

Perinatal Mental Health Needs of Indian Immigrant Women in Central Canada: Exploring the
Accessibility and Acceptability of Mental Health Supports

by

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Abstract

Life changes during pregnancy and the postpartum period (perinatal period) can be challenging and may lead to new-onset or worsening anxiety and depression. If left untreated, these symptoms can worsen, negatively affecting maternal and fetal/infant health outcomes. Immigrant women are at increased risk of perinatal mental health problems compared with their counterparts, due to stressors such as loneliness, financial constraints, and language barriers. Indian immigrants represent one of the fastest-growing immigrant populations, yet there is a paucity of literature on the mental health experiences and needs of Indian Immigrant Women (IIW), especially in the context of pregnancy and postpartum. **Objectives.** This research aimed to bridge this gap by exploring the mental health needs of IIW during the perinatal period, as well as their attitudes toward seeking mental health support. **Methods.** This was a mixed-methods study that included quantitative measures (demographics, Edinburgh Postnatal Depression Scale [EPDS], and Generalized Anxiety Disorder-7 [GAD-7]) and 60-minute individual interviews conducted over Zoom. The results were analyzed using Reissman's narrative analysis and interpreted through a postcolonial feminist lens. This study was conducted in collaboration with a not-for-profit Indian community organization, Punjabi Community Health Services (PCHS), Manitoba. **Findings.** Pregnant (n = 3) and postpartum (n = 7) IIW were recruited through social media and Indian community networks. Quantitative findings revealed possible depression and mild anxiety, based on EPDS scores (median = 11.5, range = 5-24) and GAD scores (median = 8.5, range = 2-17). Narrative storylines included *motherhood in a foreign land* (the impact of migration, partner support, and building a new village); *invisible pains during the perinatal journey* (invisible pains, navigating invalidation, and when pain becomes visible); *negotiating authority over postpartum and infant care*; and *navigating Western perinatal supports* (what it means to seek support, learning to navigate Western perinatal supports, and facilitators to seeking

psychological supports). **Implications.** Findings provided a greater understanding of the experiences of perinatal mental health challenges and unmet mental health support needs of IIW within their socio-environmental contexts, as well as directions for future program development initiatives.

Keywords: *immigrant women, perinatal mental health, mixed-methods research, support needs and barriers, narrative analysis*

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Introduction

Although pregnancy and childbirth are monumental times in a woman's life, they can also bring uncertainty as roles and responsibilities shift with parenthood. Anxiety and depression are common during this period (Fairbrother et al., 2016; Fawcett et al., 2019) and can lead to adverse health outcomes for both the mother and the infant. Immigrant women are more likely than their White counterparts to experience anxiety and depression during pregnancy and the postpartum period (Vaillancourt et al., 2022). In recent years, Canada has seen a rise in Indian immigrant populations (Statistics Canada, 2024, Table 2), yet there remains limited knowledge about the mental health needs of this community during pregnancy and postpartum (perinatal period). Research in this area is crucial, as Indian women are likely to face culturally specific risk factors that may exacerbate anxiety or depressive symptoms and deter them from seeking support.

This study investigated the mental health experiences of perinatal Indian immigrant women (IIW) in Manitoba, as well as their attitudes towards seeking mental health support. Additionally, this study was conducted in collaboration with Punjabi Community Health Services, a not-for-profit Indian organization, to ensure the study remained culturally grounded and highlighted participants' voices. This thesis will first discuss the literature on perinatal mental health problems, their implications, risk and protective factors, and barriers affecting their mental well-being. Then I will share the methodology and key findings, and highlight implications and future directions.

Perinatal Mental Health Problems and their Implications

The perinatal period, spanning from pregnancy to 12 to 18 months postpartum, marks a pivotal transition in a woman's life, encompassing changes across multiple domains, including

emerging identity, relationships, and the physical body, placing perinatal individuals at high risk for new or recurrent mental health problems (Ayers et al., 2019; Brassel et al., 2020; Lessard et al., 2025; Samra & Dryer, 2024). Although some level of anxiety, as well as fluctuations in energy, appetite, and sleep can be common and may even be a result of hormonal and lifestyle changes accompanied by pregnancy, childbirth, and/or parenthood, these symptoms may develop into diagnosable mental disorders when they become difficult to manage and interfere with daily functioning (Lorenzo, 2023; National Health Institute [NIH], 2023).

Research suggests that anxiety and depression tend to be highly prevalent during the perinatal period. While some symptoms of generalized anxiety include excessive worries across multiple domains, fear, hypervigilance, muscle tension, difficulty concentrating, and restlessness (American Psychological Association [APA], 2022), the focal content of perinatal anxiety relates to pregnancy, childbirth, and parenting (Blackmore et al., 2016). Several anxiety and related disorders such as specific phobia, social phobia, panic disorder (PD), obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) tend to be prevalent and highly comorbid in the perinatal period (Drake et al., 2022; Fairbrother et al., 2016; Fawcett et al., 2019; Howard et al., 2023; Viswasam et al., 2019). Globally, the prevalence rate of any diagnosable anxiety disorder has been estimated to be 18% in the first trimester and 15% in the second and third trimesters (Dennis et al., 2017).

Additionally, symptoms such as persistent sadness, hopelessness, irritability, guilt, feelings of worthlessness, loss of interest, fatigue, difficulty concentrating or sleeping, and thoughts of death or harm to the baby, lasting more than two weeks after childbirth, may signal postpartum depression (NIH, 2023). The worldwide prevalence of postpartum depression is estimated at 14% (Liu et al., 2021), and perinatal depression has been estimated at around 26.3%

(Al-abri et al., 2023). Notably, anxiety and depression often do not occur in isolation but rather co-occur (Shen et al., 2024; Xu et al., 2025), with 1 in 10 women experiencing symptoms of both during the perinatal period (Ou et al., 2025).

When left untreated, perinatal mental health problems can increase the risk of adverse outcomes for both the mother and the developing fetus or infant. For example, anxiety during pregnancy may increase the chances of spontaneous preterm delivery, preeclampsia (high blood pressure), infants being born with low weight, or with smaller head circumference (Grigoriadis et al., 2018). Anxiety during postpartum can negatively affect breastfeeding (Fallon et al., 2016), as well as the mother-infant interaction and attachment (Klauser et al., 2023), and the social-emotional development of the infant (Polte et al., 2019). Further, the co-occurring symptoms of anxiety and depression during the perinatal period are associated with adverse effects on cognition, language, motor, and adaptive behavioural development of infants, and these outcomes can persist through adolescence (Rogers et al., 2020). Given the high prevalence and long-lasting impacts on mothers and fetuses or newborns, it is critical that all perinatal individuals receive culturally sensitive, timely, and accessible mental health care.

Perinatal Mental Health Problems within Immigrant Populations

Immigrant women are at greater risk of developing or experiencing worsened mental health problems during the perinatal period compared to non-immigrant women, due to many factors, including but not limited to, a greater likelihood of social isolation, limited knowledge of the Western healthcare system, and language barriers (Moore et al., 2019; Stewart et al., 2008; Vaillancourt et al., 2022). In the past decade, Canada has seen a significant influx of immigrants, with individuals from India among the fastest-growing immigrant groups (Statistics Canada,

2024, Table 2). However, little is known about their specific perinatal mental health needs, as well as their attitudes toward seeking mental health support.

A Canadian quantitative study found that Punjabi-speaking women, particularly those with low English literacy, were at higher risk of perinatal depression than their English-speaking counterparts (Sanghera et al., 2015). Despite these findings, research exploring the mental health needs of this community remains limited. Given the rapid growth of the Indian population in recent years, it is critical to better understand the specific mental health problems faced by IIW during the perinatal period.

Previous studies that have explored the mental health difficulties of immigrant women during the perinatal period often combine diverse immigrant groups into a broad category of ‘immigrants.’ For example, under this umbrella term, they may include refugees, asylum-seekers, and economic migrants (Anderson et al., 2017; O’Mahony et al., 2013). However, combining these groups can be problematic, given that these individuals may have different motives for moving abroad. For instance, someone with refugee status in Canada might have fled their home country due to an imminent threat to their safety, whereas an economic migrant may have moved abroad to pursue better employment opportunities.

While studying various ethnic groups may be cost-effective and shed light on shared challenges faced by diverse immigrant groups in Canada, this approach may mask nuanced experiences and fail to capture the *specific stressors* unique to each group (Islam et al., 2010). As such, the current thesis focuses on exploring the mental health problems of IIW during the perinatal period. Given the limited literature on the mental health of Indian women, this literature review highlights findings from studies that include South Asian women (South Asian countries

include India, Pakistan, Bangladesh, Nepal, Sri Lanka) as well as other immigrant groups, where needed.

Healthy Immigrant Effect

The healthy immigrant effect (HIE) is a theory positing that immigrants to the host country often report better health outcomes than those born there, and that these improvements may be reflected in mortality rates (Vang et al., 2017). Despite evidence of positive health outcomes among recent immigrants, emerging studies suggest these findings often do not extend to general or perinatal mental health outcomes (Elshahat et al., 2022; Vang et al., 2017). For example, within the context of reproductive health, a study found that although foreign-born immigrants reported lower rates of hospitalization and illness during pregnancy, they were more likely than domestic-born individuals to report postpartum depression, regardless of length of stay in the host country (Urquia et al., 2012). Additionally, findings revealed a higher prevalence of postpartum depression among non-European immigrants, regardless of length of stay (Urquia et al., 2012). Similarly, another study found that immigrants who initially show positive mental health outcomes tend to report a decline as their length of stay in the host country increases (Mason et al., 2024). As such, while the HIE theory may initially indicate a positive trend in immigrants' health outcomes, a closer look at their mental health outcomes may suggest contrary findings, and this may be linked to the accumulation of migration-related and other psychosocial risk factors among immigrant women.

Risk Factors

There are several factors that affect perinatal IIWs' mental health. For example, research shows a prior history of anxiety and/or depression increases the chances of experiencing mental health problems during the perinatal period (Gheorghe et al., 2021; Martini et al., 2015),

especially among individuals with previous stressful life events and adverse childhood experiences (Furtado et al., 2018; Hou et al., 2023). Additionally, older maternal age and complications from previous pregnancies have been associated with increased symptoms of perinatal anxiety (Furtado et al., 2018). Among IIW, factors such as intimate partner violence (Bright et al., 2018), pressure to have a son (Insan et al., 2022), low socioeconomic status (Goyal et al., 2010; O'Mahony et al., 2013; Saad, 2018; Vaillancourt et al., 2022), and fear of judgment when engaging in traditional practices (Nagesh et al., 2024) tend to add layers of stress during the perinatal period.

Partner Support & Intimate Partner Violence

While limited studies have examined the impact of partner support on perinatal Indian women, even fewer have examined it among perinatal immigrant women. Nonetheless, a few studies have found that a lack of support with household chores and childcare was associated with greater mental health challenges among Indian women (Kalra et al., 2021; Moon & Kim, 2023; Rao et al., 2020).

Beyond the emotional and tangible support, the perinatal mental health of IIW may also be affected by their experiences of intimate partner violence.

Intimate partner violence. The literature suggests that in some Indian families, men and women often adhere to traditional gender roles, with men expected to be the breadwinners and women to care for the home and children (Sabri et al., 2018). These prescribed gender roles may contribute to unequal power dynamics, in which men might use physical violence to restore the status quo (Sabri et al., 2018). However, these rigid, traditional views are often challenged upon migration, as acculturation to the West allows women to adopt more egalitarian views, and this shift has been associated with an increased risk of violence (Rai & Choi, 2021; Sabri et al., 2018).

Conversely, women who maintain traditional views post-migration may be at risk of violence, as they may hold accepting or tolerant attitudes towards it. For example, one study found that traditional Punjabi women were more likely to engage in victim-blaming and to excuse the abuser's actions than women with more egalitarian views (Roberts et al., 2016). In other cases, women moving to a new country may rely solely on their husbands for financial support and for navigating the visa application process, which can make them more vulnerable to violence (Rai & Choi, 2021). Understanding the high rates of intimate partner violence in the community is crucial, as it can be a significant stressor for pregnant women. Research shows that South Asian women are at increased risk of physical, verbal, and sexual violence from their husbands during pregnancy, resulting in heightened anxiety (Bright et al., 2018). Additionally, domestic violence has been linked to postpartum depression (Dennis & Vigod, 2013).

Son Preference

The literature suggests a long-standing preference for sons in some Indian families, rooted in the established kinship system that designates sons as the sole heirs to their parents' assets and as bearers of their family legacy. While sex selection in favour of a male child is common in India (Kalra et al., 2021), studies show that these patterns persist among Indian women in Canada. For example, a study found that they were twice as likely to have an abortion before the third birth if their previous two births were daughters (Brar et al., 2017; Wanigaratne et al., 2018). These trends persist irrespective of length of stay in Canada (Brar et al., 2017). While it remains unclear whether these findings reflect women's personal preferences for sons, research shows that Indian women often report increased pressure from elders in the family to have male children (Srinivasan, 2017). This is especially concerning, given that son preference is linked to antenatal anxiety and depression among this population (Insan et al., 2022).

Socioeconomic Status

Job insecurity and downward social mobility contribute to mental health difficulties among immigrant women. Many immigrant women with professional degrees from their home countries report difficulty finding field-specific jobs after immigrating, as their credentials are often not recognized in Canada (Ahmad et al., 2004; O'Mahony et al., 2013). Due to the high cost of living, they often resort to low-wage, labour-intensive jobs, which significantly contribute to mental stress (Ahmad et al., 2004). Alternatively, some women enter the workforce for the first time after immigrating and are forced to take low-status jobs, which may contribute to high levels of stress (Ganapathy-Coleman, 2023). Financial stress, combined with the demands of parenthood during the first year postpartum, may increase the risk of postpartum depression among immigrant women (Goyal et al., 2010; O'Mahony et al., 2013; Saad, 2018; Vaillancourt et al., 2022).

Cultural Dissonance

IIW may fear judgment when engaging in cultural practices unfamiliar to their healthcare providers. For example, certain traditional Indian practices, such as “putting bracelets on newborns, shaving infants’ heads, ritual cluster celebrations, applying kohl around infants’ eyes, feeding infant ghutti or honey” (Nagesh et al., 2024, p. 263), may not be well received by healthcare professionals. There may be an added layer of anxiety if healthcare providers’ advice on how to care for the infant or themselves postpartum contradicts guidance from female family members, who are considered integral sources of support during this period (Nagesh et al., 2024).

Protective Factors

Although numerous risk factors exist within the Indian community during the perinatal period, social support and spirituality have been identified as important buffers. Indian society is predominantly collectivistic, placing a strong emphasis on interdependence among community members, and social support is a salient protective factor for many Indian people. After migration, individuals are likely to lose social networks and struggle to form new social ties, which may lead to feelings of isolation (Bhattacharya, 2011; Ganapathy-Coleman, 2023). These feelings may be further exacerbated during pregnancy, a time in a woman's life that would typically be spent under the care of female family members back home (Ganapathy-Coleman, 2023). Further, newborns are collectively cared for by other female family members, while women primarily focus on healing and restoration postpartum (Kandasamy et al., 2020). The lack of social support during the perinatal period in a new country may heighten symptoms of anxiety and depression among immigrant women (Alhasanat-Khalil et al., 2018; Maxwell et al., 2018). This risk may be elevated for women who struggle to adapt to the culture of the host country (Alhasanat-Khalil et al., 2018; Antoniou et al., 2021; Chen et al., 2022; Saad, 2018).

Spirituality is also a protective factor that is underemphasized in Western-focused psychology, yet it is an invaluable means by which individuals make sense of their physical and emotional suffering, find meaning, and cope with hardship (Cucchi & Qoronfleh, 2025). How individuals make sense of mental health intersects with many aspects of their identity, including cultural and religious contexts (Cucchi & Qoronfleh, 2025). Among immigrant women, spirituality has been identified as an important protective factor (Pilav et al., 2022; Zou et al., 2020) for reducing symptoms of anxiety and depression during the perinatal period. It also provides a means for women to connect with others of similar faith, offering support during

challenging times in pregnancy and the postpartum period (Keefe et al., 2016; O'Mahony et al., 2013; Simonovich et al., 2022).

Cultural-Specific Treatment for Perinatal Anxiety and Depression

Among the many psychotherapeutic treatments that are currently available, Cognitive Behavioural Therapy (CBT) is considered the gold-standard approach for treating depression and anxiety (David et al., 2018; Fernández-Álvarez & Fernández-Álvarez, 2019), particularly during the perinatal period (Green et al., 2020; Li et al., 2022; Maguire et al., 2018; Pettman et al., 2023). CBT focuses on the connection between thoughts, feelings, and actions to help recognize and challenge unwanted thoughts and behaviours.

While there is evidence that CBT is an optimal therapeutic approach, it is worth noting that the samples in these studies are largely composed of White women (Green et al., 2020) or include disproportionately few women from other ethnic backgrounds (Black, Hispanic, South Asian, Mexican, Spanish, etc.) relative to White women (Pettman et al., 2023). The underrepresentation of ethnic minorities is problematic, as these results may not fully reflect the mental health outcomes of these populations. This is because the principles guiding the standard version of CBT are rooted in Western ideologies of individualism, which emphasize one's thoughts and behaviours (i.e., problematic, distorted thinking, and maladaptive behaviour), with relatively less emphasis on broader contextual factors that contribute to poor mental health. This approach may conflict with the values of collectivist cultures, which tend to emphasize community, spirituality, and family networks in shaping mental health experiences (Naem et al., 2019; Naem et al., 2023). As such, culturally adapted versions are required.

When incorporated, culturally adapted programs that use CBT-based strategies, such as ROSHNI-2, have been shown to significantly reduce symptoms of postnatal depression among South Asian women (Husain et al., 2024). For example, the 12-week group-based program addressed participants' mental health concerns within their familial contexts, managed familial expectations, and addressed other relevant issues within their socio-environmental contexts. Research indicates that immigrant women are less likely to use postpartum mental health services (Vigod et al., 2016). A lack of culturally relevant perinatal mental health programs in Canada may be a contributing factor, along with several other barriers.

Barriers to Seeking Support by IIW

Access to perinatal mental healthcare can be influenced by multilevel factors, including: 1) individual-level factors (beliefs and knowledge about perinatal mental health), 2) varying levels of trust in healthcare professionals, 3) interpersonal factors (language and communication barriers), 4) organizational-level factors (use of Westernized screening tools, inaccessible service locations, lack of childcare services), 5) political factors (immigration and economic status), and 6) societal factors (cultural norms and stigma) (Webb et al., 2023).

Specifically, there is an overall lack of knowledge among immigrant women about perinatal mental health (Bains et al., 2023). Immigrant women tend to be in denial of their mental illness, attribute mental illness to spiritual phenomena, lack information on how to access mental healthcare, and fear child apprehension when sharing their mental health struggles with mental health professionals (Bains et al., 2023; Dela Cruz et al., 2023; Phillip et al., 2024; Wittkowski et al., 2016). IIW often work low-paying jobs with poor healthcare plans, which may prevent them from accessing psychotherapy (Naem et al., 2023; O'Mahony et al., 2013). They may also experience culturally insensitive therapy, which may discourage them from seeking

mental health support (Pilav et al., 2022). Furthermore, stigma related to mental health persists within the Indian community, where some women may fear that disclosing their mental health issues will result in them being viewed as ‘mad’ or ‘an unfit mother’ (O’Mahony et al., 2013; Phillip et al., 2023).

Current Limitations in the Literature

To date, Canadian studies investigating the mental health needs of postpartum immigrant women have combined multiple ethnic and refugee groups together (O’Mahony et al., 2013; Vigod et al., 2016). This approach can be problematic, as it tends to aggregate people with vastly different experiences under the broad category of ‘immigrants,’ leading to gaps in our understanding of the unique mental health needs of each group.

This study focused specifically on IIW, given the growing population of Indian immigrants in recent years (Statistics Canada, 2024, Table 2). To my knowledge, only one study has examined the prevalence of perinatal depressive symptoms among Punjabi-speaking women in British Columbia (Sanghera et al., 2015). A significant gap remains in the literature on the unmet mental health needs of IIW during the perinatal period, as well as on their attitudes and behaviours toward seeking mental health support during this time. Accordingly, this study explored these areas in greater depth.

Further, although most studies tend to focus on postpartum depression, research shows that anxiety tends to be more prevalent during pregnancy and the early postpartum period compared to depression (Fairbrother et al., 2016), and often co-occurs with depression (Ou et al., 2025; Shen et al., 2024). As such, my study aimed to conceptualize the mental health problems, particularly anxiety and depression, among IIW during the perinatal period.

Methodology

Community-Based Partnership

The community-based partnership approach has become increasingly crucial in research (Rodriguez Espinosa & Verney, 2021) because it facilitates mutual learning and shared decision-making between researchers and the communities in which they conduct research. It is especially useful when working with marginalized communities that are historically underrepresented in research and where stigma and mistrust within mental health professions exist (Wallerstein & Duran, 2010). Given the nature of this study, I partnered with Punjabi Community Health Services (PCHS), a not-for-profit organization in Winnipeg, to address IIW's perinatal mental health concerns. PCHS' level of involvement was guided by the partner engagement approach outlined in the *Methods of Patient & Public Engagement Guide* by the George & Fay-Yee Centre for Healthcare Innovation (May 20, 2020). According to their guidelines, the engagement level can be consultative (low-level), collaborative (moderate-level), or patient- or public-directed (high-level). For the current study, PCHS' involvement was at the consultative level, where I primarily sought their feedback and input on my research decisions at all stages, including identifying and prioritizing, designing the research, and collecting data. Additionally, I plan to consult them when we reach the stage of deciding how and with whom to share research findings.

Research assistants and I held numerous Zoom meetings with PCHS members, engaging in meaningful discussions about the community's needs, perinatal IIWs' concerns, and the cultural and systemic barriers currently affecting the community. Drawing on insights from PCHS members with experience serving the community, we brainstormed research objectives

and selected culturally appropriate measures and interview questions that ultimately guided the qualitative component of this study.

Participants

I obtained ethics approval from the University of Manitoba's ethics board prior to beginning data collection (protocol number: HE2025-0236). Participants were recruited via advertisement on social media (e.g., Instagram and Facebook) and through diverse Indian community organizations in Winnipeg, including Asian Women of Winnipeg and Malayali Association of Manitoba. Additionally, PCHS members supported recruitment by sharing the advertisement poster (see Appendix A) within their internal networks. Participants were selected based on the following inclusion criteria: 1) currently pregnant and/or up to 18 months postpartum; 2) immigrated from India five years ago, five to ten years ago, or more than 10 years ago; 3) 18 years of age or older; 4) resident of Manitoba; 5) able to converse with the researcher in English; 6) has access to a private space and a device to complete a virtual interview; 7) endorses symptoms of depression or anxiety on the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987) and the Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006), respectively. Participants did not need to meet the EPDS and/or GAD-7 cut-offs to be included in the study; those who endorsed symptoms but did not quite meet the cut-offs were eligible to participate. Individuals who did not meet the eligibility criteria were provided with a list of alternative resources (see Appendix B).

Procedure

Data collection for this study occurred between September and December 2025. Interested participants began by attending a virtual meeting with me, during which I explained the study and the consent process to ensure they understood confidentiality and its limits,

supporting their informed decision-making about participating in the study (see Appendix C). This meeting also allowed them to build trust in me as a researcher by asking any questions about their participation, and it allowed me to identify and filter out any bots. Next, eligible participants were sent a REDCap link to complete the informed consent form (see Appendix D). After providing informed consent, they received another REDCap link containing three questionnaires: a demographic questionnaire (see Appendix E), the EPDS (see Appendix F), and the GAD-7 (see Appendix G). Next, participants were invited to a 60-minute in-depth virtual interview conducted by the researcher over Zoom. During these interviews, the conversation was guided by a list of semi-structured questions (see Appendix H). Participants received an honorarium in the form of a \$25 Amazon gift card via email immediately after completing the online questionnaires, and another \$25 Amazon gift card after completing the individual interview.

Demographic Questionnaire

The demographic questionnaire inquired about participants' age, gender, length of stay in Canada, native language, education level, occupation status, marital status, number of household members, whether they are currently pregnant or postpartum, number of children they have, and their physical and mental health and mental health service use through pregnancy and postpartum (see Appendix E).

EPDS

The EPDS (Cox et al., 1987) is a 10-item self-report measure assessing for symptoms of postnatal depression, using a 4-point Likert scale (0 = *Not at all* to 3 = *Almost always*). Some examples of the items on this scale include, "I have been so unhappy that I have had difficulty sleeping," "I have felt sad or miserable," and "I have been so unhappy that I have been crying" (see Appendix F). The scale exhibits satisfactory psychometric properties, is sensitive to change

(Cox et al., 1987) and has excellent test-retest reliability ($ICC = .92$; Krenot et al., 2015). This scale is also considered acceptable for use in pregnant populations (Murray & Cox, 1990). This scale has also been used in Indian perinatal populations and has demonstrated good psychometric properties (Fellmeth et al., 2021). Please note that item 10 on the scale refers to self-harm and was removed. While removing the 10th item from the scale compromised the questionnaire's integrity, particularly its internal validity, the item was considered an insensitive question to ask the target population, given the stigma that persists within the population.

GAD-7

The GAD-7 (Spitzer et al., 2006) is a 7-item self-report measure that assesses anxiety symptoms on a 4-point Likert scale (0 = *Not at all* to 3 = *Nearly every day*). Example items include “feeling nervous, anxious, or on edge,” “not being able to stop or control worrying,” and “worrying too much about different things” (see Appendix D). The scale demonstrates excellent internal consistency (Cronbach’s $\alpha = 0.92$) and good test-retest reliability (intraclass correlation = 0.83) (Spitzer et al., 2006). It has been deemed clinically useful for assessing general anxiety in the perinatal population (Simpson et al., 2014) and shows good psychometric properties when used in Indian populations (De Man et al., 2021).

Data Analysis Strategy

I used descriptive statistics (e.g., frequency) to understand the sample’s characteristics, as well as participants’ scores on the EPDS and GAD-7, to gain an understanding of their symptoms of depression and anxiety.

Participants’ in-depth individual interviews were audio-recorded on Zoom and transcribed in Trint, an AI-based transcription service. The transcribed interviews were cross-

checked for accuracy, de-identified, and saved as password-protected Word documents, which were shared amongst the research team.

I analyzed participants' narratives using narrative inquiry, as developed by Reissman (2008), which encompassed three levels of analysis: thematic, structural, and dialogic/performative. Given the holistic nature of narrative inquiry, this approach was especially well suited for the current study, as it allowed for the exploration of a complex topic such as how IIW make meaning of their experiences with mental health problems during pregnancy and/or postpartum. This approach produced rich accounts of participants' experiences, elucidating struggles that had not previously been documented.

I began the narrative analysis by examining each dimension (i.e., thematic, structural, and performative) separately for each interview. Next, I re-analyzed participants' narratives and compared findings across all levels. Finally, I integrated the three levels of analysis into my overall understanding of participants' experiences.

At the thematic analysis level, the focus was on the content of oral and written narratives, and these narratives were interpreted in their entirety (Reissman, 2008). At this level, the focus is on "what content a narrative communicates, rather than precisely how a narrative is structured to make points to an audience" (Reissman, 2008, p. 39). This level of analysis allowed me to determine the main thematic storylines related to IIW's perinatal mental health experiences and support-seeking attitudes.

Next, at the structural level of analysis, I prioritized examining how participants organized their stories (e.g., whether they followed a pattern or were random), their use of language, and the sequence of speech to deepen my understanding of how they construct their stories and attach meaning to their experiences (Reissman, 2008).

Lastly, at the dialogic/performative level of analysis, I examined how narratives were co-constructed between participants and me and considered the influence of the environment, societal pressures, and historical events on participants' storytelling processes. This further deepened my understanding of how participants made sense of their experiences within their socio-environmental contexts.

Concurrently, I recorded my personal reactions and interpretations of the interviews in a coding reflection journal to ensure research transparency.

Epistemological framework

Reissman's narrative approach is grounded in a social constructionist framework in which participants' stories are not treated as objective facts but as constructed through the meanings they attach to them, shaped by culture, history, and social context (Reissman, 2008). Additionally, this epistemological framework views narratives as an active process of co-construction and meaning-making, in which individuals selectively share stories at specific times with specific people (Reissman, 2008). As such, I aimed not to find a single universal truth but to hear participants' diverse experiences and how they individually constructed meaning around their perinatal mental health experiences and their attitudes towards support-seeking.

Postcolonial Feminist Theory

In addition to social constructivism, participants' narratives were interpreted through a postcolonial feminist lens. Postcolonial feminist theory focuses on the intersection between race, gender, class, and colonial historical contexts in shaping women's well-being (Browne et al., 2008). Specifically, this approach amplifies the unheard voices of historically marginalized groups by shifting away from Western perspectives that tend to assume all women's struggles are similar (Browne et al., 2008).

Further, according to Chandra Talpade Mohanty, a feminist scholar who wrote “Under Western Eyes: Feminist Scholarship and Colonial Discourses” (1984), Western feminist scholars often write about the struggles of third-world women in a way that suggests they all uniformly experience oppression within their contexts, which yields an “average third-world woman,” or someone who “leads an essentially truncated life based on her feminine gender (read: sexually constrained) and being “third world” (read: ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, victimized, etc.)” (Mahony, 1984, p. 337). Instead, she contends that women’s hardships should be understood in relation to their class, race, religion, and historical and political contexts. As such, participants’ narratives were grounded in postcolonial feminist theory to ensure that their diverse experiences took centre stage, were understood within the context of their lives shaped by migration, colonialism, gender, and historical and political contexts, and were not narrowly viewed through an oppressive lens. This theory has previously been used to explore depression among immigrant women (O’Mahony et al., 2010, 2013).

Rigour

Rigour was established through Riessman's (2008) work and Tracy’s eight “big-tent” criteria (2010) to ensure transparency and ongoing reflection. Specifically, I kept a coding reflection journal to track my reactions to the interviews that could interfere with my analysis. By documenting my experiences throughout this process, I engaged in ongoing self-reflexivity about my assumptions, background, and past experiences, ensuring that the interpretations were rooted in participants’ experiences rather than influenced by my own. Further, I kept a detailed record of my and my team’s involvement, the study’s challenges, and lessons learned throughout this process. In line with my positionality statement and Tracy’s guide on improving credibility in qualitative research, I remained mindful of the diverging viewpoints of IIW and ensured that

perspectives that deviated from the dominant perspective and/or my own were given equal importance. Additionally, I worked with a team of four (myself, two undergraduate students, and Dr. Reynolds) to further delineate my experiences from those of the participants. While I analyzed all interview transcripts and tracked my interpretations independently, I assigned several transcripts to research assistants for analysis and held meetings to discuss our interpretations, ensuring consistency in our understanding of participants' narratives and grounding that understanding in the theoretical framework. We also openly discussed and resolved discrepancies by consensus, ensuring consistency throughout the data analysis. Supervision meetings with Dr. Kristin Reynolds gave me opportunities to review the findings further and process my reactions to the interviews.

Positionality Statement

My interest in this research topic has been deeply shaped by my encounters with women in the Indian community who have faced barriers to accessing mental health support because of cultural limitations and stigma. My motivation to research perinatal mental health stems from what I have learned over my academic career about the many vulnerabilities associated with this period and its profound impact on women's mental health.

I acknowledge that I am a 28-year-old first-generation immigrant woman who moved from India to Canada at a young age. My identity as an Indian immigrant is an advantage in this research, as it has helped me connect with participants' stories and better understand the struggles they may have endured while building a life in Canada. Additionally, our shared identity helped me understand subtle cultural nuances without participants having to explain them to me. It is possible that my insider status allowed participants to share their experiences with me as openly as they did.

However, I recognize that while my shared identity helped me build rapport with participants, it also carried the risk of unintentionally overlooking subtle cultural differences, especially given the diverse sub-cultures within India. I kept this at the forefront during my interviews and sought clarification when I felt unsure about certain cultural references. I also recognized that much of my upbringing took place in Canada, which contributes to my privilege. I have had the freedom to pursue higher education and work in the field of psychology, where stigma is less pronounced, and I have opportunities to conduct research and provide treatment to individuals seeking mental health support. Additionally, I am neither married nor a mother, which has made me an outsider to the participants' experiences in this study.

Throughout the study, I reminded myself of the divergent identities of my participants and of my own during the analysis to prevent my personal views, which have been predominantly shaped by Western perspectives, and my reactions from interfering with the analysis. This was especially critical given the postcolonial feminist theory that guided my interpretation, in which Mohanty cautions Western scholars, as well as third-world scholars who have settled in the West and are conducting research on women from the West, not to mislabel an entire group of women as "oppressed" but rather to look for nuances and to examine how their circumstances are shaped by their intersecting identities.

Findings

Participant Characteristics and Perinatal Experiences

All 10 women (median age = 32; range 29-41) who participated in the study were born in India and completed questionnaires that collected information regarding their demographics, as well as depression and anxiety symptoms. Four participants immigrated to Canada between five and 10 years ago; two had immigrated less than five years ago; and four had been residing in

Canada for more than 10 years at the time of this study. Participants varied in their native languages, including Marathi, Punjabi, Malayalam, Hindi, Tamil, and Gujarati, reflecting the diversity of languages spoken among Indian immigrants in Canada. Overall, the sample was highly educated, including three participants with graduate degrees; three with undergraduate degrees; one with some university-level education; two who graduated from college; and one who completed some college education. All participants were married, and nine of 10 reported living with their spouse and children; one participant reported living with her spouse and in-laws. Seven of 10 women were within 18 months postpartum, and the remaining three were pregnant.

Pregnant participants ($n = 3$) reported their physical health as *good to very good*. Postpartum participants ($n = 7$) commonly reported their physical health as *good* when reflecting back to their pregnancy and *fair* postpartum, and their mental health as *fair* before and after the postpartum period. Outside the perinatal period, participants reported *good* physical and mental health throughout their lives. Two participants reported experiencing neonatal loss prior to their current pregnancies. In the open-ended section, participants were prompted to report any complications during the pregnancy, delivery, and postpartum stages. Two participants reported complications during pregnancy, including vomiting, stress, fatigue, high blood pressure, infections, anemia, anxiety, and cervical insufficiency. Three participants reported complications during delivery, including pain and the need for an emergency Cesarean section. During recovery from childbirth, two women reported physical weakness, infection, fever, pain, swelling, itching, postpartum anxiety, anemia, fatigue, difficulty breastfeeding, and chills. Regarding the baby's health, nine out of ten women reported no challenges to their infants' health.

When asked in an open-ended format, six out of 10 women reported experiencing some level of stress, anxiety, and depression. One was diagnosed with a mental health problem and received antidepressants and psychological support for concerns unrelated to their perinatal journey. Another participant received support from a psychiatric nurse for experiencing anxiety during postpartum.

Perinatal Mental Health Symptoms

All participants completed the EPDS and GAD, self-report measures of depression and anxiety. They endorsed a slightly increased risk of possible depression and mild anxiety based on their EPDS (median = 11.5, range = 5-24) and GAD scores (median = 8.5, range = 2-17).

Narrative Storylines

While each participant's story is unique, four storylines emerged across all participants' narratives and were analyzed at the thematic, structural, and performative levels (Riessman, 2008). These storylines include *motherhood in a foreign land* (the impact of immigration, partner support, and building a new village); *negotiating authority over postpartum and infant care*; *invisible pains during the perinatal journey* (invisible pains, navigating invalidation, and when invisible pain becomes visible); *navigating Western perinatal supports* (what it means to seek support, learning to navigate Western perinatal systems, and facilitators to seeking psychological support).

During these interviews, I was positioned as both a listener who shared the in-group identity of an Indian immigrant woman with the participants and a researcher tasked with highlighting participants' unheard voices. I aimed to balance these intersecting identities and to lead with curiosity about why participants chose to share their stories with me. One possibility for their openness was our shared identity as Indian immigrant women, which may have given

them a platform to share their experiences without the pressure to explain their cultural nuances to me. Another possibility is that this may have been the first time they had the space to talk about themselves, rather than about their children, husband, or family. Taken together, the findings describe participants' experiences of migration during their perinatal journey, reflect on their invisible emotional pain, recount ways they managed conflicts and negotiated parenting authority, and explain how they navigated Western perinatal supports. Please note that the participants' names in this study are pseudonyms to protect their identities.

Motherhood in a foreign land

All participants reflected on the impacts of migration on perinatal IIW, including loneliness during the perinatal period, and on how they created a “new village” or a sense of community away from home. Traditionally, perinatal IIW have social supports in their home country, which make their transition to parenthood more manageable. For example, after delivery, female relatives such as mothers, mothers-in-law, or other older female members move in with the couple temporarily to support the postpartum woman. Many women are given a 40-day rest period, which traditionally meant they were free of household duties and could focus on healing and recovery. Knowledge of infant or childcare is typically passed down by female relatives, or, in many cases, women learn it by observing the experiences of other female relatives within their familial network. Given the collectivist nature of Indian society, this joyous occasion is celebrated by family and friends, who gather to celebrate the couple and their newborn after the 40-day rest period. This interconnected community of friends and family is often dismantled upon migration. *Motherhood in a foreign land* is a narrative told by the participants in this study, who shared their hardships with me, including stories of sacrifice and resilience as immigrant women navigating life in Canada, away from home. Interwoven within

this storyline are narrative threads that explore the *impact of immigration, partner support, and building a new village*.

Impacts of Migration. This narrative thread highlights the impacts of migration on participants' perinatal experiences. Some participants described changes in identity, interruptions in learning about pregnancy, shifts in relationships, and changes in domestic responsibilities. These narratives showed how participants made sense of their hardships, navigated physical and relational distance, and, for some, how migration brought freedom.

One example of how migration disrupts identity and social networks emerged during my interview with Shanti (pseudonym), a 38-year-old married woman who lives with her husband and two daughters. When I asked how she felt about not having family nearby to support her and celebrate her newborn's birth, she reflected on the arduous journey she and her husband had undertaken to build a life in Canada. She portrayed herself as self-sacrificing, describing how she gave up "her world", including her education, friends, and family, to support her husband's dreams and fulfil her marital responsibilities, even though she was not prepared for it. As a listener, I later came to see that she took an active role in supporting her husband's dreams, as she shifted her language from "his dream" to "we bought a house," suggesting a transition from a life "he" wanted to a life "they" were building together in shared responsibility. While sharing her experiences, I became aware of my positionality, as I quietly heard the sacrifices she made in search of a future with her husband and growing family. This was reflected in my body language as a listener on Zoom, where I nodded at times and responded with empathy. Her reaction to my understanding and empathy allowed her to take up space and elaborate on her hardships. Our shared identities as Indian immigrant women enabled the co-construction of meaning around her hardships and resilience.

In describing her pain, I interpreted Shanti's recounting of her struggles as an attempt to make sense of her shifting identities as a young girl who had once been surrounded by a support network she left behind when she stepped into a responsible, self-sacrificing role, prioritizing her husband's dreams over her own. As she recounted these stories, however, I noted that she chuckled and used phrases such as "little bit" to soften the impact, which may have helped her manage the emotional weight of the stories and her desire to visit her family.

Shanti: Sometimes I cry uh (chuckles) to get away those things, like, um, I want to visit my parents or something like that. I like, uh, because, uh, I like to go back home, frankly speaking, uh, but my husband likes it here. Like it was a dream for him. So, I just followed him and am helping him to complete whatever he dreams for. But I like to go back home. So yeah, I had so many friends over there [in India] from like family, like I have a big, big family. So, I was used to that, right? And then suddenly I came here. No one is here, like no friends, no family, just two of us. So yeah, sometimes I cry, but then after that I feel so good. I talk to friends or my husband also. Yeah, we communicate and then yeah.

Researcher: Yeah, and missing back home like that's only natural, right? Like, you spent all your, like, lifetime there, and then one year, you, you know, you just, yeah, up and, like, move.

Shanti: Because I never, never, never dreamed for the foreign life. My world was there, education, job, friends, family, everyone was there. So, everything was going smoothly, and suddenly my husband told me when we were girlfriend and boyfriend at that time. Suddenly he told me he wanted to go and then study, and then we have to settle over there, yeah. So, it was like little bit um shocking for me, but then I came. I thought we

will stay some uh year few years and then we will go back. And that was my plan, actually. But then, you know what, when we come, um here, then no one goes back, like 99 percent, no one goes back, right? (researcher nods). Yeah, so yeah, same with me, I followed him, I help him with or whatever things, like job, house – we bought house. So, we were working, doing hard work, then trying to get permanent residency. So many struggles were there, so (chuckle) after that, yeah.

Immediately after, she contrasted this by expressing deep gratitude for being a mother of two daughters, noting that her sacrifices were worthwhile, while also reflecting on times when she did not think she would be able to have children because of her age. Perhaps having a family of her own helped her cope with the loss of her social support that accompanied migration to Canada, and allowed her to reframe how she viewed her hardships as an immigrant. Her story moved from loss to gratitude as she found meaning in her challenges through the family she built here with her husband. However, motherhood did not mean she had entirely overcome her feelings of aloneness in Canada, as suggested by her statement, “I like to go back home, frankly speaking.” Rather, it appears that her identity as an immigrant mother coexists with a continued longing to be close to her family, and this may have become more apparent as she welcomed her second child and realized the demands of parenting were increasingly challenging without any familial support in Canada.

In addition to disrupting social networks, migration affects *knowledge-seeking*. For example, knowledge about caring for newborns and other pregnancy-related information is exchanged within the close family circle and by observing female relatives care for their newborns. Migration can hinder that learning for pregnant women. This is evident in the case of Ria (pseudonym), a 29-year-old pregnant woman who immigrated to Canada 11 years ago. She

described some of her fears and uncertainties related to pregnancy, using language such as “I’ve never been around a pregnant lady or a newborn” and “it’s very, very new,” emphasizing the uncertainty felt about this new life experience. By sharing her story, she framed pregnancy as unfamiliar and migration as a barrier to her learning, compounding uncharted territories.

Additionally, she described that her parents not wanting to share the news about her pregnancy alludes to the cultural norm of keeping pregnancy a secret for at least the first trimester. This may be to avoid *Nazar* (evil-eye) and to prevent sharing the news too soon, as the first trimester is the most delicate period and carries the highest risk of miscarriage. This further highlights the isolation during the perinatal period for those without close social networks in Canada, as well as their reluctance to seek help and information.

Ria: The thing is, for me, I’ve never been around a pregnant lady or a newborn. So, for me it’s a very, very new experience. I was the youngest in my family, and then all my cousins, when they had their kids, I was in Canada. I have never seen a newborn or haven’t seen my cousins being pregnant or my sister-in-law’s being pregnant. So, it’s just, it’s, yeah, so it’s very, very new. I don’t have anybody to tell me about all the experiences and like how, like, you know, the, like, parents don’t like to share the news too much about pregnancy before, like at least back home. So, I’m like, it’s just, I’m just keeping things to myself, or I’m asking my friends. So yeah, it was very new.

Knowledge seeking may be further complicated by the *number of years spent apart* from friends and family. For example, Ria described a sense of disconnection she often feels towards her female cousins back home, who hold different perspectives and ways of life. In stating “It’s been like 11 years now...there’s a gap”, she gently notes that an unintentional consequence of migration is that it has transformed her relationships with people back home, portraying herself

as a distant family member within her family system, unable to relate to her family members' experiences. Over time and distance, pregnancy-related knowledge from family and relatives no longer feels relatable, comfortable, or accessible, which may be due to differences in lifestyles, perspectives, and perinatal health care facilities between India and Canada. This narrative was echoed by other participants in the interview, who reported feeling distant despite using virtual means to connect with friends and family back home.

Ria: I'm also very shy about it; I don't know why. It is a cultural thing, I guess. I don't talk to my parents openly about it [pregnancy]. So, it's very hard to even talk to my cousins or anybody else, right? And being apart [from family] for so many years, it's been like 11 years now, now I feel that, I like, I just can't randomly call and be like, Oh, I just want to talk about this. So, so there's a gap there...and also, my opinion, like my lifestyle has been very different than my cousins back home, right? So, it's also the culture here, the facilities here are different than, than what's back home...I won't be able to relate.

When I asked her more about how she copes with her emotions, Ria noted that she is private about her feelings. She stated that she has grown accustomed to navigating challenges alone and prefers not to "burden" others. In narrating her story, she described her self-reliance as something she had to learn as a result of migration, as suggested by her statements, "you get used to it" or "you just learn to be strong." Further, her statements suggest that these hardships may have felt familiar to her during her perinatal journey; she has faced numerous challenges since migrating to Canada, and over time these hardships have become routine, and she has learned to manage them on her own.

Ria: You just get used to it once you've been so away for so many years. You just feel like there's daily challenges. Like now, of course, in the beginning, of course, there's more challenges, right? So, you don't burden anybody with those. So, you just get use to. You know that it's not a big deal and you're gonna overcome it. So, you just learn to be strong and be like, okay, this is just, you figure it out.

While many described the difficulties of being physically away from their support systems and the loneliness they experienced during the perinatal period, some women also described the positive impacts of migration on their freedom from household responsibilities. For example, this was exemplified in Kiran's narrative (pseudonym), a 31-year-old woman who immigrated to Canada over five years ago and travelled to India for a family wedding at the time of the interview. In Canada, her support network includes her husband and sister. In her interview, she described her living arrangement in India, where she stayed a few weeks with her parents and a few weeks with her in-laws. She contrasted household responsibilities in Canada and India by describing a day in her life while she was staying with her in-laws, identifying the multiple roles she balanced and prioritized as a daughter-in-law and mother over those of an independent individual.

Kiran: My mother-in-law was sick. So, I woke up in the morning, I cooked everything. We are like 7 people here. I gave food to seven people on the table. They didn't come to the kitchen to take. No, I give everybody. Then I like feed my baby. After that, I feed myself. Then I did everything, like it takes me like five to six hours. Then my mother [mother in law] said, oh, now, you go and like bathe. I said, no, I can't bathe, I have a fever, I need to take rest...Even my mother also said- you can't do this, you are late, it's already afternoon, you didn't bathe yet.

When I prompted her to contrast the two domestic lifestyles, she noted that she had fewer responsibilities in Canada than in India.

Kiran: [In Canada] There, if I don't want to eat, I can order on this type of dishes, right? So here you have to cook also, you have to serve also on the table [in India]. So, I think over there [in Canada], I see like that now I just take care of the baby. I don't have to worry about the food or the cleanliness. Here [in India], people every day, like two times, they want cleaning.

However, later in the interview, she adds a complex layer to her narrative, describing a sense of loneliness she experienced without any support in Canada. Her narrative becomes more nuanced as she highlights the dual nature of social support. In telling her story, Kiran appeared caught between two worlds: someone who both missed having company during her pregnancy and felt overwhelmed and stressed by the responsibilities placed on her back home. For example, she noted that in Canada she would wait for “someone to talk” to her, such as her husband or sister, whereas in India she had company and people around her to talk to while “working” or completing household chores, which came at the cost of her ability to prioritize rest and self-care.

Kiran: Like I would say the pregnancy journey was really tough because nobody was there [in Canda] to talk to me, nobody was there to help me to take me to the gynecologist, I have to drive myself. You will be surprised, like just one day before I went to the gynecologist alone and the next morning, my baby was born.

Researcher: Mmm [raised eyebrow]

Kiran: And I was driving a car until nine months.

Researcher: Yeah.

Kiran: So over there [Canada] I was saying like, I was waiting for someone [her husband and sister] to talk to me, but they don't have time. Here [India], like they have time, you can talk with them when you're working and all that.

These narratives highlighted the impact of migration on social networks and how individuals make sense of their loneliness during the perinatal period. Some individuals reframed their hardships as gratitude for motherhood, while others described how distance from their loved ones affected their willingness to seek pregnancy- and postpartum-related knowledge. Some shared counter-narratives about the freedom that came with migration, despite the loneliness it entailed.

Partner Support. For many participants, migration led to the loss of social networks, leaving women to rely on their husbands for support during the perinatal period. This subthread focused on participants' narratives about making sense of their husbands' support within their new relational dynamic after migration disrupted the familial supports that would otherwise have been available to them. Participants described how they and their husbands navigated shifting traditional gender roles during the perinatal period. For some women, this meant a continuation of these ascribed roles, whereas for others, it meant a change.

For example, Priya, a 32-year-old woman who immigrated to Canada approximately six years ago, described receiving limited support from her husband. At the outset of the interview, she described the multiple layers of stressors that made her pregnancy challenging. She discussed experiencing the death of her father in India, which she emphasized as “the toughest time” during her pregnancy. She also voiced an absence of support with household chores, as her mother-in-law, who was visiting her in Canada at the time, had to return to India due to a death in their family. She described feeling lonely and stressed, emotions compounded by limited

flexibility at work regarding time off. She was ultimately left to grieve, take care of herself during her pregnancy, while also supporting her first child with autism, and was responsible for doing all the housework independently.

Priya: So, I've been through a lot in my pregnancy. So, in my first trimester, like the normal things like nausea, vomiting and everything. After that, I lost my father. That was the toughest time for me. And then after that, in that time, I went into stress because losing [small pause] my father, that's the very hard part for me. And after that, my mother-in-law was here, but suddenly she has to go back to India because her brother expired. So, I had no one here for taking care of me. So, at that time, I was working because I have to take my maternity leave after that, right? So, I asked my... company if they can provide me leave so that I can take care of myself and my baby, so, they denied. They told that if I want I can go on my maternity early but we don't, we can't provide you leave early, so at that time I have to take care of myself, my baby who had autism and I have to take all of my housework that was very toughest part for me.

Later, when I asked her whether she was able to communicate with her husband about her challenges, she noted that he was unable to support her because he worked 12 hours a day and was only available for one day, which was generally reserved for running errands and going to appointments.

Priya later shared that while her husband assists with childcare after work, she specifically stated, “he helped me...in supporting my baby,” signalling her role as the primary caregiver and her husband as someone who lends support occasionally. Further, when she mentions, “you know, Indian houses,” she positioned me as someone from the in-group, who understands the traditional gender roles assumed within some Indian family dynamics.

Priya: Yeah. Like, he helped me. He helped me in like, sometimes like supporting my baby. But, you know, like Indian houses, they [chuckle] can do more than we just say, right? So, they only do the minimal work.

Researcher: Yeah. Has that impacted your stress levels at all during this time?

Priya: Yeah, because when we tell them that you can do, can you please do this? And if they are not able to do that, we have to do that thing. So that will gonna increase the stress levels, right? Because the work we expected is going to be two times.

Near the end of the interview, I asked Priya how she would manage caring for two children and household work once her maternity leave ended. She told me that her plan was to first request that her company allow her to work flexible or part-time hours, but if this request was denied, she would consider quitting. In reflecting on the possibility of having to quit her job, she shared, “That's a very hard time for me, because here I don't put all the responsibilities on my husband. So that's very challenging for me.” This statement highlights the prioritization of financial contributions over childcare and household responsibilities. According to her, raising two children, managing a household, and working a full-time job may not be enough compared to her husband's financial responsibilities. She continues to seek ways to contribute to the household, on top of the many demands she has already taken on.

Rashi, a 32-year-old pregnant woman who immigrated to Canada over 10 years ago, offered a counter-narrative to Priya's. When I asked what kept her going during the perinatal journey, she noted that her husband's support with domestic labour and childcare was helpful. She attributed this shift in gender roles to his length of stay in Canada. However, Rashi's mother's reaction to her request for her husband's support reflected a traditional understanding of gendered roles and household responsibilities. Still, Rashi notes that her husband is aware of his

responsibilities, stating that “he’s used to that,” “he’s okay with doing those stuff,” and “he thinks it’s normal.” This offers a counter-narrative to her mother’s traditional views on gender expectations and contrasts with Priya’s experience of receiving partner support.

Rashi: My husband actually, he helped a lot. So right now, our house is full of sick people [chuckles]. My son is sick, so I was looking after him for two days and yesterday night, I started feeling a little bit sick by myself, and he took off, and he’s looking after my baby now. So, he kind of, he was really... I can also see the difference. So, my husband has been here longer in Canada before I met him. So, his mentality towards cleaning and cooking is more like people from here. It’s not like, you know, back from home, like, guys, cleaning, cooking. When my mom was here, she was like, oh my God, you’re making him cook and clean. How can you do that? But he’s used to that and he’s okay with doing those stuff. And he thinks it’s normal to do it, and that kind of helps me.

Some women described not having their husbands physically present due to demanding workloads and the nature of their jobs; however, how they made sense of their husbands’ level of support depended on how they understood their husbands’ absence and their husbands’ involvement in household chores outside of work.

For example, Kiran shared that her husband works in the trucking industry, which means he is often away from home five days out of seven. She only had her younger sister for support during her pregnancy. In the interview, she portrayed herself as alone and vulnerable. She reported experiencing severe morning sickness, which left her weak and unable to cook for herself. Her struggles continued into the postpartum period as she reflected on the day she gave birth to her child, when she had only her sister for support. Kiran’s loneliness became especially apparent when she referred to herself as the taker of her baby, as she mentioned, “For the eight

months in Canada, I was alone. I was the taker of my baby. When I went to the hospital for the delivery, at that time, even my husband was in the US. And my sister took me to the hospital.” Although her word choice was ambiguous, given that English is her second language, it still provided insight into her feelings of lacking support during her perinatal period.

When I inquired whether she had spoken to anyone about the challenges she faced during her pregnancy, she noted that despite her husband’s physical absence, he was not only emotionally available but also provided tangible support, evident in her statement, “As I said, my husband was helpless, but whenever he comes home for two days, he was totally helping me. He was cooking food for me.” In describing her husband as “helpless”, she carefully distinguished his level of support from job-related circumstances beyond his control, emphasizing that although his workload and days away posed many challenges, she nonetheless felt supported by him when he returned home.

In these narratives, it became clear that migration and other socioeconomic factors added layers of stress, increasing women’s responsibilities at home and in childcare. However, for some women who received support from their partners, that support made a significant difference in their emotional well-being. Most importantly, tangible support with household chores and childcare eased the burden and relieved them of their domestic labour and childcare responsibilities.

Building a New Village. This narrative thread highlights stories of participants who learned to build a “new village” in Canada, while others struggled to do so. For example, Shanti shared a realization that asking for help is not a weakness. She initially described feeling hesitant to ask friends for help; however, when she returned from the hospital after giving birth, her friends surprised her with a decorated home to welcome the newborn, showered her with gifts,

and helped with newborn care and household chores. Shanti's reaction, such as crying, perhaps hints that the support she received came unexpectedly. She made sense of these experiences by moving from hesitation to trust, coming to understand that she may indeed not be alone in her challenges and that asking for help can sometimes even ease the burden.

Shanti: They are friends like family friends, they are close ones, but then they're like they're not actually your family, right? Not your parents, like, right? Or not your brother or sister (pause) so, I don't know I was like should I ask or no?... They were so good, you know what, like I was like so blessed to have them. Like they helped me in all ways, like helping in the kitchen, or after even after, like, when we took our first daughter like from the hospital, they all decorated the house and they surprised us, and they welcomed us, like, and it was so good, like I was like literally crying, like I didn't expect it like that, right?

When I asked her to elaborate on her initial hesitation, she noted something interesting: that receiving support without having to ask, along with her friends' kind gestures, may have created a safe space for her to ask for support in the future.

Shanti: Yeah, I was like thinking like that, like should I ask, should I tell them like that? But yeah, after that I told you that, like I mentioned that, they surprise us and then after that, I thought that we need to ask, we need to tell them. And then, yeah, after that, I was good at asking for help.

Interestingly, asking friends for help seemed more challenging than asking family. As her story moved from overcoming her hesitation to ask for support to learning to trust and accept the help she received, it highlighted the process of building a new village away from home, a new

support network that offered a space to temporarily escape her responsibilities and to receive help with postpartum challenges.

Rashi established her support by evaluating sources of knowledge and their alignment with her parenting values. In the interview, she identified differences in the advice she received from family members and doctors, which led to confusion. She noted that she sought help from 25% of her Canadian friends, who provided her with useful information.

Rashi: So well, when taking my friends, I only have like 25% of Canadian friends and 75% of Indian. I mean, if even taking friends or contacts, whatever, like so 75% is from back home and even people who migrated here. So those people include 75%. So, from this 25% I was able to get good information, like please go ahead, take the medication. Even during my pregnancy, I was afraid to take the flu shot, but the 25% was like, it is good to take flu shot because it will, I mean, your baby will get immunity...I mean the system is totally different. Even taking Tylenol, when you get sick during pregnancy. Here [in Canada] they recommend to take Tylenol, but like back home [in India], when I consult with them...So, whenever I feel any struggles, I had a tendency to call back home and talk to my mom. But the things I got from there didn't help me much.

She also shared that she is part of a WhatsApp mom's group, where she typically seeks out information on infant care. Additionally, this group chat serves as a place for her to seek emotional support, friendship, a sense of cultural belonging, and downtime.

Rashi: So, we do have a mom helping mom group, a WhatsApp group. So that group actually helps a lot. So even with baby food, so even with like when starting solids, so if my baby is sick, the first thing I will be asking is, so he's having a cold, what will I do? So, I know a lot of stuff. It's just that at the moment of that panic, you forget a lot stuff. It

[the group] does not have a lot of people in it, we only are like six or seven moms in there, but we kind of support each other. That is, that is one way we figured out how we can, and we even complain about our husbands there [laughs]. Like we sometimes hang out without babies. So, our husbands take care of the baby, we go for movies. So, those kind of actually, the me-time, and we do have cultural activities, we participate in cultural activities like dance and stuff.

In Rashi's journey of curating her new village, she emphasized her efforts to build a support network that aligned with her beliefs and to be intentional about spending time with individuals who provide her with knowledge, an outlet for expressing her emotions, and a sense of community.

While some individuals who had been here for over 10 years had learned to establish supports in Canada, some participants described facing loneliness, with little to no access to supports. For example, Sheena (pseudonym), a 32-year-old postpartum female who moved from India recently and lives with her husband and two children, described feeling depressed, exhausted, and suffocated because of a lack of support during the perinatal period.

Sheena: Sometimes I feel very depressed just because of that, because I need people. I, no one around me where I can talk with them

Researcher: Mm-hmm.

Sheena: So yeah, I just feel some time exhausted, like suffocate. Yeah sometime I feel that yeah

Researcher: Okay, and when you feel that way, do you call anyone back home or any friends you have in Canada?

Sheena: Yeah, I used to do that many times. But sometimes, due to just like time difference. Yeah, it was very difficult. Yeah. I don't have, I don't have many friends in Canada, really.

Later in the interview, she noted that she had to quit her job because childcare had become difficult to manage. At the time of the interview, she was in India with her family because she needed extra support with childcare. When I asked how she would manage her responsibilities once she returned to Canada, she acknowledged the situation would be challenging but said she would eventually learn to manage, adding, “I am also confused for that because that situation might be tough for me, because I never imagined that situation. So yeah, a task for me, but I will manage, I think.” This statement highlights both quiet resignation and resilience, despite knowing there is a lack of support and the challenges that lie ahead in Canada.

These narratives highlight the diversity of individuals’ experiences with social supports. Across their narratives, participants described actively building their support systems by assessing which sources of information to trust, whom to seek advice from, and how to build trusting relationships and ask for help. However, for some participants, loneliness remained a shared experience throughout their perinatal journeys, as they struggled to establish new support systems.

Negotiating Authority Over Postpartum Self- and Infant-Care

Another narrative that emerged in my interviews was that many participants described how they managed advice from female relatives during the perinatal period, especially when it deviated from their own more Westernized perspectives. Many women either invited their mothers or mothers-in-law to Canada or visited them in India during the postpartum period to receive support with care. Although many participants appreciated this support, they also

described ongoing conflict with their female relatives. For example, many described receiving postpartum and infant care advice that differed from their doctors' recommendations, which led to conflicts. As women made sense of their experiences, it became clearer that a key conflict they experienced teetered between their deep longing for connection and support from family and the feeling of loss of control over postpartum self-and-infant care when those supports became available. Their narratives shifted from initially receiving traditional advice and superstitions to rejecting them, either by setting boundaries or by involving their husbands as mediators. Yet, for some women who lacked control, they were unable to resist the pressure of traditional practices placed on them, while for others, they negotiated them.

An example of this tension is evident in Rashi's narrative about receiving advice from her mother regarding complete bed rest after a Cesarean section. Her narrative revealed multiple complex layers of her relationship with her mother. Rashi described the conflict she experienced after receiving two opposing pieces of advice on postpartum self-care. Later, she described the conflicting advice her mother offered regarding the baby's bath time, which Rashi initially dismissed as "small things" but later reported as a lack of control, perhaps disappointment, and a feeling of invisibility. In this manner, Rashi positioned herself first as an active agent in bringing her mother overseas to receive her support with postpartum care, but this shifted as she made sense of her reality, in which she found herself losing control over her authority as the primary caregiver to her infant. Of note, in narrating her experience, she softened her disappointment by telling me that her mother is sweet; this further heightened the tension Rashi perhaps felt as she made sense of both her disappointment and her love for her mother. Additionally, she asserted her boundaries by stating, "I even tell her now, like, I don't appreciate that."

Rashi: So, after a C-section, my mom was here, she was like, take rest, you have to take complete bed rest, like you have lay on the bed straight, so that your back heals. But here the doctors are like, you'll have to walk, to avoid a blood clot and stuff you have walk, but we had a huge fight with that and my husband was caught in between it because it's mom and daughter like [chuckles]. He wants me to walk, because when you are after the pregnancy, you kind of feel like you are cut off from the world. Like your routines change, you are, I mean, for me, I had huge help from my husband. He used to stay awake at night and I used to sleep throughout the night...So we kind of bathe the baby at night, but my mom wants to bathe baby at 10. We do the bathing at night is because baby will sleep throughout, but my mom's like, no, you have to bathe the baby morning 10 -11 because that's the perfect time to bathe the baby.

Researcher: Mm-hmm.

Rashi: So those, it's, I know it's like small things, but that was, I felt like I didn't control, I didn't have control over what is happening to my- Like, I brought her [mom] to help me. So, I really wished that she would help me rather than bring her opinions into. I mean, my mom is sweet. I'm not complaining about it. But at that time, the way she handled it, I, I did, I, I even tell her that now, like, I don't appreciate that, like don't interfere kind of stuff, because it was not helping me. Instead of getting that support and help, I was feeling that, once I had a baby, everybody wants the baby. That's how I felt. another thing, everybody wants a baby and nobody wants me. That's one of the feelings I had, actually.

Rashi's narrative highlights her struggle to regain control over her postpartum self and infant care. In her narrative, it is evident that she longed to be seen and heard, as exemplified by her statement, "once I had a baby, everybody wants the baby... nobody wants me." She also

noted the support she received from her husband, who helped mediate conflicts with her mom and sided with her in reclaiming control over postpartum care.

Similarly, when I asked Kiran to reflect on any traditional postpartum practices or advice she had received, she noted several suggestions from her mother, mother-in-law, and other family members (e.g., honey, back thread, cow's milk, sugar). However, she stated that she refused to follow those "instructions." She portrayed herself and her husband as a unified team, as suggested by the phrase "we just listened, but we never followed," which reflects shared decision-making and joint efforts to reject traditional infant-care practices without initiating conflict with family members.

She later noted that when people pushed her boundaries, she relied on her husband as a mediator. One plausible interpretation is the structural power dynamics, particularly decision-making authority, that men typically hold within some Indian families, and Kiran's statement offers me a glimpse of that. For example, she implies that her husband's boundaries may be more respected than her own, and, in that way, she relies on him to regain control of infant care. Her choice of words, "the best thing about my pregnancy, my husband, he is like very open-minded," reflects a sense of relief and appreciation for her husband's support, as well as his open-mindedness in rejecting superstitions or traditions.

Kiran: The best thing about my pregnancy, my husband, he is like very open-minded. If somebody's like, let's say my mother, my mother-in-law say you can do this, we just listen, but we never followed. Never followed...So, they say when the baby will be born, you have to give him or her honey. I said okay, but we didn't offer. We didn't offer anything. We are not following any of the superstitious things. Nothing. We're very clear. We just listen. We don't want to fight with them, but we are not following anything.

Researcher: What sort of other things they told you? I know honey, I've heard honey is like one of them. What other things did you hear?

Kiran: Sometimes they say like you can tie a black thread on her [daughter] arm, something like that. I said no, no, nothing. I'm not going to follow anything. You have to like, doctors usually say don't give a cow milk for one year. The people say, you can give cow milk, she looks little tiny, I said no, no, we are not following, but they still give instructions...If somebody is forcing me too much, then I call my husband, then my husband handles everything.

While some women were able to employ various strategies to gain control, for others, this was a constant battle. Maya (pseudonym), a 37-year-old postpartum woman who arrived in Canada less than ten years ago, recounted an experience with her firstborn during a trip to India, when she lost control, had her boundaries disrespected, and her trust broken. In this story, she shared that she gave clear instructions not to feed her baby gripe water for stomach issues. Despite setting a clear boundary, her mother and sister forcibly fed her son gripe water. In her story, Maya portrays herself as someone whose parental authority was rejected and whose trust was broken.

Maya: So, when we were in India, I told them [family members] not to give because it wasn't necessary. Like, if it's really needed, I would have taken him [the infant] to a pediatrician back home [in Canada], but then it wasn't necessary. But then they just feel like, oh, a little bit of uneasiness in the stomach. They say, oh give him gripe water, maybe he's having a stomach issue. And I very clearly told them, do not give him. So, what happened was when I was just, they took the medicine twice, but I told him, stop it. Do not keep in without knowledge. And they, you know, discard it. But then I just trusted

them, thinking, okay, they don't want to do it anymore. And I just came to the living room, was watching TV, and he was playing inside the bedroom with my sister and my mom was also there. They locked the door, and they tried to give him the gripe water and he just screaming out. And I was looking for him, and I was just checking where he is because I could hear him crying so badly. He was terrified though. And I just knocked the door, I couldn't open what's happening. And they were trying, they almost gave half the, I mean, even if you're giving gripe water, there is a limit where you can give, right? They don't know how much you should give even if you're keeping it. But again, what's the need to give them gripe water when I very clearly told them not to.

On the other hand, some women selectively resist certain traditional practices or superstitions. For example, Disha, a 33-year-old postpartum woman who arrived approximately 10 years ago and lives in a joint family with her spouse and in-laws, recounted negotiating issues related to pregnancy and the postpartum period. For her, concealing her baby's gender was important enough to maintain a boundary, rather than the "little things," such as superstitions. In this narrative, Disha positions herself as someone who can retain some level of authority over where to set boundaries and which advice to accept. Additionally, her attempts to hide her baby's gender may have stemmed from the anxiety she reported in response to her mother-in-law's comments, who was hoping for a male child. Lastly, she noted that her in-laws selectively chose to practice Traditional and Western practices based on their "convenience."

Disha: So, they wanted to know the gender, but I did not. So, at that, at that, when it comes to gender reveal, or that's where they're saying, oh, everybody does it here [in Canada]. So, whatever is convenient for them to adapt, whatever they like in this culture,

they support it; whatever they don't like, they don't support it. And because back in India, you know, we don't have, they won't reveal the gender because it's not legal in India.

However, later she noted that some of her relatives' superstitions felt trivial and were not worth arguing over, thereby exemplifying how she negotiated which traditional and Western practices she followed.

Disha: I don't fight on those things because I think those are very little things, and if they're [relatives] trying to help the baby. I just say okay, like you can't wear yellow clothes, or the baby can't wear yellow clothes for the first month; otherwise, they will get jaundice. So, it's just I feel like it's a superstition, or maybe there is a reason behind it. But I don't try to fight those things when they're trying to help the baby, as long as it's a good thing for the baby or it doesn't harm anything, or it's just like, okay, whatever, he can wear yellow after.

A common narrative among many women was their struggle to navigate their family members' expectations regarding postpartum self- and infant-care practices. Their stories shifted from initially seeking postpartum care from female relatives (e.g., mothers or mothers-in-law) to navigating advice and decision-making authority over infant care, which led to disappointment, boundary-setting with their husband's support, a total breakdown of trust, or renegotiation of authority over infant care.

Invisible Pains Throughout the Perinatal Journey

As women narrated their stories, they described experiencing emotional invalidation from their families during the perinatal period. In telling these stories, participants unintentionally demonstrated, through the ways they made sense of their experiences, how they self-silenced and minimized their emotions. As participants made sense of their emotional experiences, they also

shared moments when their invisible pain could no longer be suppressed. Within this narrative, three subthreads emerged: *invisible pain*, *navigating invalidation*, and *when invisible pain becomes visible*.

Invisible Pains. This subthread highlights participants' stories about how their emotional struggles during the perinatal period were rendered invisible by those around them. In narrating these stories, participants made meaning of the dismissals, comparisons, judgments, and invalidations they experienced from family and community members.

For example, when I asked Farah how people in the Indian community or within her family viewed mental health and well-being during the perinatal period, she noted that the focus is typically on the baby, not on the mother's mental health. She shared an example of calling her mother to discuss her worries, only to be dismissed and told she shouldn't be worried and that her focus should be on the baby. She also highlighted her family and community's understanding of postpartum depression, which she describes as "rare" or "not common."

Farah: I think people are more focused on the baby rather than mom's mental health or something. The only thing, yeah, the baby is the center of attention, and they think it's a happy occasion. So, most people like in my society or family, they don't like for like about postpartum depression, things like that. They don't really, they think it's a rare thing and it's not common. Yeah, they look at it as a happy occasion. Sometimes when I was anxious, even if I would speak over phone to my mom, she would be like, why are you worrying about all these things? It's such a happy occasion, focus on the baby, stuff like that. So, I don't think so they take it [mental health] that seriously.

Farah further described that experiencing invalidation as a "lonely" experience in which moms do not receive affection, love, or support. It was interesting that she framed this in general

terms, almost distancing herself from her opinions. Instead of stating, “I feel lonely” or “I needed more love, affection, and support,” she stated, “it can be lonely,” and “moms need more affection, love, and support.” Perhaps shifting from “I” to general terms allowed her to speak about the topic as an observer rather than as an actor in her own story, possibly creating some distance from her emotional experience. She also highlighted society’s view of motherhood, which holds that it should be “instinctive love for the baby,” “selfless,” and without any “negative thoughts.”

Many participants also shared experiences of being compared to or judged by female relatives (e.g., mothers and mothers-in-law), which made it difficult to express their emotional concerns, such as stress related to postpartum infant care. For example, Disha shared that she took two weeks off from household duties to focus on her baby. However, she then noted the “little bit” of comments and taunts she received for taking two weeks off after undergoing a C-section. When narrating this story, Disha laughed sarcastically and hesitated to share the details of the taunts and comparisons she received. At first, what felt like “a little bit of taunts” was later revealed to be taunts and comparisons made by her mother-in-law, who minimized and questioned Disha’s birthing experience. Disha noted immediately after that the C-section was not her choice but circumstantial. I wondered whether Disha felt the need to defend herself after sharing the judgment she received from her mother-in-law.

Disha: Because I had a c-section and I didn't have, it was an unplanned c- section, and didn't I did not have to go through labor so now I was hearing from my mother-in-law that oh you don't even know the pain of childbirth we used to know we used to be in labor for hours and hours, like so like she just finds something to comment on.

Researcher: Right.

Disha: It was not my decision to have a c-section if it was a breech baby, so I had to have a c section. So, she just find something. So, this is one example.

Participants' narratives highlighted their experiences of invisibility, whether through the dismissal of their emotions, being made to feel that their emotions could not coexist with caring for their baby, or being judged or compared because of differences in their bodily or emotional experiences. For many participants, their environments led them to silence their concerns and withdraw from their social supports.

Navigating Invalidation. This subthread focuses on narratives from participants who described how they navigated their emotions within their families and communities, where they were more likely to face judgment or be expected to perform the roles of a good daughter-in-law or a good mother. Their approaches included concealing their emotions, invalidating their concerns, self-silencing, or confronting judgment and asserting boundaries.

For example, Farah shared that her mother-in-law visited her postpartum to help with childcare. Although she had expressed anxiety before her mother-in-law's arrival, she often repeated phrases like "thankfully" or "thank god" to describe the experience as better than she expected. When describing her emotional fluctuations, however, she labelled herself "emotionally volatile" and wanted to conceal this side of herself, as it contrasted with the "respectful" and "nice" daughter-in-law she was familiar with. She later defined what a good "daughter-in-law" entails, according to her: someone who is a good host, cooks every day, and entertains her in-laws. Additionally, elsewhere in the interview, she noted that she could be more open about expressing her negative emotions (e.g., anger) with her mother, but had to manage her negative emotional reactions in front of her mother-in-law. In distinguishing between a mother and a mother-in-law, she appeared to describe different emotional expectations associated

with each relationship. Farah seemed comfortable identifying and labelling her anxiety, but negative emotions, such as anger, perhaps felt less accepted and less congruent with the dominant perspective on what a good daughter-in-law should be.

Farah: It's better than what I thought. Before she [mother-in-law] came here, I was more anxious, so thankfully it's been better than what I thought because I don't open up that easily. I thought right now I'm so emotionally volatile, I want to cry one minute, and I'm angry the other and happy the other. So, I did not want [pause] her to see that side of me or, because you want to be respectful and nice, and they are your guests and she came here for the first time. So, I was anxious, like she's coming at a moment where I can't be a good host because I don't have those energy levels to like maybe cook for them every day or to like entertain them the way I would if I weren't pregnant. So, I was anxious, but thankfully, like she was very supportive and understanding. Of course, she can't be my mom, but she's been really nice.

Others demonstrated internalized invalidation by self-silencing when their patience was tested. For example, when I asked Kiran how she felt about receiving judgments about her newborn's physical appearance and comparisons from her relatives in India, she said she felt "aggressive," but she also described how she manages her anger by taking the blame, thereby silencing herself. Although she knew it was not her fault, she still used her silence to navigate conflicts and maintain peace with other family members.

Kiran: Aggressive, really aggressive...But still I have to control my aggression. Oh, still I take all fault on myself on my own. Yes, my fault. Just to end up the discussion. I take all the blame on me.

Researcher: Do you believe that it's your fault?

Kiran: No, no, I know it's not my fault, but just to end of the conversation. I will take it's my fault because I can't fight, I can't debate with them. I can't explain. Just to end up everything, wind up everything, I take things on me.

While many participants shared stories of choosing to ignore or stay silent to maintain peace with others, Rashi offered a counter-narrative in which she challenged others and asserted boundaries. Rashi described an instance in which she received judgment from someone in the community who asked her and her husband why they sent their baby to daycare before he turned one, saying, "How can you be so cruel?" In her response, "It's not my problem you don't have a job," she pushed back against the dominant narrative that sending your child to daycare makes you an uncaring or cruel mother.

Rashi: I don't take anything like that. I talk back, really. I would say it's my good thing, but I don't like people like that, so I really make it visible that that's not right to say to me. So, the first reaction was like, it's not my problem that you don't have a job.

These narratives highlighted how participants navigated invalidation, judgment, or the expectation to perform. Some did so by concealing emotions that were incongruent with the expectation of being a good daughter-in-law, self-silencing, taking the blame to maintain harmony in relationships, or resisting criticism from the community.

When Invisible Pain Becomes Visible. As participants reflected on their invisible pains by sharing stories of invalidation and lack of support, and by describing how they navigated these struggles, they also shared ways in which their invisible pains became visible or could no longer be hidden.

Disha illustrated an instance when her invisible pain became visible. She noted that most days she was able to suppress her anger by ignoring her mother-in-law's judgments and taunts.

She shared that her anger may have inadvertently affected her infant and that the home environment had become inescapable. In narrating her story, Disha portrays herself as someone whose pain threshold was pushed beyond its limits.

Disha: I would say I know that people say that you should ignore, you should focus on the good part, but I've tried, and I don't, I hope I'll be there at one point, but I'm not there yet where I can just completely shut my ears and not let it impact me. It has impacted me, I was very irritated, and I would just suppress my anger and in some ways that well, research says that whatever you feel the baby feels it. So, in some ways it must have impacted the baby. I was angry and irritated a lot of times, and I also worked from home so, you can imagine that it was hard for me to escape being at home most of the time.

Disha shared that she had reached a breaking point, where her anger led to conflicts, and she described this process as a never-ending cycle. She portrayed herself as trapped in this cycle, and her only ways of navigating it were to either ignore it or react in anger, leaving a lingering aftermath with no real change.

Disha: But yeah, like I was very irritated. Yeah. But I, yeah, like I would not. So, I would keep suppressing it for days. And then one day I would vent out and then there would be big fight and drama, which is, and I would cry and then shout. And so, and of course those things impact you, and then it takes few days to calm everything down, and then it starts again. So, it has been a cycle, and it has not stopped.

Another example of participants' invisible pain becoming visible appeared in Maya's narrative. She felt overwhelmed by the stressors of the postpartum period and lacked support from her husband, whom she felt disappointed in. She eventually reached a breaking point and decided to leave her children with her neighbours to escape the pressure of caring for both her

toddler and her newborn. As she narrated this story, she became tearful, and her breathing grew rapid as she relived the guilt she may have felt about possibly never returning home to her children. In her narrative, Maya portrayed herself as overwhelmed and without support, seeing escape as her only way out. But her love for her child made her return home.

Maya: So, I called my neighbour, and I said, okay, you know what, I'm going through a hard time. Can I just leave my toddler in your house...she said, 'yeah, for sure. Like, I know it's very difficult managing two.' She said, 'okay, come in, you know leave the child.' So, I was getting dressed, and that's when my husband came, I don't know, like four o'clock. I still had the child. I didn't have a word with him. I was so mad at him. And I just walked out for like a couple of hours. I did not want to come back home at all. I was almost thinking of just not coming home, go somewhere, but then that's when my bus passed my bus stop, and I was just thinking of my children, you know, he's [the toddler] going to be looking for me, so I just got on another stop, and then I came back home.

In this narrative thread about when invisible pain became visible, Disha and Maya's stories served as counter-narratives to the dominant perspective many women held: pushing through pain quietly, despite the overwhelming challenges they faced during their perinatal journeys. Disha and Maya's narratives highlighted what it is like when suffering reaches its breaking point and how they dealt with it, through tears, conflict, or a desire to escape. Perhaps these experiences of suffering underlie a larger expectation held of IIWs, which was best captured by Priya's understanding:

Priya: In our community, people are judging women, right? That she can do everything, like she's a superwoman. She can do households, she can take care of babies, she can take care of herself, right? So, she can take care of her husband too and family too.

Navigating Western Perinatal Supports

In this storyline, women shared their experiences navigating Western perinatal supports, organized into three narrative threads: *what it means to seek psychological support? Learning to navigate Western perinatal systems and facilitators for seeking psychological support.*

What Does It Mean to Seek Psychological Support? While many participants reported openness to seeking psychological support, they differed in how they made sense of what it would mean for them to seek that support. For some, seeking psychological support meant being considered “weak”, whereas for others, it was only a viable option if their mental health became unmanageable. One participant feared that people in their family or community would find out. Additionally, how they made sense of what support meant to them shaped their support-seeking preferences.

For example, when I asked Farah about her openness to seeking psychological support, she expressed ambivalence about sharing her concerns with anyone, as she did not want to show her “weak side” to the world or tell a “sob story” that would make her come across as “complaining” or “whining.” She seemed to judge her feelings, implying self-stigma and perhaps a belief that sharing vulnerabilities equals weakness. She noted that she would consider seeking support only if she could not manage it alone, in which case she would talk to friends with lived experience. When asked whether she would be open to seeking psychological support, she stated:

Farah: Not really like because maybe I would if I'm really, like if I think I can't manage it, but otherwise I would not like to share this side with my family or friends because, like yeah, it's a weak side or it's something that you don't want to show the world. Maybe with friends who are postpartum or new moms, with them I can. But otherwise, no, I would not like to speak to people about it.

Researcher: Is there a reason why you wouldn't want to share that stuff?

Farah: Because like I don't want a sob story or tell people oh this and that so yeah because like it goes through stuff in life you don't have to always like tell people or complain and whine about it because it's I think everyone goes through these things. If I if I'm unable to manage it then it's different, but otherwise I don't think so that I need to tell everyone about these things.

When I asked Farah about her support preferences, she noted that she would not be comfortable in a group-based format, which may partly stem from her fear of being perceived as weak for being vulnerable. She noted that if she was “deeply distressed about something,” she would like to “speak one-on-one to someone rather than in a group setting.”

This idea of being a “strong” or tough woman was especially evident in Seema’s narrative, that of a 41-year-old pregnant woman who immigrated to Canada when she was young and recounts her experience with depression after multiple miscarriages before her most recent pregnancy. In her narrative, she sheds light on the theme of being a strong wife and mother, as well as her sense of self-reliance during very challenging times. She contrasts the time she spends alone, crying in bed, with the time she spends being strong for her family, almost putting on a mask to conceal her true feelings. However, as she recounts these experiences, her shaky voice and affect demonstrate the unresolved emotions she carries regarding the previous neonatal losses she experienced prior to this current pregnancy. Perhaps this interview gave her a platform to express herself. Her apology to me as the researcher, while she was crying, may have been her attempt to apologize for her vulnerability.

Seema: I don't know, I think I just wanted to deal with it on my own, and I think I wanted to also kind of like be strong. Sorry [shaky voice]...I didn't want to talk about it because

um, either with my husband or my you know around my daughter because I didn't want them to get worried [shaky voice]. Um, so. Sorry.

Researcher: No, it's okay. It's okay. It's okay to let it out.

Seema: Yeah, I just I just wanted to be like strong when I would be alone. I took I took some time off work. And I just want it to be in bed and just cry or just be myself. And when they would come home from work or school, then I just wanna be like, be there for them. And not let them worry about me. So yeah, I noticed that I wasn't myself. I kind of didn't feel like I didn't feel like putting makeup on or dressing up. Or I just felt like it wasn't fun. But now that I'm almost 31 weeks into this pregnancy, I feel like. Um, uh, starting to feel a little bit better, and I'm starting to put makeup on or dress up, but only if things fit me and my clothes are getting too small. But yeah, I feel like this time around I'm doing better mentally.

When I asked her whether any other factors prevented her from seeking support, she further shed light on the broader cultural stigma surrounding mental health. Note how she uses “us” instead of “me” when discussing how mental health was not something promoted within the culture. By doing so, she aligns herself with a larger audience and speaks on behalf of individuals in her community who may be in similar situations.

Seema: I don't want to face it. I don't want to talk about it. I don't know maybe that's how I deal with stress. I just don't talk about it with other people. I've never actually been to counselling. It's not, I don't know, it's not like something that was promoted to us. And you know, like it's when we were sick, mom would be like, go to the doctor. But if you have mental issues, you just kind of don't talk about it or just talk to her about it, things like that. So, I've yeah, I just feel if I do go talk to somebody, I would have to open a can

of worms. And also I have to let a stranger into our life and just the whole, you have to go down other paths and things like that.

Although Seema demonstrated internalized stigma about seeking support, she noted that a group-based support program was more appealing. She stated, “one-on-one would be a little bit more intimidating and the focus would be on me and having to open up too much and give out too much information. But I think if I was to do a group session with other moms, I wouldn't mind.”

In Disha's narrative, a concern about confidentiality emerged. Her narrative began by describing a fear she had before the interview about confidentiality, specifically worries that I, belonging to the same culture as hers, might know her family and share her concerns with them. However, her narrative reflected a transformation from initial hesitation to an understanding of the benefits of therapy and confidentiality, which she attributed to our conversation about confidentiality when she first signed up for this research. Later, she identified that gossip or fear of others finding out about mental health vulnerabilities, along with the broader cultural stigma, might prevent people from seeking mental health services.

Disha: I think yes people feel that, I felt that too, that what if what if like you know my family and then you talk to them, you know? Yeah, that that prevents people from getting help, yeah. Now we understand, and not everybody understands this, that it's [therapy] confidential. But yeah, that prevents people from getting help.

She later elaborated on the cultural stigma surrounding mental health, noting that seeking therapy is seen as a sign of being “mentally sick.” She stated, “And they [community] think that the therapy getting help is like, you're mentally sick,” and added that this stigma might prevent people from seeking services.

In these narratives, participants shared their understanding of what it means to seek psychological support. For some, seeking psychological support is a sign of weakness; for others, it may be seen as a sign of being unable to control their emotions in front of their husbands and kids; and for others, seeking services could risk their families or communities finding out and accusing them of being “mentally sick”. Altogether, participants made sense of seeking services by describing what it means for them within the context of their families and communities.

Disha noted that she would be comfortable with both one-on-one and group-based supports; however, the barrier – fear of others finding out – shaped her preferences for psychological supports. She noted that she would seek out one-on-one support if she wanted to vent “every detail,” but would prefer a group-based format for more “general things.” In her narrative, she demonstrates selectivity, sharing only what she is comfortable with others knowing.

Disha: I think I'm comfortable with both. Yeah, yeah. Yeah. Some of the very like if I'm actually just getting help specifically for myself, and I'm luckily I'm not struggling so so much. But if I was going into, like, going into depression, or I was very, very stressful, then I would want one-on-one where I can vent out every detail. But if it's just overall mental health postpartum, I could do a group session, but I can just vent out general things and then ask for help.

These narratives highlight how individuals attached different meanings to support and, in turn, how those meanings shaped their support preferences. For some participants who worried about coming across as weak or dramatic, the one-on-one therapy format and informal support (e.g., friends, family) were more attractive than formal one-on-one supports. Others, although

ambivalent, shared that they were comfortable with a group-based format, in which they could be selective about what they shared and would not feel as exposed.

Learning to Navigate Western Perinatal Systems. Many women reported challenges navigating the perinatal systems (e.g., healthcare and other services) in Canada and described difficulties learning about new medical rules and the perinatal services currently available. For example, Priya shared a lack of understanding of how Canadian systems work, including the rules, what to buy, and where to buy necessary baby items.

Priya: Yeah, so the lack of knowledge, I guess, is the main culprit here because we don't know much about the country rules, the country things, everything. So, everything was new to me. New to us. So that was the main reason.

In addition, she noted the unfamiliarity she experienced in a new country, without the support of her family back home. Her mother-in-law's visa being rejected created further uncertainty; she described it as the "worst situation" for her. It is interesting how she shifts from "I was alone here at the time COVID was here, no one was here to help me" to "me and my husband both were only here," suggesting that she may have perceived herself as alone during this experience, despite her husband being physically present. Similarly, she uses "we" or "us" to discuss her individual experience, sharing a collective experience of what it means to be a newcomer in Canada navigating perinatal services. The lessons Priya learned from her struggles during her first pregnancy helped her during her second pregnancy, and this was reflected in many participants' stories.

Priya: Yeah, because here, for example, if we are India, our family, our mother-in-law, our mothers and everyone has gone through all the stuff, right? So here, everything to us is new, right? Nothing we had gone through previously. So that is our first-time

experience, so we don't know much about the things, right? So, that's the biggest part.

Even, yeah, when my first one was born, even I didn't know that I had to buy that stuff or other things. So, I was alone here at the time COVID was here, no one was here to help me and me and my husband both were only here and my mother-in-law, her visa got rejected at that time and she was not able to come and that was the worst situation I experienced in my life. The second one, second time that is much like, it was way better, but my first baby, she was, this was really tough time.

In the interview, she also noted a lack of knowledge about where to seek mental health support, noting that while she was willing to get mental health support, she did not know how to go about seeking such services.

Like Priya, Rashi described setbacks during pregnancy and childbirth as a first-time pregnant woman. Her challenges included delayed perinatal medical care because she did not have access to a gynecologist until the seventh month, limited knowledge of how to request a C-section, and a lack of transparency about physical challenges (e.g., the possibility of severe morning sickness) related to pregnancy and childbirth. In sharing these setbacks, she portrayed herself as feeling lost in a new medical system and longing for transparency and guidance.

Rashi: So overall, I'd never had a pregnancy before in Canada, not even in, so since it's my first time and I didn't have anybody go through this experience. I didn't know that we could have asked for a C-section at first. I wish that was a little bit more, I mean if the doctor would have told me that, it would been really helpful. I mean, I felt, like, I didn't know a lot about that stuff. Then, but then after 36, like 35 or 34 hours, I asked them like, can we do a C-section because it was exhausting for me, then only they were like, yeah,

we can go ahead. So, it was like, I didn't know that we had to ask for it rather than they will give it as an option.

All of her setbacks led her to question whether she wanted to have another child. As she made sense of her perinatal journey, she also expressed disappointment and frustration with the women around her (e.g., her mother and friends) for not being transparent about the challenges of pregnancy, noting, “all I could hear was that, ‘oh you just have to go through pregnancy and after pregnancy you will forget everything’”. Indeed, other participants echoed this, describing a cultural silence around difficult pregnancy-related topics, with pregnancy often portrayed as a smooth journey that did not align with many IIW’s perinatal experiences.

Rashi: That's what I heard, and, but this first pregnancy itself, like now it's making me think that should I need another child? Maybe I won't do that. Like that's how my thinking process now, it might change in future. I don't know, but that's how I think.

Later, Rashi noted that this experience has taught her to be transparent and to share both the good and the bad that accompany pregnancy. Through this experience, she demonstrated a narrative arc in which she became the hero she would’ve appreciated in others. For example, she moved from someone who dealt with uncertainty to a transparent knowledge-sharer within her social circle, telling her friends when to advocate for themselves and request a C-section.

Participants’ narratives highlighted the challenges of navigating unfamiliar perinatal systems in Canada, where they not only had to learn new rules and how to access resources in a new country, but also had to make medical decisions within that system. For some, the challenges of their first pregnancies helped them navigate subsequent pregnancies, whereas others’ challenges gave them opportunities to share their knowledge with those in similar circumstances.

Facilitators to Seeking Psychological Support. While participants described barriers to seeking psychological support, their narratives also highlighted what ultimately led them to seek help.

For example, Rashi attributed her husband's support as a significant factor in her help-seeking when she was initially hesitant to open up about her experiences with postpartum depression. Her husband's support included encouragement and a strategy for writing down her thoughts so she could discuss them with her therapist later, which enabled her to take the first step towards getting help.

Rashi: I was not open to it [seeking psychological support]. Even I haven't taken counselling or anything earlier. So, for me, taking counselling is a very, like, opening up to someone else is a little bit like, it was difficult for me. Like, it was not normal. I was brought up into a background that asking for psychological help is a bad thing. So, I was having difficulty in opening with even with the counselling sessions, first three, first two sessions, I was not even open. Then when I discussed it with my husband, he's like, "why don't you tell those things? Like you tell those things". So he started making me write points. And when I talk, I started, like, telling that point...So, when the doctor called me asking, like, if you want any help, then, uh, I first told her, no, I don't need any help. Then my husband was near me, and he's like, "Can you ask her that you need help? Like, it will be nice for you to talk with someone else other than me." So, yeah, he actually motivated me to do that.

However, in therapy, her fear of child apprehension if she disclosed her symptoms of depression, and her belief that this would ultimately be added to her file and become a permanent record, interfered with her ability to open up to her therapist. Only after the mental health

professional clarified the limits of confidentiality and explained the process of therapy did she feel comfortable enough to continue. In the interview, she looked back on her worries with a sense of embarrassment. As Rashi narrated this story, I felt as if she were defending herself to me, a psychology researcher, by explaining that she was educated and that she had a “stupid mentality.” Her worries shed light on their fears and mistrust of larger institutional systems, and these fears may be one reason for hesitating to seek support.

Rashi: I was afraid that if I say something bad during those psychological section, if my baby will be taken away from me, those kind of. Even I talked with the person who was giving me help about that actually. And she assured me it's, it's not like we only take away the baby when you go extreme. But for you, you are kind of understanding that, that itself is helping you to cope with it. It depends on people and it depends on the situations there and if you are a drug user and like, you don't take care of your baby, you have very bad thoughts about things that are going on in your life, then only it will happen. So, I mean, it kind of assured me. So, for me, I was like, oh, I will get into a file. So I was into a pre-nomination that... Oh, I will get into, my name will be added to a file, then they will keep continuous track of it. And if something happens, if accidentally something happens to my baby, like they will take the baby away from me that was, I don't know why I was thinking like that. I know I'm an educated person, there is no way that I should think about, but thinking about that now I feel like it was a stupid mentality, but yeah.

In addition to partner support and discussions about confidentiality and limits, the interpersonal qualities of mental health professionals may facilitate support-seeking. This was illustrated by Maya, who had self-harming thoughts and postpartum anxiety. In this narrative,

Maya portrayed herself as vulnerable yet engaged in help-seeking behaviours, with her kids being her source of strength amid the self-harming thoughts she had been experiencing. Although she was unable to reach her psychiatric nurse right away, she called a local crisis centre for support. The next morning, her nurse called to check in and advocate for her by speaking with her husband and explaining Maya's experiences to him, which seemed to make all the difference. Her nurse's deep concern for Maya's safety and advocacy made a significant difference in Maya's mental health, as suggested by her account of initially having no support, her husband hugging her, and her finally getting a break from her childcare responsibilities. Additionally, Maya contrasts the support she did not receive from her family with feeling understood and supported by her psychiatric nurse, which suggests an important role the mental health provider had in her narrative of someone who heard her and made her feel seen.

Maya: So yes, but my second pregnancy and I just felt like nobody's even cared about, nobody even cares that I needed enough rest or enough food. Um, and that's when I had this thought. I was, I had thought of self-harming and, uh, I know my nurse, she's not, she is only working during the days, but still I try reaching out to her. I left out a voice message and like, you know, having this thought [name of nurse], can just give me a call the moment you... come to office in the morning. And I was completely blank. I didn't know whom to reach out to because I know there are a lot of centers where you can, you know, connect. But then thinking about my children's future, like though I had, I still had that thought of, at one side and the other side, I was just just pushing me to reach out for help and, I then called [name of local crisis centre] in the middle of night.

Then she goes on to explain the next morning when her nurse called her.

Maya: But the first thing I received a call from [name of nurse], my nurse, and I had to share things with her and she was on call with me most of the time. She kept calling every now and then to check if I'm doing okay because it's the weekend. She was afraid that the weekend is coming and there wouldn't be anybody to reach. So, she wanted to help as much as possible and she um, spoke to my husband, telling that, hey, you know, she's going through this. Just check on her. I wasn't at home at that day because I wanted to just step out for a while. And it's cry out. I don't want to cry inside when in my home, because back home, nobody will understand what mental health is or postpartum anxiety. They don't know anything about it. Right? Even if you tell them, they'll be like, oh, you know, we gave birth to so many children.

So, I just wanted to step out and breathe, take fresh air and cry out if I wanted to. And yeah, that's when [nurse] had a call with my husband, and she, you know, she discussed about what I'm going through and how he could help me with. So, when I came back, it's been, so he gave me a hug, and he was like, don't worry, I'm here, and said, you take care, go get some sleep, like I'll take care of the kids. My mom was there, so my youngest was always with my mom...And I came and slept for like, I think that's the first time I slept for four hours a stretch. And I really felt better.

Across participants' narratives, psychological support became possible through their partners' support, transparent discussions about confidentiality and its limits, and mental health professionals' interpersonal characteristics. Through these experiences, participants learned to trust the therapy process, overcome their fears of child apprehension, and feel understood and seen.

Story Endings

IIW's stories concluded with participants demonstrating ongoing perseverance in the face of their challenges. Some concluded with a sense of acceptance of circumstances that seemed beyond their control, while others ended abruptly, leaving participants still feeling stuck and trapped. A few participants ended their stories by reflecting on their perinatal experiences, expressing relief at what they had managed to overcome.

Discussion

To my knowledge, this is the first study in central Canada that exclusively examined the mental health experiences of perinatal IIW, their unmet mental health needs, and their attitudes and behaviours regarding seeking mental health support. In total, pregnant ($n = 3$) and postpartum ($n = 7$) perinatal IIW completed questionnaires (demographics, the EPDS, and the GAD) and participated in 60-minute Zoom interviews, during which they shared stories about the impact of migration on their mental health experiences, psychological support needs, as well as attitudes and behaviours regarding seeking mental health services.

Quantitative findings, based on EPDS and GAD scores, suggested possible depression and mild anxiety among participants in this study. Additionally, six of 10 women reported experiencing some level of stress, anxiety, and depression when asked about their mental health concerns in an open-ended questionnaire. While quantitative findings provided a general understanding of participants' perinatal mental health landscape, qualitative findings, analyzed using Reissman's narrative analysis, further deepened my understanding of the factors that influenced their mental health symptoms during the perinatal period. Interpretation of participants' narratives occurred at the thematic, structural, and performative levels (Reissman, 2008), examining the content (thematic level) and the ways in which they narrated their stories

(structural and performative), allowing me to contextualize their experiences within their environments. Further, the interpretation of participants' narratives was grounded in a social constructionist epistemological framework, in which their stories were treated not as absolute truths or facts but as constructions shaped by the meanings they ascribed to their experiences within their cultural, historical, and social contexts (Reissman, 2008). Additionally, narratives emerged from active co-construction between participants and me, as well as from what participants chose to share during their individual interviews.

Additionally, participants' narratives were interpreted through a postcolonial lens, which suggests attending to how gender, race, class, historical background, and societal and political power structures intersect to shape women's experiences (Browne et al., 2008). Postcolonial feminist scholars conducting research with women of colour and third-world women caution against treating women's experiences as homogeneous or reducing their struggles to "oppression" (Mohanty, 1984). Instead, they suggest seeking divergent viewpoints that challenge or offer a nuanced understanding of the common stereotype of third-world women as oppressed, timid, shy, domesticated, and traditional (Mohanty, 1984). This approach does not necessarily imply the absence of oppression, but rather that oppression should be understood within the contexts of each woman's class, race, religion, and history and political contexts. As such, postcolonial feminist theory informed the interpretation of this study's findings and grounded my understanding of participants' hardships during their perinatal journeys by situating those hardships within their socio-environmental contexts. I also aimed, where relevant, to highlight divergent viewpoints and experiences that differed from dominant perspectives held by IIWs within Indian communities and from how immigrant women's experiences are understood in Western contexts.

Participants' narratives featured multiple storylines that differed in topic and temporal sequence. Overarching storylines that emerged within participants' narratives included *motherhood in a foreign land; negotiating authority over postpartum and infant care; invisible pains during the perinatal journey; and navigating Western perinatal supports*. Within these storylines were narrative threads highlighting participants' hardships stemming from migration, the overwhelming demands of motherhood, and the challenges of navigating unfamiliar rules and service pathways in a new system, all while facing judgment, invalidation, and stigma within their families and communities. At the same time, many participants shared stories of how they adapted to their hardships by developing strategies, intentionally building supportive communities, negotiating authority over infant care, and resisting overwhelming pressures. When interpreted through a post-colonial lens, these narratives showcase the multidimensionality of an immigrant woman, who is not simply a passive agent in her life but actively resists dominant perspectives on motherhood and on being a perfect daughter-in-law and daughter within her environmental contexts. Still, many participants' stories ended with ongoing challenges in coping with the stressors of motherhood and a quiet resignation to circumstances beyond their control. Participants often expressed this through statements such as "I will manage" and a desire to push through difficulties for their kids, and in their efforts to portray themselves as strong women. This was also evident in the way stories were told through nonverbal communication, in participants' affect, and in how participants and I constructed meaning of their experiences. Taken together, participants' narratives across all storylines highlighted the coexistence of oppression and resistance, and of vulnerability and resilience.

In the first storyline of *motherhood in a foreign land*, IIW reflected on both the positive and negative impacts of migration on their perinatal experiences. For example, participants

reported losing social networks as a result of migration; however, their stories differed in how they made sense of their hardships and the loss of supports. Some participants expressed gratitude for motherhood and reframed this new life stage as worthwhile despite the hardships they endured as newcomers. Still, some described how migration created physical and relational distance from their supports in India, disrupting access to perinatal information and emotional support. However, for some, migration led to liberation from traditional gender roles and marital responsibilities. Additionally, greater expectations of their husbands for domestic support emerged as a common thread, as the demands of domestic labour and infant care became increasingly challenging during the postpartum period, resulting in higher levels of stress, feelings of aloneness and isolation, and job loss. This aligns with the literature, which identifies a lack of husband support as a risk factor for Indian women during the perinatal period (Ganjiwale & Nimblakar, 2025). Some participants reported a lack of instrumental support from their husbands, attributing it either to their husbands' limited experience and knowledge of household chores or to socioeconomic circumstances that required them to work long hours and spend many days away from home. However, a few participants reported receiving adequate support with childcare and household chores from their husbands, which reduced their stress and aided postpartum recovery. This finding aligns with the literature, which suggests that partner support is positively correlated with improved perinatal mental health outcomes for women (Antoniou et al., 2021).

Although a lack of spousal support reported by IIWs may be viewed as stemming from persistent gender inequality and the unequal division of labour, as evident in the literature (Ladkat et al., 2025), it is important not to treat women's experiences as a universal truth. Instead, variation in participants' narratives within their familial structures should be considered,

and their experiences contextualized within their environments, while holding space for the divergent stories shared by IIWs in this study. Viewing through this lens allowed me to move away from labelling the entire group as oppressed at first glance and towards identifying key environmental factors that maintain or alleviate some of their challenges during the perinatal period. For example, a closer look revealed that participants' narratives varied in how they negotiated traditional gender roles and interpreted their husbands' levels of support, within the context of their husbands' and their own socioeconomic circumstances and acculturation levels during the perinatal period.

Further, findings highlighted the influence of multigenerational family structures on decision-making power in postpartum maternal and infant care within Indian families. Although migration created physical distance between family members, fragmenting multigenerational households into nuclear units, the perinatal period was unique for participants in that it temporarily rebuilt these structures, as female relatives such as mothers or mothers-in-law moved in with the couple to care for the mother and infant. This new, temporary dynamic appeared to reshape decision-making power in postpartum and infant care, as participants shared narratives in which their mothers and mothers-in-law offered advice that conflicted with participants' values and beliefs. Their stories also reflected confusion and distress as they navigated traditional family expectations and Western medical advice from their doctors. For example, stories ranged from individuals longing to be seen and heard by their family members to others who turned to their husbands for mediation when they felt dismissed. Some recounted carefully negotiating between traditional and Western practices in line with their personal values, while one described a complete loss of control over their decision-making. These findings were consistent with those of Suri et al. (2025), who examined the role of family caregivers, particularly mother-caregiver

dyads (spouse, mother, or mother-in-law), within families in India following childbirth.

Participants in Suri's study reported having less decision-making power over their own and their infants' health. Notably, participants' mental health was negatively associated with mental well-being when the caregiver was their mother-in-law, whereas the opposite was true when the caregiver was their mother.

Although the current study did not explicitly examine the dynamics of mother-caregiver dyads, participants' narratives nonetheless revealed frustration, disappointment, and resentment towards their mothers or mothers-in-law, especially when they received unsolicited self-care or parenting advice or were asked to follow superstitions in caring for the infant. Many participants expressed a desire to move away from superstitions and traditional postpartum and infant care practices and to adopt scientifically validated or Western practices (e.g., advice from family physicians). These findings were consistent with those of Selvaraj Prasannakumari et al. (2026), who found that while guidance from elders was generally considered supportive, it often left Indian postpartum women feeling judged, confused, and lacking agency and confidence in their infant-care decisions.

In the current study, participants' narratives showed that they negotiate decision-making power within their family dynamics through various strategies, such as staying silent to maintain harmony, ignoring advice to minimize conflict, involving their husbands as mediators, or refusing to comply outright. In line with Mohanty's (1984) viewpoints, variations in how IIWs navigated authority over postpartum and infant care diverged based on how they had constructed their social identity (e.g., daughter/daughter-in-law) within their family dynamics. Some participants chose to involve their husbands, some chose to stay silent, and some pushed back on traditions and family advice, thereby, in many ways, emphasizing their acts of resilience and

nonconformity and countering the “average third-world woman” narrative that is often cited by Western feminist scholars working with women of colour (Mohanty, 1984). Further, while silence is often viewed through the lens of oppression, it can also be a means of reclaiming agency (Mannergren Selimovic et al., 2020), as evidenced in many participants’ narratives, who used silence to maintain peace both internally and externally in their relationships. For example, many participants reported that by choosing to stay silent, they were able to “ignore” or filter out advice from relatives and follow practices that aligned with their values.

Interestingly, the study's findings further provide a nuanced understanding of how complex family relationships and migration-related factors influence perinatal IIWs’ authority over postpartum and infant care. Complicating these findings is that, for most perinatal IIWs, emotional support from family members remained crucial, and loneliness resulting from being away from loved ones appeared to be a shared emotional experience across all participants. This suggests that IIWs do not simply prefer total independence from their family supports during the perinatal period but rather value a combination of emotional and instrumental support from their female relatives while retaining autonomy and authority over their own and their infant’s health. This insight is an important lesson learned and may be applied in therapeutic interventions, where balancing autonomy and family relationships is valuable for perinatal IIWs seeking mental health support.

Additionally, social support, particularly from friends with shared lived experience, emerged as a protective factor for many women. Findings revealed stories of how IIW built new support networks after migration. These networks offered women a sense of cultural belonging and connection, emotional and instrumental support, and a place to exchange knowledge about pregnancy, the postpartum period, and infant care. However, many participants who had recently

immigrated described loneliness and a lack of social networks. For those women, perinatal journeys appeared quite challenging without support in Canada. Many voiced feeling alone and expressed sadness, and this was supported in the literature, which has found social isolation as a risk factor for depression during the perinatal period (Dela Cruz et al., 2022; Kay et al., 2024).

While social support was deemed significant, many participants also described barriers, including internalized and broader cultural stigma and fear of child apprehension, that had previously hindered or made them reluctant to seek psychological support. For example, internalized stigma was evident in how some participants viewed seeking psychological support as a weakness and portrayed themselves as strong and self-reliant. Further, many participants expressed the need to seek a mental health professional only if things became unmanageable, suggesting the notion that one should seek a mental health professional as a last resort. This perspective might offer insight into participants' attitudes toward seeking psychological support.

Regarding cultural stigma, one participant shared that fear of family or community members finding out about their mental health problems was a barrier to seeking mental health services. A commonly expressed worry, "What will people say?" or fear of social ostracization, may prevent people from discussing their concerns with others in the community. This barrier has also been identified in the literature as a barrier to seeking treatment for mental disorders among South Asian American women (Goel et al., 2023). Additionally, fear of ostracization can be closely tied to one's gender and may supplement our understanding of this community's help-seeking attitudes. For example, in a study examining the influence of shame on British-born South Asian girls' help-seeking attitudes, Sangar and Howe (2021) found that shame was understood in both negative (e.g., oppressive, controlling, or restrictive) and positive (e.g., protective, helpful, and morally guiding) terms. Further, shame was closely tied to family

honour, with girls bearing greater responsibility for avoiding bringing shame upon their families and for protecting their family honour. When constructing mental health, participants viewed help-seeking as abnormal, as a disease, or as something to hide to avoid bringing shame or embarrassment, inviting potential gossip, or being seen as damaging to family honour (Sangar & Howe, 2021). Although the role of shame and honour wasn't explicitly studied in the current study, it is important to consider how shame may play a role in hindering women from seeking mental health services during the perinatal period, in addition to other barriers that were identified.

One participant expressed fear that their infant would be apprehended, as well as fear of being monitored and tracked by the government. These concerns may be a significant barrier to seeking psychological support, may reflect mistrust of psychology among some women, and have been previously identified in a study examining the postpartum mental health of queer parents, who voiced concerns about discrimination, such as being labelled unfit, and feared involvement with child welfare systems (Goldberg et al., 2025). Another study found that UK mothers had heightened fears of judgement for having perinatal mental health problems and of potentially losing their baby as a result (Taylor et al., 2019).

However, it would be remiss not to acknowledge that divergent narratives from participants who engaged in help-seeking behaviours highlighted important facilitators of help-seeking. For example, some participants with prior experience with psychological support cited three primary factors that influenced their willingness to seek help, including their husband's supportive role in encouraging them to seek services, learning about the confidentiality of therapy, and mental health professionals' interpersonal qualities, which increased their trust and sense of being seen. Taken together, findings on participants' help-seeking attitudes support a

model proposed by Webb et al. (2023), which noted that access to perinatal mental healthcare is influenced by several factors, including varying levels of trust in healthcare professionals and societal factors (e.g., cultural norms and stigma). Taken together, these findings highlight the importance of increased awareness of how psychological services are operated (e.g., limits of confidentiality), greater efforts to promote trust within psychology as an institution, and initiatives to reduce cultural stigma to promote help-seeking attitudes and behaviours.

Lastly, participants reflected on the invalidation they experienced from their families regarding their emotional and physical challenges, and how this contributed to their feeling neglected or invisible as the focus shifted from the mother to the baby. This was also echoed in a study by Selvaraj Prassannakumari et al. (2026), which examined Indian women's postpartum experiences within their familial contexts. Some also shared stories of being judged, compared to others, and having the legitimacy of their birthing experience questioned. Many dealt with their pain internally by concealing their emotions, self-silencing, or taking the blame to maintain harmony in relationships; however, they later described how their pain, which could no longer be suppressed, became visible. Some women responded to their suppressed anger, while others confronted judgmental comments. By sharing their narratives, many participants highlighted how they challenged the dominant portrayal of Indian women as "timid, shy, and domesticated" by resisting, fighting back, and taking up space. However, these counter-narratives should not overshadow the persistent judgments, self-silencing, and comparisons that many endured for as long as they did before reaching their breaking points, as these experiences contributed to ongoing distress throughout their perinatal journeys.

Lastly, I observed that participants recognized their physical symptoms (e.g., morning sickness) more readily than their mental health experiences and had a limited vocabulary for

describing their emotions. These observations were not part of overarching storylines but rather notes I documented during my interviews and analysis. Nonetheless, they further enhanced my understanding of how participants constructed meaning from their mental health experiences. For example, participants were more likely to discuss distress related to bodily experiences, possibly due to the normalization and acceptance of somatic experiences within the community (Selvaraj Prassannakumari et al., 2026). Moreover, participants displayed a limited vocabulary for describing emotional experiences, possibly due to English not being their first language. For example, many participants described their experiences as “hard” or “very hard,” which might have been an overly simplistic way of describing their stressors. In this way, quantitative measures served as a useful tool for gathering information about participants' anxiety and depressive symptoms, as they responded to written statements, whereas qualitative interviews provided cultural nuance and contextualized their symptoms within their circumstances. Ultimately, these findings highlight the complexity of identifying symptoms of anxiety and depression within this community and the need for increased efforts to improve recognition, labelling, and normalization of mental health within the perinatal IIW.

Strengths and Limitations

This study had a few strengths and limitations. For example, the study was conducted in English, which was a barrier to recruitment. Conducting interviews in English may have affected how individuals made sense of their experiences, as English was not their first language. This is consistent with the literature suggesting that meaning-making of one's emotional experiences can be shaped by their spoken language (Hoemann et al., 2025; Lindquist et al., 2015). Other barriers to recruitment stemmed from the study's narrow focus on Indian immigrant women. Future research may want to expand the scope of the study to include other South Asian communities

(e.g., Pakistan, Bangladesh, Nepal, Sri Lanka). Additionally, participants in this study were highly educated, and their narratives may not be representative of women with lower education, or from more conservative and highly stigmatized backgrounds. Despite these limitations, this study has several strengths that cannot be overstated.

First, this study is among the few conducted in Canada and, to my knowledge, the very first conducted in Central Canada, thus filling a major gap in knowledge. Second, this study was conducted in partnership with a Winnipeg-based not-for-profit community organization. This collaborative approach, together with the identification of gaps in the literature, addressed the most pressing research questions within the Indian community and ensured the study remained culturally informed and community-relevant. Third, this study provided a space for women to share their experiences, which, in and of itself, was considered therapeutic, validating perinatal IIWs' struggles and empowering many women to contribute to important knowledge that can later be used to design programming for other women like them. Fourth, my identity as an Indian immigrant gave me an advantage, helping me build rapport with participants and collect rich data. Lastly, Reissman's narrative analysis, as a methodological framework, enabled in-depth interpretation of participants' narratives and provided space for divergent experiences to co-exist. The online format of qualitative interviews made this study accessible to individuals who already experience internal and cultural stigma surrounding mental health, as they were given the option to turn off their cameras.

Future Directions

Based on findings from the current study, IIW's mental health experiences and support-seeking attitudes are best understood within the context of their family and social networks. In particular, many participants reported isolation and loneliness during the perinatal period, along

with inadequate partner support, which heightened their stress and anxiety. The absence of a support network disrupted perinatal knowledge exchange for many participants, which may have contributed to their depressive symptoms. Participants with access to social supports reported receiving emotional and tangible support, including help with household chores, a sense of belonging, and a temporary escape from their responsibilities. Many participants also reported having to negotiate authority over postpartum and infant care, which appeared to lead to frustration, distress, and resentment towards female relatives. Lastly, participants' narratives revealed a limited mental-health-related vocabulary for describing their emotional experiences, as well as a greater emphasis on bodily experiences over emotional experiences during the perinatal period. These key findings can inform future program development aimed at supporting the mental health of perinatal IIWs and increasing their support-seeking attitudes.

For example, one area of intervention could be to create a culturally relevant peer support program for perinatal IIWs that emphasizes informational and emotional support. Peer support is a valuable intervention for perinatal individuals, as it provides support from individuals with shared lived experience, which may help normalize and validate their mental health experiences without the involvement of mental health professionals (Rice et al., 2022). Given the heightened stigma towards seeking formal psychological support expressed by many participants in the study, peer support may be useful. Additionally, many participants expressed interest in group-based formats, which may align well with those of peer support programs.

Another area of intervention could be a group-based, culturally adapted CBT-based program to support perinatal IIWs' mental health. For example, Husain et al. (2024) developed ROSHNI-2, a culturally adapted, 12-week program based on CBT strategies to support British South Asian women. The research team engaged faith leaders, informed them of the study's

objectives, and asked them to share this information at the end of their sermons. Additionally, participants' family members were involved and briefed on the study's importance for participants' and infants' mental health. The study materials and communication with the research team were available in many Indian languages. Other efforts, such as drop-in chai or tea sessions to stimulate perinatal mental health conversations and reduce stigma, were undertaken to increase recruitment. The program covered topics such as the challenges of "being a British South Asian woman, the role of religion and spirituality in mental health, issues affecting self-esteem and their management, exercise, relaxation, assertiveness, self-confidence, and tackling social isolation" (Husain et al., 2024). The study's findings demonstrated a significant improvement in postnatal depression (Husain et al., 2024).

Similarly, a group-based program that uses CBT strategies to address topics raised by participants in the current study, including negotiating and communicating boundaries, tackling loneliness and isolation, building self-efficacy, navigating confusion between traditional and Western postpartum and infant care practices, and recognizing and labelling emotional experiences, may be a key area of focus. Efforts to reduce stigma and raise awareness of how confidentiality works in psychology could be integrated throughout the research process, from the initial stages of advertising and participant recruitment to ongoing conversations about cultural stigma during sessions.

Further, given that partner support was found to be an important factor in perinatal IIWs' mental health, future interventions may consider involving IIWs' husbands. Since many women reported a lack of tangible support from their husbands, particularly for household chores and infant care, they may greatly benefit from increased instrumental support. This aligns with findings from a study by Rao et al. (2020), which examined Indian women's experiences of

receiving postnatal support in Australia. Perhaps an intervention that increases husbands' psychoeducation on perinatal mental health challenges and encourages them to provide tangible support to their wives may also benefit perinatal IIWs.

Lastly, family-focused psychoeducation, as emphasized by Selvaraj Prasannakumari et al. (2026), can be prioritized to increase understanding and empathy among husbands and relatives (e.g., mothers and/or mothers-in-law), reduce judgments and comparisons, normalize maternal distress, and develop strategies for navigating postpartum and infant-care authority, while prioritizing IIWs' autonomy without compromising access to familial supports.

Conclusion

This study aimed to understand perinatal mental health experiences among perinatal IIWs, their unmet support needs, and attitudes and behaviours toward seeking support. Participants described both positive and negative migration-related experiences throughout their perinatal journey; ways they negotiated authority over postpartum self- and infant care; shared narratives of enduring invisible emotional pain during the perinatal journey; and stories of how they navigated Western perinatal psychological supports. Together, these findings underscored the need for culturally tailored programs that focus on increasing recognition and labelling of emotional experiences, reducing loneliness and isolation, increasing informational, emotional, and instrumental support, reducing stigma, and managing family and community judgments and comparisons. Possible interventions may range from peer support and group programs grounded in CBT strategies to increased psychoeducation for husbands and family members, and can serve as points of intervention to support the mental health of perinatal IIWs.

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Appendix A

Recruitment Poster

ARE YOU A WOMAN FROM INDIA AND CURRENTLY PREGNANT OR GAVE BIRTH WITHIN THE PAST 18 MONTHS?

We want to hear about your emotional experiences during pregnancy or after childbirth



What is involved?

Complete a 10-20 minute online survey regarding your emotional experiences and participate in a 60-90 minute one-on-one conversation over Zoom.

Receive a \$50 e-gift card for your time

You may be eligible if you :

- Are currently pregnant OR gave birth within the past 18 months
- Immigrated from India
- Are 18 years +
- Live in Manitoba
- Fluent in English
- Are experiencing emotional challenges, stress, or low mood during or after pregnancy



health info.
exchange
lab.

Interested in this study?

Contact Bhavya Arora
at arorab4@myumanitoba.ca

Advisor: Dr. Kristin Reynolds
Kristin.reynolds@umanitoba.ca



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Instituts de recherche en santé du Canada

We respect your privacy. This study has been approved by the Research Ethics Board at the University of Manitoba. Your information will be handled privately and used only for research purposes.

Appendix B

List of Resources

Culturally Responsive Counselling Resources: FREE TO LOW COST

Punjabi Community Health Services (PCHS)

- Supporting diverse communities in a culturally appropriate manner to receive equitable services. Services include mental health supports, including counselling, system navigation, and referrals. Services are offered in Punjabi, Hindi, and Urdu. Meetings can be scheduled in home, at a public community location, or online. No diagnosis or health card required.
- Self-referral by e-mail : rdhaliwal@pchsmc.com
- Call: (431) 990-7247
- Website: <https://www.pchsmc.com>

Community Wellness Program — Mount Carmel Clinic

- This program features culturally appropriate supports. Members can access advocacy supports, help navigating systems for newcomers to Canada, culturally appropriate parenting and family supports, and counselling supports which are offered in several languages. No diagnosis or health card required.
- Call: (204) 589 – 9477
- Address: 886 Main Street, Winnipeg, Manitoba, R2W 5L4, Canada
- Hours of operation: Monday, Wednesday*, Friday: 9:00 AM – 5:00 PM
Tuesday + Thursday: 9:00 AM – 8:00 PM
*Closed 9:00 – 11:00 AM on the first Wednesday of each month.
- Website: <https://www.mountcarmel.ca/how-we-help/community-services/>

Resilia Community Wellness Centre — Newcomer Mental Health Program

- Free, trauma-informed individual, family, and group counselling for immigrants, refugees, and international students in Manitoba. Services are culturally responsive and offered in multiple languages. Transportation support to get to the office is available or meet via phone or video chat. No diagnosis or health card required. Self-referrals and third-party referrals accepted.
- Call: (204) 786- 9251
- Address: 5th Floor – 491 Portage Avenue, Winnipeg, Manitoba.
- Website: <https://resiliacentre.ca>

Family Dynamics (Winnipeg, MB) — Counselling Services

- Offers individual, couples, family, and group counselling with a supporting, trauma-informed approach. Services are available in-person and virtually, on a sliding scale or free. They also offer in-home family support. Self-referrals via phone, email, or walk-in. No diagnosis or health card required.
- Call: (204) 947- 1401
- Address: 401- 393 Portage Avenue Winnipeg, MB R3B 3H6
- Email: info@familydynamics.ca

- Website: <https://familydynamics.ca>

Aulneau Renewal Centre (Not free but low cost)

- Counselling offered to adults, children, families, and couples. Health card not required.
- Phone: 204-987-7090
- Location: 228 Hamel Ave, Winnipeg, MB
- Website: <https://aulneau.com/>

Additional FREE Counselling Services

Anxiety Disorders Association of Manitoba

- This organization offers a 6-week online Anxiety and Worry Program to help individuals with anxiety, health anxiety, and social anxiety. Individuals can complete this program in a small group or individually. No health card required.
- Email: adam@adam.mb.ca
- Phone: 204-925-0600
- Location: 100 – 4 Fort Street, Winnipeg, MB R3C 1C4
- Website: <https://adam.mb.ca/programs>

Fort Garry Women's Resource Centre

- Services include one-time or ongoing counselling for women on a variety of topics, including parenting, trauma, and domestic abuse, childhood abuse, body image, self-esteem, and other related issues. No health card required.
- Phone: 204-477-1123
- Address: 1150-A Waverley St. Winnipeg, MB R3T 0P4
- Website: <https://fgwrc.ca/our-programs/counselling/>
-

Sexual Assault Crisis Program

- Klinik Community Health (Klinik) also provides care for survivors of sexual assault and/or intimate partner violence. This program is available for anyone 16 years of age or older who have experienced sexual assault and/or intimate partner violence. Available 24/7. No health card required if examination is conducted in a community-based setting.
- Phone: (204) 786-8631
- Toll Free in Manitoba: 1-888-292-7565
- Website: <https://klinik.mb.ca/in-person-counselling/sexual-assault-crisis-counselling/>

Crisis Supports: Province-Wide Support and Counselling (24/7 Available and FREE)

Confidential 24-hour crisis lines for anyone who is at risk of suicide, concerned about someone who may be at risk, or who has experienced a suicide loss can call them.

Manitoba Suicide Prevention and Support Line

- Phone: [1-877-435-7170](tel:1-877-435-7170) toll-free 24 hours
- Website: <https://reasontolive.ca>

Klinik Crisis Lines

- Phone: (204) 786-8686

- Toll free: 1-888-322-3019
- Website: <https://klinik.mb.ca/crisis-support/>

Crisis Response Centre

- Phone: 204-940-1781 or go 817 Bannatyne Ave.

Domestic Violence Crisis Line

- Phone: 1-877-977-0007 (toll-free in Manitoba).

Crisis Stabilization Unit (WRHA)

- For adults residing in Winnipeg, who are experiencing a mental health or psychosocial crisis.
- Phone: 204-940-3633

Free Hospital-Based Supports for Women in Pregnancy and Postpartum (FREE)**Anxiety Disorders Clinic (St. Boniface Hospital)**

- This clinic offers treatment for anxiety during pregnancy and postpartum. Treatment is often provided in a small group with a limited availability for individual treatment. The sessions range from 6-16 sessions.
- Requires a referral from a family physician, other medical specialist, psychiatrist, psychologist, or another health care provider. Manitoba health card required.
- Phone: 204-237-2335
- WRHA's website: <https://wrha.mb.ca/psychology/services/anxiety-disorders/>

Health Sciences Centre (HSC)

- This hospital offers treatment for depression during pregnancy and postpartum.
- Therapy is offered in a group (10 weeks) or individually (2-10 sessions). Services offered to women experiencing depression during pregnancy and the postpartum period. Services are also offered for depression secondary to miscarriage or termination of a pregnancy, or due to loss related to still birth or neonatal death.
- Referrals from health-care professionals are requested. Health card required.
- Phone: 204-787-7424
- WRHA's website: <https://wrha.mb.ca/psychology/services/depression/>

Women's Hospital (Health Sciences Centre)

- Psychological treatment is available for women experiencing anxiety and depression during pregnancy or postpartum, as well as for those experiencing mood disorders related to miscarriage or traumatic birth experiences.
- Treatment lasts between 8-12 sessions individually and if offered in group format will last for 10 weeks with 6-10 group members.
- Wait times for pregnant women are usually 1-3 months and are 2-10 weeks for postpartum women.
- This program requires referrals from psychologists, physicians (family practitioners, obstetricians and gynecologists, psychiatrists), midwives, public health nurses, and nurse practitioners. Health card required.
- Phone: 204-787-8237 or 204-787-5212

- WRHA's website: <https://wrha.mb.ca/psychology/services/womens-health/>
-

Information about Perinatal Anxiety and Depression

Please visit these websites to learn more about topics related to depression and anxiety during pregnancy and postpartum:

- American Family Physician: <https://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=6>
- Anxiety Canada: <https://www.anxietycanada.com/>
- BeyondBlue: <https://healthyfamilies.beyondblue.org.au/>
- March of Dimes: <https://www.marchofdimes.org/index.aspx>
- MIND UK: <https://www.mind.org.uk/>
- Postpartum Depression Association of Manitoba: www.ppdmanitoba.ca
- United Kingdom National Health Service: <https://www.nhs.uk/>

Appendix C

Screening Script

Hi, my name is * RESEARCHER NAME* and I'm *the student investigator/a research assistant* for this study. Thank you for your interest in our study.

I have a series of screening questions for you, which will help us to determine whether you fit the criteria to participate in this study. This screening will take about 5-10 minutes of your time. Do you have any questions before I proceed?

- Did you immigrate from India? How long ago? (0-5 years, 5-10 years, 10+ years).
- Are you currently pregnant or have given birth within the last 18 months?
- Are you 18 years or older?
- Do you live in Manitoba?
- Are you fluent in English?
- Will you have access to a private space and device to complete this study?
- Are you experiencing emotional challenges, stress, or low mood?

If participant meets screening criteria: Thank you for answering all of my questions, based on your responses, you meet the eligibility criteria. I will now give you a brief explanation of what study participation will entail. If you are still interested in our study after hearing this information, I will email you a consent form for you to review.

This research study involves completing 4 online questionnaires and taking part in an online interview over Zoom. The questionnaires and interview are meant to provide us with a deeper understanding into the emotional experiences and challenges that Indian immigrant women experience during pregnancy and postpartum.

I will send you an email with a link to a consent form for you to read and sign, as well as a set of questionnaires to complete.

The consent form is a document that highlights the purpose of the study, more details regarding what your participation would entail, benefits and risk related to the study, the amount you will receive for your participation, security measures that would be taken to protect your data and privacy, as well as confidentiality and its limits. Confidentiality basically means that everything you share with us will be kept private and will not be shared with anyone outside the research team. Your name will not be attached to anything you say. We are only doing this study to learn from your experiences, not to judge or report anything. Should you decide to participate in this study, you will be given a participant ID, and we will only address you with that, not by your name.

Please note that while we will do our best to keep what you share private, there are a few situations where we might have to share something. For example, if we become aware that you are an imminent threat to someone else or yourself, if a child or other vulnerable person is being abused or neglected, or if a court orders us to share information in case of a legal proceeding, we will have to report it. These are very rare situations, but it's important that you know when we

might have to share your information. This is also explained in the consent form, so please take time to carefully read the document and ask questions, should you have any.

Also, please note that you can only participate in this study if you consent to being video and audio recorded during the interview. If you are uncomfortable being video recorded, you are welcome to turn the camera off during the interview, but the audio recording is important for data analysis purposes. Also, please refrain from sharing your name or any identifying information during the interview. I will remind you of this again on our interview day.

Since this is an online study, please ensure that you are in a private space when completing the questionnaires and interview, to help protect your own privacy. Lastly, at any time you are not comfortable and would like to drop out of the study, you are free to do so.

Is this study still of interest to you?

Do you have any questions?

If you have any questions, you can email me or contact my advisor Dr. Kristin Reynolds at Kristin.reynolds@umanitoba.ca, whose information is on the consent form. Thank you for your time.

Once you have completed the consent form, make sure to also complete the questionnaires, which will appear immediately after.

If the participant decides they are not interested in participating:

No problem at all. Thank you for your time.

If the participant does not meet screening criteria: thank you for answering my questions. Based on your responses, there may be better resources that are available based on your needs and concerns. Review this list with the person and thank them for their time.

Appendix D

Informed Consent Form

Perinatal Mental Health Needs of Indian Immigrant Women in Central Canada: Exploring the Accessibility and Acceptability of Mental Health Supports

Advisor/Supervisor

Dr. Kristin Reynolds, Ph.D., C. Psych
Associate Professor, Department of Psychology, University of Manitoba
kristin.reynolds@umanitoba.ca

Study Investigator

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Research Assistant

Jasmine Dhalla
BSc. Psychology (Hons), Department of Psychology, University of Manitoba
dhallaj@myumanitoba.ca

This consent form, a copy of which you can download or print, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, feel free to ask any of the people named above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand:

- what is being asked of you,
- what the risks and benefits of participation are, and
- how the information you provide will be used and stored.

Purpose:

Pregnancy and childbirth are important times in one's life; however, they can be accompanied by some levels of worries, nervousness, and stress due to changing roles and responsibilities. The goal of this research is to hear about your mental health experiences during pregnancy or postpartum, identify ways in which the mental health of pregnant or postpartum Indian women could be better supported, and explore some reasons for why it might be difficult or easy for women in the Indian community to seek mental health support during this time.

Participation:

Your participation in this study is completely voluntary. Should you choose to withdraw from this study at any point or feel that you would rather leave some question(s) unanswered, you may do so.

Once you have completed this consent form in RedCap, you will be sent an email with a link containing access to a set of questionnaires to better understand your current mental wellbeing on

REDCap. REDCap is a secure platform that uses Transport Layer Security (TLS) encryption (also known as HTTPS) for all transmitted data. Please note that you can skip any questions you are uncomfortable completing. These questionnaires will take approximately 10-20 minutes to complete.

Once the questionnaires are completed, you will be contacted by the study investigator (Bhavya Arora) or research assistant (Jasmine Dhalla) to schedule a 60–90-minute virtual interview over Zoom Professional to further understand your mental health experiences during pregnancy or postpartum. The link to the Zoom meeting will be provided to you in your email. To join the interview, you will need to set up a free Zoom account.

With your consent, the study investigator or research assistant will audio and video record our meeting. Zoom Professional does not allow for only audio recording of meetings, and as such, your interview will also be video recorded. However, the video recording will be deleted immediately at the end of the interview. Alternatively, you can choose to turn off your video during the interview if you are uncomfortable with the video being recorded. The audio recording will be entered into Trint, a secure, encrypted, and AI powered transcription service, where the audio recording of your interview will be processed into a written document and used for data analysis. All transcripts will be reviewed for accuracy either by the study investigator (Bhavya Arora) or a research assistant (Jasmine Dhalla). Once transcripts are reviewed for accuracy, audio recordings will be deleted immediately.

Benefits:

There are no direct benefits to participating in this study. However, your participation will provide us with greater understanding regarding the mental health problems that Indian immigrant women experience during pregnancy and postpartum. Your participation may also help us identify some of the unmet mental health needs, as well as barriers and facilitators to accessing mental health supports — all of which would contribute greatly to informing future intervention. You may also gain personal insight through this experience and may feel a sense of empowerment by sharing your experiences.

Risks:

There is a possibility that you may experience emotional discomfort while reflecting on your personal experiences related to your mental health. Please contact the principal investigator (Bhavya Arora) or advisor (Dr. Kristin Reynolds) if you notice a significant worsening of symptoms. Please also see a list of resources (below).

Compensation:

You will receive a \$25 gift card via email immediately after completing the online questionnaires, as well as another \$25 e-gift card following your participating in the virtual interview.

Cost:

Other than your time, use of your computer or device, free Zoom account, and Internet connection, there are no direct financial costs associated with participating in this study.

Results:

The summary results of this study (not your individual results) should be available by approximately May 2026. If you would like to receive a summary of the results, please provide your email address below. The email address you provide will strictly be used to communicate with you throughout the study and to share the summary of the results. After that, your email address will be deleted from our records.

Withdrawal:

Your participation in this study is completely voluntary. Should you choose to withdraw from this study at any point or feel that you would rather leave some question(s) unanswered, you may do so without any penalty or consequences. If you choose to withdraw from the study, you may also choose to have your data destroyed and not used in the data analysis. To withdraw from the study please email Bhavya Arora at arorab4@myumanitoba.ca or Jasmine Dhalla at dhallaj@myumanitoba.ca. We will send an email after your withdrawal asking if we can keep your data to include in the final analysis of the results of this study. However, if we do not receive a response from you within 72 hours indicating whether you would like your data retained or destroyed, we will assume that we do not have your consent, and we will destroy your data. Thirty days after data analysis has begun (03/2026), we may not be able to destroy individual data, as at this stage isolating and removing a single participant's data may not be feasible, and doing so could compromise the integrity of the study's findings.

Confidentiality:

Only the advisor/supervisor (Dr. Kristin Reynolds), study investigator (Bhavya Arora), and trained research assistant (Jasmine Dhalla) will have access to the identifying data, the audio recording to your interview, and the written document containing the interview transcript. This transcript will be stored in a secure drive accessible only through the University of Manitoba VPN. Please note that all data stored and shared using Office365 files is hosted in Microsoft Data Centres located in Toronto and Quebec City.

Information gathered through data analysis of your interview may be published or presented in public forums; however, no identifying information will be included. Data will be presented as a whole, rather than showing each participant's individual results. When using direct quotes, we will refer to them by your participant ID — for example, "Participant 1 shared that..." This way your personal information cannot be traced back to the quote. We will share our findings through thesis-related research, journal articles, conference presentations, and other forums (e.g., research presentations, colloquia). Summary findings will also be shared with members of Punjabi Community Health Services (PCHS), a not-for profit community organization, that is dedicated to promoting equitable mental health services. Additionally, findings may be presented at local community health fairs and infographics, or brief educational handouts may be created to promote awareness.

Limits to confidentiality:

If you disclose information that you are an imminent threat to someone else or yourself, we are required to break confidentiality to ensure the safety of the person at risk. If you disclose information that a child (under 18) or other vulnerable person is at risk of harm or has been harmed, we are required to break confidentiality and report the information to the appropriate

authority. Lastly, in the case of a legal proceeding whereby a court of law issues a subpoena or order requiring the release of your records, we will be required to share that information.

Additionally, please note that your interview will be recorded for data analysis purposes and only those who agree to be recorded will be able to participate in this component of the research. Please note that researchers will only address you by your participant ID, not by your name. Before the recording begins, the researcher will remind you to not share any identifying information in order to maintain confidentiality. However, complete confidentiality cannot be guaranteed, as identifying information could be disclosed during the interview. If there is any mention of identifying information, researchers will ensure that those details are removed from the written transcript before data analysis begins.

Lastly, given that this is an online research study and there is a possibility that a third party (e.g., family member) might become aware of a participant's involvement. To maintain confidentiality, we kindly ask that you schedule the interview at a time when you have access to a private space with a stable internet connection.

University Approval:

A designated University of Manitoba auditor may check that this study is being done safely and properly. To do this, they may visit the study site or review the research records. We will tell you if someone outside the research team will be there while you are participating. If this makes you uncomfortable, please tell the study investigator, who will ask the auditor to return at another time. This study has been reviewed and approved by the Research Ethics Board, Fort Garry campus. However, this does not mean that participation is risk-free. If you have any questions, concerns, or complaints about this study, you may contact any members of the research team listed on the first page or the Office of Human Research Ethics at humanethics@umanitoba.ca or (204) 474-7122.

Security:

All data will be stored on secure drives accessible only through the University of Manitoba VPN. The Research Ethics Board at the University of Manitoba, Fort Garry campus may review research-related records for quality assurance purposes. Your data (identifiable and de-identifiable information) will be stored for a seven-year period as per standards and operating procedures and will be destroyed by 05/2032.

Contact:

If you have any additional questions about this study or your rights as a research participant, please feel free to contact the study investigator, Bhavya Arora at arorab4@myumanitoba.ca or research assistant, Jasmine Dhalla at dhallaj@myumanitoba.ca

Statement of Consent:

I have read this consent form, and I understand my role as a participant. If applicable, I have had the opportunity to discuss this study with Bhavya Arora, Jasmine Dhalla, or Dr. Kristin Reynolds, and I have had my questions answered. The risks and benefits have been explained to me. I have not been influenced by any study team member to participate in the study by any

statements or implied statements. I understand that I can download or print this consent form for my records. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I understand that after 03/2026 my data may not be able to be destroyed because this is after the data analysis process has begun. I freely agree to participate in this research study. I give permission for my interview be recorded. I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I permit the inspection of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

1. I agree to participate in this study. ☐ YES ☐ NO
2. I agree to be video and audio-recorded in this study. ☐ YES ☐ NO
3. I agree that the information I provided to the research team can be shared with or used by other researchers, funders, research or community organizations, journals, or other third parties for any future research purposes only if anonymized (my personal information is not included). ☐ YES ☐ NO
4. I agree to be contacted by a member of this research team for questions related to my participation in the current study. I understand that this is entirely voluntary and my participation in this study will not be affected if I choose to decline to be contacted in the future. I am also aware that I can ask for my information to be removed at any time. ☐ YES ☐ NO

Participant printed name: _____

Participant signature: _____

Participant email address: _____

Summary of Results:

I would like to be sent a summary of the study results. Yes ☐ No ☐

Notice Regarding Collection, Use, and Disclosure of Personal Information

Your personal information is being collected under the authority of *The University of Manitoba Act*. The University of Manitoba is committed to preserving your right to privacy. The information you provide will be used by the University to support our research. Your personal information will not be used or disclosed for other purposes, unless permitted by *The Freedom of Information and Protection of Privacy Act* or *The Personal Health Information Act*. If you have any questions about the collection of personal information: Ph: 204-474-9462 or Email:

fippa@umanitoba.ca

Appendix E**Demographic Questionnaire**

Department of Psychology

What is your age? _____

What is your gender? _____

Were you born in Canada?

1. Yes
2. No

If answered no

Where were you born? _____

How many years have you lived in Canada?

1. Less than 5 years
2. 5-10 years
3. More than 10 years

What is your native language? _____

What is your highest level of education?

1. Primary school or less
2. Some high school
3. High school graduate
4. Some college/trade school
5. Graduated college/trade school
6. Some university
7. University undergraduate degree
8. University graduate degree (e.g., Masters, PhD, M.D)

What is your current occupation status?

1. Full-time
2. Part-time
3. Maternity leave
4. Health leave
5. Unemployed

If you are currently employed, please list your occupation: _____

What is your marital status?

1. Single
2. Common law
3. Married
4. Widowed
5. Separated
6. Divorced

Who do you currently live with? (Select all that apply)

1. Spouse/Partner
2. Children
3. Parents/Parents-in-law
4. Siblings
5. Extended family (e.g., grandparents, uncles, aunts, cousins)
6. Friends/Roommates
7. Other (Please specify) _____

Are you pregnant now?

1. Yes
2. No

If answer yes

If you are currently pregnant, how many weeks pregnant are you?

What is your due date? _____

How has your physical health been throughout your pregnancy?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

Did you recently give birth (up to 18 months ago)?

1. Yes
2. No

If answered yes

If you have recently given birth, what date was your baby born?

How was your physical health throughout your pregnancy?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

How was your mental health throughout your pregnancy?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

How has your physical health been since giving birth?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

How has your mental health been since giving birth?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

If you are pregnant or recently gave birth (up to 18 months ago), is this your first baby?

1. Yes

2. No

If you are pregnant or recently gave birth (up to 18 months ago) and this is not your first baby, how many other children do you have (not including your current or most recent baby)?

Have you ever experienced a neonatal loss (e.g., miscarriage, stillbirth)?

1. Yes

2. No

Have you experienced complications during pregnancy, delivery, or recovery (check all that apply)?

- ☐ Pregnancy
- ☐ Delivery
- ☐ Recovery
- ☐ None of the above

If pregnancy is selected

Please explain the pregnancy complications that you experienced.

If delivery is selected

Please explain the delivery complications that you experienced.

If recovery is selected

Please explain the recovery complications that you experienced.

How would you describe your baby's health during pregnancy and/or postpartum? Were there any challenges?

In general, how has your physical health been throughout your life?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

In general, how has your mental health been throughout your life?

1. Poor
2. Fair
3. Good
4. Very good
5. Excellent

Have you ever experienced a mental health problem in your life?

1. Yes
2. No

If yes...

Please specify the mental health problem(s) that you have experienced.

Has the previously stated mental health problem(s) been diagnosed?

1. Yes
2. No

If yes...

When was/were your mental health problem(s) diagnosed?

Have you previously taken medication for your mental health?

1. Yes
2. No

If you have previously taken medication for your mental health, what type of medication did you take?

When did you start taking this medication?

Are you taking this medication now?

Have you ever sought psychological help (e.g., counselling, psychological treatment, psychiatric treatment)?

When did you seek psychological help?

For what reason did you seek psychological help?

How did you find psychological help?

How was this experience?

Are you currently engaged in psychological treatment?

1. Yes
2. No

If you are currently engaged in psychological treatment, please describe your current treatment plan (e.g., seeing a psychologist once a month).

Appendix F

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

As you are currently pregnant or have recently given birth, we would like to know how you are feeling. Please select the answer which comes closest to how you have felt in the past 7 days—not just how you feel today.

1. I have been able to laugh and see the funny side of things.

As much as I always could (0)

Not quite so much now (1)

Definitely not so much now (2)

Not at all (3)

2. I have looked forward with enjoyment to things.

As much as I ever did (0)

Rather less than I used to (1)

Definitely less than I used to (2)

Hardly at all (3)

3. I have blamed myself unnecessarily when things went wrong.

Yes, most of the time (3)

Yes, some of the time (2)

Not very often (1)

No, never (0)

4. I have been anxious or worried for no good reason.

No, not at all (0)

Hardly ever (1)

Yes, sometimes (2)

Yes, very often (3)

5. I have felt scared or panicky for no very good reason.

Yes, quite a lot (3)

Yes, sometimes (2)

No, Not much (1)

No, not at all (0)

6. Things have been getting on top of me.

Yes, most of the time I haven't been able to cope at all (3)

Yes, sometimes I haven't been coping as well as usual (2)

No, most of the time I have coped quite well (1)

No, I have been coping as well as ever (0)

7. I have been so unhappy that I have had difficulty sleeping.

Yes, most of the time (3)

Yes, sometimes (2)

Not very often (1)

No, not at all (0)

8. I have felt sad or miserable.

Yes, most of the time (3)

Yes, quite often (2)

Not very often (1)

No, not at all (0)

9. I have been so unhappy that I have been crying.

Yes, most of the time (3)

Yes, quite often (2)

Only occasionally (1)

No, never (0)

Appendix G

Generalized Anxiety Disorder 7-item (GAD-7)

(Spitzer et al., 2006)

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritated	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3

Appendix H

Qualitative Interview Protocol and Questions

- Hello, nice to see you again/nice to meet you *depending on whether the research coordinator/assistant has met with this participant previously*. Thank you for your interest in this study.
- Today I will be asking you several questions about your emotional experiences during pregnancy or postpartum *depending on whether the participant is pregnant or postpartum*
- **During this interview, you may recall stressful and challenging events. You do not need to go into the specific details of these events, but rather, the ways that they are impacting your pregnancy and postpartum.**
- Please note that this interview will be recorded. Zoom Professional does not allow us to record audio only when saving to a local computer, so both audio and video will be recorded; however, we will only store the audio recording of this meeting and will delete the video recording immediately after this interview. You can choose to turn your video off if you're uncomfortable being video recorded.
- During this interview, please try not mention any identifying information about yourself (e.g., your name, date of birth, address). I will be uploading the interview audio file to Trint, an AI software, where the audio recording will be converted into a typed document. So, if any identifying information is shared, it will be removed from that document before other members of the research team have access to it. The audio file of this interview will be destroyed once the transcript (the typed document) has been reviewed for accuracy. The transcript will be stored in a password-protected secure OneDrive that is only accessible via UM's VPN.
- Do you have any questions before we begin?
- I will now start the recording.

Questions:

1. How would you describe your pregnancy and postpartum experience so far?
2. How do you view or experience the emotional changes that accompany pregnancy and postpartum?
 - What emotions have you noticed? Has this been a change from pre-pregnancy or baby?
 - Have you talked with anyone about how you are feeling? Have you shared your feelings (to whom, when, why/why not)
 - How would you feel discussing your mental health with your family and friends?
 - How do people in your community and family view mental health and well-being in pregnancy and after childbirth? How have these views impacted you?
3. What kind of traditional/cultural practices have you seen or used related to pregnancy and postnatal period?
 - How do you feel about continuing these practices in Canada? What has this meant to you?
4. In times of struggle, what keeps you going? (what do you do?)

5. How comfortable would you be seeking support from a mental health professional during pregnancy and/or postpartum?
 - Probe for barriers and facilitators
 - What kind of support would you be looking for (e.g., virtual/in-person/group/individual)
 - What would be of most value to you
6. Is there anything else related to your experience in pregnancy and/or postpartum that we have not covered, that you would like to include?
 - Anything you like to share about your experience as a participant in this study.

List of additional probes:

- Tell me more about that
- What does/did that mean to you
- Give me an example of that
- How did that make you feel?
- What was that like for you?

This brings us to the end of the interview. Thank you so much for your time. I will contact you via email regarding compensation. In the meantime, if you have any questions/concerns please do not hesitate to ask me or my advisor, Dr. Kristin Reynolds.