Postnatal depression and language proficiency

Postnatal depression (Source: rcpsych.ac.uk)

Last week I was interviewed for a publication intended to showcase the achievements of women in research. When the interviewer, Meryl Hancock, asked me about the biggest challenge I had faced in my career, I answered "motherhood' without any hesitation. In a career where you need to work 150% to succeed, having a child is always going to be a challenge. Facing that challenge as a migrant mother without access to a support network of extended family is twice as hard. Indeed, the only time I've ever been seriously homesick was right after my daughter was born. Sleep-deprived and pained by a stitched-up perineum I wanted nothing more than to be holed up in my parents' house for a while and to be pampered by my mother. Instead, I was marking essays while breastfeeding baby …

Even so, I was lucky: I had a healthy child, a secure job with flexible hours, a supportive partner, and a good network. Not everyone is so lucky and the combination of two deep human experiences, migration and motherhood, poses a major settlement and mental health challenge. In Western countries, the majority of new mothers experience some form of 'baby blues' and around 20% are estimated to be affected by post-natal depression (PND). It is widely assumed that these numbers are higher in migrant mothers.

Does being of non-English-speaking background really affect your mental health in a migration context? A 2005 study by Cordia Chu was designed to examine exactly that question with reference to Chinese mothers in Brisbane, Queensland.

To begin with, cross-cultural comparative studies have shown that PND is virtually unknown in China, including Hong Kong and Taiwan. New mothers get *tso yueh-tzu* (special treatment during the postpartum month) and are typically expected to stay in bed for a month, they are given special strengthening foods to eat, and they are relieved of all household chores during that period. The idea is for them to regain their health but also to be rewarded for the effort of producing a child.

However, while PND is virtually non-existent in Chinese mothers in China, its incidence in Chinese migrant mothers in Australia is higher than in the general population.

Chu (2005) argues that the occurrence of PND in Chinese migrant mothers is an outcome of the intersection of the quality of their support network, employment issues and financial problems, and feelings of isolation. She demonstrates this in an interview study with three different groups of Chinese migrants, who had had babies in the past three years in Brisbane, Queensland. The key variable was their country of origin (PRC, Hong Kong, Taiwan).

That country-of-origin variable translates into a number of additional differences as the migration circumstances of each group differ. As a group, the Chinese in Australia are highly educated (see also 'Human Capital on the Move') and have mostly been admitted as skilled or business migrants. However, while most PRC migrants came initially as tertiary students or skilled migrants, most migrants from Hong Kong and Taiwan were admitted

as professionals and business owners. In addition to their human capital they thus usually also brought financial capital to Australia.

At the time of the study in the late 1990s, all three groups were more likely to be unemployed or underemployed than the general population, as is still the case today. Despite the fact that PRC migrants were the most highly educated group of the three, they were most likely to work in unskilled or semi-skilled jobs and thus experienced the greatest downward occupational mobility.

Another difference between the three groups was that Hong Kong- and Taiwan-related community organizations were abundant in Brisbane: of 21 Chinese religious and voluntary associations operating at the time of the study, nine serviced Taiwanese only, five Hong Kong-born only, five were open to all Chinese (including those from South-East Asia) and only one catered exclusively to migrants from the PRC.

> This lack of voluntary associations combined with our network analysis showed that there was far less availability of social support, access to information and services, recreational and networking activities for the PRC migrants than for those from Taiwan and Hong Kong (Chu 2005, p. 44).

Eleven out of 30 interviewees (10 in each group) reported experiencing symptoms of PND. Six of these originated from the PRC. Ten of these cited lack of social support as their main problem – a problem that the women who did not experience symptoms of PND were able to circumvent by bringing their mothers out to Australia during the postpartum period or by going back home to give birth. Both these options of securing family support were costly and thus open only to the financially secure participants, mostly from Hong Kong and Taiwan in the study.

Financial concerns also were the base of whether women could choose to become housewives after the birth of their child or not. Six each of the women from Hong Kong and Taiwan chose to become stay-at-home mums and not return to paid work. None of these reported symptoms of PND. By contrast, becoming a housewife was not an option for any of the women from the PRC, who said they needed to accept paid employment to survive. Unsurprisingly, all of them reported various degrees of stress and fatigue as a result of being in paid employment while also caring for a young baby.

Despite the fact that they were in paid employment (often assumed to be closely linked to higher levels of English proficiency in the literature), the PRC-born women, and also those from Taiwan, reported that they were not confident enough in their English to use it in health communication. Consequently, they had to seek out Chinese-speaking (Western-style; i.e. not traditional Chinese health practitioners) to obtain care for themselves and their babies. Given the limited availability of Chinese-speaking surgeries, this meant long travel and waiting times and was thus another source of stress.

Finally, the women who reported symptoms of PND were also less likely to be aware of support services available to them and thus failed to access mainstream services such as antenatal classes or mother-and-baby groups.

So, is there a link between English language proficiency and PND in migrant women? As is usually the case, the link is not direct but mediated by other – and usually less conspicuous – factors such as financial security and

community networks in this case. For financially secure women from Taiwan who could bring their mothers to Queensland to help them, who had the choice to become stay-at-home moms and who had access to Taiwanese networks for support and information, English did not matter. By contrast, for PRC-born women who were struggling financially and did not have a wide community network, their lack of English proficiency (or their lack of confidence in their English proficiency) became another source of stress and anxiety (e.g., having to accept work they were overqualified for; having to spend long hours attending a Chinese-speaking surgery). At the same time, lack of English made finding solutions to these problems even more difficult for them.

Chu, Cordia M. Y. (2005). Postnatal Experience and Health Needs of Chinese Migrant Women in Brisbane, Australia Ethnicity and health, 10 (1), 33-56 DOI: 10.1080/1355785052000323029