Mental Illness in Refugee and Immigrant Women: A Midwife's Perspective on Culturally Competent Care

La Maladie Mentale chez les Immigrantes et les Réfugiées : Une Perspective Sage-femme sur les soins adaptés sur le plan culturel

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ABSTRACT

The assessment, diagnosis and referral for mental illness management have been recognized as indispensable roles within midwifery practice both in the United States and in Canada. War, civil unrest and natural disasters, have made mental health assessment crucial for refugee and new immigrant women who present as midwifery clients. Since 1991, National Depression Screening Day (NDSD) had been conducted in cities across the United States and Canada using the Harvard Department of Psychiatry National Depression Screening Day Scale (HANDS©). It facilitates the diagnosis of depression based on DSM-IV criteria. The HANDS© tool includes a 10-item interview guide which is a "self-report scale". HANDS© demonstrated good internal consistency and validity and was 95 percent sensitive.[33] Responses could indicate the need for thyroid screening, referral for mental health counselling or psychiatric care. Strategies for transforming midwifery practice are explored: taking a holistic approach, communication strategies, continuing education strategies, documentation and empowerment issues, multidisciplinary team approach, clinic environment issues, resources and referral base. As we develop expertise in the care of torture and trauma survivors, it behooves us to identify the experts amongst our ranks and to refer our clients to these midwives who will best meet their needs. Further research is needed to guide our incorporation of the skills for treating survivors in our educational programs for the midwives of the future.

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PRECIS

Mental illness amongst refugee and new immigrant clients of midwives may be identified using the Harvard Department of Psychiatry National Depression Screening Day Scale (HANDS©).

KEY WORDS

midwifery, women, mental health assessment, refugee, immigrant, culture, war, depression.

This article has been peer reviewed.

RÉSUMÉ

L'évaluation, le diagnostic et l'aiguillage vers d'autres services ont été reconnus comme ayant un rôle indispensable à jouer dans la gestion de la maladie mentale au sein de la pratique sage-femme, et ce, aux États-Unis ainsi qu'au Canada. La guerre, l'instabilité sociopolitique et les catastrophes naturelles ont rendu cruciale l'évaluation de la santé mentale pour les

réfugiées et les nouvelles immigrantes qui se présentent à nous en tant que clientes. Depuis 1991, la Journée nationale de dépistage de la dépression, le National Depression Screening Day (NDSD) est organisé dans les villes à travers les États-Unis et le Canada, et ce, utilisant l'échelle de la Journée nationale de dépistage de la dépression du Département de Psychiatrie de Harvard (HANDS©). Cet outil facilite le diagnostic de la dépression basé sur les critères du DSM-IV. L'outil HANDS© comprend un guide d'entrevue de 10 éléments qui est une " échelle d'auto-évaluation". HANDS© a démontré un bon coefficient de cohérence interne et de fiabilité et était sensible à 95 pourcent33. Les réponses pourraient indiquer le besoin pour un dépistage de troubles de la thyroïde, un acheminement pour un counseling en santé mentale ou pour des soins psychiatriques. Des stratégies pour transformer la pratique sage-femme sont explorées: la prise d'une approche holistique, les stratégies de communication, les stratégies de formation continue, les questions de documentation et d'autonomisation, l'approche d'équipe multidisciplinaire, les questions d'environnement clinique, les ressources et la banque de références. Au fur et à mesure que nous développons une expertise en ce qui a trait aux soins des survivantes de tortures et des personnes ayant vécu un traumatisme, il nous incombe d'identifier des experts parmi nos collègues et d'acheminer nos clientes vers ces sages-femmes qui seront les mieux placées pour répondre à leurs besoins. Plus de recherches sont essentielles pour guider l'intégration des compétences nécessaires pour traiter les survivantes dans nos programmes d'éducation, et ce, pour les sages-femmes de l'avenir.

MOTS CLÉS

Pratique sage-femme, évaluation de la santé mentale, réfugié, immigrant, culture, guerre, dépression

Cet article a été évalué par des pairs.

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PRÉCIS

La maladie mentale parmi les clientes de sages-femmes qui sont réfugiées et nouvelles immigrantes peut-être identifiée en utilisant l'échelle de la Journée nationale de dépistage de la dépression du Département de Psychiatrie de Harvard, le National Depression Screening Day Scale (HANDS©).

Introduction

Voluntary immigration and forced migration due to war, civil unrest, and natural disasters have led to pluralistic and diverse populations in the US and in Canada. In 2006, Citizenship and Immigration Canada recorded 21,380 temporary Canadian residents who arrived for "humanitarian" reasons (refugee claimant, "special considerations", "compassionate grounds").[1] Of these residents, 9,570 were female. In addition, 251,649 newcomers to Canada became permanent/landed immigrants in 2006. The percentage of the Canadian population comprised of new immigrants and refugees has remained fairly stable over the past 40 years with occasional declines or increases during the implementation of special immigration acts.[1] When immigrant and refugee women present in our clinics with mental illness, are we equipped to care for them?

Since 1991, National Depression Screening Day (NDSD) has been conducted in cities across the United States and Canada using the Harvard Department of Psychiatry National Depression Screening Day Scale (HANDS). After participating in the 2004 NDSD[2] in metropolitan Atlanta, Georgia, it was apparent that my office would benefit from the use of a simple assessment tool to effectively and diligently identify clients at risk for mental illness. This paper will describe the

implementation of the HANDS screening tool in my midwifery practice, and will discuss practical tools and insights to help reduce barriers to mental health care for new immigrant and refugee women.

This paper was written from the perspective of a certified nurse-midwife (CNM) practising full-scope midwifery (for obstetrical and gynaecological clients) in the United States. In my practice, I care for both privately and publicly insured clients who span all socio-economic levels, races and cultures. About 30% of the women I care for are new immigrants or refugees. The most common ethnic groups I encounter are Somali, Sudanese, Ethiopian, Liberian, Nigerian, Latin American, Caribbean and Vietnamese. These clients range from pubescent girls to postmenopausal women. The clients may require health counselling, psychotherapy and/or medication for postpartum depression (PPD), bipolar disorder, major depression and posttraumatic stress syndrome (PTSD). Four providers (three physicians and one CNM) co-manage the clients.

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Our practice with immigrant and refugee women is grounded in antiracist and midwifery models. Anti-racism acknowledges multiple and intersecting sites of oppressions such as race, gender, class and sexual orientation.[3] The midwifery model identifies the midwife's role as an advocate and facilitator, who empowers through education and support of the woman and her family. To this end, the midwife promotes clients' equal access to services and privileges in the community. Midwives, and other practitioners who support anti-racism strategies, focus on changing power relationships between their clients and the elements within the community that are perceived by clients as intimidating: government officers, family members, employers.

Determinants and Assessment of Mental Health among Immigrant and Refugee Women

Fox[4] and Summerfield[5] distinguish between immigrant and refugee women's experiences leading up to migration. Although Fox describes an overlap in the mental health issues experienced by both groups, refugee women typically flee their countries of origin under extreme duress due to threat of injury or death, severe poverty or political, gender or religious persecution.[4,5,6] By contrast, new immigrants may emigrate for family reconciliation and economic or educational advancement.[4] Both immigrant and refugee women need to adapt to many socio-economic and cultural changes during resettlement. The effects of acculturation can be compounded by hormonal and biochemical changes during a woman's reproductive cycle.[7]

Therefore, pregnant refugee and immigrant women are at risk for depression, social isolation, acculturation induced stressors, and dysthymia (i.e. recurrent episodes of mild depression).[7,8] It should be noted that women are diagnosed with major depression and dysthymia twice as often as men, regardless of racial, ethnic or economic status.[9] Throughout the reproductive cycle, women may also experience anxiety disorders, fertility-related depression such as postpartum depression, post-abortion depression, and premenstrual dysphoric disorder (which is a severe form of premenstrual syndrome), eating disorders, substance use problems and posttraumatic stress disorder. Women will express symptoms of these disorders in a manner that is specific to their experiences and culture, e.g. in some cultures pelvic pain can be indicative of depression.[10,11]

Depression and anxiety disorders are also common among women who have a history of domestic or sexual abuse. It has been well-documented that domestic abuse tends to escalate during pregnancy and the postpartum period.[12-16] In my experience, many immigrant women state that they are financially dependent on an abusive partner, family member or employer. The Woman Abuse Screening Tool, described by Brown[13] is a short scale that can be used to identify women who are experiencing intimate partner violence. Early recognition and referral are important, particularly in situations of violence.

Health professionals estimate that 13 per cent of women experience symptoms of postpartum depression (PPD) that warrant treatment.[10] Many new refugee and immigrant women are of childbearing age and are even more predisposed to PPD because of the life stressors that surround resettlement, especially if the move to another country was out of the woman's control. Cultural values and customs (such as a preference for male children) create additional stressors and may put women at greater risk for developing PPD.[17] The Edinburgh Postnatal Depression Scale (EPDS) is a short 10-item tool that has been widely and effectively used to screen women for PPD.[10]

Low socioeconomic status presents another barrier that may negatively impact the mental health of immigrant and refugee women. Poverty is associated with social isolation, uncertainty, poor nutrition, poor access to healthcare, poor educational opportunities, and poor access to resources.[6, 18] In my practice, I observe many women who have experienced a downward shift in economic status after immigration. This observation is supported by Papillion[19] who reports that there is a significantly higher rate of poverty among new immigrants compared to the Canadian born population in Canada's cites (52.1% compared to 24.5%). Even skilled or professional immigrants (e.g., registered nurses) require re-accreditation in order to practice in a new country whether by re-examination or by endorsement depending upon their country of origin. This leads to further economic hardship and can accentuate negative affect and mental health problems.

When women are diagnosed with symptoms of mental illness during pregnancy, they are often treated with prescription drugs. Due to the potential risk to the woman and the fetus, it is critical to accurately assess risks and benefits before proceeding with drug therapy.

Culturally Sensitive Screening and Referral

Immigrant and refugee women who settle in Canada assume various identities or roles that change in different socio-cultural contexts. Rather than taking into account the multiplicity of roles and experiences of immigrant and refugee women, care providers throughout the health care system have labelled the difficulties in getting women to follow through with continuing care "non-compliance." Perhaps if we better understood clients' cultural dictates, economic constraints, concerns and fears we would provide them with options for care that empower them and respect their right to choose or refuse care.

Summerfield[5] recommends that health care providers examine the "role of social action and empowerment in promoting mental health" and to depart from the traditional psychiatric medical models. In short, he advocates using a biopsychomedical[5] model with survivors of war and socio-political trauma. Ross[12] describes a similar "biopsychosocial" model. Both models describe a holistic or multidisciplinary approach to assessing individuals in order to provide culturally and socially relevant care. These models take into account the diverse representations of mental illness even within one culture which may be affected by specific situational events; e.g., war. Summerfield[5] and other authors challenge health care providers to rise above previous psychiatric models that give "little acknowledgment to the role of social action and empowerment in promoting mental health."

Implementation of the HANDS© Tool

HANDS facilitates the diagnosis of depression based on DSM-IV criteria. HANDS demonstrates good internal consistency and validity and is 95 percent sensitive.[20] The HANDS tool includes a 10-item interview guide (see Table 1) which is not meant to replace a complete psychiatric clinical interview. With the results, the general practitioner may identify the need for further follow-up or referral. The client is asked whether she has experienced any of ten (10) items. The tool is scored by giving 0 points for "none or little of the time", 1 point for "some of the time", 2 points for "most of the time" and 3 points for "all of the time". A total score of 0-8 indicates unlikely presence of a major depressive disorder (MAD). A score of 9-16 indicates that mild to MAD is likely. Responses

Table 1: *Items described in the HANDS© Tool* *

1. low energy, feeling slowed down
2. self-blame
3. poor appetite
4. difficulty falling and/or staying asleep
5. feeling hopeless about the future
6. feeling "blue"
7. lack of interest in things previously enjoyed
8. feeling worthless
9. thinking about or wanting to die by suicide
10. difficulty concentrating or making decisions.

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could indicate the need for thyroid screening, referral for mental health counselling or psychiatric care. A score of 17-30 indicates that a major depressive episode is very likely and complete evaluation is strongly recommended immediately. One of the questions "Are you feeling blue?" is difficult to translate accurately for most patients and so produces an ethnocentric bias.

During one month of screening in my practice, I encountered three African patients who had experienced female circumcisions (one of whom experienced post-traumatic stress syndrome since the circumcision was performed at age 9 in the Sudan). I also met one depressed Liberian teenage client who witnessed the torture of fellow villagers during her escape to the jungle following the raid of her village by rebels. I screened a South Asian (East Indian) woman for depression following the loss of her job at the onset of pregnancy. She finally consented to antidepressant therapy for PPD after reassurance from the social worker that she would be referred for social assistance and that these category B medications were safe for breastfeeding. I encountered a Hispanic woman previously diagnosed with bipolar disease for whom the HANDS© tool was inappropriate. Her midwifery care was co-managed by the obstetricians and psychiatrists, enabling her to deliver safely with a valued family member at her side. With the diagnosis of pregnancy, her psychiatrist discontinued her Lithium (Category D) and instead prescribed Diphenhydramine (Benadryl, Category B) for sleep and Respirdal (Category C) for anxiety. In addition, several women reported pelvic pain, which is commonly experienced by depressed women.[21]

From the incorporation of mental health assessment into midwifery practice (using the HANDS© tool), recommendations for midwifery practice were developed.

Strategies for Transforming Midwifery Practice

1. Taking A Holistic Approach: Maintain a State of Readiness to Change

As a midwife, I have had the privilege of implementing the principles of midwifery ethics: to treat every client with dignity and respect for her social, spiritual, religious, racial and health care rights.[22] I was required to shift paradigms from viewing behaviour as pathological or "non-compliant" to discovering the intricacies of transition and adaptation following migration. Each word, gesture and referral can be carefully considered to empower an already vulnerable population. I had to remain non-judgemental in my documentation when treatment options were presented to and declined by the client. It will remain a challenge to develop relevant questions in order to assess clients and then to re-evaluate the effectiveness of my plan of care.

In that same vein, try the following questions with your clients:

(a) Ask the client what she believes is wrong and what terms she uses to identify her mental illness.
   - If she is from Bali, she may describe her emotional stress, confusion or hopelessness and cold feeling in her extremeties as "bebalnan".
   - If she is Caribbean or an African American from the South, she may describe her behaviour as "falling out" when she feels dizzy, faint and powerless to move although there is no apparent physical/medical diagnosis.

- If she is from Latin America, she may use "billis" or "colera" to describe her extreme mental illness caused by an imbalance of hot and cold in her body.
- If she is from Japan, "talijin kyofusho" may describe her syndrome of intense fear that her body or body parts or bodily functions displease, embarrass or offend. She may even describe her illness as "in her stomach" because that is the location of emotions.[11]

(b) How long has she experienced the problem and how does she believe it will get better?
(c) Is she using any alternative/complementary therapies? Are there any possible drug interactions or contraindications? Is she using the services of a traditional healer?
(d) Why (if applicable) does she believe that what the care team has done or proposes to do would be ineffective?
(e) What are her greatest fears surrounding her current state? Is there any stigma attached to this illness?[23]

2. Communication: Maintain Respect and Genuine Interest

The language used in clinic appointments and the atmosphere that I created was subject to change in order to empower my clients. Providing professional translators and consulting knowledgeable community liaisons can demonstrate the atmosphere of privacy, confidentiality, and genuine interest.

A dependable, empathetic translator should be contracted to be readily available on the premises or by phone. They are invaluable as we implement large-scale population screening for mental health. In order to respect the woman's privacy, friends, relatives or religious members of the woman's community may not be appropriate and may result in further stressful confrontations.

3. Education: Keep Informed

There is an increasing body of literature in which issues of cross-cultural mental health are identified and recommendations are made to health care professionals.[24,25]

- Skill in screening for mental health needs to become a core competency in the curriculum of every healthcare profession. Training programs should include basic mental health screening criteria, awareness of cultural differences in the expression of mental illness, and how to make appropriate referrals. According to Chud et al[25], cultural awareness training needs to include a discussion of: the trauma associated with being uprooted; loss of social support and economic status upon emigration; role reversal of family members where women leave the home to become the sole financial providers for the family and fathers acquire an unaccustomed childcare and domestic role; parenting dilemmas (e.g., how working parents can care for children when no subsidized child care is available and no other family member is in the country to help, or how to discipline in a society that may frown upon corporal discipline or discourage restrictions upon children's expression; language barriers; and adjustment to the new educational system.
- There are many resources available for clinicians to provide culturally sensitive care. It is important to learn the behaviours for seating, body postures, personal distance, teaching-learning paradigms, approaches to childrearing, view of self and when it is necessary to ask permission from a respected family member. Chud and Fahlman[25] describe these issues in detail for Greek, Japanese, African American, Chinese and Canadian families to name a few.
- Midwives and the health care workers throughout the practice should try to keep abreast of the current socio-political events occurring in the women's countries of origin.
- Effective and efficient continuing education for the professionals who will provide screening (i.e., both the midwives and adjunct staff) should be available. Such training programs could also provide current lists of referral sites. Training should include role-playing and coaching opportunities as clinicians develop the culturally sensitive language needed to empower clients.

For more information on internet resources, see Appendix A.

4. **Documentation and Empowerment Strategies: Leave a Paper Trail!**

All relevant data obtained from a medical history should be documented to maintain continuity of care among caregivers. Previous treatments and results of referrals are important. As we learn how to empower clients, these strategies should be documented and implemented. Some of the questions to consider include:

(a) How can the administrative staff minimize communication barriers?
(b) What roles do childcare or transportation problems play in appointment attendance?
(c) What factors (e.g., goals, fears, medication side-effects) influence clients' health care decisions?
(d) What are the unique past experiences of this woman as an immigrant or refugee?

5. **Multidisciplinary Teams: Don't be a Lone Ranger!**

Mental illness in refugee and immigrant women is complex, and different cultures may have unique expressions of mental health problems. A multidisciplinary team (including teachers, social workers, nutritionists, physicians, clerical staff, translators and nurses) can work together to evaluate, treat and provide advocacy and continuity for clients.

6. **Provide A Warm Clinical Environment**

Many women require encouragement to keep their appointments due to a lack of childcare. The clinic staff can be helpful by providing a child-friendly environment. In addition, if the budget allows, a childcare attendant could be hired to provide supervision in a "play room" similar to what is found in many community gyms (provided the parent signs a release form). Practitioners should train support staff to be respectful and thorough during intake and appointment scheduling. The client should have a clear understanding of the follow-up plan. Restrictive rules (e.g., restricting children or penalties for being over 15 minutes late) should be modified; as they may become a barrier to accessing care.

7. **Resources: Always Do Your Homework!**

There are many resources for health and social service professionals. The American College of Nurse-Midwives, the Renfrew Center Foundation, the Centre for Addiction and Mental Health in Toronto, Quebec's Alliance for the Mentally Ill and the British Columbia Division of the Canadian Mental Health Association (CMHA) have produced valuable publications and websites for professional development.

Midwives have an important role to play in the development of assessment tools that more effectively capture the culture, language and socio-political factors that influence the expression of mental illness amongst women.

8. **Referrals & Resources: Don't Get in Over Your Head!**

Mental illness referrals should be a mandatory function of all practitioners. Implement a system of calling ahead to inform your colleague of the referral, so that the client's call is expected and welcomed. Often in our office the nurse or referral coordinator was delegated this role of calling to set up the first appointment; and giving more than one option for referrals so that the clients could choose the health care workers with whom they feel most comfortable. Each midwife needs to keep a current list of local referral sites to facilitate timely evaluation and treatment.

Future Research

Our future research and screening must be based upon the assumption that any professional dealing with health, social welfare or education has an important and valuable part to play in the identification of mental illness. The findings of a recent study suggest that screening and management of mental illness (namely depression) is not completely integrated into current midwifery practice.[26] Reasons posed included attitudes concerning midwifery's role in primary care, insufficient knowledge or education, perceived inability to manage mental illness, and legislative variations in prescriptive privileges. The mass community-screening model may offer a gateway to

community awareness and health promotion programs from which midwives may benefit as we attempt to serve refugee and immigrant women with mental health problems. At all levels, the goal should be to compassionately care for a growing number of immigrant and refugee women.

Midwives have an important role to play in the development of assessment tools that more effectively capture the culture, language and socio-political factors that influence the expression of mental illness amongst women. The HANDS© tool has been implemented in both Canada and the U.S.A. with mixed results. The next step is to modify the tool to meet the needs of each new population. This will be a challenge considering the diversity in our cities.

Further research is needed to determine the prevalence of mental illness among refugee and immigrant women, to understand the differences in cultural expressions of mental illness, and to identify the unique needs of refugee and immigrant women with mental health concerns. Many of these women are survivors of torture, trauma, female circumcision or war. As we develop expertise in the care of torture and trauma survivors, it behooves us to identify the experts amongst our ranks and to refer our clients to these midwives who will best meet their needs.

Further research is needed to guide our incorporation of culturally sensitive care in our educational programs for the midwives of the future. In addition, we may need to provide continuing education for the identification and referral of the mental health issues specific to new immigrants and refugees.

Conclusion

In my experience the HANDS© tool can be adapted to be somewhat useful with clients from a range of cultures. However, an assessment tool may not represent a final destination but a point of departure for the cultural assessment of mental health. Although it clearly conforms to the DSM IV definitions of depression, it is not culturally specific enough. Nor does it take into account the broad spectrum of definitions that new immigrant and refugee women use to describe their illnesses. Perhaps the HANDS© is in fact a bridge, a translation tool that the provider may use to translate the client's language of mental illness into the medical model that indicates need for medication.

The HANDS tool may identify illnesses that have pharmacological treatments and psychotherapies that are based upon the Western Medicine paradigm. By contrast, the tool may also serve to alert the midwife to the need for treatments or therapy that are culturally bound and not based upon the medical model at all. In both scenarios, a holistic approach must be harnessed to decide upon treatment for new immigrant and refugee women. Midwives continue the role of "being with women" and so are poised to lead in this new era of caring for women in a changing and often traumatic world. That world is no longer across the globe. That world is at our doorstep

APPENDIX A

Internet Resources for Professional Development

1. American College of Nurse-Midwives. Resources and patient literature from: *www.midwife.org/siteFiles/news/sharewithwomen47_5.pdf* published by the Journal of Midwifery & Women's Health.
2. American Psychiatric Association. Practice guideline for the treatment of patients with Major Depressive Disorder, 2nd ed. In American Psychiatric Assoc. Practice guidelines for treatment of psychiatric disorders, Compendium 2004 (p. 424). Arlington, VA: APA, 2004.
3. Centre for Addiction and Mental Health. Alone in Canada: 21 ways to make it better: a self-help guide for single newcomers. Toronto: CAMH, 2001.
6. Hall, T.M. Glossary of Culture-Bound Syndromes. Available from *http://weber.ucsd.edu/~thall/cbs_glos.html* then use link to *http://homepage.mac.com/mccajor/cbs.html*. [Accessed November 5, 2006].
7. Lacombe, M.C. Committee to British Columbia's Health: National Depression Screening Day. British Columbia's Mental

Health Journal: Visions, Cross Cultural Mental Health 2000;9:3738. Available from *http://www.cmba.bc.ca/resources/visions* and then choose the Cross Cultural Mental Health, Winter 2000 issue. [Accessed December 31, 2005].

9. Motherisk information about the risk or safety of medications, herbs, diseases and chemical exposures during pregnancy: *www. motherisk.org* or (416) 813-6780.
11. Organization of Teratology Information Specialists (866-626-OTIS/6847) lists a directory of its membership organizations throughout Canada, U.S.A., the U.K. and Israel. The site also provides specific drug information, safety for pregnancy and lactation issues and printable handouts for patients. Available from: *http://otispregnancy.org/otis_find_a_tis.asp*

REFERENCES

1. Citizenship and Immigration Canada. Canada annual flow of temporary residents by primary Status, 1980 to 2006; Canada-Permanent residents, 1860 to 2006; Canada-Permanent residents as a percentage of Canada's Population, 1860 to 2006. Available from: http://www.cic.gc.ca/English/resources/statistics/facts2006/temporary/01.asp; http://www.cic.gc.ca/English/resources/statistics/facts2006/teporary/03.asp [Accessed December 9, 2007].
2. Screening for Mental Health, Inc. Suicide Education and Research Division. National Depression Screening Day kit materials. Wellesley Hills (MA): SMH, 2005. Available from: http://www.mentalhealthscreening.org/events/ndsd/conduct_materials.aspx#hands [Accessed October 28, 2006]
3. Mohanty, C.T., Russo, A., Torres (Eds.). Third World Women and the Politics of Feminism. Bloomington, IN: University Press, 1991.
4. Fox, P.G., Burns, K.R., Popovich, J.M. & Ilg, M.M. Depression among immigrant Mexican women and Southeast Asian refugee women in the U.S. International Journal of Psychiatric Nursing Research 2001; 7(1):778792.
5. Summerfield, D. War and mental health: a brief overview. [Electronic version]. British Medical Journal [online]2000; 321(7255): 232235.
6. Boyd, M. Canada's Refugee Flows: Gender Inequality. June, 2004. Available from: http://www.statcan.ca/english/ads/11-008-XIE/refugees.html. [Accessed January 2, 2006]
7. National Institute of Mental Health. Depression: What Every Woman Should Know. (DHHS Publication No. 00-4779). Washington, DC: U.S. Government Printing Office 2000. Available from: http://www.nimh.nih.gov/publicat/depwomenknows.cfm. [Accessed January 2, 2006]
8. Wong, P.W. Dysthymic disorder: European description. The ICD-10 Classification of mental behaviour by the World Health Organization, Geneva, 1992. Available from http://www.mentalhealth.com/icd/p22-md04.html. [Accessed July 22, 2006].
9. Weissman, M.M., Bland, R.C., Canino, G.J., Faravelli, C., Greenwald, S., Hwu, H.G. et al. Cross-national epidemiology of major depression and bipolar disorder. Journal of the American Medical Association 1996; 276:293299. Abstract retrieved December 29, 2005, from OVID Medline database. [Accessed December 29, 2005.]
10. Ross, L., Dennis, C., Robertson Blackmore, E. & Stewart, D. Postpartum depression: a guide for front-line health and social service providers. Toronto: Centre for Addiction and Mental Health, 2005.
11. Hall, T.M. Glossary of Culture-Bound Syndromes. Available from http://weber.ucsd.edu/~thall/cbs_glos.html then use link to http://homepage.mac.com/mccajor/cbs.html. [Accessed November 5, 2006].
12. Martin, F., Younger-Lewis, C. More than meets the eye: Recognizing and responding to spousal abuse. Canadian Medical Association Journal 1997;157(11):15551558.
13. Brown, J., Lent, B., Brett, P., Sas, G., Pederson, L. Development of the woman abuse screening tool for use in family practice. Family Medicine 1996; 28:422428.
14. Haber J.D. & Roos, C. Effects of spouse and/or sexual abuse in the development and maintenance of chronic pain in women. In H.L. Fields, R. Dubner, F. Cervero (Eds.), Advances in Pain Research and Therapy, IX. New York; Raven Press, 1985.
15. Drossman, D.A., Lesserman, J. & Nachman, G. Sexual and physical abuse in women with functional or organic gastrointestinal disorders. Annals of Internal Medicine 1990;149:828833.
16. Stewart, D. & Cecutti, A. Physical abuse in pregnancy. Canadian Medical Association Journal 1993;149:12571263.
17. Ekuklu, G., Tokuc, B., Eskiocak, M., Berberoglu, U. Saltik, A. Prevalence of postpartum depression in Edirne, Turkey, and related factors. Journal of Reproductive Medicine 2004;49(11):908914.
18. Pullenayegem, C. Let's Lose the Second Limbo! Canada Should Shorten the Wait for IRB-Recognized Refugees. Toronto: Citizens for Public Justice, 2004.
19. Papillon, M. Immigration, diversity and social inclusion in Canada's cities. Canadian Policy Research Network; December 2002:133.
20. Baer, L., Jacobs, D., Meszler-Reizes, J., Blais, M., Fava, M., & Kessler, R. Development of a brief screening instrument: The HANDS. Psychotherapy and Psychosomatics 2000;69:3541.
21. Harrop-Griffiths, J., Katon, W., Walker, E., Holm, I., Russo, J., Hickok, L. The Association between chronic

pelvic pain, psychiatric diagnosis, and childhood sexual abuse. Obstetrics and Gynecology 1988; 71: 57995.
22. American College of Nurse-Midwives. Code of Ethics of the ACNM 2004. Available from http://www.midwife.org/display.cfm?id=483. [Accessed January 2, 2006].
23. Canadian Mental Health Association, BC Division. (2000). Committed to BC's health: National depression screening day [Electronic version]. Visions: BC's Mental Health Journal, 9, 3738.
24. Chud, G., Fahlman, R., Baker, R., Wakefield, P. Early Childhood Education for a Multicultural Society: A Handbook for Educators. Vancouver: University of British Columbia, 1985.
25. Waxler-Morrison, N., Anderson, J. & Richardson, E. (Eds.). Cross-Cultural caring: a handbook for health professionals in western Canada coping with final tragedy. Vancouver, BC: University of British Columbia Press, 1992.
26. Sanders, LB. Attitudes, perceived ability, and knowledge about depression screening: a survey of Certified Nurse-Midwives. J Midwifery Women's Health 2006;51:340-345.

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