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Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective

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Abstract
Canada has one of the world's largest refugee resettlement programs in the world. Just over 48 percent of Canadian refugees are women, with many of them of childbearing age and pregnant. Refugee and asylum-seeking women in Canada face a five times greater risk of developing postpartum depression than Canadian-born women. Mainstream psychological approaches to postpartum depression emphasize individual-level risk factors (e.g. hormones, thoughts, emotions) and individualized treatments (e.g. psychotherapy, medication). This conceptualization is problematic when applied to refugee and asylum-seeking women because it fails to acknowledge the migrant experience and the unique set of circumstances from which these women have come. The present theoretical article explores some of the consequences of applying this psychiatric label to the distress experienced by refugee and asylum-seeking women and presents an alternative way of conceptualizing and alleviating this distress.

Keywords
Asylum-seekers, critical perspectives, postpartum depression, refugees

Canada has one of the world's largest refugee resettlement programs in the world (Citizenship and Immigration Canada (CIC, 2013), and current public policy is such that Canada will continue to receive a significant number of refugees yearly (CIC, 2013). According to CIC (2013), women account for 50 percent of refugees and asylum-seekers

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in Canada, a proportion that is steadily increasing. Many of these women are of childbearing age (Wilson-Mitchell, 2008) and pregnant (Caulford and D'Andrade, 2012). Despite the cultural positioning of motherhood as a largely joyous and rewarding experience (e.g. Bobel, 2002; Choi et al., 2005; Nicolson, 1998), many women experience uncertainty and distress during the postpartum period that ranges from mild to debilitating (Driscoll, 2006; O'Hara and Swain, 1996). Postpartum depression (PPD) was established as a psychiatric condition in order to account for this distress in new mothers (American Psychiatric Association, 2000; World Health Organization, 1992). Refugee and asylum-seeking women in Canada face a five times greater risk of developing PPD than Canadian-born women (Stewart et al., 2008). While the etiology of PPD is not well understood, individual biological (e.g. hormones) and psychological factors (e.g. thoughts and emotions) are emphasized within the field of psychology (e.g. Beck, 2001; O'Hara and Swain, 1996; Robertson et al., 2004; Sword et al., 2012). And while studies on PPD in refugee and asylum-seeking women cite stressful life events as factors in the development of this disorder (Collins et al., 2011), the focus is on the *woman's reactions* to such events, often in the form of psychiatric symptoms (e.g. low mood), rather than on the events themselves. An individualized approach to PPD in these women fails to acknowledge this crucial experience of migration to Canada, a unique set of circumstances from which these women have come, and their settlement experience in Canada. Accordingly, any individualized approach to these women's distress de-emphasizes both past and present traumatic experiences linked to the woman's status as a refugee or asylum-seeker. We argue that focusing on individual symptoms (i.e. low mood, fatigue) that stem from traumatic events, while neglecting the social, political, and economic context of these symptoms (e.g. poverty or discrimination when trying to access health care in the host country), is problematic. Focusing on the individual woman's psychopathology promotes the development and dissemination of individually focused solutions (e.g. psychotherapy, medication), which may further disempower and marginalize these women.

Many refugee and asylum-seeking women are exposed to extensive trauma in their country of origin in the form of ethnic or religious persecution, rape, torture, mutilation, sexual slavery, coercion, and/or deprivation and have witnessed the torture and deaths of loved ones (e.g., Allotey 1998; Gagnon and Tuck, 2004; Kennedy and Murphy-Lawless, 2003; Nahas et al., 1999; Zimmermann et al., 2010). In addition, women are often exposed to traumatic events during forced migration in the form of rape, sexual abuse, or in granting sexual favors for food, protection, or migration papers. These women may have been forced to leave family, including children, behind or may have been separated from them during the process of fleeing (McLeish, 2005; Zelkowitz et al., 2008). These experiences may be compounded by insecurity and uncertainty about the future once they have arrived in Canada, difficulties adapting to a new culture, and social marginalization due to language difficulties and discrimination (Carballo et al., 1996; Irvine, 2011). In their post-migration experience, the discrepancies between their life as a refugee and their life as a citizen reflect social, historical, political, and economic factors. The loss of identity, status, and material resources that is associated with the transition from being a citizen to becoming a refugee is significant and greatly impacted by the receiving country's welcome. Recent public policy changes in Canada may be contributing to a reduced welcome; whereas Canada once emphasized and prioritized the

protection of refugees from hardship (e.g. in the 1970s and 1980s), the emphasis has increasingly been on the protection of Canadian citizens and institutions *from* refugees (e.g. from the 1990s onwards; Irvine, 2011). The June 2012 passing of federal Bill C-31, Protecting Canada's Immigration System Act, gave the federal government greater control over refugee claimants, including increased powers to deport, delay, or deny medical care and deny appeals (Library of Parliament, 2012).

Adopting a critical health psychology framework (Christodoulou, 2010; Crossley, 2001a, 2001b, 2008), this article describes the Canadian context of refugee and asylum-seeking women, problematizing current dominant psychological conceptualizations of PPD and offering an alternative paradigm for understanding and addressing this problem, including the promising role of midwives as an illustrative example. Emphasis on the sociocultural, economic, and political contributors to these women's perinatal distress may facilitate development of socially located, rather than mainly individualized, solutions. Midwifery has demonstrated effectiveness in managing complex sociocultural needs of new immigrant and refugee women, including navigation through the health care system, case management, and advocacy (Wilson-Mitchell, 2013).

PPD in refugee and asylum-seeking women

Most research on the prevalence of PPD has been conducted with non-immigrant women in Western countries, and most studies on PPD in immigrant women fail to distinguish between refugees and other types of immigrants in their analyses (e.g. Collins et al., 2011; Sword et al., 2006; Zelkowitz et al., 2008).

The few studies with immigrant subgroup analyses have found significantly higher rates of PPD in refugee and asylum-seeking women than in other types of newcomers (e.g. Mechakra-Tahiri et al., 2007). In a Canadian study comparing PPD rates in refugees, non-refugee immigrants, asylum-seekers, and Canadian-born mothers, all groups were significantly more likely to have PPD than Canadian-born mothers, and refugee women had the greatest risk (five times greater) compared to Canadian-born women (Stewart et al., 2008).

Theoretical and epistemological perspective

It is prudent for both clinicians and researchers to adopt a framework that highlights power imbalances and political, socio-economic, and ideological factors in order to examine issues related to pregnant refugee and asylum-seeking women's pre-migration, peri-migration, and post-migration experiences. This is essential because many of these identities (newcomer, visible minority, patient, woman) are associated with relatively less power and relatively greater disadvantage and marginalization. This article argues for going beyond the limits of mainstream psychology's focus on the individual and de-emphasis on contextual factors such as cultural specificity, ideology, and social inequality, oppression, and power imbalances (Prilleltensky and Prilleltensky, 2003; Rogers, 1996). Critical health psychology and other social sciences, however, emphasize the ways in which history, politics, economy, values, and ideologies impact and shape health care, beliefs, practices, and outcomes (e.g. Christodoulou, 2010; Crossley, 2001a, 2001b, 2008; Prilleltensky and Prilleltensky, 2003; Rogers, 1996; Stam, 2000; Yardley, 1996).

Likewise, while mainstream health psychology focuses on facilitating behavioral change in the individual in order to change health status, critical health psychology focuses on bringing about changes in the social, political, and ideological contexts of health and health care to achieve better health outcomes (Christodoulou, 2010; Prilleltensky and Prilleltensky, 2003).

One's theoretical framework matters when it comes to health because "how we define problems determines to a great extent how we go about trying to solve them" (Caplan and Nelson, 1996 cited in Miller and Rasco, 2004, p. 35). Prilleltensky and Prilleltensky (2003) write

> The critique leveled against health psychology is not only that it responds late to conditions, but also that it addresses individuals and not societal structures … Most risk conditions do not reside within the individual but within the social and physical environments. (pp. 203, 208)

Accordingly, the adoption of a critical health psychology lens allows for alternative ways of conceptualizing PPD in refugee and asylum-seeking women. The sociopolitical location of refugee and asylum-seeking women during pre-migration and post-migration is central to their experience of birthing and motherhood. Our understanding of their postpartum distress depends upon the extent to which we consider this sociopolitical matrix in our research designs and analyses.

Language is a powerful tool for generating and perpetuating particular constructions of groups of people, systems of power, and social structures (Burr, 2003; Park, 2008). Critical health psychologists argue that language exists not merely as a neutral tool that conveys objective reality; it actively constructs and shapes reality (Park, 2008).

According to this perspective, language is not viewed as a "transparent medium" that reveals a core "truth" about some objective reality (Potts, 2002: 3). Rather, language is constitutive of our sense of the real and the ways we understand and manage our experiences. Thus, examining the ways in which refugees and asylum-seekers, PPD, and motherhood have been socially constructed and linguistically constituted is important.

"Refugees" and "asylum-seekers": socially constructed categories

Being identified as a refugee or asylum-seeker is not indicative of any inherent characteristics of a person or group of people, rather these identity labels are socially negotiated and deeply contextual (Park, 2008). Furthermore, these identities are accompanied by significant material consequences (e.g. who gets aid and access to housing, health care, and other social supports; who is granted permanent status; who is designated as vulnerable and worthy of refugee status) and social consequences (e.g. who is valued by the host society; who is viewed as able to make a contribution vs who is viewed as being a drain on resources in the host country) (Masocha and Simpson, 2011; Park, 2008). Definitions of refugees are not static, but shift greatly depending on political, economic, and social climates (Masocha and Simpson, 2011; Park, 2008). Depending on the historical time period, refugees have been alternately valorized and demonized (e.g. Irvine, 2011; Park, 2008).

For example, a current informational website on health coverage for asylum-seekers in Canada published by CIC (2012) begins with, "Too many tax dollars are spent on asylum claimants who are not in need of protection." This opening sentence strategically sets the stage for a document that goes on to outline cuts and barriers to health coverage for asylum-seekers. Changes which came into force in 2012 to the Interim Federal Health Program (a program that provides health benefits and coverage for refugees; Library of Parliament, 2012) have resulted, for example, in reduced health care for asylum-seekers from designated countries of origin. The federal government also provides a list of countries deemed not likely to produce legitimate refugees (CIC, 2012).

In sum, the social construction of refugee and asylum-seeker is not static or fixed; rather the meanings associated with these categories change depending on who is in power and how particular constructions of these people fit with particular political agendas, social climates, economic factors, and global events. In the present day Canadian context, refugees are positioned in particularly negative ways, as social pariahs. This cultural positioning creates an aversive milieu for refugee women, which may contribute to feelings of alienation, displacement, and despair. This is an important factor to consider when approaching and addressing PPD in these women.

PPD: pathologizing distress in new mothers

Just as "refugee" is a socially determined identity category, so too is "mother." Scientists have made various claims about mothers and motherhood and these claims are often rooted in discourses of naturalness, biology, and essentialism (Blum and Stracuzzi, 2004; Bobel, 2002; Miller, 2007; Nicolson, 1998, 2000; Quiney, 2007; Woollett and Marshall, 2000). Motherhood is commonly constructed as a universally fulfilling and positive experience for women and as something that women are both meant to do and want to do. Giving birth and being a mother are often constructed as being natural, biological, and inevitable parts of being a woman. Because a woman can give birth, the assumption is that she will want to get pregnant, give birth, and mother her children, and that she will be naturally good at these tasks. Critical perspectives posit that the intense distress identified in many new mothers does not fit with prevailing dominant discourses of new motherhood; thus, the distress itself is pathologized, rather than the circumstances that may have contributed to the distress (e.g. Barclay and Kent, 1998; Bobel, 2002; Choi et al., 2005; Miller, 2007; Nicolson, 1998, 2000).

Similar assumptions are made about PPD in refugee and asylum-seeking women. Research emphasizes individual factors such as a personal history of depression rather than focusing on broader social causes or implications when addressing PPD in these women (Nicolson, 1998). Applying an individualized perspective places responsibility on the woman to help or cure herself from her psychological ailment while underemphasizing the role of her citizenship status, what she has endured during migration, where she has come from, where she is now, and the discrepancy between these social positions. While links have been made between refugee status and PPD, refugees are often discussed as a homogeneous group of people who are traumatized, broken, and vulnerable to mental health problems with little focus on how the host county's construction and treatment of these individuals may contribute to their distress. Maintaining the status quo, that PPD is

a psychiatric problem, elides the social and political determinants of maternal distress in refugee and asylum-seeking women. It allows care providers and policy makers to underemphasize ongoing trauma and distress associated with these women's precarious status. Furthermore, current approaches to PPD within psychology de-emphasize socially located solutions or solutions that might be perceived as safer and more accessible to these women than individual treatments situated in institutional settings.

A period of mourning versus PPD

An alternative to the pathology model of postnatal distress is a perspective that points to PPD as a normal and natural reaction to the upheaval and multiple stressors that occur during the transition to motherhood (e.g. anxiety about breastfeeding, social isolation, lack of sleep, lack of social support, feeling overwhelmed, marital stress; Choi et al., 2005; Miller, 2007; Nicolson, 1998, 1999, 2000; Oakley, 1979). Nicolson (1998, 1999) argues that PPD is a normal response to a challenging time in women's lives and that their depression is linked to the social and political conditions of motherhood. In other words, it may be motherhood itself that is depressing, not each individual mother who is depressed (Lewis and Nicolson, 1998).

Qualitative research on PPD has identified loss and grief as common themes that emerge for women during the postnatal period (e.g. Lewis and Nicolson, 1998; Oakley, 1979). New mothers have described loss in a number of life domains: autonomy, time, appearance, femininity, sexuality, and occupational identity (Nicolson, 1998). This list can be expanded to include loss of family and social supports, economic stability and parity, employment, home, certainty about the future, citizenship status and all of the associated benefits that come with that, for refugee and asylum-seeking women. In addition, ongoing reminders of loss and trauma may contribute to a woman's distress and mourning. For example, if the child was conceived from rape, the infant may be a constant reminder of a traumatic event. The birth of a new baby may also be a reminder of children who were either left behind during migration or who were murdered during events leading to migration. Women may also be coming from cultures where the mother role is more integral and revered than in North America. For example, research has identified that in the Ecuadorian culture, the role of mother is closely linked to the cultural ideal of woman and is held in higher esteem relative to Euro-American culture (Mealy et al., 2006). Women coming from cultures where the mother role is revered may experience postpartum distress during the post-migration period as a great personal failure. Yet these women may struggle to find support for their mourning, loss, and sense of failure related to both pregnancy and migration without being pathologized.

Institutional intervention: birth as a medical and technological event

Approaches to perinatal care vary greatly across time periods and socio-historical contexts (Downe, 2010). The maternity health care system in Canada includes a variety of health care providers such as nurses, nurse practitioners, obstetricians/gynecologists, anesthesiologists, family physicians, doulas, prenatal educators, and midwives, with the

exact composition of the health care team varying from province to province (Canadian Institute for Health Information, 2004). However, the prevailing birth paradigm in Canada is one dominated by technology and biomedicine. Davis-Floyd (2001) describes a technocratic birth paradigm which is characterized by the following: technology is supreme and is influenced by science, high technology, economic profit, and large patriarchally governed institutions; the body is viewed as a machine and birth is treated like factory production; the focus is on regulating the unpredictable and unruly birth process, with practitioners as ultimate authority; and aggressive intervention is adopted for short-term results. Thus, control and supervision of the birth process in Canada largely rests in the hands of formally trained, historically mostly male, medical professionals. Birth is generally depicted as risky, unnatural, and needing the supervision, monitoring, and intervention of highly trained medical specialists (Littlewood and McHugh, 1997; Nicolson, 1998; Walsh, 2010).

The rituals and procedures surrounding birth in the Western medical model (e.g. routine IVs, routine use of Pitocin, flat-on-the-back birth position) may be jarring for women of different cultural backgrounds with different expectations of the birth process (Cox, 1996). For example, in many cultures, experienced women from within the community typically guide women through pregnancy and the birth process and rich social networks exist to support women through the transition to new motherhood (Littlewood and McHugh, 1997). Refugee and asylum-seeking women may experience a great disconnect between their expectations of perinatal care and the actual experiences of care in Canada. Studies have identified the following sources of distress for refugee women during birth in the Western cultural context: inability to communicate with staff, leading to mismanagement of pain (Bulman and McCourt, 2002; Reitmanova and Gustafson, 2008); lack of understanding of birth options (Bulman and McCourt, 2002); insensitivity and poor clinical care surrounding female genital mutilation (Bulman and McCourt, 2002; Correa-Velez and Ryan, 2012); use of technology and unfamiliar or unexplained machines and procedures (Correa-Velez and Ryan, 2012); and lack of support following discharge from the hospital (Correa-Velez and Ryan, 2012; Reitmanova and Gustafson, 2008).

While the medicalization of birth has been linked to poor mental health outcomes in women generally (Littlewood and McHugh, 1997), no studies directly link poor mental health outcomes to the context of perinatal care in refugee women. However, it is fair to hypothesize that such a link exists. Barclay and Kent (1998) note, for example, that "immigrant women also lose … familiar birthing practices, care providers and patterns of care. Our scientifically ritualized and professionally dominated alternatives may appear not only inhuman, but incorrect to (these) women" (p. 5). While this study did not identify unique challenges faced by refugee women or consider the ways in which refugee women may experience biomedical approaches to birth, it is likely that their experiences would be equally, if not more, distressing when compared to those of immigrant women.

A socioecological framework for PPD in refugee and asylum-seeking women

The ways in which motherhood, PPD, birth, and refugees are socially constructed are not typically identified as key factors in PPD, as models tend to focus on individual-level

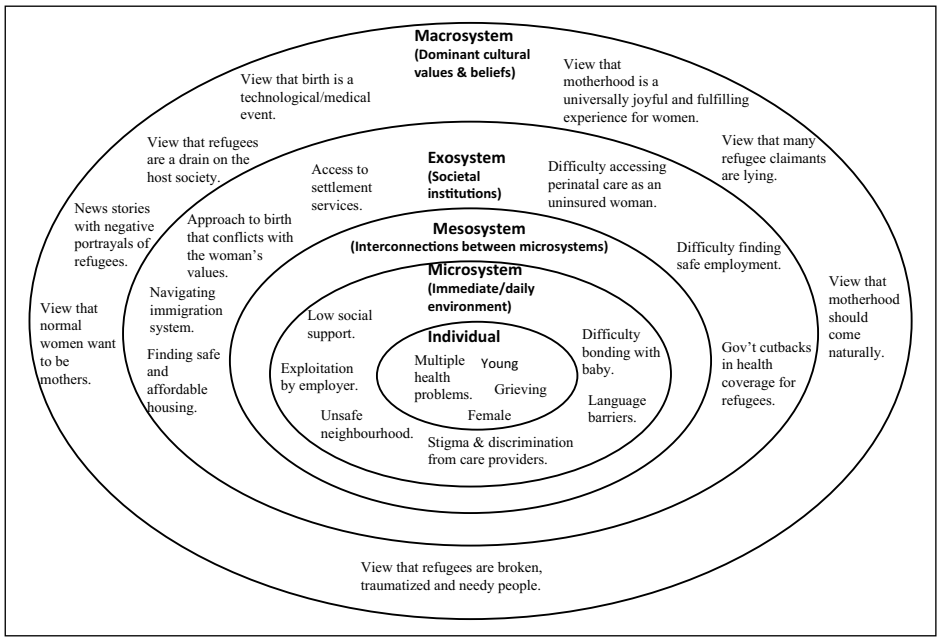

Figure 1. This figure illustrates risk factors for postpartum distress in immigrant, refugee, and asylum-seeking women using Bronfenbrenner's (1977) socioecological framework.

factors and intrapsychic processes. However, a critical health psychology approach to PPD necessitates inclusion of broader social systems and processes. Bronfenbrenner's socioecological model (Arnett, 2007; Bronfenbrenner, 1977) is a well established and useful framework for mapping the elements that influence PPD from a critical health psychology perspective given its emphasis on sociocultural factors.

Figure 1 illustrates risk factors for PPD in refugee and asylum-seeking women using the socioecological model. The individual refugee or asylum-seeking woman, with her individual characteristics and history, resides in the center of the framework. She is embedded within the microsystem, which includes her immediate living environment and her network of relationships (e.g. daily interactions with neighbors, employers, her infant, landlords, peers, friends, and health care providers). The mesosystem is the space in which different elements of the microsystem interact. For example, an asylum-seeking woman's unsafe housing situation may impact the formation of relationships with her neighbors and her ability to access other potential social supports in her community. These interconnecting relationships exist within the exosystem, which includes social institutions and formal and informal supports that a woman may interact with, such as the immigration system, social services, settlement services, and the health care system. This system of institutions is nested with the macrosystem, which includes broad cultural values, beliefs, and ideologies, as well as the various social institutions that support these. Examples of elements of this system include dominant Canadian attitudes, values

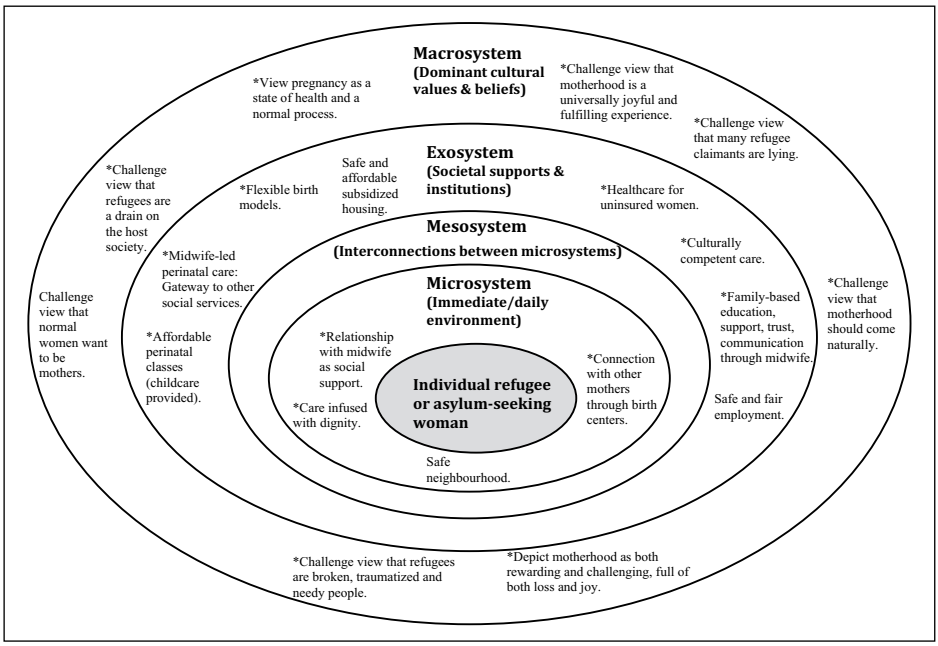

Figure 2. This figure illustrates socially located solutions for postpartum distress in refugee and asylum-seeking women using Bronfenbrenner's (1977) socioecological framework.
*There is a possible role for midwives in the identified solution.

and beliefs about motherhood (e.g. that it is a universally joyful experience; that motherhood is natural; that all women want to be mothers), refugees (e.g. that refugees are a drain on Canadian resources; that many refugees are not legitimate), and birth (e.g. that birth is a medical event that requires intensive monitoring and intervention).

This framework illustrates a reconceptualization of risk factors for PPD in refugee and asylum-seeking women. Specifically, the model encourages consideration of a multiplicity of sources of stress for the woman, which extends far beyond her individual risk factors. This model is also useful for expanding the scope of possible solutions for PPD in these women. Figure 2 is an illustration of ecological solutions to PPD in refugee and asylum-seeking women using Bronfenbrenner's socioecological framework. Just as factors at all levels of the system may contribute to a refugee woman's postpartum distress, there is also opportunity and necessity for intervention at all levels. A broader conceptualization of mental health difficulties shifts the focus from fixing individual women to fixing broader social systems impacting these women:

> From an ecological perspective … many types of mental health problems including most of the displacement-related distress experienced by refugees, are best understood as reflecting problems in the relationship between the demands of the settings in which people live and the adaptive or coping resources at their disposal. This conceptualization leads to a fundamentally different set of intervention strategies, all of which focus on changing the problematic

> person-setting relationship rather than "fixing" something inside the person experiencing the problem. (Miller and Rasco, 2004: 35)

Chavez (1998) describes the life of undocumented immigrants as being a life in the shadows wherein these individuals live at the margins of society and contact with institutions and social agencies is limited for fear of deportation. When the normally problematic transition process of settlement and integration is pathologized, safe access to maternity care is denied to migrant mothers. At a time when migrant women are most vulnerable to discovery, they hesitate to access prenatal care (Gagnon et al., 2006, 2013). To access maternity services often means to accept the risk of losing autonomy, decision-making capacity, and control over the welfare of their newborn. The perinatal period offers a brief window of opportunity for acknowledging and addressing the multi-level concerns and needs of refugee and asylum-seeking women. And although well intentioned, most care delivery models fail to meet the needs of these women, unless the care is well integrated into the woman's community and social services. The midwifery model of care offers a promising bridge for migrant mothers, which may assist them in holistic support and case management.

Integration of the midwifery model into the Canadian health care system

Globally, midwifery supports dignity, respect, and self-determination for the woman in care (International Confederation of Midwives, 2013). Midwifery is not the only Canadian health care profession to espouse the philosophy of caring, respectful relations, and culturally sensitive care. However, Canadian midwives protected these tenets in regulation mandating informed choice decision-making and continuity of care provider.

In the midwifery model, the woman is perceived as an equal decision-maker on the health care team with respect to her autonomy and agency surrounding reproductive health interventions. This positions women, such as refugees and asylum-seekers, who very often experience intersections of oppression by gender, race, immigration status, religion, and poverty, in a less vulnerable stance for decision-making.

Prior to regulation in 1993, Canadian midwives provided care using a fee-for-service model, and often *pro bono* work was provided to the poor and disenfranchised. Consequently, midwifery has traditionally been used as an act of social justice and service to vulnerable populations. Since regulation of the first Canadian midwives in 1993, the primary remuneration for care comes from provincial ministries of health that fund various care models. Midwives are among the three classes of providers funded to deliver maternity care by provincial health insurance and the Interim Federal Health Program. The others are obstetricians and family physicians. Unlike many providers who bill for discrete "point-of-service," midwifery payment is tied to "courses of care" (Hanna, 2007). The inter-professional and complementary relationships among the different maternity and newborn care providers create an arena in which each team member contributes a specialty of practice. For midwifery, that specialty is normal birth, breastfeeding support, well-newborn care, client education, and advocacy. In situations where there are medical complications necessitating obstetrical referral, this emotional and advocacy support continues until 6 weeks postpartum and also encompasses normal newborn care.

The context of midwifery in Canada is currently undergoing rapid change. The Canadian Association of Midwives (CAM, 2014) has approximately 1300 midwives, regulated in eight provinces and two territories. According to CIC (2013), Toronto, Vancouver, and Montreal are gateway cities, each with a high influx of new immigrants and asylum-seekers. It is opportune that these cities also hold the highest concentrations of midwives nationwide (CAM, 2014), which makes the midwifery model accessible to migrating women.

Analysis of the midwifery model of care

The midwifery model is congruent with a socioecological orientation to PPD since midwifery conceptualizes the pregnancies of migrant women within their unique and multifaceted context. This includes what the pregnancy means to the woman and the social, economic, physical, and emotional context in which the pregnancy occurs. For example, midwifery acknowledges the often challenging transition to becoming a mother. Rooks (1999), one of several midwife-scholars who address the relational outcomes of midwifery, uses a classic description to remark on the woman-centered nature of midwifery: "The baby is not the only important outcome of the pregnancy. Pregnancy, especially every first pregnancy, is a critical developmental process for a woman. Pregnancy results in a *mother* as well as a baby" (p. 373). With its recognition of the broad context of pregnancy and birth and the focus on the social identities associated with the perinatal period, the midwifery model of care lends itself to the complex psychosocial needs of refugee and asylum-seeking women in the context of community, transition, and the normal process of adaptation (Burton and Bennett, 2013; Wilson-Mitchell, 2008, 2013).

The Midwifery model also accommodates alternative places of birth that may be a better fit for refugee and asylum-seeking women in Canada (e.g. planned home births or birth centers[1]). The migrating mother deals with chaotic transitions to a new culture, new conceptions and expectations of motherhood, a new health care system, and new ways of obtaining social support. By supporting cultural diversity, the midwifery model provides stability and continuity in an otherwise foreign maternity care system. Many refugee and asylum-seeking women come from backgrounds where a great deal of nurturing and community support is traditionally provided for new mothers during the perinatal period (Barclay and Kent, 1998; Best Start Resource Centre, 2009; Canadian Council for Refugees, 1998; Oates et al., 2004). This is in stark contrast to the post-migration perinatal experience of many of these women who often face a vacuum of social support. The isolation, multiple losses, and distress that these women face are profound, hidden, and often ignored (Barclay and Kent, 1998). The introduction of perinatal care that is familiar and supportive has the potential to mitigate these women's distress and the effects of migration.

The Canadian midwifery model involves the assignment of a small team of midwives to provide more seamless care by a known provider throughout the perinatal period (Sandall et al., 2013). This consistency in care and advice during pregnancy, childbirth, and the postnatal period is in contrast with standard maternity care model, whereby women receive fragmented care from dozens of different providers, which may include nurses, family physicians, and obstetricians (Davis-Floyd et al., 2009; Henderson et al., 2007). In general, the model of care offered by midwives is more likely to promote a feeling of control by the mother with emphasis placed on the relationship developed

between the woman and her caregiver (Hatem et al., 2008; Sandall et al., 2013). This may provide a welcome alternative to the technology-based hospital environment, where often technology is substituted for person-on-person monitoring and care (Hatem et al., 2008). The solo or small team of midwives is able to accommodate longer clinic visits and frequent postpartum home visits. This practice may facilitate trust and better communication so that difficult topics like female genital mutilation, preferences, choices, and a birth plan can be articulated and navigated with sensitivity (Henderson et al., 2007). Studies on migrant and immigrant women's views of postpartum care have identified the importance of the relationship between these women and the people who care for them (e.g. Small et al., 1997), and some studies suggest that qualities like sympathy and friendliness, kindness, and support may be more important than having a midwife who has specific knowledge about a woman's cultural background (Cape, 1999; Small et al., 1997, 1999) as these qualities provide the foundation for trust and communication. As Sandall (2012) notes, "In addition to normalising and humanising birth, the contribution of midwife-led care to the quality and the safety of health care is substantial" (p. 78). Finally, while midwives may not be able to address the myriad stressors in refugee or asylum-seeking women's lives, the relationship of trust and communication established between a refugee or asylum-seeking woman and her midwife may serve as a portal to other kinds of services and supports (e.g. housing services, legal advocates), which may help address other social and economic challenges in these women's lives.

This article proposes integrated perinatal health care for refugee and asylum-seeking women that incorporates midwives as a microsystem element that can strengthen the interactions these women experience within the mesosystem and exosystem. We propose that midwives may serve in the roles of advocate and power broker, as well as providing a portal/conduit to access information. These roles could be protective in terms of psychological distress.

However, these providers may be restricted when operating within the dominant medical *model* of maternal health care, and the dominant psychological approach to PPD, which fails to acknowledge or address many of these women's needs. The authors seek to emphasize the contribution that midwives can make to integrated partnerships with other care providers in the care of refugee and asylum-seeking women, as an example of a response to perinatal distress that emphasizes socially located change and support rather than individual psychopathology. In the last decade, innovative examples of successful integrated midwifery–medicine partnerships have emerged in Canada[2] (Hanna, 2007; Harris et al., 2012; Jay MacGillivray, personal communication, May 5, 2014; Mackrael, 2013), and there is support for expansion[3] of such partnerships, which meet the needs of vulnerable groups (Hanna, 2007; Harris et al., 2012; Mackrael, 2013). In addition, midwives and maternal child health nurses have been successfully providing perinatal care to vulnerable women in other countries such as Australia (e.g. Armstrong et al., 2000) and in the United Kingdom (e.g. Barlow et al., 2003; Leggate, 2008).

Conclusion

Critical psychology queries a number of assumptions built into traditional psychological approaches to studying health, including the predominant focus on the individual and the

relative neglect of the economic, political, sociocultural, and discursive conditions of a person's health and well-being (e.g. Christodoulou, 2010; Crossley, 2001a, 2008; Miller and Rasco, 2004; Prilleltensky and Prilleltensky, 2003; Rogers, 1996; Stam, 2000; Yardley, 1996). A critical psychological approach involves questioning the belief that diseases and symptoms are objective entities that exist outside of subjective interpretation or cultural context. This is not to say that a particular cluster of symptoms doesn't exist, but rather that the symptoms may be labeled, experienced, and treated differently and be given different meanings depending on the social and historical context (e.g. Rogers, 1996). Thus, this article does not deny that individual refugee and asylum-seeking women in Canada experience postpartum distress; rather, it stresses that current individualized ways of conceptualizing this distress are problematic. Caution should be exercised when conceptualizing the grief and mourning of refugee and asylum-seeking women as intrapsychic pathology. While refugee and asylum-seeking women may meet diagnostic criteria for PPD, relevant aspects of their experiences are sidelined if social, historical, political, and economic circumstances (e.g. poverty, discrimination, barriers to health care services, trauma, homelessness) are not incorporated into the conceptualization of their distress. Individualized approaches risk marginalizing these women and further alienating them from the Canadian health care system and the network of social services and supports available.

A socioecological framework is a useful tool for understanding and addressing health problems in a way that is consistent with a critical health psychological approach and social model of health (Arnett, 2007; Bronfenbrenner, 1977). This model can be used to map out risk factors for postpartum distress in refugee and asylum-seeking women in a way that captures the social embeddedness of the problem. It can also be used to generate solutions that extend beyond the individual and that target social conditions relevant to refugee and asylum-seeking women. One example of a socially informed solution is the expansion of multidisciplinary perinatal teams that integrate midwifery into the care of refugee and asylum-seeking women in Canada. Given the history, philosophy, and current expansion of Canadian midwifery, midwives are uniquely positioned to be part of a system of solutions that mitigate the postpartum distress experienced by refugee and asylum-seeking women. Some researchers argue that successful migratory integration and mental health is closely tied to resilience as well as strong community ties and supports, which constitute "social capital" (Boardman et al., 2010; Whitley and McKenzie, 2005). When the midwifery model is utilized within a comprehensive and integrated perinatal health network, social support increases and there is an opportunity for migrant maternity care that normalizes the settlement and integration process and that mitigates distress.

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Notes

1. The Toronto Birth Centre (TBC) opened during winter 2014 in Toronto, Canada, as one of two midwife-led pilot birth centers in the province of Ontario (Gordon, 2014; TBC, n.d.). The TBC adopts a culturally integrated and community-based approach to care and is located in Canada's largest public housing development, near many immigrant and refugee services.

2. The Positive Pregnancy Program, St. Michael's Hospital in Toronto, Canada, is an example of effective integration of midwifery and medicine in maternal health care. Recognizing the stigma and significant barriers faced by pregnant HIV-positive women, midwife Jay MacGillivray, RM, and obstetrician Dr. Mark Yudin, MD, co-founded an inter-professional multidisciplinary perinatal program specially tailored to meet these women's unique medical and psychosocial needs. This collaboration also includes social work and community groups (Caprara et al., 2014).
3. The South Community Birth Program in Vancouver, Canada, is a partnership of family physicians, midwives, community health nurses, and doulas caring for a multiethnic, low-income population (Harris et al., 2012).

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