Family Medicine and Community Health

'You withhold what you are feeling so you can have a family': Latinas' perceptions on community values and postpartum depression

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ABSTRACT

Objective The purpose of this study was to explore the postpartum depression (PPD) beliefs and experiences of mothers who access local community faith-based organisations providing family services to low-income, predominantly immigrant Latino populations.

Design Using a qualitative research design, we conducted 18 focus groups with Latina mothers to inquire about their community values and beliefs of PPD. All groups were conducted in Spanish.

Setting An academic research team located in Houston, Texas, USA, partnered with six faith-based organisations in five cities to recruit and host focus groups at the site of the organisation.

Participants One hundred and thirty-three women participated in the focus groups across all sites. Thirty-seven of them (27.8%) had given birth to a child in less than 1 year. Inclusion criteria included mothers 18 years and older and Latino ethnicity.

Results A six-step process was used to apply thematic analysis to sort data into the themes. All mothers had heard of depression after childbirth, some had experienced it and most remarked that the personal experience and community acceptance of it vary by family. The main findings suggest that mothers take pride in parenting by instilling values to support family and the value of relying on family for emotional support. Findings reveal that many mothers suffer and sacrifice for their children, they feel judged and feel they must hide their emotions. Factors such as birth and postpartum customs from a native country, gender roles and beliefs of what a good mother shape their beliefs and messages about PPD.

Conclusion Our findings indicate that programme developers should consider family and community focused education and intervention efforts to help decrease stigma and increase understanding of PPD.

Key points

Question

► What are the beliefs surrounding postpartum depression (PPD) and personal experiences of PPD of Spanish-speaking Latina mothers?

Finding

► Latina mothers experience PPD as isolating and something that potentially renders them useless to their families. Mothers want to be able to rely on community and family for support but often feel stigmatised and judged.

Meaning

► This study centred the voices of marginalised, low-income, Spanish-speaking Latina mothers to help us gain understanding of how community and family beliefs and values may affect their experience of depression and willingness to ask for help.

INTRODUCTION

Mothers are often the nucleus of a family. However, as a society, we tend to overlook the importance of positive maternal mental health functioning. Perinatal mood disorders are now the leading cause of maternal morbidity,[1 2] and unfortunately, some subgroups are more at risk than others. Postpartum depression (PPD) is defined as a major depressive disorder with peripartum onset.[3] Known risk factors include, but are not limited to, depression during pregnancy, low self-esteem, stressful events, poor marital relationship, low levels of social support, low socioeconomic status and being single.[4] Latinas in the USA often experience many of these risk factors, such as living in poverty and enduring multiple adverse experiences and chronic stressors.[5] Indeed, research among the US-born and foreign-born Latinas indicates depression prevalence during or after pregnancy ranges from 23% to 51%,[6–9] while rates among the general population are estimated at 11%.[10] As demographic trends indicate the continued growth of the Latino population in the USA,[11] mothers comprise an especially vulnerable population that merit continued investigation.

Early intervention is ideal for proper treatment of PPD, but disparities exist in

the identification, referral to treatment and treatment engagement among Latinas,[12] especially those who have immigrated to the USA. Stigma, lack of recognition of symptoms and/or misconceptions about PPD among Latinas and their obstetric service providers often complicates early detection of depressive or anxiety symptoms.[13 14] Importantly, both individual and cultural attitudes may complicate the presentation and interpretation of depression among Latina mothers. High rates of trauma history are documented among Latino immigrants.[15 16] Immigrant mothers may have experienced family separation, wars in their country of origin, past sexual assault and on entering the USA, a heightened experience of discrimination.[17–19] These experiences have been evidenced as risk factors toward various mental illness symptoms and disorders, including depression.[20 21] As immigration trauma is contextualised within preexisting cultural values of placing greater emphasis on the collective need over individual needs and cultural stigma against validating mental health,[22 23] Latina mothers may find it increasingly difficult to understand and process their emotions (ie, alexithymia), an aspect of trauma well documented in the literature.[24–26] Social, emotional and geographic isolation may occur as a result of immigration, especially if immigration has been traumatic. The feeling of being alone, of being isolated, is one of the strongest predictors of depression during the pregnancy and.[14] As such, empirical work must investigate cultural attitudes, values and the context of their lives for Latina mothers as it relates to the manifestation of PPD and treatment-seeking behaviours.

Individual's cultural beliefs on mental health affect their perception of mental illness and treatment-seeking behaviours.[27] In most Latin American countries, cultural beliefs that family should provide support to newly postpartum mothers are passed down generationally.[28] For example, the traditional Latin American practice of cuarentena is a period of approximately 40 days in which the mother abstains from cooking and cleaning to allow healing and complete focus on the baby. Family and friends help with household responsibilities and cooking for the mother after childbirth for the purpose of supporting mother and baby during the early postpartum period. For Latina immigrants, the absence of culturally sanctioned rituals that support new mothers and her own level of acculturation may affect seeking professional help.[29] Differences between birth cultures of Latino heritage and the US culture in the macrolevel beliefs and structures that support a mother's transition after childbirth may mean Latinas in the USA experience PPD but do not seek help.

Research on perinatal mental health has historically been dominated by homogenous samples of White, married mothers; current efforts to build knowledge must include the often unrecognised mothers' experiences with intersectional marginalised experiences.[30] The purpose of this study was to explore the experiences of mothers who access local community faith-based organisations providing family services to low-income, predominantly immigrant Latino populations. Using focus groups to collect data, the current study aimed to engage in meaningful discussion that could inform how lay health workers can engage women in discussions of PPD in the communities they serve. We adopted the matricentric feminist approach to centre experiences of Latina mothers in the context of PPD, to guide our study design and interpret findings.[31] Matricentric feminism asserts that the voices and experiences of mothers is 'deserving of serious and sustained scholarly inquiry.'[31] Applying maternal-driven theory and practice within a context of intersectionality, Rich argues that we must disentangle the institution of motherhood (which is born of and supported by patriarchal systems) from the experience of mothering—which is female-centric.[32] By centring the voices of mothers, we potentially elevate scholarship on maternal mental health and well-being by offering counter narratives to the traditional patriarchal lens.

METHODS

This study used a qualitative descriptive research design, specifically, focus groups was the method for collection and thematic analysis was the method for analysis.[33] Results were interpreted using a lens of matricentric feminism. Conducting focus groups allowed us to explore perspectives on the communities' overall values and cultural beliefs of maternal depression. Krueger states that using focus groups is to hear how and understand the problems faced by the community from their perspectives.[34] Through focus groups, researchers could also learn that community's language for talking about the topic.

According to Ayala and Elder, focus groups can provide a synergistic atmosphere that affords useful information when determining if an intervention will be acceptable to a target population.[35] Common barriers to the acceptability of community-based interventions are distrust in the programme's meaning or usefulness and lack of cultural appropriateness.[35] Focus groups were conducted in the same cities where a PPD intervention would be implemented the following year (from a W.K. Kellogg grant initiative). Working with our community partner, Urban Strategies, who has numerous years of experience conducting focus groups in similar communities, the authors created a focus group guide that would elicit information from mothers about how mothers' mental health is perceived. Given that PPD is a highly stigmatised condition,[13 36] the authors and her collaborators planned accordingly for how best to raise interest in participation in a mental health intervention on PPD and learn the communities' language and perceptions so interventionists could be cognizant of them.

Recruitment

The research team, located at a large public urban university in Southwestern US, partnered with Urban Strategies, to recruit women from six faith-based organisations

located in five cities in Texas, Arizona, Florida, Illinois and Puerto Rico. Each site was compensated with US$2000 for their time, space and help with recruitment. Lay health workers and supervisors at each site communicated verbally with clients and posted flyers in English and Spanish in nearby churches, fitness centres, and grocery stores. All recruitment materials were typed in English and Spanish and said: 'Discussion Group: Are you a mother or a family member, spouse or sibling of a mother? We want to hear from you! Please let agency staff, for example, community health workers, know if you would be interested in participating in a small group with other mothers and other family members to discuss: Any challenges of being a mom; family and community beliefs of motherhood; how to support mothers emotionally.' Each site recruited approximately 20 people. Inclusion criteria included mothers who are 18 years and older and Latino ethnicity. They did not have to be depressed nor did they have to report any past depression screening scores to be eligible.

Data collection

A facilitator (author), who had worked with these organisations on a previous project, travelled to each site and conducted all group interviews using a 6-question focus group guide. The facilitator (author) has professional experience in Latino psychology and knowledge of cultural norms and beliefs about mental health. She has expertise in women's health and immigrant issues and is bilingual and bicultural herself. By partnering with the facilitator, the academic team strove for cultural competence in recruitment and data collection, as recommended by Ojeda *et al*[37]

After obtaining written consent and confirming that everyone had signed in and completed a few demographic questions (age of mother, age of the child, marital status, US born or non-US born, language spoken at home), the facilitator began with introductions and then asked questions. All sessions were conducted in Spanish, as most participants in each group spoke Spanish at home. Each session lasted approximately 45 min. A bilingual notetaker was present, and all groups were audiorecorded with consent. Food and beverages were provided, and a US$10 gift card was given to each participant at the end of the focus group. Extra research assistants were present to help with childcare if needed.

Theoretical underpinnings of the focus group guide

The research team used feedback from prior focus groups in the same communities, expertise in Latino culture and health, and concepts from the cultural dimensions theory to design the focus group guide.[38] We also applied the incorporated cultural norm of marianismo in our focus group questions. Marianismo characterises Latina women as virtuous, humble, submissive, self-sacrificing for the sake of her family, and spiritually superior to men.[39] In general, Latino cultural norms encourage self-sacrifice, endurance of pain and suffering, and reliance only on the family for support—'la ropa sucia se lava en casa,' which translates into a common English idiom 'Don't air your dirty laundry in public.'[14] Feeling pressure to fulfil the ideals of marianismo is observed in prior qualitative studies among Latina mothers regarding parenting and PPD.[13 40 41] To explore these concepts we included the following key questions in focus group interviews: what values are important to your culture and community? What is said about a woman who feels sad or depressed after having a baby? Some say that we sacrifice ourselves or suffer. Some say that mothers sacrifice. What is your opinion on these comments? When you have feelings of depression how do you resolve them? Who do you talk to?

Data analysis

Audiorecordings of all focus groups were encrypted for safety and sent to a professional transcription company verified by the university. These recordings were listened to in Spanish and translated into English by the transcription company. Once transcripts were sent to the research team, they were back-translated by a bilingual research assistant to ensure the data's integrity. The research team also analysed the written notes from each group. We did the same back translation for the notes. The team worked together to conduct handwritten manual data analysis. The research team openly discussed their own values, assumptions, and biases about the US-born and foreign-born immigrants to raise their own awareness of how personal beliefs may shape the research.[37]

Thematic analysis was conducted with the step-by-step guide by Braun and Clarke.[42] Initially, three research assistants familiarised themselves with the data by reading and rereading the transcripts and written notes. Incorporating the notes taken during focus groups into transcripts helped to add more context.[35] The second step is that the three research assistants generated initial codes on their own and collated data relevant to each code. Then they compared and collated their codes and finalised the codebook. Based on the codebook, the principal investigator (PI) and research assistants collated codes into potential themes. What emerged as themes are the topics/results that were heard in each group. Data analysis was conducted by the PI and three research assistants initially and sent to the research team's community partners for peer debriefing and observer triangulation.[43]

RESULTS

Participant profile

One hundred and thirty-three women participated in the focus groups across all sites. The average age of mothers was 35.3 (SD=8.1); 37 of them (27.8%) had given birth to a child in less than 1 year. As shown in table 1, the sample in this study comprised mostly of non-mainland US-born mothers: 57 (32.8%) participants were born in Mexico, 33 (19.0%) in Puerto Rico, 27 (15.5%) in the USA and 37 (21.3%) in various Central or South American countries. One hundred participants (57.5%) spoke primarily

Table 1 Demographic information of participants

	N (%)
Place of birth	
Mexico	57 (32.8)
Puerto Rico	33 (19.0)
Other Central or South American countries	37 (21.3)
The USA	27 (15.5)
Primary language at home	
Spanish	100 (57.5)
English	3 (1.7)
Both	30 (17.2)

Spanish at home, 30 (17.2%) spoke both Spanish and English, and 3 (1.7%) spoke English at home. During the analysis, we found no differences among Puerto Rican data compared with other ethnicities. Results are organised by broad themes: (1) values-based parenting; (2) PPD is judged, criticised and stigmatised; (3) suffering and sacrifice in motherhood and (4) the pathway to help is not clear. Quotations that further illustrate the themes are presented in online supplemental table.

Mothers use values-based parenting

The majority of participants spoke of mothers, specifically and family broadly, as the bedrock for the socialisation of children. The most notable values discussed across all groups were family, respect for others, religion and preserving Latino culture. Participants discussed examples of how, as mothers, it is their job to impart the value of familismo and use family time to teach cultural values. Familismo is the Latino cultural belief that encourages loyalty to and identification with one's family, and that family needs come before individual needs.[44] Mothers teach (by modelling behaviour and through verbal instruction) what is 'right and wrong' and 'the importance of faith in religion'. In all groups, many women spoke of the role of the mother as a primary educator of values and behaviours in life. For example, one mother said, 'Education is different at school and at home; Respect for the elderly; The value of the family; The structure of the family; School is only based on study'. It was clear that there is a cultural attitude that mothers should put the needs of their children and husband first and that she comes last. One woman said: 'The value of the family is a value for me and depression, if I manifest it, then I lose my family, if I say that I feel bad I will be judged, they will not understand me and I will lose my family It is first what the children want'. If family is a cultural value and, it is the mother's role to impart the value of family above all else, it seems likely that the experience of depression could be seen as selfish, something that could hurt the family. It is possible that feeling depressed or anxious could be internalised as a weakness that must be tucked away in order to perform for the family. The following quote illustrates the pressure mothers may feel to keep the family running even if it is at her expense: 'There are many functions that a woman has; raising children and studying with her children; the work of a woman is a lot when they babies, we don't sleep at all'.

PPD is judged, criticised and stigmatised

PPD is judged by negative reactions interpersonally and at the community narrative level. Below is an example of interpersonal judgement shared by one woman:

> We as women also judge other women. To me it happened to me and I had to endure, and I was very nervous and if I commented, I felt afraid to be judged, but if they judge us nothing happens. Sometimes when a woman is sad and depressed, she is judged, because she is lazy, even the relatives do.

Several women in the groups spoke of community level judgement: 'People do not know what that is'; 'Having just had her baby the neighbors say she is crazy and haunted'. [mothers who are depressed are….'alone,' 'loco,' or 'seeking attention'; 'There is ignorance and people do not know; The first thing they do is judge.' Some mothers in the group who had suffered from depression described scenarios when they needed help because they were emotionally and physically exhausted but they stayed silent about their emotions and did not ask for help for fear of being judged. One woman said: 'When someone helps you do what you are unable to do…because you feel so incompetent to do things that you are used to doing them with no problem.' Much of what the women were accustomed to 'doing' was the cooking, cleaning, and emotional caretaking for the family. Women who had been depressed spoke of feeling useless to their family or being afraid that if they were to admit feeling depressed, they would 'lose' their family. To be incompetent to one's family is stigmatising as it goes against the value, the expectation, that mothers are the foundation of family functioning.

A subtheme we heard related to the experience of PPD being criticised was about the premium placed on family support. Family support was valued highly and to not have the support of one's family was judged. Participants described assumptions that if a mother with young children is depressed, she must be 'all alone' or 'not have any help' from her own family. A common discourse among many participants was that having support from the family and help with taking care of the child/children can prevent depression. However, not having help from family, especially from husband, is a bad thing and can worsen any sadness or other signs and symptoms of depression. Many women spoke of unhelpful mothers and aunts saying, 'it will pass' and 'That this is normal and that it will happen after months and is part of the pregnancy'.

Mothers who shared stories of aunts, mothers and mother-in-laws dismissing the participant's feelings of depression reported feeling ignored and felt there was no compassion among elder women and the Latino

culture at large when it comes to mothers experiencing PPD. Many women discussed wanting to rely on the men as witnesses and as emotional support, but this desire was not always fulfilled. There seemed to be the general consensus among our participants that men could not possibly understand the range of emotions and the depth of suffering a mother feels simply because these are the experiences of mothers. Men are also 'impatient' when a mother is experiencing depression and sometimes dismiss the mother's mood by making suggestions to just take a bath or complaining that he's been gone all day and none of the housework is done. One woman said, 'We at least want them(men) to know, many times the only thing we need is—is to be heard, or to help by looking up information'. Another woman seemed to echo the general exasperation with husbands: 'Men can not understand. Why? it has never happened [to them]'.

It was clear that community views on PPD are not value-free and often reflect misconceptions about the prevalence, symptoms, and aetiology of PPD. Some women talked about how the amount of information and views on mothers experiencing PPD varied greatly in their native country than in the United States. For example, women shared stories relayed by their friends and relatives in their native country. The stories from Mexico and other native countries centred around community and family denial or labelling the depressed mothers as 'bewitched'.

> Not too long ago, my husband's cousin told me that there was a woman in Mexico who was going through a very big depression after having her baby. So, the neighbors would say that she was crazy, and that she was bewitched, and that her sister was going to get married, but she wasn't going to get married [decided not to get married] because the same thing could happen to her. So she [husband's cousin] told her mom in Mexico, "No, mom, what she has is postpartum depression. Look, my neighbor had it, too, and it's the same symptoms." And it's that there is a lot of ignorance; people don't know. It's worse over there [Mexico]. Here, [United States] they know a little more.

The participants were making the point that in the US more is known and discussed about PPD than in other places.

Suffering and sacrifice in motherhood

The acts of suffering and sacrifice were spoken of as inherent to mothering, something that all mothers are expected to do. One participant said: 'It's part of life that has to be like this; It is learning because women learn to support [child] development… I suffered with a smile and with a good attitude.' Sacrifice was described as acts of selflessness so that the child can have a better life, better jobs, or better relationships in the future. Suffering and sacrifice is expected. Many women spoke of suffering and sacrifice as ingrained cultural attitudes: 'We come [to the U.S.] educated, the Mexican culture is machismo, the custom is that regularly the woman does the work and the men go to work.' One mother articulated 'In society a mother who does not suffer is a bad mother, is selfish, for society this is a good myth, but also bad. Suffering connects you with your children'. From the discomforts and sometimes difficult limitations of pregnancy to the emotional, empathic suffering she feels when her child is hurting, many participants agreed that suffering is a part of motherhood.

Sacrifices are made, so the child does not have to suffer as the mom did: 'We all want to give our children the best, those are the expectations, and if I do not do them, then I also suffer.' Sacrifice is seen as something positive and necessary to do to help their children suffer less even if this means limited one's own personal interests and friendships during the child rearing years (online supplemental table for more quotes). Only three women across all groups confronted the group narrative that suffering is acceptable and expected. One woman said, 'no mother should suffer in this world.'

The pathway to help is not clear

The following quote is a good example of what how many women described dealing with their PPD alone:

> I had postpartum depression. It was such a struggle to get up and make him something to eat all day. I didn't know why I felt this way. I spent an entire week without bathing and without cleaning the house, and my husband kept asking me why I didn't have time to do these things. All I did was cry and feel like the most disgusting woman but did not have the willpower or strength to change. I would just question myself and wonder what was happening to me. I came out of this all on my own. I forced myself to get out of it.

There seemed to be no clarity around knowing if one has PPD or if one has 'regular sadness' that can be handled on their own. Someone said, 'My sister helped me she searched the internet, for lack of information… I did not know' and another said, 'Sometimes you do not know what you have'. One woman said, 'I prefer to solve everything on my own, everything stays in me, and I do not tell anyone.' Another said, 'we are afraid to admit that we need help' Given the community judgements shared in group discussions, it was not surprising to hear that many women who had suffered depression struggled alone to overcome it. There were mixed feelings about seeking professional help. Most women mentioned they feel comfortable talking to their female friends to get information about PPD and seeking ways to resolve the depression. Most respondents reported the use of prayer and engaging support through their church as a pathway to healing. Many women said dancing, singing and being with family helped them to feel better when feeling down. One woman said 'I play music and I dance. I clean. I exercise. I take my mother-in-law to shopping'. Qualitative research with Latina mothers with depression supports

the use of prayer, self-reflection and talking about feelings with family as coping behaviours.[45]

DISCUSSION

Key findings from this study reveal mothers in this study felt cultural expectations that mothers be the glue that holds families together and that mothers suffer and sacrifice their own needs for their children. Taken together with feeling they will be judged if they have PPD and must hide their emotions, findings illuminate the need for prioritising and centring mothers experiences and needs in the postpartum phase. Listening to mothers' voices, we learnt that they view the experience of PPD as one that can be isolating, entail judgement by the community, and potentially threaten one's usefulness to her own family. Participants in the focus groups had varying awareness of PPD and shared stories of misinformation or negative assumptions of what it means for a mother to have PPD. All mothers had heard of depression after childbirth, many had experienced it, and most remarked that the personal experience and community acceptance of it vary by family. Acceptance and support from their community and family were highly valued and desired. Negative views of depression during or after pregnancy may be stemming from a lack of information about the causes, variation in severity and treatment. Mothers felt judged by their communities (eg, family, neighbours, church). Stigmatising community beliefs and misconceptions about the causes and progression of PPD within Latino communities are not uncommon.[46] Beyond the stigma, it was also evident that mothers were unsure of how to know the difference between a sadness that passes and depression symptoms that require professional help. Providers should be aware of a need for dialogue about the continuum of emotions from baby blues to severe PPD.

Affiliation with cultural values was woven through the discussions. The prioritisation of family over the individual needs and the cultural value in focusing on the family (familismo) is common in Latino families.[44] Some cultural beliefs such as familismo seemed to provide great support to mothers, while others such as maternal self-sacrifice (marianismo) or traditional gender roles resulted in mothers feeling ashamed, incompetent and alone. Data from these focus groups reveal that suffering and sacrifice are expected in motherhood as mothers tend to put their children first and put her own happiness aside. Parenting by teaching cultural values of family, religion and respect was discussed by most mothers in the current study and supported by Calzada, Fernandez and Cortes' qualitative study among Mexican-born and Dominican-born mothers.[47]

The shared experience of not feeling useful when having PPD should be interpreted within the context of the high value of the mothers' role in their family as reported by participants. Our focus group participants worried that if they could not perform their duties as a mother, they would feel incompetent and might lose their family if they succumb to depression. Qualitative studies among Mexican-American immigrant women describe how the mothers view themselves as serving a central role in the home, responsible for the children's moral education, and the primary source of teaching children how to get along in the world.[48 49] Based on the findings in this study and other qualitative studies among Latinas, mothers are likely to feel a great sense of responsibility to stay well and be the leader of socialisation for the family. This expectation may prohibit the admission of depression symptoms and or help-seeking behaviours. As stated by one of the participants, 'I keep my feelings to myself…', the admission of depressive feelings could be seen as an admission that the mother can't handle her 'job'.

The point that the community says 'she must not have any help' when they see a depressed mother brings up a valid perspective that is often not discussed enough in mainstream research and media in the USA. Childbirth can result in physical trauma from which it takes time and rests to recover. Effective recuperation is not possible if a mother has no help from family or friends. In Latin American countries, traditional customs are performed to help and support new mothers. For example, peers who are also mothers, sisters and grandmothers assisted the new mother with household duties, newborn care, and enforcing periods of rest for the new mother.[29] These customs are not universally practised in the USA, and it is worth exploring strategies that non-native Latina mothers use to get the help they need and avoid feeling alone in their experience. There are likely many strengths that exist interpersonally and at the community level that can be leveraged to support their maternal well-being. Increasing awareness that pregnant women may need extra help and time to care for own mental well-being after childbirth could result in increased community and family level support.

Social support and instrumental support are known buffers of PPD.[50] In focus groups with Spanish-speaking mothers, husbands have been cited as the primary support system followed by mothers, cousins and friends.[45] However, in the cited study by Negron *et al*[45] mothers also reported that they expected their husbands and family to implicitly understand that new mothers need help with the care of the baby and need positive emotional support. Mothers said they would often not ask for help from family for fear of having their parenting criticised or feeling like a burden to others.

One topic of conversation in the focus groups that has potential for future research is the question, 'is suffering and sacrifice part of being a good mother?' Keefe *et al* suggest that a narrow conceptualisation that 'good mothers' do the majority of child rearing and sacrifice their own needs contributes to women feeling they do not measure up and, therefore, being more at risk for depression after childbirth.[30] From a strengths-based perspective, Keefe *et al* recognised definitions of what it means to be a good mother in the mothers' stories, such as being

resourceful, strong and able to juggle multiple responsibilities and seek self-care when depressed.[30] Our participants spoke of suffering and sacrifice as a natural part of motherhood. They discussed the transmission, internalisation and passing down cultural values as a strength in group interviews. Similar to the findings reported in a Child Trends research brief,[51] the mothers in our group spoke with pride of their sacrifices for their children. According to the Child Trends report, understanding and incorporating cultural values such as respeto, familismo and sacrifice is vital to engaging Latino parents in early childhood education. Their findings are transferable to ours in support of incorporating a maternal strengths-based approach that is aligned with cultural values when working with foreign-born mothers.[51]

For example, sacrifice could be seen as a strength, and within the context of experienced trauma history and immigration trauma, resiliency. Many of our mothers live in the intersections of immigrant, poor and Latina. Practitioners and researchers must ask themselves: how can we centre the resiliency and strength born from this intersectional identity versus continuing to simply report poverty, immigration and ethnicity as risk factors for depression? More qualitative research is warranted to explore how behaviours and beliefs such as sacrifice for children can co-exist with behaviours such as self-care of one's own mental health. Left unchallenged, beliefs and expectations that mothers should sacrifice their own needs for the needs of children can be a dangerous set up for untreated depression. Living in poverty and being an immigrant are known to be factors that exacerbate depression yet also, act as barriers to help seeking.[7 14 22] If a mother experiences ongoing depression symptoms and yet she does not feel permission to share her struggles, she is unlikely to admit symptoms, let alone, seek professional help.[52] Our findings indicate that programme developers should consider family-focused education and intervention efforts.

Family plays a central role in providing emotional support for Latinos.[47] In our study, mothers felt useful when performing household duties and emotional support for the family. Husbands and life partners could play a vital role of 'witness' if they were educated to be more vigilant about the mother's mental health. The current study expands what we know from smaller focus groups with Latina immigrants who spoke of their cultural beliefs of PPD.[13] In both Sampson *et al* 's study and the focus groups presented in this paper,[13] mothers spoke about not knowing (within themselves and when observing others) how to distinguish the normal range of suffering from a level of emotional and physical suffering that requires professional help. Although there was not enough discussion specifically about lack of information contributing to difficulty in distinction, several women mentioned a lack of clear and consistent information about what PPD looks like, feels like and how to know when to ask for help.

With national PPD prevalence in the USA higher among Latinas than non-Latina Whites,[6–9] there remains a need for more accurate screening and intervention. Progress toward the goal of decreasing PPD and negative outcomes is only possible with more inclusive research. Researchers and practitioners must be careful not to ascribe a 'one size fits all' mentality when inquiring about symptoms or offering interventions for mothers with PPD. As research on perinatal mood disorders such as PPD broadens in its breadth and depth, it is apparent that we must decrease the stigma of PPD and apply more understanding of culturally specific norms and practices that prevent or exacerbate depression. We must also explore how the experience of foreign-born mothers living in the USA is characterised by clashes in cultural expectations and norms about how a mother adjusts after childbirth.D'Anna-Hernandez *et al* observed that the US values of independence and self-reliance was a risk factor for increased depressive symptoms among Mexican-Americans during the pregnancy.[53] This information can only be gleaned from PPD-related research that centres Latina women. Innovation in awareness building and intervention implementation is needed. Researchers have demonstrated success with recruitment for a randomised trial of PPD intervention among US-born and non-US-born Latinas by using online recruitment methods aimed at a global audience.[54 55] Le *et al* successfully recruited over 100 women through internet marketing and substantiated efficacy for an evidence-based intervention of Curso Mamás y Babés.[56]

This study has several limitations. First, it only represents a sample of 133 Latinas, some US-born, some foreign-born with similar demographics but unknown amount of variation in ethnicity differences. One danger that research among Latino populations face is the homogenisation of a population with a large amount of ethnicity variation. More research needs to be done to disaggregate qualitative and quantitative data within Latino populations. Second, given that it is a qualitative study, we cannot generalise our findings to broader populations. Although external validity is not a goal or a promise of qualitative research, we hope our results could inform practice and research on mothers with similar cultural norms and demographics. Third, our community partner gathered the demographic data before the focus groups, so we missed an opportunity to get more precise data in demographics such as whether they had ever had a positive PPD score, numbers of years in the USA, and specific country of origin. Lastly, despite our efforts to ensure the trustworthiness and rigour of this study, such as keeping it embedded in communities, having bilingual facilitator and having diversified reviewers during the data analysis, it is possible that research reactivity and researcher bias still existed.

CONCLUSION

This research implies that providers who work with US-born or foreign-born Latinas during pregnancy and postpartum should consider the broader context of a

woman's life that may prevent identification and or admission of PPD symptoms. The lack of formalised supports in the USA for pregnant women and new mothers supports narratives that PPD is an individual problem that must be solved one one's own. Yet, all of the research on predictors and effective treatment for PPD points to a need for increased community awareness and support. A paradigm shift away from individualised culture to communal culture is needed for inclusive early identification and treatment of PPD. When society can openly discuss maternal mental health in the peripartum period, this may greatly influence mothers' ability to internally and externally navigate depression, anxiety, chronic stress.

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