and preferences are critically important in providing care for immigrant Afghan women.

Introduction

Postnatal depression is a major health issue for a significant number of women all over the world (O'Hara and Wisner, 2014). Research shows that between 10% and 20% of mothers in high income countries will experience depression after the birth of their baby (O'Hara and Swain, 1996) and there is recent evidence of higher prevalence in low and middle income countries (Fisher et al., 2012).

Postnatal depression is a complex health issue with numerous risk factors contributing to its onset (O'Hara and Swain, 1996). Considerable research conducted to identify risk factors for postnatal depression has revealed consistent findings; that the most salient factors associated with depression are those embedded in women's social context: lack of support and isolation, partner conflict and stressful/negative life events (O'Hara and Swain, 1996; Beck, 2001; Yelland et al., 2010). Research also demonstrates that these factors tend to be universal (Oates et al., 2004), and maternal depression in the postnatal period is not limited to Western or developed cultures as previously often believed (e.g. Stern and Kruckman, 1983).

Immigrant women's experiences

There has been a consistent finding of an association between immigrant status and postnatal depression, especially among those not speaking the dominant language of the new country (Dennis et al., 2004; Collins et al., 2011; Urquia et al., 2012). Immigrant women's experiences of depression are associated with their social

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http://dx.doi.org/10.1016/j.midw.2015.03.011
0266-6138/

context and life stresses particularly those related to their migration status, such as isolation, lack of practical and emotional support (Small et al., 2003; Ahmed et al., 2008; Collins et al., 2011), and financial stress (Ahmed et al., 2008; Morrow et al., 2008). In other words, immigrant women are often socially isolated in their new country and separated from their usual postpartum contexts and supports (Small et al., 2003; Sword et al., 2006; Morrow et al., 2008), something which appears to contribute to the higher prevalence of depression for immigrant women.

Help-seeking behaviour

Commonly, women experiencing emotional difficulties after birth do not seek help from health professionals (Small et al., 1994; McGarry et al., 2009; Woolhouse et al., 2009; Ganann et al., 2012). Recognised problems with disclosure by women and lack of identification of depression by healthcare providers mean that women who are postnatally depressed may often go undetected and untreated (Small et al., 1994; Templeton et al., 2003; Dennis and Chung-Lee, 2006). Reasons for lack of disclosure and identification are complex; particularly so in the context of language and cultural differences in ethnic minority populations.

Women's lack of knowledge of postpartum depression and treatment (Templeton et al., 2003; Dennis and Chung-Lee, 2006; Hanley, 2007; Sword et al., 2008) are cited as significant barriers for help seeking, with some women not knowing where to seek assistance (Buultjens and Liamputtong, 2007; Ahmed et al., 2008; Abrams et al., 2009) or considering health professionals to be an inappropriate source of assistance (Chew-Graham et al., 2009; Woolhouse et al., 2009). The social stigma and the fear of being labelled mentally ill also deters some mothers from seeking help (Templeton et al., 2003; Hanley and Long, 2006; Ahmed et al., 2008; Abrams et al., 2009). Over-normalising of symptoms by women, their family members and friends, and by healthcare providers has been reported as another reason for not seeking help (Sword et al., 2008; Abrams et al., 2009). Caregiver attitudes, being rushed or neglecting to ask women about their emotional health also contributes to women not seeking help from health professionals (Ahmed et al., 2008).

Afghan people are one of the largest refugee populations in the world (UNHCR, 2010) and are also among the top ten groups of refugee/humanitarian arrivals to Victoria and Australia in recent years (Department of Immigration and Citizenship, 2013). However, we identified no studies conducted among childbearing Afghan women to examine their emotional health after birth, either in Afghanistan or after resettlement in other countries. This study aimed to explore and describe immigrant Afghan women's emotional well-being and experiences of depression after having a baby; and their use of health services particularly in relation to emotional health issues in the first few months following childbirth in Melbourne, Australia.

Methods

A mixed methods design was chosen for this study, using both quantitative and qualitative approaches (Liamputtong, 2013). Quantitative outcomes were elicited from a semi-structured questionnaire used in the telephone interview; qualitative data were drawn both from the telephone interview open-ended questions and face to face interviews.

Telephone interviews were conducted four months after the birth in women's preferred language (Dari/Persian or English) by one of the authors (TS), a bilingual researcher. A semi-structured questionnaire was used, including both closed and open-ended response alternatives. Women were asked about their emotional well-being and any experience of depression following the birth. The Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) – a 10-item self-report measure of depression specifically designed for the postnatal period – was included in the interview as a measure of probable depression in women as well as women's own descriptions of their emotional well-being since the birth. Women were asked about how they had been feeling since the birth, whether depression had been a problem for them, and about any possible contributing factors if they responded that they had been feeling depressed. Women were also asked about their use of health services since the birth. In addition, open-ended questions were used to explore women's views regarding their ability to talk to health professionals about their own health, particularly regarding their emotional health problems.

As safeguards need to be taken to ensure accurate and reliable translation of standardised instruments in cross-cultural research (Small et al., 1999), the EPDS was independently translated into Persian by two accredited professional translators, and independently back translated by two other professional translators (Sousa and Rojjanasrirat, 2011). The EPDS was also translated into Dari by an accredited professional translator. Translations of the EPDS were then reviewed and discussed by a group of professional translators, bilingual mothers from the community, and members of the research team; in order to address questions of accuracy and appropriateness of the translated items. There were problems identified with the translations of a few questions: some inconsistency in item response choices, and some literal or too formal translation of items, making the language inaccessible. After discussion, the best option, closest to the intention of the original English and using common and appropriate colloquial expression was agreed by the group. Piloting of the translated version of the EPDS was also undertaken (Sousa and Rojjanasrirat, 2011) to assess the quality of the translation and its acceptability to women.

The aim of this study was to explore women's experiences of depression. The study was small and exploratory, and was not designed to be a full validation of the EPDS nor to provide definitive answers to the question of the most appropriate cut-off score for the EPDS in our participant group. Previous research with immigrant women in Australia has found that non-English speaking women from different cultural backgrounds responded very similarly to the EPDS when compared with English-speaking women, suggesting no need to consider using different cut-off scores (Small et al., 2007). For this study, therefore, the generally recommended score of 13 or above was regarded as indicative of probable depression (Cox, 1983; Cox et al., 1987). When we first started the study, no study was identified assessing validity of a Persian (or Dari) version of the EPDS. However, subsequently a study evaluating the sensitivity, specificity, and positive likelihood ratio of the EPDS compared with a psychiatric diagnosis indicated the best cut-off score for major depression on the Persian version of the EPDS is 12/13 (Mazhari and Nakhaee, 2007).

In order to develop greater understanding of women's experiences, in-depth face-to-face interviews (Liamputtong, 2013) were also conducted nine to 15 months after birth, with a small number of women ($n=10$). Women were asked to choose the place of interview that would be most convenient for them and in all cases the woman's home was chosen. Interviews were conducted in women's preferred language (Dari/Persian or English). Interviews were tape recorded with women's permission and transcribed verbatim (Liamputtong, 2013).

Simple descriptive statistics were used to describe the background characteristics of participants, their emotional well-being and use of health services after birth.

Thematic analysis was undertaken for the open-ended questions in the telephone interviews and the face-to-face interview transcripts (Liamputtong, 2009). Analysis involved coding the interview transcripts, labelling words and phrases to examine and sort information according to particular topics (Green et al.,