

Understanding Experiences of Social Support as a Coping Resource among Immigrant Women
with Postpartum Depression: An Integrative Literature Review

by

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Abstract

The purpose of this project was to conduct an integrative literature review that explores experiences of social support as a coping resource among immigrant women with postpartum depression (PPD). Postcolonial feminism and Stewart's (1989) conceptualization of social support as a coping resource informed my review revealing contextual complexities and deepening comprehension of a determinant of health as well as a population that has historically been poorly understood. In applying Whittmore and Knafl's (2004) integrative literature review methods, I found 11 primary sources conducted in Canada, Australia, United States and Malaysia between 1999 and 2013. Data analysis revealed four themes and three coexisting issues illuminating contextual influences of poverty, gender, culture, abuse and trauma. The themes also emphasize the exchange of knowledge within trusting relationships as significant within the experience of a coping resource. Recommendations for practice are discussed within the advanced practice nurse's three spheres of influence (Fulton, 2010).

Key words: immigrant women, postpartum depression, social support, coping, postcolonial feminism

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Chapter One: Area of Interest

Introduction and Context

The purpose of this project was to conduct an integrative literature review that highlights experiences of social support as a coping resource among immigrant women with postpartum depression (PPD). My project was informed by a postcolonial feminist theoretical lens to facilitate awareness of power imbalances and health inequities that are “taken-for-granted [and] often invisible to us” (Anderson, 2000, p. 225). Miriam Stewart’s (1989) coping theory also informed my project by conceptualizing social support as a coping resource experienced by immigrant women with PPD.

My interest in current nursing knowledge involving immigrant women with PPD stems from my own career as a community health nurse where I have cared for immigrant women struggling with depression after birth, in the confines of their home. Working in the community has also fuelled my interest in understanding contextual complexities of how social determinants of health influence the mental health of immigrant mothers. Reflecting on my practice, many times I have found myself questioning whether I have understood immigrant mothers with PPD and how they experience social support as a coping resource. For example, in caring for a mother, Farah, who recently emigrated from Central Asia, it was evident she was enduring symptoms of mental health issues after having her fifth baby. Her prenatal care had been carried out within a prenatal clinic and her pregnancy was “uneventful” according to the communication

documents received. In caring for Farah within the community, I was unsure how much Farah understood her symptoms of postpartum depression and her need for help. Mental health was not a priority for her or her husband in spite of her emotional distress and lack of caring for herself. In addition, her strained finances, dependency on her husband for transportation and lack of friends and family made her care planning more complex. I was concerned that I was not understanding all of her needs. Through reflective dialogue with other nurses, I discovered many had felt this same concern in caring for immigrant mothers such as Farah. Sword et al. (2006) support this common concern among nurses in their study where they found social support needs of immigrant women with PPD were going unmet.

In exploring current literature, I was informed by postcolonial feminism's emphasis on contextual influence and discovered how experiences of immigrant mothers with mental health issues are shaped by low income, language constraints, lack of social support, and anxiety related to trauma (Bouris, Merry, Kebe, & Gagnon, 2012). The concept of social support has recently been explored in current literature revealing how immigrant women are particularly vulnerable to social isolation resulting from disrupted social relationships following migration (Simich, Beiser, Stewart, & Mwakarimba, 2005; Sword, Watt, & Krueger, 2006). The significance of social support among immigrant women dealing with PPD is highlighted in Ahmed, Stewart, Teng, Wahoush, and Gagnon's (2008) finding where women's capacities to cope postpartum were influenced by social support provided by their families and friends. In my quest to further understand social support, I discovered how current literature has identified social support as influential in coping with the demands of new motherhood and the stresses of feeling isolated and in crisis (Letourneau, Stewart, & Barnfather, 2004; Simich et al., 2005; Stewart, Simich,

Shizha, Makumbe, & Makwarimba, 2012). Coping became a significant concept within my exploration of the literature when I questioned where the knowledge we need could be found to develop a better understanding of social support experiences among immigrant women with PPD. This question led me to Miriam Stewart's (1989) conceptualization of social support through her theory of coping. Within her conceptualization, Stewart (1989) described social support as a coping resource. Coping resources involve interactions that bare support in the form of information exchanges, emotional and practical assistance, and encouragement (Stewart et al., 2001). It is through these conceptual linkages between immigrant women with PPD and social support, and social support as a coping resource, that I questioned what guides nursing practice in understanding social support experiences of immigrant women with PPD. How aware are nurses of the conceptualization of social support as a coping resource and how can this conceptualization be illuminated to enhance the understanding of immigrant women with PPD and their social support experiences? What current literature is available to nurses to understand immigrant women with PPD and their experiences of social support as a coping resource?

Statement of Research Problem

The significance of social support as a coping resource for immigrant women with PPD exposes the question: "What current knowledge is available to help nurses understand experiences of social support as a coping resource among immigrant women with PPD?" With the growing number of immigrants within Canadian demographics, it behoves us as health professionals to unearth and contribute knowledge that can advance our care and practice for vulnerable populations such as immigrant women with PPD. Through my project, I have illuminated the current state of literature exploring experiences of social support as a coping

resource among immigrant women with PPD, and have provided awareness needed to inform nurses in advancing their practice and offer direction for future research.

Significance of Inquiry

It is essential to note that my inquiry was informed by postcolonial feminist thought as viewed by Reimer Kirkham, Baumbusch, Schultz, and Anderson (2007), and stimulated my questions around how experiences of social support as a coping resource among immigrant women with PPD are represented within current knowledge. My philosophical orientation allowed for a deeper understanding of historically unheard voices of immigrant women with PPD and revealed their experiences of a domain that has also received little attention, social support. Being grounded in postcolonial colonial feminism changes how we understand immigrant women's experiences by delving deeper into analyzing contextual factors that influence those experiences. Further, my postcolonial feminist orientation informed my decision to further analyze the concept of social support and reveal experiences among immigrant women with PPD. In locating such experiences, I turned to Stewart's (1989) coping theory which complements the postcolonial feminist goal of illuminating voices of unheard populations. Stewart's (1989) coping theory unearthed the concept of social support as a coping resource, where experiences of informational exchanges, encouragement and assistance can be found (Stewart et al., 2001). With current literature emphasizing coping as influential in postpartum health (Letourneau et al., 2004; Simich et al., 2005; Stewart et al., 2012), I was informed by my philosophical and theoretical underpinnings to question what current literature is available to help nurses understand experiences of social support as a coping resource among immigrant women with PPD. The concepts of immigrant women, postpartum depression, immigrant

women with PPD, and social support as a social determinant of health and as a coping resource are significant to my inquiry and are discussed further within this section of my project.

Immigrant women. In defining the population for this literature review, I drew on O'Mahony, Donnelly, Raffin Bouchal, and Este's (2013) view where an 'immigrant' is "a person who has moved from his or her home country to take up permanent residence in a new country," (p. 300). Global migration is increasing at a profound rate. In fact, the current number of people migrating around the world has reached 214 million, the highest number in history (International Organization of Migration, 2012). The main influence of economic growth and pluralistic development in Canada's population is immigration. In fact, Canada will potentially have an estimated 11.1 million immigrants, 5.8 million of which will be women making up almost a third of the total number of females living in Canada (Chui, 2013).

If we look at the statistics in 2009, over a quarter million immigrants were admitted into Canada, 52% of whom were women (Chui, 2013). Immigrant women frequently come from countries where the role of a woman is viewed differently than in Canada. Some of these countries subjugate the role of women in their societies putting these women at an automatic disadvantage. The Canadian immigration system, however, does not seem to consider this disadvantaged state and perpetuates the power imbalance in their policies. Immigrant women enter into Canada under one of three types of status: Family Class, Refugee Class, and Economic Class (Chui, 2013). Those considered within refugee class are fleeing from actual or fear of maltreatment stemming from discrimination against their race, religion, ties to social groups and political beliefs (Immigration and Refugee of Canada, 2014). According to Chui (2013), women who are given refugee status reflect a smaller proportion of immigrants admitted into Canada

each year. Of the 52% of immigrant women who entered into Canada in 2009, 39% entered *as spouses or dependents* in the Economic Class, (Chui, 2013) indicating that most immigrant women rely on others for financial support. This creates a sense of power imbalance where immigrant women are automatically at an increased likelihood of experiencing vulnerability. This vulnerability can lead to unfortunate circumstances such as domestic abuse and oppressiveness.

Exacerbating the vulnerability of immigrant women is the issue of women living in oppressive environments within their home countries. Guruge and Humphreys (2009) cite how out of 24,000 women from 10 different countries, 15% to 71% experiences physical and/or sexual violence. Moreover, the authors found in their study that immigrant women facing violence stemming from unsafe living conditions face barriers in seeking social support. These findings contribute to the call for enhancing care for immigrant women who often are dealing with experiences of violence and in need of quality social support.

Immigration plays a critical role in Canada's diverse society that is socio-political and ethical in nature where creation of a strong economy, ensuring family integrity and assisting humans in need are key goals outlined within the Immigration and Refugee Protection Act as well as in the mission of Citizenship and Immigration of Canada (Government of Canada, 2013). In alignment with these goals, promoting the health of immigrant women should be a priority, however, contradiction exists where much of Canadian policy excludes emphasis on immigrant health (Beiser, 2005) and the contextual issues that influence their health. Moreover, the European roots within Canadian health care creates a context within which immigrant women face social challenges of being limited in opportunities and resources (O'Mahony et al., 2013).

This imbalance in power and inequity in health policy development has likely steered the focus away from immigrant health creating a profound need for research to enable more appropriate program development and care delivery standards for immigrant populations (Browne et al., 2012). The structural underresourcing for caring for vulnerable populations such as immigrants identified by Browne et al. (2012) might be somewhat mediated by creating new knowledge for healthcare providers to inform and enhance their practice with immigrant women dealing with postpartum depression.

Postpartum depression. The phrase ‘postpartum depression’ (PPD) is a Western conception that has been used within much of current literature (Morrow, Smith, Lai, & Jaswal, 2008), but is considered a global issue which the World Health Organization (WHO) addresses at length (O’Mahony et al., 2013). In Stewart, Robertson, Dennis, Grace and Wallington’s (2003) extensive literature review on PPD referred to by WHO’s Maternal Mental Health initiatives, PPD is defined as “an episode of non-psychotic depression according to standardized diagnostic criteria with onset within one year of childbirth,” (p. 2). The significance of inquiring into PPD is to address and prevent the distressing effect PPD has on maternal health and well-being that can be long-lasting and traumatic (Beck, 2008). Not only do mothers suffer, but so do their children and their families. In addition, Fung and Dennis (2010) cite how PPD is “the leading cause of nonobstetric hospitalization among women aged 18-44 years in the United States,” (p. 342). An abundance of literature has focussed on what factors can be identified as instigators of PPD. Stewart et al. (2003) found a consistent presence within the literature of poor social support as an identified, strong predictor of developing PPD. Stewart, Gagnon, Saucier, Wahoush and Dougherty (2008) discovered in their research that immigrant women with limited

social supports are at a higher risk for developing PPD than native-born women, which obliges researchers to inquire into the complexities of immigrant women with PPD.

Immigrant women with postpartum depression. From a perinatal care perspective, the lack of inquiry into healthcare delivery to immigrant mothers is concerning and impacts the quality and effectiveness of care provision (Alvi, Zaidi, Ammar, & Culbert, 2012; O'Mahony, Donnelly, Raffin, Bouchal, & Este, 2012; O'Mahony et al., 2013; Sword, et al., 2006;Zelkowitz et al., 2008). Awareness that despite poor overall postpartum health and limited social support, immigrant women can be hesitant to seek help is needed among healthcare professionals (Sword, et al.,2006). In addition, a growing concern has recently surfaced that immigrant women lacking social support are more at risk for becoming depressed in the postpartum period (Alvi et al., 2012; O'Mahony et al., 2012; O'Mahony et al., 2013; Stewart, et al., 2008; Sword et al., 2006; Zelkowitz et al., 2004; Zelkowitz et al., 2008). This concern justifies the need to explore what knowledge currently exists that can inform nurses in their care delivery to immigrant women with PPD. Viewing this exploration through a PCF lens will further magnify and uncover the voices of a population that has historically been overlooked.

Social determinants of health. The World Health Organization (WHO) guides my understanding of social determinants of health as being the contextual influencers woven within an individual's well-being (WHO, 2014). These influencers contribute to the social, economic, historical and political fabric people live within. Embedded within this fabric, complexities can be located where health inequities and power imbalances need to be revealed and better understood in order to enhance the quality of healthcare provision. I have chosen to deepen my

understanding of social support as the social determinant of health concept within my project to help reveal such experiences of immigrant women with PPD.

Social support. Social support is a domain that has been underexplored within research (Stewart, Anderson, Beiser, Mwakarimba, Neufeld, Simich, & Spitzer, 2008). The concept of social support is an influential social determinant of health that involves an individual's relationship with family, friends and communities and is linked to health promotion (WHO, 2014). Many nursing scholars identify the complexity of health determinants such as social support as poorly understood due to shallow efforts to conceptually understand each domain (Anderson, 2006, p. 8; Guruge & Khanlou, 2004). In my quest to understand social support experiences of immigrant mothers with PPD, I drew on Stewart (1989). Through Stewart's (1989) coping theory I conceptualized social support as a coping resource and revealed themes where voices of immigrant mothers with PPD can be located.

Social support as a coping resource. In assuming a postcolonial feminist lens to reveal the experiences of immigrant mothers with PPD, I further explored the domain of social support through a theory that explicated the concept of a coping resource. Stewart's (1989) conceptualization of social support as a coping resource involved "interactions with the natural network of spouses, family and friends, and with peers and professionals" (Stewart, Davidson, Meade, Hirth & Weld-Viscount, 2001, p. 192). Located within these supportive interactions are experiences of enhanced coping which need to be frequently assessed during times of stress and vulnerability in order to achieve deeper understanding (Stewart, 1989; Stewart et al., 2001). In applying Stewart's (1989) coping theory through a postcolonial feminist lens, I was informed to consider contextual complexities influencing the experiences of social support as a coping

resource among immigrant women with PPD. In the case example provided previously, Stewart's (1989) coping theory raises awareness of Farah's lack of resources where information could be located. Her previous postpartum experiences were in her homeland where she was surrounded by family which she turned to for such information sources, thereby enhancing her coping experience. Migration disrupted her natural social support network but cannot be seen as the only contributor to Farah's vulnerable support conditions. Considering the contextual complexities reveals how being dependant on her husband for finances, transport, informational, emotional and practical support, rendered Farah powerless. This power imbalance further intensified Farah's vulnerable state and disrupted coping resources while dealing with her diminishing mental well-being.

It is Stewart's (1989) conceptualization of social support as a coping resource viewed through a postcolonial feminist lens that sheds light on contextual connections seen within Farah's story where immigration, social support and coping intersect with her postpartum mental health well-being. The concern that immigrant women, such as Farah, are receiving care that inadequately addresses their mental health needs postpartum (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Sword et al., 2006) illuminates the problem that nursing practice is in need of guidance that increases the understanding of social support experiences among immigrant women with PPD.

In summary, my project addresses the changing demographics globally and the resulting health issues revealing the need for guidance to inform nursing practice. The integrative literature review assists in addressing these issues by exploring current knowledge of

understanding experiences of social support as a coping resource among immigrant women with PPD.

Project Objectives and Implications

Through conducting an integrative literature review underpinned by postcolonial feminism and Stewart's (1989) coping theory, I aimed to learn about what knowledge exists and generate transformative knowledge that informs nursing practice. Drawing on Reimer-Kirkham et al. (2007), transformative knowledge involves the inclusion of subjugated information translated into practical recommendations.

The objectives met within my project are as follows:

- To critically appraise current literature and reveal what is known about immigrant women facing PPD and their experiences of social support as a coping resource.
- To present themes embedded within the current state of knowledge that enhance understanding of experiences of social support as a coping resource among immigrant women with PPD
- To provide recommendations that inform nursing practice framed by Fulton's (2010) three spheres of influence: patient/client, nurse and nursing, and organizational/systems.
- To provide a postcolonial feminist perspective on understanding experiences of social support as a coping resource among immigrant women with PPD, a population that has historically been overlooked

As a result of attaining these objectives through my project, I anticipate my project may:

- Inform development and evaluation of programs for women with PPD that create supportive communities.
- Inform healthcare professional practice in enhancing awareness and equitable delivery of care to immigrant women with PPD.
- Stimulate further research into immigrant women with PPD using a postcolonial feminist lens

It is my hope that these anticipated implications will contribute to the current state of health care delivery to immigrant women with PPD.

Chapter Two: Approaching Inquiry

Conducting an integrative literature review illuminates existing knowledge and enhances quality of healthcare practice (LoBiondo-Wood, Haber, & Cameron, 2013). My project methodology was guided by Stewart's (1989) coping theory which emphasizes exchanges of information, emotional and practical help and encouragement. I approached Stewart's (1989) coping theory through a postcolonial feminist (PCF) lens as viewed by Reimer Kirkham, et al., (2007) that emphasizes understanding inequity and power imbalances influencing social support experiences. PCF is a relevant lens that gives voice to a population that has historically been a minority within Eurocentric societies such as Canada (Anderson & Reimer Kirkham, 1998). Moreover, PCF has guided my conceptualization of social support as a coping resource, a domain that has also been historically underexplored (Stewart, et al., 2008).

Theoretical Underpinnings

Coping theory. The broad concept of social support can be further understood through Stewart (1989) who sheds light on an unrecognized domain of healthcare provision where social support and coping interface. Through her coping theory, Stewart (1989) draws on Lazarus and Folkman's stress, appraisal and coping model that describes coping as relational and transactional. She further develops the interface between social support and coping within her theory by explicating the concept of coping resources within the determinant of social support. Coping resources are further clarified by Stewart et al. (2001) 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). I drew on this definition of social support as a coping resource within my literature review.

Postcolonial feminism. Understanding experiences of social support as a coping resource among immigrant women with PPD from a postcolonial feminism (PCF) theoretical perspective provided depth and illumination of an undervalued domain. The contemporary foundations of PCF provides a critical perspective that approaches information with the intent to give a voice to subjugated knowledge and move nursing scholarship forward. The central tenets of PCF contribute to illuminating the voices of subjugated populations and their healthcare experiences (Kirkham & Anderson, 2002).

The central tenets of PCF interwoven within my project are as follows: (a) the human experience of health is viewed beyond individual experiences and is rather embedded within the complexities of the social determinants of health (Kirkham & Anderson, 2002), (b) health

experiences can be understood through examining political, historical, social and economic contexts (Racine, 2003), (c) power imbalances exist within health systems and can be located through analyzing social determinants of health (Anderson, 2000; Anderson, 2006; Guruge & Khanlou, 2004; O'Mahony & Donnelly, 2010; Racine, 2003; Racine & Petrucka, 2011; Reimer-Kirkham & Anderson, 2012; Reimer-Kirkham, et al., 2007), (d) power imbalances and health inequalities can be remedied through developing transformative knowledge (Reimer Kirkham, et al., 2007), and (e) voices of minority populations such as immigrant women with PPD have been unheard within healthcare due to the Eurocentric context of Canada (Anderson & Reimer Kirkham, 1998). Therefore, inclusivity of voices is a central assumption of PCF.

Informing my project's methodology with these postcolonial feminist assumptions and coping theory principles revealed current nursing knowledge that explored experiences of social support as a coping resource among immigrant women with PPD. In revealing this knowledge, I was guided to look at literature where researchers considered contextual complexities that influence how social support as a coping resource is endured, thereby inquiring beyond the surface of an individual experience. Consequently, my project provided space for emergence of health inequities and power imbalances embedded within the experiences of social support as a coping resource among immigrant women with PPD.

Methodology

Within choosing the integrative literature review methodology, I utilized Whittmore and Knafel's (2005) inclusive methods that facilitate deeper understanding of concepts through allowing the use of both quantitative and qualitative research. The five methods in Whittmore

and Knafl's (2005) review process include: (1) problem identification; (2) literature search;(3) data evaluation; (4) data analysis; and (5) presentation of conclusions. In conducting these steps, PCF and Stewart's (1989) coping theory informed my identified research problem of needing to comprehensively understand and reveal health inequities and power imbalances within experiences of social support as a coping resource within a minority, non-Western population: immigrant women with PPD.

Methods

Problem identification. The research question that guided my literature review is: "What current knowledge is available to help nurses understand experiences of social support as a coping resource among immigrant women with PPD?" In reviewing current literature, my research question provides the boundaries necessary to reveal relevant primary studies within my literature search.

Literature search. Within this stage of my literature review, I used three search strategies to locate primary sources of research:

- a computer-assisted strategy;
- an ancestry approach to help locate earlier relevant literature where I assessed cited research from studies generated within the computer-assisted strategy(Cooper, 1984); and
- a "location-of-central-thinkers" approach, where I searched for the publications of central thinkers in the field of immigrant women with PPD. I looked for scholars

who have conducted research in my area of interest and found Dr. Anita Gagnon and Dr. Joyce O'Mahony as central thinkers on challenges faced by immigrant women.

After deciding on these approaches, I consulted with the University of Victoria librarian to ensure the databases I used were relevant to my identified problem and to ensure the search words I used were appropriate and inclusive of the concepts I was interested in capturing. The University of Victoria Library's databases that were relevant to my computer-assisted search included: the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Psych Info. Three dissertation databases were also searched including ProQuest Dissertations & Theses, Dissertations & Theses at the University of Victoria, and ProQuest Dissertations & Theses: UK & Ireland. The search words used reflect concepts within my research question and included:

- 'immigra*';
- 'refugee'
- 'wom*';
- “postpartum depression” OR “perinatal depression” OR “postnatal depression” ’;
- ‘ “social support” OR “coping” ’;and
- ‘experienc*’.

Application of search words. As advised by the librarian, I applied these terms within the subject terms of the articles found within the computer-assisted search to further refine my search. The words ‘immigra*’, and ‘wom*’ both captured the underpinnings of my postcolonial feminist theoretical foundation with the goal of revealing the concepts of unheard minority

voices and of gender. In applying inclusivity of PCF orientation, I also applied the word “refugee” to encompass the population of newcomers within my search. Surprisingly, no further literature was generated. Three different ways of wording PPD were used within my search words to capture the varying clinical terminology used globally. In addition, since I did not apply any publication limits to my search, the following question was raised: What historical language was used in researching postpartum depression? I found words such as ‘blues’, ‘psychoses’ and ‘psychiatric’ (Held & Rutherford, 2012). Applying these words in conjunction with the previously mentioned search terms, however, did not generate any further literature. A total of twelve primary sources and three dissertations were found in my computer-assisted search. I then moved onto applying inclusion and exclusion criterion to further refine current literature relevant to my research question.

Inclusion and exclusion criteria. In this section, I will outline what criteria I used to select articles to review. The literature I identified needed to have the following inclusion criteria: (a) peer-reviewed;(b) written in the English language;(c) available in full text; (d) primary source; (e) qualitative methodology that captures the voices of immigrant women; (f) immigrant mothers either formally diagnosed with PPD or enduring postpartum depressive symptoms at any point after giving birth; and (g) consideration of how social support as a coping resource was experienced by an immigrant women with PPD. No limits on publication dates were applied since inquiry into understanding immigrant women with PPD and their experiences is a growing area of global research. Exclusion criteria included literature that:(a) were not peer-reviewed; (b) were not written in the English language; (c) were unavailable in full text; (d) were secondary sources; (e) were quantitative in methodology; (f) sampled immigrant women who

were not diagnosed or did not experience depressive symptomology; (g) did not inquire in social support as a coping resource; and (h) was a dissertation where the researcher's findings were reflected in other primary sources that were authored by the same researcher.

Through the process of applying my inclusion-exclusion criteria I refined the twelve primary sources and three dissertations found in my computer-assisted search to a total of 6 primary sources. In applying my ancestry and central-thinker search strategies, I added five more primary sources to bring my total number of current literature to eleven studies. To show how I generated these eleven sources, I created a flow diagram that depicts my search steps (see Appendix B). These eleven studies would now be evaluated and analysed through my PCF lens, applying the central assumptions to guide my decision making and reflections. My next step was to determine rigor within these articles through evaluating the articles using a critical appraisal tool that appreciated criteria unique to qualitative research: credibility, auditability and fittingness (LoBiondo-Wood, Haber & Singh, 2013). Credibility is ensuring the truth is captured within research as defined by the participants who are immersed within their own experience. Transparency of findings with participants is one example of this criterion. Auditability is authenticating the thoughts of a researcher. For example, using field notes and explicating examples throughout each method used. And lastly, fittingness, clarifies transferability of a researcher's findings to the reader's practice.

Data evaluation. Whittmore and Knafl (2005) underline the significance of evaluating primary research for quality in a meaningful way. This involved incorporating the criteria used to approach rigor in qualitative research within my critical appraisal tool as well as ensuring

congruence of the tool with my postcolonial feminist orientation and coping theory concepts as defined by Stewart (1989). I thereby adapted and built upon Fossey, Harvey, McDermott and Davidson's (2002) appraisal tool that appreciated the credibility, auditability and fittingness of qualitative research. In addition, since Whitemore and Knafl (2005) advised using a quality scoring system during data evaluation, I also drew on the Joanna Briggs Institute's (2011) template for scoring literature. The appraisal tool that evolved from my adaptation ensured rigor through incorporating the three criteria of evaluating authenticity and through aligning with the qualitative methodology and postcolonial feminist tenets of inclusivity and revelation (see Appendix A).

In scoring each article, I determined how many 'Yes's' were determined versus 'No's' – 'Unclears'. None of the articles had a 'Not Applicable' score. Those with a higher score of 'Yes's' were viewed as more rigorous and contributed more within the data analysis stage through the relevance of their data to my research question (Whitmore & Knafl, 2005). In keeping with the postcolonial feminist tenet of inclusivity, I did not exclude any of the articles which is advised by Sandelowski and Barroso (2003) who contend that excluding articles based on inadequate reporting risks excluding potentially valuable knowledge. One article with low scoring and poor rigor contributed minimally within my data analysis, including only the documented words of the study participants. The principle of inclusivity within my PCF orientation informed my decision to not exclude low-scoring articles in order to capture the words and experiences of participants who voiced their stories. The process of assigning scores shed light on those articles that were more rigorous and were therefore influential in my results.

Data analysis. Whittmore and Knafl (2005) discuss analyzing data through the use of systematic steps that include data reduction, data display, and data comparison.

Data reduction. Within this section, I will explicate how data was extracted through subgrouping and predetermined conceptual classification which facilitated data analysis (Whittmore & Knafl, 2005). Conceptual classification consisted of developing questions through a PCF lens that addressed Stewart's (1989) conceptualization of social support as a coping resource. I will also discuss the next step in data reduction, constant comparison, where data was coded into systematic categories, thus creating the evolution of themes (Whittmore & Knafl, 2005).

Extraction of data from each of the eleven articles occurred through sub-grouping information according to methodology used, theoretical standing, study setting, participant characteristics, method used, geographical context, cultural context, and phenomena of interest. From these data extraction subgroups, I applied questions relevant to my research inquiry that aligned with postcolonial feminism which revealed embedded information on social support as a coping resource as viewed by Stewart's (1989) definition, and on coexisting issues reflecting contextual influences. These questions included (1) how do participants experience social support as a "coping resource" (Stewart, 1989, p.1276) 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, 2001, p. 192), and (2) what co-existing issues are apparent within participants experiences of social support as a coping resource. Through these questions, I looked for intersections where immigrant women with PPD were experiencing social support and power imbalances where these women were subjugated.

What were these intersections and why were these women subjugated? These questions also influenced the data I extracted.

According to Whittmore and Knafl (2005), data extracted through subgrouping and predetermined conceptual classification need to be compiled into a spreadsheet. Once I achieved this step and created a matrix of extracted data from all eleven articles, I continued on to the next step of constant comparison through coding.

In my quest for congruency within my review, I wanted to use a coding approach that aligned with qualitative methodology and found Cameron's (2013) explication of coding qualitative literature useful. Cameron (2013) cites three types of coding: descriptive, topic and analytic. I started off with descriptive coding which assists in keeping track of knowledge that is based on fact. In creating a spreadsheet, I kept track of each article through color coding, and extracted descriptive information from each article relative to the research question and to the relevant coexisting issues embedded within study findings.

Next, topic coding, the most commonly used coding approach, was conducted and consisted of reducing the descriptive data into topics in order to reveal patterns (Cameron, 2013). The process of reducing data into topics was guided by the foundations of Stewart's (1989) coping theory and postcolonial feminist lens which encouraged illumination of social support networks as well as power relations and inequitable healthcare provision.

Once topics were formed, I was ready for analytic coding which facilitates theme development through conceptualization of the data (Cameron, 2013). With the central tenets of postcolonial feminism and Stewart's (1989) coping theory informing my decision-making, I

assumed a reflective stance of expecting the unexpected and developed themes relative to how immigrant women with PPD experience social support as a coping resource. Remaining close to the words used within the data while discerning thematic words that captured the essence of each piece of data within a topic was essential to avoiding bias in my decision-making. Referring back to Stewart's (1989) coping theory as well as Stewart et al.'s (2001) discussion on social support as a coping resource, I ensured the themes I decided on involved immigrant women's experiences with their "natural network" (p. 192) and related to the theory's concepts of information exchanges, emotional and practice help, and encouragement. Moreover, I wanted to also ensure contextual issues that co-existed within the data were revealed and integrated into my data display, which is where I converted my data into a visual network and assisted my process of identifying relationships amongst my themes (see Appendix C).

Data display. Within this step of data analysis, visualization of conceptual relationships can be enhanced through converting data into a display (Whittmore & Knafl, 2005). I developed a color coded spreadsheet that helped me visualize the emergent relationships within each subgroup. This process of identifying patterns through a spreadsheet was useful in discovering relational patterns and themes.

Data comparison. "Creativity and critical analysis of data and data displays are key elements in data comparison" (Whittmore & Knafl, 2005, p. 551). The themes developed within the data display process evolved into a visual "floral" design of overlapping petals (themes) arched by the presence of co-existing issues. The display represented the embedded and interwoven nature of social support as a coping resource and reminds me of the data's emergence of coexisting issues. The "floral" design inspired reflection on appreciating deeply rooted contextual forces that

interplay with experiencing health. In addition, through my visual display I appreciated my stance of not knowing what to expect during my experience of revealing themes and coexisting issues that surfaced through my data analysis process. Moving from this interpretive stage of data analysis to a level of abstraction (Whittemore & Knafl, 2005) was my next step in understanding immigrant women with PPD and their experiences of social support as a coping resource. Advancing into a level of abstraction occurred throughout the data analysis process through forming conceptual relationships within key findings, methodologies and theoretical approaches.

Presentation of conclusions. Within this final stage of Whittemore and Knafl's (2005) integrative review process, the authors recommend explication of key features from each primary source. In presenting these features, I will review the geographical location and publication dates of the eleven studies I used in my literature review. This will give a contextual awareness of how the topic of immigrant women with PPD experiencing social support as a coping resource is being inquired into globally. I will also present the methodologies that were used in the eleven studies to increase awareness on approaches used to inquire into my research question. Lastly, I will provide a brief overview of each study's theoretical location, participant characteristics and key findings in table format.

Geographical location and publication dates. Seven of the eleven articles analyzed within this review were conducted in Canada, and two were carried out in Australia. One study was done in the United States, and one other was conducted in Malaysia. The date of publication for all eleven studies ranged between 1999 and 2013, indicating how young the area of inquiry is into experiences with social support as a coping resource among immigrant women with PPD.

Methodologies used. Within the eleven studies I explored, seven were guided by varying forms of ethnographic methodologies consisting of four critical ethnographies, one narrative ethnography, one focused ethnography, and one ethnonursing. One article was a case study, and one used a phenomenology approach. The remaining two studies did not make their research methodologies explicit other than stating they were using qualitative approaches to inquire into their questions.

In the following table, a brief review of all studies I used in my project outlines key findings related to my research question of understanding the experiences of social support as a coping resource among immigrant women with PPD.

Table 1

Brief Overview of Studies

Author(s) and Title	Theoretical Stance, Methodology/Method	Participant Characteristics	Key Findings
<p>O'Mahony, Donnelly, Raffin Bouchal, & Este. (2013).</p> <p>Cultural background and socioeconomic influence of immigrant and refugee women coping with PPD.</p>	<p>Postcolonial feminism</p> <p>Critical ethnography</p> <p>In depth interviews/semi-structured questionnaires influenced by Kleinman's explanatory model</p>	<p>30 non-European women living in Canada for <10years, 22 were immigrants and 8 were refugees</p> <p>>18 years of age</p> <p>EPDS¹ screening indicated a high risk for PPD within past five years or already formally diagnosed with PPD by physician</p>	<p>Immigrant and refugee women are influenced by culture and socioeconomics within their experiences of social support.</p> <p>Spirituality was also located within women's experiences.</p> <p>Exposure to violence and domestic abuse was revealed as an issue within women's experiences of social support.</p>
<p>¹EPDS 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).</p>			

<p>O'Mahony, Donnelly, Raffin Bouchal, & Este. (2012).</p> <p>Barriers and facilitators of social support for immigrants and refugee women coping with PPD.</p>	<p>Postcolonial feminism</p> <p>Critical ethnography</p> <p>In depth interviews/semi-structured questionnaires influenced by Kleinman's explanatory model</p>	<p>30 non-European women living in Canada for <10years, 22 were immigrants and 8 were refugees</p> <p>>18 years of age</p> <p>EPDS screening high risk for PPD within past 5 years</p>	<p>Social support networks influence well-being and can be either supportive or nonsupportive.</p> <p>Culture and socioeconomics influence the experience of social support.</p> <p>Relationships with health care providers are essential within the experience of social support.</p>
<p>O'Mahony & Donnelly. (2013).</p> <p>How does gender influence immigrant and refugee women's PPD help-seeking experiences?</p>	<p>Postcolonial feminism</p> <p>Critical ethnography</p> <p>In-depth interviews/ semi-structured questionnaires, and field notes</p>	<p>30 non-European women living in Canada for <10years, 22 were immigrants and 8 were refugees</p> <p>>18 years of age</p> <p>EPDS screening high risk for PPD within past 5 years</p>	<p>Immigrant and refugee women were found to experience many complex gender-related issues.</p> <p>Poverty, immigration status, discrimination, and poor spousal relationships influence women's experience of support.</p> <p>This study reveals the complexities of social, economic, and political influences on women's experiences of social support in coping with PPD.</p>
<p>Gagnon, Carnevale, Mehta, Rousseau, & Stewart. (2013).</p> <p>Developing population interventions with migrant women for maternal-child health: A focused ethnography.</p>	<p>Critical social justice</p> <p>Focused ethnography</p> <p>In-depth interviews and participant observation, and field notes</p> <p>Influenced by the Population Health Promotion Model developed by Public</p>	<p>16 international migrant women living in Canada for <8 years</p> <p>>27 years of age</p> <p>High psychosocial risk profile (low income, experienced</p>	<p>Migrant women drew on a range of coping resources experiencing a need for more education, creation of supportive environments and building healthy public policy.</p> <p>This study highlighted women experiencing social support through helping others, seeking information and advice, and withdrawing.</p>

	<p>Health Agency of Canada</p>	<p>violence, war or trauma from home country or abuse (physical or sexual) in last year)</p> <p>vulnerable = 4 months postpartum scored high on EPDS, and/or presented symptoms of depression/ anxiety/ somatization and/or symptoms of post-traumatic stress disorder</p>	
<p>Morrow, Smith, Lai, & Jaswal. (2008). Shifting landscapes: immigrant women and PPD.</p>	<p>‘Feminism’ Ethnographic narrative Semi structured interviews, and open-ended questions</p>	<p>18 immigrant women who have lived in Canada for 7 to 29 years >27 years of age</p> <p>Experienced PPD during perinatal period up to 1 year postpartum</p> <p>Either diagnosed with PPD or self-identified as having experienced depression after birth</p>	<p>Women’s experiences and expressions of PPD involved psychosocial stresses of migration experience, and adherence to societal and culturally influenced gender roles.</p> <p>The role of family and community within PPD experiences was salient.</p> <p>Help seeking found community health nurse and family members as key to support networks, however lack of information and awareness about PPD was experienced.</p> <p>The role of interpersonal relationships was significant within women’s experiences with social support in coping with PPD. Support for women needs to involve social, cultural and other</p>

			contextual factors.
<p>Nahas, Hillege, & Amasheh. (1999).</p> <p>Postpartum depression: The lived experiences of Middle Eastern migrant women in Australia.</p>	<p>Not made explicit</p> <p>Phenomenology - drawn from Colaizzi (1978) and Spiegelberg</p> <p>In-depth, unstructured interviews</p>	<p>45 immigrant women from Middle East living in Australia for last 5 years</p> <p>>19 years of age</p> <p>PPD experience and ability to articulate experience</p>	<p>Experience of loneliness due to feelings of isolation and lack of social support. Migration was a contributing factor to feeling separated from community.</p> <p>Feelings of helplessness due to inability to cope with the overwhelming task of fulfilling her traditional role as mother and wife.</p> <p>Endured fear of failure and being labeled a ‘bad mother’ by in-laws.</p> <p>Having insufficient knowledge about PPD and available support services.</p> <p>Coming to terms with PPD by undertaking diversional activities and learning new skills.</p> <p>This study raised awareness of culturally influenced gender issues within experience of social support.</p>
<p>Nahas & Amasheh. (1999).</p> <p>Culture care meanings and experiences of PPD among Jordanian Australian women: A transcultural study.</p>	<p>Leninger's theory of culture care diversity and universality was used as a conceptual and theoretical guide</p> <p>Ethnonursing</p> <p>OPR: observing, participating, reflecting: observing, interviewing and listening to women's experiences and reflecting on them</p>	<p>22 immigrant women from Jordan living in Australia;</p> <p>Diagnosed as suffering from PPD</p>	<p>Preserving cultural identity and culturally influenced gender issues are revealed within this study.</p> <p>Family support and sense of community are also within the women’s experiences of social support.</p>
<p>Ahmed, Stewart, Teng,</p>	<p>Theoretical stance not</p>	<p>10 immigrant</p>	<p>Social support as a coping</p>

<p>Wahoush, &Gagnon. (2008).</p> <p>Experiences of immigrant new mothers with symptoms of depression.</p>	<p>made explicit</p> <p>“Qualitative”</p> <p>Semi-structured, open-ended interviews</p>	<p>mothers</p> <p>>early 20s of age</p> <p>'Scored highly on [EPDS] at a 2-3 week postnatal visit'</p> <p>all had permanent relationships with fathers</p>	<p>resource was experienced through being with friends, partners, family, and community support groups.</p> <p>Experienced social support through a good relationship with a health care provider where space was given to discuss emotions facilitated coping.</p> <p>Experienced a need for advice and knowledge sharing on supports within community.</p>
<p>Khan, Hayati, Tahir, & Anwar. (2009).</p> <p>Role of the husband's knowledge and behaviour in postnatal depression: A case study of an immigrant Pakistani woman</p>	<p>Theoretical stance not made explicit</p> <p>Case study</p> <p>Face-to-face interview</p>	<p>Immigrant woman from Pakistan living in Penang (an island off of Malaysia)</p> <p>32 years old and married</p> <p>Symptoms self-reported of PPD on postpartum day 4</p> <p>Low income</p>	<p>Care and support traditionally received from family was not available due to migration.</p> <p>Husband had poor understanding and knowledge of PPD.</p> <p>This study emphasized the need for knowledge and information focused on the woman’s partner and/or family.</p>

<p>O'Mahony, Donnelly, Este, & Raffin Bouchal. (2012).</p> <p>Using critical ethnography to explore issues among immigrant & refugee women seeking help for PPD.</p>	<p>Critical social justice</p> <p>Critical ethnography</p> <p>In-depth critical ethnographic interviews, dialogic data generation, and field notes</p>	<p>30 immigrant and refugee women</p> <p>Have experience(d) PPD</p>	<p>Migration contributed to separation for sense of community.</p> <p>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.</p> <p>Experiences of social support was located within the need for information, within women's family values and within spiritual practices.</p> <p>Domestic abuse, immigration status, and poverty, influenced experiences with social support.</p>
<p>Callister, Beckstrand, & Corbett (2011)</p> <p>PPD and help-seeking behaviors in immigrant Hispanic women.</p>	<p>No theoretical stance made explicit</p> <p>Qualitative descriptive study</p> <p>Semi structured interview, and field notes</p>	<p>20 immigrant Hispanic women</p> <p>>17 years of age</p> <p>Scored positive for symptoms of PPD within one year postpartum</p>	<p>Some women did not recognize and/or denied their PPD symptoms attributing their sadness to financial concerns, family relationships, and/or work stressors.</p> <p>Experiences included cultural beliefs about emotional health, the perceived stigma of mental illness, and cultural beliefs about motherhood.</p> <p>Experiences with inadequate social support, lack of information, immigration causing separation, and low income were also found.</p> <p>Gender, culture and poverty issues were located within the experiences of social support.</p>

Chapter 3: Findings

This section of my project is dedicated to revealing and exploring emergent themes from my analysis of the eleven selected articles that address understanding experiences of social support as a coping resource among immigrant women with PPD. O'Mahony and Donnelly (2010) eloquently state that health care needs to explore "how inequity and unequal social power relations influence the distribution of health care resources and accessibility of health care services for women of marginalized social groups," (p. 442). This statement and the central tenets of postcolonial feminism and Stewart's (1989) coping theory will guide my exploration.

Themes

In looking at how the emergent themes within my project are represented within current literature, I reflected on how each of the eleven articles contributed to my research question. All articles were utilized, but found the following five articles had the most influence on the themes generated: O'Mahony et al. (2012), O'Mahony and Donnelly (2013), O'Mahony et al., (2013), Gagnon et al., (2013), and Nahas and Amasheh (1999). These articles were foundational to the development of themes highlighted in my project that reflect experiences of social support as a coping resource in immigrant women with PPD. Although a few articles scored higher in quality appraisal, they were not as useable with my concerning issue as I thought they would be. In looking at why this occurred, I found that although scoring high in quality and rigor, the articles did not explore participant experiences specific to social support as coping resources within their research questions. The one article, a case study, that scored the lowest in my critical appraisal

was drawn on minimally, but was still represented for its finding related to experiencing social support as a coping resource.

In presenting the findings within my review, I will discuss the four themes and one subtheme that emerged from my review and describe how they relate to my research question. The four themes drawn from the voices within the articles reviewed are as follows: maintaining cultural identity, connecting with community, relational space provided by health care providers, and seeking and exchanging knowledge. The subtheme, connecting with spirit, also developed through my analysis. Each theme extracted from the eleven studies I reviewed is grounded in postcolonial feminist thought and draws on Stewart's (1989) conceptualization of social support as a coping resource involving connecting with a network that is informative, emotionally and practically effective as well as provides affirmation (Stewart et al., 2001). This was accomplished through the conceptual classification process previously described where I developed questions that magnified the concepts within Stewart's (1989) notion of social support as well as paid attention to the intersectionalities and power imbalances being experienced.

Maintaining cultural identity. In seeking social support, researchers found immigrant women with PPD experienced practical and emotional help by leaning on their cultural traditions and beliefs. In doing so, these women seemed to preserve their sense of identity and empower themselves to engage with women of similar cultural beliefs. Some literature found that immigrant women primarily sought social support based on cultural background, beliefs and traditions (O'Mahony et al., 2013; Nahas & Amasheh, 1999). For example, traditions such as resting for a number of days in the house without leaving (Nahas & Amasheh, 1999) are seen as a valuable coping resource for some postpartum immigrant mothers. A few studies also found

that cultural centers set up for immigrant women with PPD created a network of women with similar cultural beliefs, facilitating emotional and practical support (Nahas, Hillege, & Amasheh, 1999; Nahas & Amasheh, 1999; Callister, Beckstrand, & Corbett, 2011). Interestingly, this theme also revealed how healthcare professionals need increased awareness on how stigma related to postpartum depression can be embedded within such cultural beliefs (O'Mahony, Donnelly, Este & Raffin Bouchal, 2012; O'Mahony et al., 2013). From a PCF standpoint, this leads me to think about the assumptions underpinning Western healthcare presume the diagnosis of postpartum depression is a recognized one which non-Western women and families should be familiar with. How do we know that the approaches taken in the West to manage PPD are suitable among immigrant women and families? How are current ways of providing care perpetuating stigma present among immigrant women with PPD and delimiting coping resources? It is the awareness of stigma being a strong embedded influence in the daily lives of immigrant women living with PPD that can spark such questions that stimulate the need to question our practice in care delivery.

With the literature identifying how maintaining cultural identity is a coping mechanism that has the potential to provide a natural network of individuals that can provide support, it is necessary to explore the potential negative effects due to cultural stigmatization of mental health issues. For example, clinics that offer social support groups for new immigrants emphasize physical changes in maternal and newborn health postpartum with significance placed on medical outcomes. Perhaps, this medical goal that is conveyed in pamphlets and websites could broaden to encompass the mental health aspect of postpartum adjustment, implying the importance of holistic healthcare. In reflecting on my own personal practice, as a nurse

delivering perinatal education, I had the experience of facilitating a group of new immigrant mothers and their families. However, the topic of PPD was challenging to carry, with silence filling the room as I posed open-ended questions on emotions and feelings of being supported. Are these silences a sign that the domain of mental health should not be approached in a group setting? Or are they a cue to create more discussion on an individual basis? I wonder if such silence is an indication for health professionals to frequently discuss and provide information to families on PPD rather than brush over mental health as an unspoken subject.

Exploring how culture interplays with gender in rendering immigrant women with PPD silent and stigmatized about their mental health concerns could deepen our understanding of their experience of social support as a coping resource. What power imbalances can be located within this intersection of culture and gender? Perhaps the power lies within the individuals who are the most connected to their cultural beliefs. This could be the elders of the immigrant woman's family, or the spouse, or it could even be the immigrant woman herself. What about health professionals, do our assessment skills and words we use with immigrant women create a power shift? Inquiring into cultural beliefs around mental health and stimulating dialogue is an area where health care professionals need to explore to understand the immigrant woman's experience further. In exploring culture, gender and stigma with immigrant women with PPD, I wonder what knowledge can be discovered pertaining to how maintaining cultural identity is experienced. The predominant assumption currently made in health care literature is how beneficial it is for culture to be preserved, but how authentic is this assumption? Much of the literature within my review did not make any in depth inquiry into the negative experiences of immigrant women maintaining culture while experiencing PPD. For example, how are

immigrant women with PPD coping with cultural expectations as well as societal expectations? Such inquiry could expand knowledge in the domain of maintaining cultural identity as a coping resource among immigrant women with PPD.

This theme also revealed inequity within migration policies which disrupts the maintenance of cultural identity through hindering the notion of family entering the immigrant woman's country of livelihood to provide the support needed (O'Mahony & Donnelly, 2013). This inequity in how our immigration system is structured devalues the cultural need for immigrant women to reach out to family from whom they have been disconnected, and who help sustain their tradition and beliefs. In other words, migration policies have managed to ignore the importance of family as a coping resource necessary to maintain cultural identity among immigrant women with PPD.

In summary, maintaining cultural identity is a theme within current literature that emphasizes the notion of beliefs and cultural traditions as a coping resource for immigrant women with PPD. In exploring this theme from a PCF standpoint, complexities were revealed in realizing that immigrant women with PPD may be challenged in balancing cultural and societal expectations. More inquiry is needed in understanding this experience to broaden our grasp on the well-being of immigrant women with PPD. In addition, the challenge of facing stigma embedded within cultural beliefs disempowers immigrant women from accessing coping resources. The reviewed studies published most recently reveal a need to understand how stigma can be embedded within cultural belief systems that can negate the experience of seeking social support to cope with PPD. Raising questions within current healthcare practice can create awareness on stigmatization of mental health issues. And lastly, structural inequities are present

within migration policies that narrow immigrant women's choices of coping resources, and devalue the significance of family, thereby diminishing her experience of social support and deteriorating well-being. Viewing these findings from a PCF perspective and incorporating Stewart's (1989) coping theory assists in locating where support lies and encourages critical exploration of areas that need further exploration and awareness due to lack of inquiry.

Connecting with a community. Within the experiences of social support as a coping resource among immigrant women with PPD, researchers found a strong need to connect with a sense of community. This community was predominantly defined as the woman's partner and/or family and were the primary resources immigrant women turned to for support postpartum (Ahmed et al., 2008; Callister et al., 2011; Gagnon, Carnevale, Mehta, Rousseau & Stewart, 2013; Khan, Hayati, Tahir & Anwar, 2009; Nahas & Amasheh, 1999; O'Mahony & Donnelly, 2013; O'Mahony et al., 2012; O'Mahony et al., 2012; O'Mahony et al., 2013). In the form of practical, emotional and financial support, the partner and/or family was found to be the most important social group for immigrant women with PPD to depend on (Callister et al., 2011; Nahas & Amasheh, 1999; O'Mahony & Donnelly, 2013). Awareness of the value immigrant women put on their partners and/or family is integral for health care providers in order to provide holistic, contextualized care. From a postcolonial feminist perspective, there also needs to be awareness of the immigrant woman's dependency on her partner and/or family creating an inequitable relationship where the immigrant women can be rendered powerless (Morrow et al., 2008; O'Mahony et al., 2013). The concept of dependency resonates within my PCF lens as it creates the power imbalance where immigrant women are rendered vulnerable to suppression, decreased confidence and abuse. From the literature, the origins and complexities of dependency

was touched on ranging from the political roots of migration status rendering immigrant women as ‘dependants’ (O’Mahony & Donnelly, 2013), to the economic roots of depending on spouses for money (O’Mahony et al., 2013; O’Mahony & Donnelly, 2013) and emotional dependence on spouses (Morrow et al., 2008). The complexity of dependency having cultural origins was not delved into within the literature and warrants further inquiry – what do we know of the cultural origins of spousal dependency? How do immigrant women experience spousal dependency? Understanding these questions could reveal deeper issues which immigrant women have not had a chance to voice. Resulting issues of potential exploitation and lowered self-esteem facilitated by spousal dependency was briefly explored (Morrow et al., 2008; O’Mahony & Donnelly, 2013) but in need of deeper inquiry. What are the experiences of immigrant women enduring abusive relationships as a result of spousal dependency? How do these relationships affect immigrant women’s experiences of PPD and their experiences of social support as a coping resource? These questions have the capacity to bare knowledge that lies hidden from healthcare and can deepen our awareness of what immigrant women are actually facing in their quest for well-being.

The experience of immigrant women with PPD needing to connect with a community to enhance well-being was a consistent theme within the literature. Assisting immigrant women in identifying and establishing relationships within a community which she can turn to can provide these women with a valuable source of information, emotional support and practical help.

Within this theme of coping through connecting with a community, the literature revealed the likelihood of immigrant women not having a sense of ‘natal family’ (Callister et al., 2011; Nahas & Amasheh, 1999; Ahmed et al., 2008) as being high due to immediate family being in their

countries of origin. Moreover, with partners needing to return to work and unavailable for emotional and/or practical support, the need for other females to provide this type of support is significant to coping with PPD (O'Mahony & Donnelly, 2013). What seems to be fundamental about this type of connection is the *established relationship* between the immigrant woman and the female(s) providing this support. Viewing this connection from a PCF perspective, the concept of intersectionality comes into play. Intersectionality within feminist scholarship can be defined as "a complex process by which people's positions of race, class, gender and sexuality...explains the multiple, complex dimensions of inequality and power structures that create roles of domination and subordination," (Rogers & Kelly, 2011, p. 399). Intersectionality sheds light on the various complexities within establishing a community a relationships involving migration intersecting with disruption of family and financial need/job security as well as with culture and tradition. It is considering these complexities and layers that can assist health care professionals in their approach to concepts needing to be understood and valued in working with immigrant women with PPD.

Connecting with spirit. A subtheme within the domain of connecting with a community was immigrant women connecting with themselves and with others through spiritual and religious beliefs. This spiritual connectedness provided a social support as a coping resource. O'Mahony et al., (2012), O'Mahony et al. (2013) and Gagnon et al. (2013) all identified how immigrant women with PPD rely on faith and spirituality within their experience of social support. Interestingly, spirituality seemed to also enable the experience of building of relationships as "a means for coping," (O'Mahony et al., 2013, p. 309). Being aware of the value spiritual connectedness brings to immigrant women with PPD is significant knowledge to carry forward

within the care planning and relationship-building in which health care professionals engage. While the literature emphasizes spirituality as a coping resource, little attention seems to be on how to understand the relationship between spirituality and well-being. What current knowledge is available for health professionals to enhance their practice in understanding the spiritual health of immigrant women with PPD? How do health professionals approach spiritual health with immigrant women? The domain of spirituality seems to be an underexplored area of health and wellbeing. Healthcare providers can enhance their understanding of spiritual health among immigrant women with PPD, however, knowledge is needed for health professionals to provide authentic, quality care.

Relational space imparted by health care providers. Health care providers have the unique opportunity to provide space to develop a trusting relationship. For example, Ahmed et al. (2008) identified how immigrant women with PPD appreciate experiencing the opportunity of being “able to talk to someone” (p. 299) about their experience. O’Mahony & Donnelly (2013) developed the idea of ‘talking to someone’ in their finding that the community health nurse was the most valuable coping resource for immigrant women with PPD. However, some researchers also found that space is not adequately given by other healthcare providers creating a power imbalance where immigrant women with PPD needing support are not given any opportunity to voice their emotional concerns (Callister et al., 2011; O’Mahony & Donnelly, 2013; O’Mahony et al., 2012; Ahmed et al., 2008; Morrow et al., 2008). The need to create space within appointments with healthcare providers to discuss emotional needs and have mental health concerns addressed was a clear message within the literature reviewed. This theme emphasizes attentiveness to the value of relationship building with immigrant women. Moreover, this theme

illuminates these women's positions of powerlessness in depending on health care providers for support. The relational space that health care providers impart within their interactions give immigrant women with PPD the power to communicate their need for information or emotional help within their experience of social support.

Seeking and Exchanging Knowledge. Acquiring information and knowledge was a consistent theme that emerged and contributed to understanding the experiences of social support among immigrant women with PPD. Coping resources that provided information and advice was viewed as valuable. For example, much of the reviewed literature found that advice and information that helped and affirmed their role as a mother was empowering to immigrant women with PPD (Ahmed et al., 2008; Callister et al., 2011; Gagnon et al., 2013; Nahas & Amasheh, 1999; O'Mahony et al., 2012; O'Mahony et al., 2013). Empowering immigrant women with information and knowledge can alleviate the powerlessness of being in a new role of motherhood within a new culture and environment. However, this makes me question the following: How do we really know if she has been empowered? Does giving information mean we have facilitated coping and empowered her? Callister et al. (2011) identified how most information given to immigrant women does not address perinatal mental health. Viewing this from a PCF lens, the power essentially shifts within the exchange and provision of knowledge towards the healthcare provider who, according to Callister et al. (2011), minimally provides the opportunity to discuss the emotional and mental health of the immigrant mother with PPD. The contextual complexity of cultural meanings of PPD and presence of stigma within these meanings, as discussed previously, further suggests the significance of health care providers creating space for open-ended questions, listening, valuing and exchanging knowledge. The

transactional nature of these interactions aligns with Stewart's (1989) conceptualization of social support as a coping resource where listening and valuing the knowledge and experiences of immigrant women with PPD are located. Awareness of this need for space to occur frequently during an immigrant woman's perinatal journey could be pivotal in her experience of seeking and exchanging knowledge as a coping resource. Within this space, healthcare providers have the opportunity to equalize power, shifting focus on what immigrant women with PPD want to explore and reveal within this space. Moreover, healthcare providers have the chance to inquire into how information is being provided in a culturally appropriate approach that considers traditions, beliefs, values, and language. From a PCF perspective, the awareness of how new immigrants with PPD may be excluded as a result of decreased literacy or misalignment of cultural values is significant to dissolving vulnerability. This awareness of space and provision of power to immigrant women with PPD may help diminish the "fear and mistrust" (O'Mahony et al., 2013, p. 306) that immigrant women with PPD experience within their interactions with healthcare providers.

Coexisting issues. In grounding my review in postcolonial feminism and Stewart's (1989) coping theory, I found it necessary to create awareness of relevant coexisting issues embedded within the reviewed literature to illuminate the contextual complexities which immigrant women with PPD face when experiencing support as a coping resource. Shedding light on coexisting issues aligns with the concept of intersectionality, as previously discussed. Intersectionality is significant to note within postcolonial feminist thought as it highlights the various concepts that coexist, revealing the extent of complexities present within understanding a population that has received little attention in current literature. The issues that resonated within the literature were

the experience of poverty, the experience of trauma and abuse, and the experience of concealing to maintain gender-driven role expectations. These issues need to be frequently considered and inquired into in order to deepen our understanding of social support experiences among immigrant women with PPD (Stewart, 1989).

Experience of poverty. The presence of poverty and low socioeconomic positioning was a significant coexisting issue located within the experience of social support among immigrant women with PPD. O'Mahony et al., (2012) found in their study how poverty was induced by their precarious immigration status and contributed to power imbalances among immigrant women. This power imbalance influenced the "limited support received" (p.721) and affected coping experiences. Morrow et al. (2008) also found low income as constraining to the experience of social support among immigrant women with PPD. Insecure employment and immigration status contributed to increased fear of partners losing income if they requested parental leave, leaving women with unmet emotional needs and limited choices in acquiring social support (Callister et al., 2011; Morrow et al., 2008; O'Mahony et al., 2012). Awareness of how poverty can exist within the experience of social support among immigrant women with PPD is significant in deepening our understanding of health and well-being needs.

Experience of trauma and abuse. It is significant to highlight trauma and abuse potentially experienced by immigrant women with PPD, a contextual factor mentioned within many of the studies I reviewed. O'Mahony et al. (2013) highlighted how the experience of trauma was positively reframed by many of their study participants allowing "growth and a stronger sense of control of their situation," (p. 309). This finding furthers our understanding of how a strength-based attitude facilitates resiliency which seems to be a coping resource in itself

allowing immigrant women with PPD to manage stressful conditions. Resiliency as a result of experiencing trauma is also highlighted in Gagnon et al.'s (2013) findings where immigrant women with PPD and histories of conflict and/or war induced trauma drew on their inner strength to maintain their health and cope with such adversity.

The findings of O'Mahony and Donnelly (2013) also address how the experience of violence in an immigrant woman's home country can affect dealing with family left behind who are continuing to experience trauma and in facing concerns of needing to return to an unsafe environment due to their uncertain immigration status. This uncertainty impacted the immigrant women in this study creating a sense of fear within experiences of social support. From a PCF lens, I am concerned with how this fear intensifies suppression of immigrant mothers voicing their mental health concerns. This enhances vulnerability and increases these women's feelings of powerlessness in wanting to cope with the overwhelming symptoms of PPD. As a result, it is my sense that acknowledging and valuing an immigrant mother's history and migration conditions through giving time and space to listen and learn about the unique circumstances she is enduring and the emotions associated would be beneficial in further understanding the experiences of social support as a coping resource. This inquiry would open up a relationship that shifts power toward immigrant women with PPD, promote interaction and prevent ignoring the influence of contextual issues such as historical trauma and/or violence that are woven into a woman's sense of being.

Another perspective within the literature discussed how enduring spousal abuse dampened immigrant women's experiences of support and exacerbated their limited opportunities of emotional and informational support (O'Mahony et al., 2012; O'Mahony et al.,

2012). The existence of power imbalance is evident within the experience of abuse where immigrant women experience limited coping resources. This emphasizes the importance of ongoing assessment and dialogue with immigrant women with PPD and their relationships with their partners. In addition, ongoing assessment of immigrant women and their relationships with other family members is an area that is not discussed within the literature. Experiencing abuse from other sources, such as family members, should not be overlooked and explored regularly. Unfortunately, this power imbalance extends further than an immigrant mother's spousal and family relationships and into her relationship with her health care providers. Immigrant women with PPD are dependent upon the assessment of their health care provider to inquire into their relationship issues. As discussed previously, assessment into emotional issues are minimal and commonly overlooked, resulting in further limitations in supportive opportunities. It is likely that health care providers themselves are also constrained by system restrictions as well, such as appointment times, volume of patients to assess, and clinical guidelines that are limited in trauma-informed care. Therefore, from a PCF lens, I can see how power imbalances extend beyond health care providers and into the health care system where the system controls the influence of abuse on the experiences of social support as a coping resource among immigrant women with PPD.

Concealing to maintain gender-driven role expectations. Related to the theme of maintaining cultural identity is the issue of gender-driven role expectations that resonated in much of the reviewed literature. Immigrant women with PPD experienced social support as a coping resource through drawing on the notion of being a successful mother as defined by their cultural traditions. For instance, O'Mahony and Donnelly (2013) found that immigrant women

with PPD tend to hide their true feelings, coping with their mental health issues through concealment in order to maintain gender-driven role expectations. Morrow et al. (2008) and Callister et al. (2011) found similar results within their studies where immigrant women were hesitant to seek social support, feeling guilty and embarrassed about their depressive symptoms. Other studies also reported immigrant women with PPD endure a fear of failure in their role of a mother and show their ability to cope through not expressing any challenges they may be experiencing (Nahas & Amasheh, 1999; Nahas et al., 1999). More recently, Gagnon et al. (2012) discovered immigrant women with PPD cope by withdrawing with the hope of dealing with difficulties on their own. What the literature did not address is exploring how social support as coping resources can address the experience of concealing among immigrant women with PPD? Addressing this line of inquiry could steer current support structures in the direction that aligns with what immigrant women are enduring as a result of the interplay between culture, gender, and the experience of PPD.

Recommendations for Practice

As community health nurses, it is our unique role to discover contextual influencers within the well-being of vulnerable mothers such as immigrant women with PPD. The social determinants of health guide our practice and inform our assessment. How can research, such as my literature review that summarizes current studies on the experiences of social support as a coping resource among immigrant women with PPD, inform my own practice as a community health nurse? My theoretical underpinnings guide my choice in establishing my recommendations for practice within Fulton's (2010) advanced practice nursing framework which exhibits the three areas where nurses have the ability to create awareness and illuminate

the vulnerable voices of immigrant women with PPD. Fulton's (2010) three spheres of influence, (patient/client sphere, nurses and nursing practice sphere, and the organizations/system sphere) reveals domains where nurses can be influential and thereby guides how my practice can be informed and/or transformed by the knowledge generated within my project.

Patient/client sphere of influence

My goal as a public health nurse is to understand the uniqueness of an immigrant mother with PPD and the contextual realities that influence her well-being. This goal stems from viewing my practice through a PCF lens and drawing on Stewart's (1989) coping theory, stimulating me to question how we, as public health nurses, seek to understand immigrant women with PPD. How are we approaching these women who are prone to concealing their mental health concerns but are in need of supportive interactions in the form of emotional encouragement and informational exchanges with health professionals (Stewart et al., 2001)?

Within my own clinical practice, I can be guided by the themes generated through my literature review in wanting to understand what PPD means to immigrant women. My increased awareness of cultural stigma being attached to PPD and mental health issues encourages me to look at ways of relating with immigrant women on their perceptions and knowledge base. This approach can occur through creating space for establishing trust that allows the mother to guide the process of revealing-concealing information. This may unfold as having quiet moments with a mother as she breastfeeds her baby. These quiet moments are an opportunity for nurses to provide social support as a coping resource through emotional encouragement and through being

present, ready to listen and hear what a mother wants to discuss. Incorporating this unstructured time into clinical appointments values the need for immigrant mothers to receive reassurance and to seek information at their own pace. Clinical appointment times are valuable in gaining knowledge through codiscovery. My understanding that has developed through my review also encompasses intersectionality which can underpin questions healthcare professionals ask during clinical appointments. Approaching the interplay of concepts such as culture and gender on well-being and motherhood through open ended questions can create space for understanding. Such questions can open up dialogue which will allow for codiscovery of issues important to that individual and/or family. Creating this space for codiscovery can also be facilitated by developing a trusting relationship. Allowing for the development of a reliable relationship early on in an immigrant woman's perinatal journey that is grounded in trust and provides the mother with decision-making power is a recommendation that is informed by PCF tenets and Stewart's (1989) coping theory where information transactions occur at the lead of the mother.

Through enhancing my relational practice and attending to immigrant women, allowing for space where unearthing of issues can take place under the direction of the mother creates the opportunity to discover and understand. In fact, through a PCF and coping theory (Stewart, 1989) lens, public health nurses have a chance to question ways of being facilitators of revealing the unique social networks that enhance the experience of social support as a coping resource. I am informed by my literature review to integrate exploration on the meaning of family post-migration, and how this family is a source of social support as a coping resource. From a PCF perspective, this would entail exploring the complex intersections an immigrant woman with PPD is experiencing. Approaching how family intersects with culture, gender and historical

social traditions could bring to surface complex issues that are impacting an immigrant woman's well-being. Being aware of the interconnection within such contextual influencers and focusing on how they interplay rather than how they are experienced individually could bring more understanding of how family is experienced for immigrant women with PPD.

In sum, assessments need to expand to incorporate the interplay of social support with culturally-influenced gender expectations, spiritual and cultural values unique to each woman, socioeconomic status, and experiences of migration. In doing so, health professionals would be able to gain better understandings of the complex experiences of social support among immigrant women with PPD.

Nurses and nursing sphere of influence

As a nurse, I am informed by my PCF and coping theory (Stewart, 1989) lenses to illuminate the experiences of social support as a coping resource among immigrant women with PPD as valuable knowledge that will enhance nursing care. How can I increase awareness of the themes generated from my literature review? How can these themes be applied to the community context of nursing?

Within my interactions with community health nursing peers, I am inspired through knowledge generated in my project to encourage dialogue on cases related to social support needs of immigrant women. Exploring how information exchanges can occur within immigrant women who conceal to meet gender-driven expectations or endure domestic abuse and are more limited in their options would create an opportunity for inquiring with my peers into current models of care. Increased awareness of the significance of social support experiences among

immigrant women with PPD as well as increased recognition of the unique contextual circumstances that increase vulnerability and diminish the health of immigrant women would be goals of my peer interactions. In engaging in dialogic reflection with my peers, discussion on creating relational space to enhance trust and openness with immigrant women with PPD can be achieved.

Stimulating curiosity among my peers has been inspired by the knowledge generated within my project where questions still exist. How can our current practice improve to better understand the experiences of social support among immigrant women with PPD? How can we evaluate our current model of care delivery in the community to ensure we are connecting immigrant women with PPD to a sense of community structures? I propose revisiting decision support tools where assessments are compartmentalized and catalogued in a systemic fashion, trifling through considering social support as a coping resource and through the importance of investing in relational practice. Depth within our clinical practice guidelines as to how to assess social supports as coping resources among immigrant women with PPD would give more specific direction to perinatal nurses in their decision-making and caregiving. This may be achieved through knowledge translation initiatives that facilitate the influence of current evidence on assessment tools. For example, looking at the current model of public health nursing postpartum and identifying how space is being created to promote relational practice among immigrant women with PPD can allow for revealing the need to integrate and/or build upon the current state of valuing relationships as a coping resource. Lastly, encouraging inquiry and discussion with peers can inspire the need to add to our current knowledge base through continued research. For example, looking at how comfortable nurses feel in assessing the

interplay of spirituality, culture, gender-roles, power imbalances, and creating relational space, can stimulate thought and inspire illumination of current knowledge or creation of new knowledge. Assessment that incorporates the language of such intersectionality can be made more explicit within educational tools and thereby increase awareness of the value of intersectional thought and advancing nursing practice.

Organizations/system sphere of influence

Within this sphere, I am guided by my PCF and coping theory (1989) orientation to question inequities present within our current health system that devalue and neglect the experiences of social support as a coping resource among immigrant women with PPD. Questioning these inequities leads to inquiring into how health systems are overlooking the role of public health nurses and the supportive resources they need to provide quality care to vulnerable populations. In doing so, I draw attention to the processes that guide nurses in their decision-making and delivery of care and what is missing within these processes that inadvertently suppress the experiences of contextual influencers on the well-being of immigrant mothers.

Structural inequities are present within our current health system that can be questioned and highlighted. My hope is to speak of the experiences of social support as a coping resource among immigrant women with PPD as discovered through my literature review at venues where immigration is discussed and where the health of vulnerable populations are explored. This may be at conferences, webinars or within a team meeting of health leaders and decision-makers.

Integrating stories of immigrant women with PPD within these speaking opportunities would give a voice to this population that historically has been overlooked.

Questioning processes in place, such as the Perinatal Services BC postpartum nursing care pathway, can create awareness of gaps that are suppressing understanding experiences of social support as coping resources among immigrant women with PPD. For example, integrating experiences of poverty, culture, gender, abuse and trauma into “variances” to assess within a psychosocial assessment would provide a holistic approach to understanding immigrant women with PPD. In addition, reviewing how the concept of relational practice can be enhanced and made more explicit within nursing care pathways would give the opportunity for nurses to further develop their relational skills.

Engaging with community stakeholders and creating partnerships with agencies that focus on mental health issues and women’s health would speak to the PCF tenet of inclusivity and working across disciplines. In collaborating with organizations beyond our own, creative solutions and information sharing can result.

Lastly, inquiring into how immigrant women who have experienced PPD can have a voice within decisions affecting their health system could provide an empowering strategy for these women to influence change. For example, some health authorities have portfolios dedicated to engaging the community in decision-making dialogue impacting “conditions that influence the health of communities and contribute to better health” (Fraser Health, 2009). How are the voices of vulnerable populations such as immigrant women with PPD being represented? How are the interplay of cultural traditions, gender expectations and mental health issues being

discussed and represented at such decision-making venues? Non-health venues also need to be considered as forums where we can advocate for the health of immigrant women through influencing policies related to immigration, social justice, and resource distribution. Becoming aware and involved in the political arena through committees such as the Standing Committee on Citizenship and Immigration or non-profit organizations such as the Canadian Forum on Civil Justice can provide a forum for influencing policy-making and research on immigrant women's health.

The lack of awareness and inquiry into a complex population that is growing globally makes it necessary to shed light on experiences of immigrant women with PPD. With social support being a health determinant influenced by the social, economic, historical and political context of women, it is essential to explore with health leaders how health systems can improve in delivering more equitable and evidence-based care.

Future Directions for Research

It is clear through this literature review that research is limited in the domain of understanding experiences of social support as a coping resource among immigrant women with PPD. Deepening our understanding of concepts within the health determinant of social support will contribute to nursing knowledge and care delivery. Adding to the qualitative domain of understanding immigrant women through more research that illuminates their voices would contribute to the current limited state of knowledge and further inform health care delivery practice. In addition, the need for more inquiry into experiences within intersecting concepts would enrich and reveal issues that are being overlooked. For example, Gagnon et al. (2013)

allude to how immigrant women with PPD are more resilient than given credit for, even with added issues of experiencing trauma and violence. How mental health issues compound the resiliency of these women enduring trauma and violence would assist in generating new knowledge and advancing care plans that contribute to sustainable well-being.

Another interplay that needs to be further inquired into is how the concept of family intersects with an immigrant woman's sense of culture, gender and well-being. Approaching inquiry from a PCF lens could reveal power imbalances and hierarchies that have been not yet been discovered. The significance of needing healthy, equitable relationships in the experience of PPD among immigrant women supports more study to deepen our understanding of inequities that are present.

Lastly, my review focused on the postpartum phase of an immigrant woman's perinatal journey. Expanding research to inquire into prenatal experiences of social support among immigrant women who are enduring or at risk for PPD and how interactions with natural social networks can be fostered would develop the domain of understanding this population further.

Project Limitations and Challenges

As mentioned, the current state of knowledge regarding experiences of social support as a coping resource among immigrant women with PPD is limited. This limitation kept my review to eleven primary sources of which most were grounded in postcolonial feminist thought. Efforts were made throughout to ensure each stage in the process was grounded in approaches that aligned with my theoretical perspective and methodology. However, as Whitemore and Knafl (2005) explain, the area of data analysis with integrative reviews is underdeveloped and

can contain errors. Within my search words, I could have missed language that is used in other cultures or historically used when PPD was not a clear experience. In selecting a qualitative research appraisal tool, I found I needed to craft one that tailored to my PCF orientation. The consequence of doing so may have limited the areas I critiqued. However, I am satisfied that, in keeping with my orientation, I was able to draw on all articles in varying ways guided by my philosophical and theoretical assumptions and my research question. What I learned in this process is that the score an article may receive within appraisal, does not always reflect the amount that article is used. The complex layers of the assumptions used and research question concepts also heavily influence the capacity an article will contribute to a literature review. As mentioned previously within my data analysis, I kept a self-reflexive position of expecting the unexpected and documenting my thoughts throughout to monitor my thoughts and decision. There were times where I had to step back from my project to truly appreciate what was unfolding. For example, the concept of intersectionality was not one that I had initially considered and appreciated its value toward the end of my project. The area of social support was also broad, and I did not realize initially how I needed to refine what element within social support resonated for me. This project, thus, reflects what resonated for me and in my experiences. Future thought and study is necessary on other elements that lie within the domain of social support to fully grasp this health determinant. In extracting data from the articles on social support as a coping resource, I noticed how literature also used social support as a broad term and did not explicate the concept to explore its realms. The embedded nature of social support as a coping resource also posed a challenge and necessitated clarity in my inquiry.

Referring back to my research question and reflecting on the concepts became continuous and allowed me to understand my own inquiry further.

In embracing the notion of inclusivity as part of my PCF lens, I did not exclude any of the articles found. Sandelowski and Barroso (2003) support such inclusivity contending that excluding articles based on inadequate reporting risks excluding potentially valuable knowledge. However, in doing so, I am limiting the rigor within my findings in including the one article that scored poorly, affecting the credibility, auditability and fittingness of my own results.

The philosophical orientation of PCF has been of interest to me since I first started my Masters of Advanced Practice Nursing Leadership program. However, it was during my project that I furthered my understanding of PCF and the lens that assists in discovery and analysis of overlooked concepts and people. Being and staying within this lens was a challenge and a part of my learning process. In continuing this learning, I have challenged myself to practice viewing everyday activities and discussions, or current events and happenings, from a PCF lens to continue my journey of revealing and understanding current disparities and those who are underrepresented.

Conclusion

The themes that emerged from this integrative literature review reflect the current state of knowledge from postcolonial feminist and coping theory (Stewart, (1989) perspectives on understanding experiences of social support as a coping resource among immigrant women with postpartum depression. Through a postcolonial feminist lens, I drew on Stewart's (1989) coping theory and conceptualized social support as a health determinant that involves coping as a

resource that reveals transaction of knowledge and provision of encouragement, emotional help and practical assistance. Further, PCF draws attention to the intersectionality of social support as a coping resource and the culture, gender and well-being of immigrant women with PPD. My review adds to viewing PPD as experienced by immigrant women from a perspective that illuminates the complexities of a population that has historically been unheard and emphasizes the area of social support as a coping resource, which has historically been underexplored. In addition, this review adds an interconnected set of themes that I have displayed in a framework that highlights the need for more knowledge transactions, the need to consider cultural identity, the need to reflect on connecting with a community and the significance of trusting relationships with health professional where space for dialogue can develop. These themes are overarched by noteworthy co-existing issues contextually influencing the experiences of immigrant women: the concept of gender-driven roles, the experience of poverty and the experience of trauma and abuse. The themes that emerged contribute to the current state of knowledge through informing advanced nursing practice within three spheres of influence adding awareness to further our understanding of social support experiences among immigrant women with PPD.

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Appendix A

Qualitative Research Appraisal Tool

Article Title: _____

Author(s): _____ Year of publication _____

Journal title: _____

Criteria	Considerations	Yes	No	Unclear	Not Applicable	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 (eg: were participants involved in documenting, checking or analysing 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					

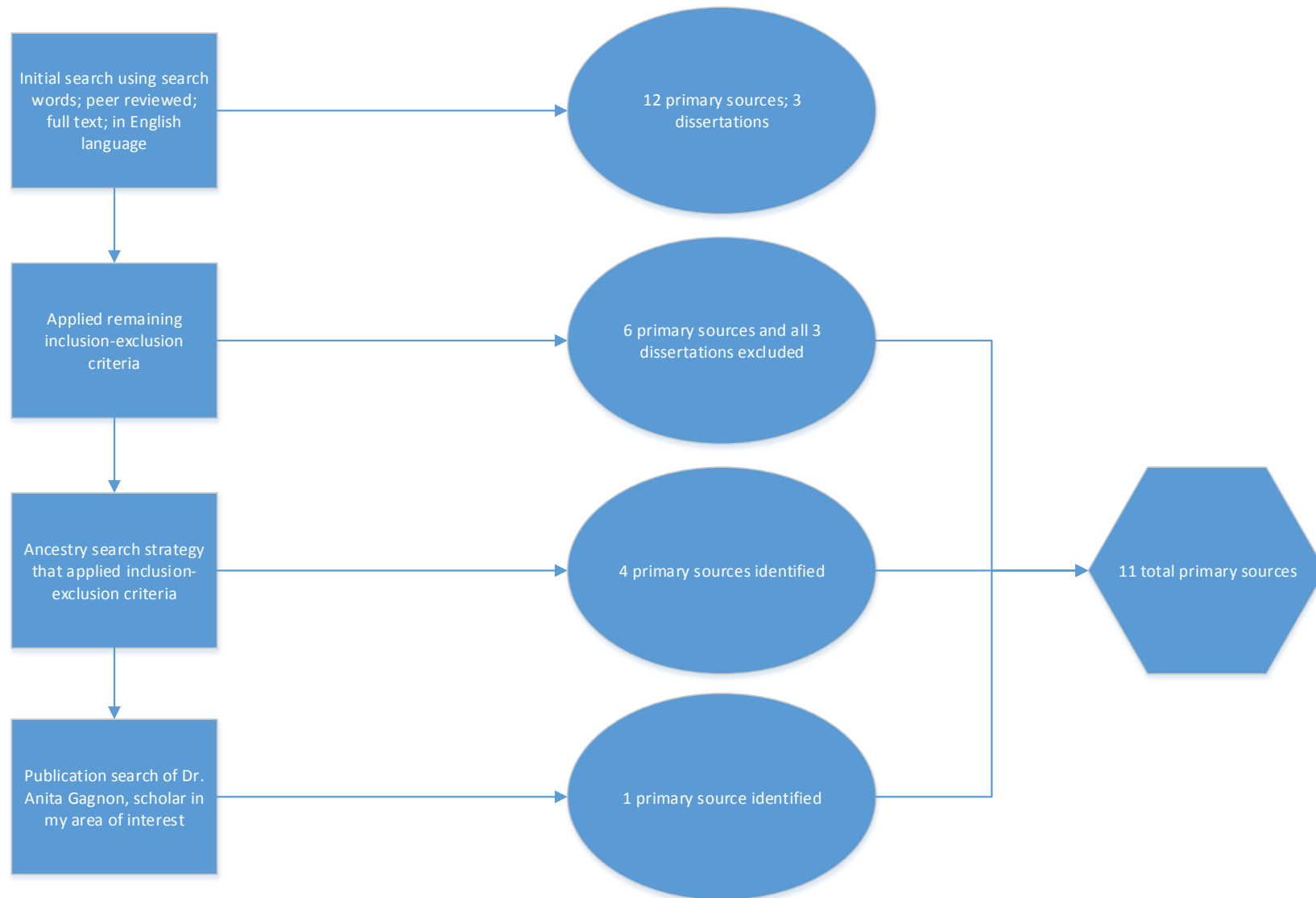
	flow from the analysis, or interpretation, of the data					
	Themes are drawn and transformed to reconceptualise phenomenon being studied					
	Depth is achieved through explaining experiences rather than through listing and labeling themes					
	Summary of findings:					

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 doi:10.1177/

Appendix B
Flow Chart of Literature Search Process



Appendix C – Data Display

