

Postpartum Depression in Women Refugees/Asylum Seekers- Recognition and Coping Strategies

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ABSTRACT

Immigrant families form a quickly changing multicultural context in many European countries and particularly in Greece. This study is a narrative review regarding postpartum depression within the refugee/immigrant population, in an attempt to increase understanding of immigrant women's mental health care postnatally. First, we provided a brief review regarding the causes and symptoms of postpartum depression; moreover, we presented the already established bibliography concerning the immigrant/refugee population. Finally, we present several coping strategies that can be applied for dealing with such occurrences. Depression rates are higher among immigrants and refugees than in the general population due to their living conditions. New immigrant mothers may often be particularly vulnerable to less than optimal mental health following childbirth given the cultural and geographic isolation, socioeconomic factors, gender roles, and language difficulties that influence their postpartum experiences. Refugee women's mental health issues often go unrecognized.

Maternity health professionals, especially midwives, should recognize the inequalities and provide culturally sensitive health care services and help to design tailored prevention programs in order to protect women in these population groups from postpartum depression.

Keywords

Postpartum depression; Women immigrants; Refugees; Asylum seekers; Emotions; Mental health; New mother; Postpartum period.

Introduction

During 2020, an estimated 11.2 million people became newly displaced – a total that includes people pursuing long-term residence or citizenship in another country for the first time, as well as people displaced repeatedly. This comprises 1.4 million who sought protection outside their country, plus 9.8 million new displacements within countries. This figure exceeds the 2019 total of 11.0 million [1].

Between January and August 2020, nearly 50,000 refugees and migrants (25 per cent children) arrived in Europe (Greece, Italy, Bosnia & Herzegovina, Bulgaria, Montenegro and Serbia), a trend likely to continue in 2021 [2].

In a recent study [3], participants working in arrival camps stated that they met numerous refugees in need of psychosocial assistance and support. They described that this was attributable to the circumstances and traumatic experiences migrants often encounter, before and during their journey. Besides, participants outlined that repressive police actions, extended asylum procedures, unexpected displacements, threat of deportation might lead to psychological disorders. In spite of all that, participants highlighted that there was insufficient psychological support to help refugees with traumatic experiences and there were difficulties in accessing specialist therapies. Some participants outlined that specialist care was covered, but only in limited range to vulnerable persons with special needs (e.g.: victims of trafficking, torture or sexual violence) and on condition of approval by a special commission.

Nearly half (48%) of global refugees are women, many of childbearing age, who experience pregnancy and give birth during their migration journeys or upon resettlement [4]. Europe has

received considerably large flows of immigrants and refugees, mainly from Middle Eastern countries (namely, Iraq, Iran, Syria, and Afghanistan) [5]. Thus, maternity care is often among the first exposures to a new healthcare system for migrant women. Moreover, pregnancy and birth may exacerbate already existing vulnerability factors [6].

In lifetime, women experience depression two times more likely than men, due to their reproductive nature, caring and rearing of children [7]. Pregnancy, childbirth, and the postpartum period are key phases in a woman's life, potentially causing noteworthy emotional changes. The psychological state of a pregnant woman is mostly changed by the hormonal fluctuations that occur during pregnancy and later in childbirth. It is well documented, that the health information need is particularly high during perinatal period, due to substantial physical and psychological changes, in addition to the concerns about the embryo [8].

Postpartum depression (PPD) is the most common complication of childbearing age and is a considerable public health problem [9]. Postpartum depression, is recognized by the American Psychiatric Association as a major depressive disorder, characterized by depressive mood symptoms such as appetite changes, insomnia, decreased energy, low self-esteem, cognitive difficulties, and anxiety [10]. It usually occurs during the first four weeks but can occur up to a year after birth. Regarding both the general and the migrant/refugee population, the percentage of postpartum depression prevalence is between 5%–25% [6] and 11%–60%, respectively [11,12].

The purpose of this study was twofold; first, to provide factual information regarding postpartum depression, and second, to present the latest literature regarding postpartum depression in the female refugee and immigrant population.

Materials and Methods

We conducted an online search in the Medline-PubMed digital databases—per the guidelines of international organizations—as well as in bibliographic article references. Articles both in English and Greek were searched, using the following keywords: postpartum depression, migrant women, refugees, asylum seekers, emotions, mental health, new mother, and postpartum period, ultimately selecting the most relevant.

Results

Causes and risk factors

The causes of postpartum depression are unknown; however, factors that correlate with its prevalence include history of depression, anxiety disorders, insufficient—or lack of—emotional support from loved ones following birth, low income, and a dysfunctional husband-wife relationship [13]. Women either with a severe premenstrual syndrome or prevalence of depressive symptoms during the administration of birth control pills are also in risk of developing postpartum depression. Finally, both childbearing at a young age and the birth of premature/unwanted

children are significant risk factors for the development of postpartum depression.

Symptoms

Postpartum depression can affect a woman anytime during the first postpartum year; it can either occur suddenly or develop in a progressive manner. During the first postpartum week, the mother's feelings are constantly fluctuating; it is considered normal for a woman to experience stress, fatigue, and a loss of energy during the first postpartum week; however, these symptoms might indicate the prevalence of other underlying disorders should they persist [14]. Namely, postpartum depression is characterized by a persistent feeling of sadness; a negatively affected mood; a general loss of interest, both in otherwise significant matters and usually pleasant activities; constant fatigue; sleeping disorders during the night; and feelings of sleepiness during the day. Moreover, the individual presents no willingness to tend to the new-born's needs, with any actions that are performed for this matter being conducted in a mechanical fashion; additionally, there is either a lack of appetite or an incidence of overeating, feelings of either overall guilt or despair, and difficulty in establishing an attachment with the child. Finally, these women occasionally experience an incidence of either scary or self-harming thoughts [15].

Research conducted on immigrants/refugees

An indicated the prevalence of high levels of depressive symptoms among refugee women during the postpartum period; they experienced stress triggered by moving away from their homeland, family, and friends, as well as the challenges they will face regarding their integration in the new country caused by cultural and normative differences [16,17]. Additionally, another research found that women who receive little support tend to more frequently develop postpartum depression. Initially, they experience loneliness, face several communicational challenges—as they do not speak the new country's language—constituting a socially isolating factor. Finally, asylum seekers and immigrants present postpartum depression at rates of 14.3% and 11.5%, respectively, thus deducing that the former experience postpartum depression more frequently [14].

Psychotherapeutic approaches

"Guided self-help"—which includes working through a book or an online course, either alone or under professional supervision—is the first therapeutic approach for the treatment of postpartum depression. It is, mainly, applied on mild cases, with the class material constituting routine and frequent challenges that could be experienced by the individual; the individual usually receives advice regarding coping strategies. The classes usually last between 9–12 weeks. Given the paucity of treatment trials using medication for postpartum depression, and the fact that psychotherapeutic interventions do not confer any “exposure” risks to breastfeeding infants, the data also suggest that psychotherapy should be considered a first-line treatment, rather than as an adjunct to medication treatment [18].

Another approach is cognitive behavioural therapy, which is

a specific therapeutic type that is based on the principle that a non-helpful or non-realistic cognitive process is associated with the formation of a specific negative behaviour. Its aim usually constitutes the attempt to break this association and provide alternative ways of cognitive processes that may lead to the formation of newly acquired and healthy ways of thinking that can assist the individual in holding a more positive outlook towards their life. Namely, some women might hold non-realistic expectations regarding the ways motherhood is experienced, believing that mistakes are forbidden. Through this approach, the individual can gather the courage that will enable her to realize that these thoughts are not helpful. This treatment can be conducted both at an individual and a group setting, usually lasting between 3–4 months; however, its duration can vary, depending on the individual and their symptoms' severity [19].

Alternative therapeutic approach is interpersonal therapy (IPT), which includes the conversation with a mental health expert—usually a psychologist—regarding the challenges that the woman is facing. The aim of interpersonal therapy is to determine challenges that occur within the family, between friends, and work partners, and their potential correlation with depression symptoms. The course of this therapy could last between 3–4 months; however, its duration could vary, depending on symptom severity and personality traits. IPT appears to be a promising treatment, in order to not only decrease depressive symptoms but also increase marital functioning, social support, and mother-infant bonding [20].

Medical intervention

A medical intervention that includes the administration of antidepressants is indicated either in cases of moderate to severe depression, or when other methods do not produce desired outcomes. This medication balances the brain's mood-related chemical substances; they can assist the individual in relieving symptoms such as a negatively affected mood, irritability, lack of focus, and insomnia, thus improving the relationship between the mother and the new-born. Antidepressants must usually be administered for at least a week, before their benefits are experienced; however, it is vital that the individual must not discontinue their administration, even if no immediate improvement is felt. They are usually administered for another 6 months after their effect takes place. Should the individual stop receiving antidepressants, depression is likely to be re-experienced [21].

Discussion

Postpartum depression is a serious mental illness that needs immediate treatment. Depression rates are higher among immigrants and refugees than in the general population due to their living conditions. Barriers remain to accessing specific health services, such as specialist psychological and mental care; women care; child care and victim of violence care [22]. Reasons for that vary across countries and are often determined by the discrepancies between what the law says and what is implemented in practice.

Despite considerable evidence that linguistic and cultural barriers are among the biggest obstacles in providing comprehensive and

quality healthcare for migrants, in many countries the availability of professional interpreters or intercultural mediators is still limited because of lack of government policies and subsidies. Education of women, their partners, families and their wider communities is key to reducing the stigma and fear related to a PPD diagnosis. Community-based group meetings for women who may have no family or friend support networks are a valuable source of education, networking, and support and may also provide a therapeutic benefit for women struggling with PPD. Health professionals working with this particular population need to both focus on and identify women who do not receive support; they must support and encourage them, either individually or in groups. Interpreters from various languages need to reflect gender sensitivity and be accessible across primary maternity care, so as to support screening tools such as the EPDS. This could include gender sensitive, e.g. female interpreters, cultural brokers and/or peer mentors.

This population is more at risk of developing PPD due to a complexity of issues including pre- and post-migratory stressors; however, there is currently little research on this topic available to health care providers and policy makers [23].

A total of 26,800 refugees and migrants have arrived in Europe through the Mediterranean since January 2021 [24]. Further research, into how maternity care providers and especially midwives are educated and trained to diagnose, treat, and support immigrant women who suffer with PPD is required. Inquiry into the experiences of front-line workers who provide care to immigrant women with PPD would help bring a profounder understanding of the precise educational and support needs these workers have and may provide keys to how those gaps could be addressed.

Conclusion

Postpartum depression (PPD) is a highly prevalent mental health problem that affects parental health with implications for child health in infancy, childhood, adolescence and beyond. Immigrant families make up a quickly changing multicultural context in many European countries and particularly in Greece. Women and children refugees should be able to access mental health and psychosocial support (MHPSS), child protection case management and referral. Targeted interventions should be applied to adapt mental health services to linguistically diverse patients, especially women during perinatal period, including the provision of tailored health education and prenatal classes that consider the specific needs of newly arrived migrants. Treatment considerations include severity of depression, whether a mother is breastfeeding, and mother's preference.

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