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Mexican Women and Postpartum Depression in Maricopa County, Arizona

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Walden University
2019

Abstract

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Julio Presendieu

MHA, University of Phoenix, 2013

BS, Kaplan University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

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Abstract

Researchers have found that postpartum depression affects 10 to 15% of new mothers in the U.S. Empirical studies of PPD found that minority groups experience more depressive symptoms than the majority of the U.S. population. PPD is a common health problem among Mexican women in the United States. In Maricopa County, Arizona, research studies of PPD suggested that Mexican women had the highest PPD rate when compared to African-American, Cuban, and Puerto-Rican women. In Maricopa County, 21 to 58% of Mexican women experience depressive symptoms. Research has indicated that Mexican women's national culture and beliefs were related to their depressive symptoms. However, existing literature provides little information about the relationships of social factors, Mexican national culture, and beliefs. The purpose of this qualitative interpretive descriptive study was to explore what experiences Mexican women in Maricopa County have with PPD. The theoretical basis for this study was Engel's biopsychosocial model of perinatal mood. Ten Mexican women living in Maricopa County with PPD were interviewed to help gain a deeper understanding of past experience with PPD. The key findings in this study were that socioeconomic status, social support, cultural beliefs, and intimate partner violence were associated with Mexican women PPD before and after childbearing. The participants in this study also confirmed that lack of public transportation, illegal status, and spouse deportation to Mexico were associated with their PPD. A better understanding of these experiences could lead to policies and practices that address those women at greater risk of PPD. Thus, this research could result in a positive social change by improving the lives of new Mexican mothers and their families.

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Dedication

I dedicate this doctoral study to my 15-year-old daughter, Bianka-Mentor Presendieu. I encourage you to trust God in everything and anywhere. There is nothing too small or too big for God. You know my background and my story. Despite all challenges and Naysayers' critics, I was able to overcome all and achieved the greatest good for the greatest number. In Philippians 4:13, (NKJV), Paul says: I can do all things through Christ who strengthens me. Education is the cornerstone to overcome your social factors and gives you opportunities to open doors. "Education is the most powerful weapon which you can use to change the world." -Nelson Mandela

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I would like to give thanks to my God in Heaven for the strength and health that He gave me to achieve this historic journey. To my Dissertation Chair, Dr. Diana Naser, Dissertation Committee Member, Dr. Kimberly Dixon-Lawson and Editor, Dayna L. Herrington. I would like to take this opportunity to acknowledge your professionalism. As long as I live, I will always remember your contribution to my educational journey. You both provided me the tools that I needed to overcome challenges regarding my dissertation topic. You never turned your backs on me. Today, tears of joy are flowing down my cheeks, not for sadness, but for joy.

I extend my thanks and gratitude to my uncle Renaud Presendieu, my friends Dieuna Jean-Baptist, Olguine Theard, and Iclide Casimir. I will always remember your unconditional support to my educational journey.

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Chapter 1: Introduction to the Study

Empirical research has found that postpartum depression (PPD) is characterized by psychosocial factors or social life events during the pregnancy period and after childbirth (Callister, Beckstrand, & Corbett, 2011; Guerrero & Singh, 2013; Gilead, 2012; Ojeda, Flores, & Navarro, 2011). PPD is a prevalent health issue among women particularly among minority groups in the United States (Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2011). Among minority groups, Mexican women have the highest PPD rate; this prevalence is associated with a plethora of indicators or variables (Bobo et al., 2014; Gress-Smith et al., 2011). PPD is a serious health issue that can affect the family, and more importantly, the newborn child's development (Wylie et al., 2010).

This study was conducted to develop a better understanding of factors associated with PPD in Mexican women. Socioeconomic status (SES)(Jimenez et al., 2012), social-support (Corrigan, Kwasky, & Groh, 2015), education (Dolbier, Rush, Shadeo, Shaffer, & Thorp, 2013), race/ethnicity (Guerrero & Kao, 2013), intimate partner violence (Cummings, Gonzalez-Guarda, & Sandoval, 2012), discrimination (Chou, Asnaani, & Hofmann, 2012), and cultural beliefs (O'Mahony, Donnelly, Bouchal, & Este, 2013) have negatively impacted this population's well-being. A social change implication of this study could be the implementation of early diagnostic testing for prevention, for Mexican women in Maricopa County, for PPD. In this chapter, I described the background for my study, problem statement, and theoretical framework, the nature of study, purpose, research questions and significance as well as assumptions and limitations of the study.

Background of the Study

PPD is a major health problem that can affect both the mother and the development of the child (Abbasi, Chuang, Dagher, Zhu, & Kjerulff, 2013). During the perinatal or postnatal period, PPD can bring serious health concerns and create a distance between the mother and the child (Abbasi et al., 2013). Abbasi et al. (2013) argued that mothers can feel intense irritability, anger, anxiety, guilt, and a sense of being unable to care for the baby. Abbasi et al. (2013) also indicated that PPD could have somatic manifestations such as a headache, fatigue, decreased appetite, insomnia, and lack of energy.

In the United States, PPD affects 10 to 15% of new mothers (Gress-Smith et al., 2011; Pooler, Perry, & Ghandour, 2013). Gress-Smith et al. (2011) argued that PPD is a prevalent health issue among Mexican mothers in Maricopa County. Researchers have suggested that 21-53% of Mexican-American mothers experience high depressive symptoms, which is the highest rate observed when these mothers are compared to African-American, Asian, and non-Hispanic mothers (Gress-Smith et al., 2011). Pooler et al. (2013) have demonstrated that low-income families are more likely to experience many of PPD's risk factors and suggested low-income mothers are at the greater risk for having their depression overlooked by healthcare professionals. Shellman (2013) stated thatthe consequences of unrecognized, untreated PPD to individuals, families, and communities are significant.

Despite evidence of social factors among Mexican women with PPD, Mexican women may have cultural beliefs about postpartum depressive symptoms that may delay

seeking medical treatment or medical assistance through healthcare professional in Maricopa County. Researchers provided little evidence regarding factors that are associated with Mexican women's depressive symptoms. However, healthcare professionals should address PPD effectively through cultural understanding among Mexican women. Lack of knowledge of cultural understanding may underscore effective treatment to Mexican women in Maricopa County. Thus, in this study, I aimed to promote social change among Mexican women with PPD by implementing an early diagnostic test of PPD and cultural knowledge.

Problem Statement

PPD is a common health problem among Mexican women in Maricopa County (Gress-Smith et al., 2011). Research studies on PPD have indicated that there are many factors associated with depressive symptoms in Mexican women in Maricopa County. These factors include SES (Jimenez et al., 2012), social-support (Corrigan, Kwasky, & Groh, 2015), education (Dolbier et al., 2013), race/ethnicity (Guerrero & Kao, 2013), intimate partner violence (Cummings et al., 2012), discrimination (Chou, Asnaani, & Hofmann, 2012), and cultural beliefs (O'Mahony et al., 2013). Despite the research that has been done about PPD in Mexican women in Maricopa County, few research studies about factors impacting PPD in Mexican women, in general, have been found (see Gress-Smith et al., 2011; Jimenez et al., 2012; Ojeda & Pina-Watson, 2014; O'Mahony et al., 2013). Based on this identified gap in the literature, there is a need to explore the perceptions held by Mexican women with PPD in Maricopa County about social support,

SES, education, intimate partner violence, discrimination, cultural beliefs, and race/ethnicity.

Purpose of the Study

The purpose of this qualitative interpretive descriptive study was to explore what experiences Mexican women in Maricopa County have with PPD and their perceptions of factors such as low-income, cultural beliefs, intimate partner violence, social support, and healthcare services. Additionally, I explored barriers that may prevent Mexican women in Maricopa County from receiving diagnostic care for PPD.

Research Questions

RQ1- What perceptions do Mexican women with PPD, in Maricopa County, Arizona have regarding low-income, cultural beliefs, and intimate partner violence?

RQ2-How do Mexican women with PPD, in Maricopa County, Arizona perceive social support and healthcare services before and after childbearing?

RQ3-What are the experiences among Mexican women of postpartum depression?

RQ4- What barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD?

Theoretical Framework

The theoretical basis for this study was Engel's (2012) biopsychosocial model of perinatal mood. Empirical studies have shown that depressive symptoms among women after childbirth can best be explained by using the biopsychosocial model (Engel, 2012). The biopsychosocial model is aligned with biological, psychological, and social factors and is linked with PPD (Engel, 2012). For example, research studies have showed that

social factors such as SES, cultural beliefs, and social support are associated with the development of PPD among Mexican women in Maricopa County (Gress-Smith et al., 2012; D'Anna-Hernandez, Garcia, Coussons-Read, & Ross, 2016). By using Engel's biopsychosocial model, I was able to understand the influence of determinant factors for PPD, primarily among Mexican women in Maricopa County.

Nature of the Study

In this study, a qualitative interpretive descriptive approach was used to explore the factors that are associated with PPD in Mexican women living in Maricopa County. Qualitative research can provide more information about participants' experiences with PPD. In addition, as a researcher, philosophical hermeneutics helped describe and interpreted the phenomenon of PPD. Using this approach, interviews were conducted with 10 Mexican women living in Maricopa County who experienced PPD to gain a better understanding of how these women perceive factors such as low income, cultural beliefs, intimate partner violence, social support, and healthcare services contributing to postpartum depression and what barriers may prevent Mexican women in Maricopa County from receiving diagnostic care for PPD. The interview was both in-depth and unstructured. Each participant felt comfortable to express themselves about their past experiences (see Thorn, 2016). An unstructured interview was useful to collect data about participants' experiences (Dana, Dawes, & Peterson, 2013). Data were analyzed by using NVivo as software management.

Definition of Terms

Caballerismo: A term referring to Mexican husbands who take their responsibility in their family (Ojeda, Pina-Watson, 2014).

Cultural globalization: A term used to fix complex or solve social problems between two cultures. For example, immigrants who have embraced both American culture at the same time as their own native culture have encountered fewer social problems than those who do not (Liu, 2012; O'Mahony, 2013; Rusell, 2013).

El apoyo: Loving support among family members in Mexican culture (Ressel, 2013).

Machismo: The opposite of caballerismo, a term referring to Mexican husbands who demonstrate a lack of responsibility, manipulation or abusiveness in their relationships (Ojeda, Pina-Watson, 2014).

Marianismo: Values and beliefs that make Mexican women proud as mothers in the Mexican society (Callister et al., 2011).

Postpartum depression (PPD): A diagnosis that is applied to women before and after childbearing and symptoms usually detected between 6 and 12 weeks (Mrisri et al., 2010; Sadat et al., 2014).

Postpartum psychosis: A severe form of depression that occurs after childbirth that develops in approximately 1 to 2 per 1,000 women who give birth; the chief symptom is a loss of contact with reality (Malard & Dawson, 2010).

Assumptions

An assumption of this study was the belief that PPD impacts Mexican women's well-being (emotionally, economically, educationally, and mentally). To overcome many of social issues, it takes education and income to maintain a sustainable well-being. When both are unmet, then people might find it difficult to overcome their social issues and maintain their well-being effectively and efficiently. I assumed that participants would answer all questions asked by the interviewer with confidence and honesty. At the same time, participants had the full legitimate right to refuse to answer questions during the interview process. I assumed that participants were volunteering of their own free will and had not coerced to participate in any way. I also assumed that each participant responded to all questions without fear of exposure or consequences.

Scope of the Study and Delimitation

In this study, I focused on Mexican women with PPD in Maricopa County. This study did not include all Hispanic subgroups, for example, Puerto-Rican, Cuban, and Dominican women. I chose Mexican women as opposed to other Hispanic women, because researchers studying on PPD have found that Mexican women have the highest rate of PPD. Therefore, it became imperative to study Mexican women instead. To reduce bias in this study, I chose one subgroup among Hispanic subgroups. The delimitations identified in this study included that participants reside in Maricopa County. The age of participants was from 18 to 30 years and the participant had experienced depressive symptoms before or after childbearing. The educational level of the participant included 7th to 12^{th} grade or higher.

Limitations of the Study

A limitation of this study was that PPD depressive symptoms may have a different impact in different subgroups of Mexican women and psychosocial factors may have different results. Different subgroups of Mexican women may have a different understanding of PPD. My primary focus while gathering extensive information from participants' experience was paying attention to details and acting as a participant-observer. It was also important to set apart my bias, and let the participants presented the full version of what happened to them regarding the phenomenon of interest. Additional limitations such as choosing one homogenous group among Hispanic subgroups, age group, group demographic, geographic characteristics, and using an unstructured interview were considered as potential weaknesses. My personal bias could also be considered as a potential weakness. I brought my personal experience, which I described in Chapter 3. Thus, to address limitations, I focused on participants' experience and set apart my personal bias during the interview process.

Significance of the Study

In the United States, PPD affects 10 to 15% of new mothers (Gress-Smith et al., 2012). It has been recommended that primary care physicians evaluate women for PPD during their first visit (Bobo et al., 2014). Diagnostic tests would help prevent additional risks of depressive symptoms (Centers for Disease Control and Prevention [CDC], 2013). Research studies found that PPD can affect the child's development and their cognitive functioning (Gress-Smith et al., 2011). An empirical research study showed that Mexican women experienced the highest PPD rate in Maricopa County (Gress-Smith et al., 2011).

Therefore, it has become imperative for healthcare leaders to design a substantive program to reduce the PPD percentage rate among Mexican women in Maricopa County. A social change implication of this study was the implementation of early diagnostic testing, as prevention, for Mexican women in Maricopa County for postpartum depression. Yearly diagnostic testing could enhance Mexican women's knowledge and healthcare professionals' knowledge regarding postpartum depressive symptoms. It could help healthcare providers in Maricopa County identify PPD symptoms and provide adequate healthcare needs to Mexican women.

To promote social change among Mexican women in Maricopa County, public health practitioners also need to apply the community health assessment, an effective tool to assess the social needs in that community. More importantly, effective public health policy should be included in the community project along with community leaders to bring this prevalence health issue to pass among Mexican women in Maricopa County (Minkler, 2012). As the Mexican population continues to increase in Arizona, healthcare practitioners and the government should increase their awareness in public health policies, and the cultural background of different communities, and emphasize community health issues, particularly in underrepresented communities in order to promote healthcare equities to reduce healthcare disparities, especially among Mexican women in Maricopa County.

Summary

Empirical research studies have shown that PPD is a global health issue among women. It has recommended for primary care physicians to diagnose women with PPD

during their first pregnancy test visit. In this study, I explored perceptions held by Mexican women with PPD living in Maricopa County about various social factors and barriers to receiving diagnostic care for PPD using unstructured interviews as well as their experience with PPD. In Chapter 2, I described the search strategy, theoretical framework, and literature review for this study.

Chapter 2: Literature Review

PPD is a global health issue that demands attention from healthcare practitioners and world leaders. Recent research on PPD has suggested that 10 to 15% of new mothers in the United States has experienced PPD (Gress-Smith et al., 2011). Bobo et al. (2014) posited that depressive episodes may have occurred during the first postpartum year, but not necessary after the first 4 weeks of childbirth. However, researchers have recommended that women be screened for PPD during pregnancy to reduce the risk of depression symptoms (Bobo et al., 2014). Empirical research has identified a range of factors that are linked with PPD, particularly among underserved minority groups (Callister et al., 2011; Gress-Smith et al., 2011). Minorities, while more likely to experience PPD, are less likely to seek professional help before and after childbearing (Callister et al, 2011). Other research studies have suggested that the postpartum and postnatal periods receive less attention from health-care professionals than the prenatal and perinatal periods (Corrigan et al., 2015). Bobo et al. recommended that women should be screened for PPD during pregnancy to reduce the risk of symptoms.

Given the increased risk of PPD and decreased likelihood of treatment among Mexican women, the purpose of this qualitative interpretive descriptive study was to explore how Mexican women with PPD, in Maricopa County, perceive factors such as social support, SES, education, intimate partner violence, discrimination, cultural beliefs, and race/ethnicity. Additionally, I explored barriers that may prevent Mexican women in Maricopa County, from receiving diagnostic care for PPD. In this chapter, I described my search strategy, the theoretical framework supporting my research, and the major themes

related to PPD in the Mexican community. I conclude the chapter with a summary of the findings of my literature review.

Search Strategy

To gain insight into the phenomenon of PPD among Mexican women, the following themes were explored in this literature review: PPD, postnatal and prenatal depression, SES, intimate partner violence, education, social support, discrimination, and the social cognitive theory of well-being. I conducted research using multiple sources, such as online journals, books, government resources regarding the Mexican community, mental health, prenatal care, and PPD. Walden University Library offered me access to the following databases: Google scholar, Thoreau, PsychInfo, Medline, Academic Search Premier, MedEdPPD.org, and Postpartumprogress.net. I used the following key words in my search: "*education*, "*social*", "*culture*", "*society*", "*problem*", and "*needs*." This is not an exhaustive list of the terms used.

Theoretical Framework

The theoretical framework upon which this research was based on Engel's (2012) biopsychosocial model. Engel developed a biopsychosocial model of psychological health that is currently recognized by many clinicians and healthcare researchers. Engel's model stated that factors (e.g., biological, psychological, and social) are all interconnected in promoting health or causing disease. Wellness or illness is seen as being subject to a person's biological, psychological, and social state and not just their physiological state (Engel, 2012).

Engel, in his biopsychosocial model, recommended that clinicians explain PPD by exploring all important biological, psychological, and social factors that may be contributing to the development of the disorder (as cited in Smilkstein, Helsper-Lucas, Ashworth, Montano, & Pagel, 1984). For instance, a biological factor may be a history of depression in the family. Women who have family members who suffer from mental illness are at a greater risk for developing a mental illness (Sperry, 2008). A psychological factor may be individuals' need for control over their emotions and surroundings. A social factor may be the feeling of isolation and hopelessness. The combination of factors such as these exacerbates the chances of developing PPD.

A biopsychosocial perspective provides insight for patients suffering from PPD in addition to assisting physicians in recognizing the needs of their patients. Clinicians are therefore able to view PPD from a perspective that includes the different dimensions of the illness. The biopsychosocial model's most important contribution to understanding postpartum illness is the manner in which PPD is viewed (Sperry, 2008).

Maricopa County

Gress-Smith et al. (2011) conducted a study in Maricopa County and found that 74% of participants were from Mexico, 42% did not complete high school, 71% primarily used Spanish, and SES was determined to be one of the prevalent factors of postpartum depression among Mexican women. Based on postpartum depression results from developing countries, researchers determined that the findings were consistent with postpartum depressive symptoms (Gress-Smith et al., 2011; Lucero, Beckstrand, Callister & Birkhead; 2011). A previous study conducted in South Phoenix among low-income

minority women found that 33 to 38% Latinas experienced PPD (Gress-Smith et al., 2011).

Depression During Pregnancy

Depression during pregnancy is deleterious and can affect both the mother and the infant. It has been seen a challenge for health care professionals to treat patients with depressive symptoms (Chaudron, 2013). However, focusing on patient native culture, values, and religion could help healthcare professionals deliver holistic care to their patients (Chaudron, 2013; Ko et al., 2012). Chaudrom (2013) found that 14.5% of women experienced minor depression and 7.5% experienced major depression during pregnancy. Furthermore, major depression is considered the most prevalent form of morbidity during the postpartum period (Chaudron, 2013). Wang (2014) found that there is a positive relationship between stress and depression. Women who have no social support during pregnancy and after childbirth can be affected by both stress and depression (Wang et al., 2014).

According to Wang et al. (2014), social support is the care or help from others that an individual can feel, notice, or accept. Wang et al. agreed that a lack of social support, having a history of depression or anxiety, having an unintended pregnancy, being of lower SES, being exposed to domestic violence, being single, and having stressful life events are considered risk factors for depression. Furthermore, PPD among Mexican women was also related to acculturation, immigration, discrimination, and education (Afable-Munsuz et al., 2013; Arreola & Hartwell, 2014**;** Callister et al., 2011; Gress-Smith et al., 2011; Jimenez et al, 2012; Radillo, 2015; Wang et al., 2014)

Perinatal Depression

Perinatal depression can be a serious health issue for both mother and the infant. Therefore, yearly screening is found to be important to prevent perinatal depression before and after childbirth (Zande & Sebre, 2014). Lara et al. (2014) indicated that risk factors associated with major depression in pregnancy include a history of depression, unplanned pregnancy, lack of social support, and previous miscarriages. According to Lara et al., prenatal depression can affect not only the mother, but also the baby's cognitive and language development, and eating habits, and can also result in significant short and long-term negative effects on the mother and the child. Some researchers have considered the psychosocial factors associated with postnatal depression as well as with perinatal depression (DeMontigny et al., 2013; Folkman, 2014; Grier & Geraghty, 2015).

Postnatal Depression

According to the CDC (2013), PPD is a type of depression that occurs after having a baby. The CDC reported PPD symptoms as the following:

- A low or sad mood
- Loss of interest in fun activities
- Changes in eating, sleep, and energy
- Problems in thinking, concentrating, and making decisions
- Feelings of worthlessness, shame, or guilt and
- Thoughts that life is not worth living

Researchers have shown PPD negatively affects child-maternal attachment and can affect child development (Tough & Whitfield, 2012). Therefore, yearly intervention

for both prenatal and postpartum maternal distress would benefit the infant and the mother (Tough & Whitfield, 2012). According to Tough and Whitfield (2012), prenatal and postpartum maternal psychological distress affects five factors of infant development: global, cognitive, behavioral, socioemotional, and psychomotor. However, Tough and Whitfield also noted that there is insufficient evidence to support an association between maternal prenatal or postnatal distress and the global indices of infant development. Jahromi, Umana-Taylor, Updegraff, and Lara (2012) showed that demographic factors, such as adolescent mothers and lack of self-efficacy, affect child development. Intervention related to depression offered through postpartum care could reduce the level of distress for both the mother and the infant (Zlotnick et al., 2014).

Depression and Maternity Care

According to some researchers, the process of maternity care should begin before the pregnancy (Grussu & Quatraro, 2014; Kim et al., 2012; Liberto, 2012). For low-income families or underserved population, it is a challenge to be prepared at the early stages of pregnancy (Srivastava et al., 2015). To assess maternity care, it is important to analyze and measure demographic, psychological, and psychosocial factors to maintain extensive maternity care and reduce PPD (Gallo et al., 2012). Researchers have found that psychosocial factors, such as, low-level of parenting efficacy, prior experience of a miscarriage, lower SES, lack of social support, emotional distress, and chronic stress have been linked with PPD, particularly among minority groups (Bermudez-Parsai et al., 2012; Crammond & Carey, 2015). Researchers have recommended early screening for depressive symptoms among pregnant women to prevent depression and promote optimal

care to both the mother and the infant (Grussu & Quatraro, 2014; Lothian, 2014). Adequate health insurance was also found to be important during the pregnancy period (Amendola, 2012). Several researchers have posited that minorities in the United States receive less care and less quality of care than the White population (Amendola, 2011; Guerrero & Kao, 2013). When compared to care, in developing countries, maternal care disparities among the underserved community in the United States have been identified as consistent and notable (Chin et al., 2012; Srivastava, 2015).

PPD among Mexican Women

In Maricopa County, Mexican-American women experienced the highest PPD rate among ethnic groups in the County (Gress-Smith et al., 2011). The same literature found that 21 to 53% of Mexican-American mothers experienced some types of depressive symptoms during the first four to six weeks after giving birth (Arizona Postpartum Wellness Coalition, 2013; Gress-Smith et al., 2011; Maricopa Integrated Health System, 2014).

Postpartum Visits

Postpartum visits help healthcare practitioners measure the effects of postpartum depressive symptoms (Bermudez-Parsai et al., 2012). Mexican women need to acculturate themselves, in other words, learn the United States health care system and follow the postpartum visit appointments. A research study showed that the more women acculturate themselves with the healthcare delivery system in the United States, the fewer barriers they have (Callister et al., 2012, Bermudez-Parsai et al., 2012; Liu, 2012). Studies indicated that those who acculturated or embraced the ideal of bicultural have

fewer health issues (Afabe-Munsuz et al., 2013; Bermudez-Parsai et al., 2012; Liu, 2012; Walker, 2012). By contrast, other studies found (Bermudez-Parsai et al., 2012) that Latino individuals who are less acculturated may have better health outcomes than more acculturated ones

Researchers at Arizona State University, located in Tempe, Arizona, conducted research on postpartum visits among Mexican women (Bermudez-Parsai, Geiger, Marsiglia, & Coonrod, 2012). For Bermudez-Parsai et al. (2012) the goal of the study was to increase postpartum care utilization. In this study, participants were recruited at the Women's Care Clinic at Maricopa Medical Center in Phoenix, Arizona.

Bermudez-Parsai et al. (2012) used a bicultural involvement questionnaire which assigned participants to five categories: assimilated, separated, moderated, bicultural and alienation. The authors recruited 440 women over the age of eighteen, at or less than 34 weeks pregnant, and having no prior prenatal visit. The average age of the participants was 27 years old. The majority of participants were first generation Americans (84%) and had Mexican heritage (81%). The study showed about 85% of the participants were under the federal poverty level;11% of the participants attended college, the majority of the participants completed 8-12 years of school; 26% completed 1 to 7 years school. At the time of the interview, according to the researchers, most participants were not working. However, the results of the five groups presented the following: the largest group (37%) were the "Separates," who are women who adhere to their culture of origin only; 34% was the "Bicultural," or women who embraced their original culture and to the American culture; 20% of the participants were labeled the "Moderates," or those who are fairly

adjusted to both cultures; and finally, “Assimilated and Alienated” were estimated at 4 to 5% which was the smallest group.

According to the logistic regression analysis from the questionnaire, Bermudez-Parsai et al. (2011) indicated that women in the separation and assimilation groups were found less likely than bicultural group members to attend the postpartum visit. The research study on postpartum visit found that PPD links women with psychosocial needs connect them with health care needs and provides them access to navigate the United States health services (Bermudez-Parsai et al., 2011).

Mexican Community Health Assessment

The National Institute of Health, National Institute of Mental Health, and Arizona State University worked in collaboration with Maricopa Integrated Health System to help women in Maricopa County with prenatal and postnatal care needs through a postpartum program called “Coregulatory Processes in PPD (Maricopa Counsel Government Health Centers, 2014). The primary goal of this program, according to Maricopa Counsel Government Health Centers, is to decrease preterm birth by 5%, increase follow-up postpartum visit by 5%, and lower maternal and immediate neonatal medical costs for the intervention group by 5%. The deadline for accomplishing this program was May 2016. However, conducting community health assessment, in the United States, is found to be effective and efficient for health care practitioners to assess health care needs or disparities, especially among underserved communities (Becker, 2015; Goodman et al., 2014). The Affordable Care Act required public health practitioners to use Community Health Needs Assessment (CHNA) to deliver quality care to consumers (Becker, 2015).

Thus, Maricopa Counsel Government Health Centers applied CHNA in Maricopa County to reduce PPD rate among Mexican women.

However, a community health assessment identifies community health problems to tailor implementation policies to develop programs to solve community health disparities. In addition, public health practitioners must assess a community's needs and assets to facilitate health care practitioners to deliver health services in the community. Minkler (2012) noted community organizing as the process by which community groups are helped to identify common problems, mobilize resources, and develop and implement strategies to reach collective goals. To solve community health issues, health care leaders must first address community health problems through effective public health policies targeted to the community's health problems (Minkler, 2012).

Health Problem

An empirical research study conducted by Arizona State University, in Maricopa County, found 21 to 53% of Mexican American mothers experienced PPD during their first four to six weeks (Gress-Smith et al., 2011). PPD is a prevalent health problem for Mexican women in the United States (Callister, Beckstrand, & Corbett, 2011; Gress-Smith et al., 2011; Lucero et al., 2011). Other studies showed that racial/ethnic groups received less health services in the United States than Whites (Guerrero & Dennis, 2013).

Solution

To reduce health disparities among underserved communities, Community Health Needs Assessment (CHNA) should include community development, health education, and promote a comprehensive health care delivery system to provide optimal care to

minorities (Becker, 2015; Goodman, 2014). For example, Minkler (2012) argued that if public health practitioners and community organizers are going to improve social conditions and physical environment in a lasting way, they must be involved in policy development and policy advocacy. It has been suggested that community empowerment is considered an effective tool to improve health disparities in underserved communities (Sakeah et al., 2014). Furthermore, empowering community members with effective tools to become leaders or health advocates in Mexican communities, particularly in Maricopa County, would reduce health disparities.

Stakeholders

Community stakeholders have played major roles in today's healthcare organizations. They can help identify key issues in the community, such as acculturation, social support, language barriers, lack of insurance, low-income households, and inadequate education (Balestrini, 2014; Fernandez & Newby, 2010; Grier & Geraghty, 2015; Hernandez & Organista, 2013; Walker et al., 2012). According to Minkler (2012), stakeholders can help identify and build on their assets by stimulating community involvement, developing, and implementing a resident-driven action plan to address local issues. Therefore, it becomes imperative to implement stakeholders in community health projects and make them a part of the decision-making process to achieve the greatest good for the greatest number in Latinos' community. Lightfoot, McCleary, and Lum (2014) posited asset mapping is the process by which the community identifies individual, associational, institutional, economic, physical, and cultural assets.

Roles of Stakeholders

The primary roles of stakeholders are to be involved in community change, contribute to policy change to improve community's well-being, participate in decision-making, and become health advocates in order to protect community's interest (Glanz, Rimer, & Viswanath, 2008; Minkler, 2012). According to Laureate Education, Inc. (2012), a project brought in without the support and approval of the community leaders is going to be a failure before it begins. To contribute to Mexican women's health disparities, especially PPD, stakeholders must anticipate the following to promote social change:

- Policies that address health disparities in the community
- Support any project that promotes social change in the community
- Participate and vote any project that can contribute to community's well-being
- Support any other activity that indicates involvement in a problem solving

Quality of Life

Health is essential to a good quality of life. A good quality of life is an essential component for individuals to acquire and accentuate to remain physically healthy. Thus, the United States Department of Health and Human Services (2012) indicated that health-related quality of life (HRQoL) is a multi-dimensional concept that includes domains related to physical, mental, emotional and social functioning. However, when it comes to good quality care in the United States, health disparity becomes a local or national issue for minorities. As the Hispanic population is continuing to increase, which represents

15.4% of the United States population, health disparities are common among them (Bermudez-Parsai et al., 2012). An empirical research found that the Mexican population accounts for 12.7 million people in the United States (Callister, Beckstrand, & Corbett, 2011). Thus, it is essential for health care practitioners to focus on the effect of the growing Hispanic population and their health disparities. Guerrero and Kao (2013) noted growing evidence has suggested that significant disparities exist in access to mental health treatment providers among racial and ethnic minority groups and those living in high-poverty neighborhoods.

Relevant Assets

The relevant assets that can be used, for example, for profit and not-for-profit organizations, individual-level skills and cultural assets are useful to promote social change among Mexican women in Maricopa County (Lightfoot, McCleary, & Lum, 2014). Furthermore, geographical information system (GIS) considered one of the most effective software to help health care practitioners or researchers identify assets in a community (Lightfoot et al.; 2014; Minkler, 2012).

Empowerment

Empowering members of the Mexican community to become local leaders would improve Mexican's health disparities in Maricopa County. Using community empowerment to enhance community's well-being is essential to promote social change and reduce health disparities (Minkler, 2012). Amendola (2011) noted that empowering minorities is one approach to achieving positive health care outcomes. When people are involved in their community and are utilizing their experience, knowledge, and

leadership skills to promote health outcomes, it could make the community stronger and more powerful regarding health equities and health literacy.

According to Glantz, Rimer, and Viswanath (2008), empowerment is an action-oriented concept with a focus on removal of barriers and on transforming power relations among communities, institutions, and government agencies. To reduce Mexican women's PPD, public health practitioners must understand Mexican culture, in terms of values and beliefs, for instance, the role of Mexican mother and father in a relationship (Pina-Watson et al., 2013) or seek understanding of *caballerismo, machismo, el apoyo, and marianismo* in Mexican's society (Ojeda & Pina-Watson, 2014). These terms are important in Mexican culture; therefore, it becomes imperative for health care professionals to understand these terms to provide optimal care to Mexicans community.

Cultural Globalization

It has found that the English language is becoming a dominant language in the world, which allows countries like China, Japan, and Chile to adopt cultural globalization through English literature, rhetoric, and philosophy (Liu, 2012; Russell, & O'Mahony, 2013). The Mexican community can similarly embrace cultural globalization to surpass their challenges. The American ideology or philosophy of individualism or consumerism has been applied by many parts of the world (Liu, 2012). As Liu (2012) noted, cultural globalization is not about the homogenization of national cultures but the inseparable interconnections among different national cultures as well as the increasing consensus about and consciousness of global issues.

Garrett and Wrench (2012) argued, in some societies, informed by the logic of neo-liberalism, individual happiness and satisfaction are tied to consumption and enterprise across domains of life that include health and wellbeing. However, culture is sensitive and complex; to some degree, culture can be used to unite community and family by solving complex issues (Bermudez-Parsai et al., 2013; Chinn, 2015; Garrett & Wrench, 2013; O'Mahony, 2013). Garrett and Wrench (2012) noted that culture could be seen as the network of values, social relations and practices that are inscribed and deployed through discourses. Mexican women who have experienced postpartum depression in the United States do not comprehend how the mental health system works and; therefore, are unable to perceive and attain quality care concerning postpartum depressive symptoms (Bermudez-Parsai et al., 2012; Callister et al., 2011; Callister et al., 2011; Ko et al., 2012; Lucero, 2012). The same predictors and culture issues about Mexican postpartum depression were found consistence among African-American women and non-Hispanic White women (Dolbier et al., 2013) as well as immigrants who live in Canada (O'Mahony et al., 2013).

Socioeconomic Status

Many research studies showed SES is related to PPD symptoms in Mexican women (Afable-Munsuz et al., 2013; Dolbier et al., 2013; Gallo et al., 2012; Gallo et al., 2013; Gress-Smith et al., 2011; Jimenez et al., 2012; O'Mahony et al., 2013). According to Jimenez et al. (2012), low SES is a predictor of health outcomes. For example, Gress-Smith et al. (2011) selected 132 low-income mother-infant pairs to participate in an investigation of maternal depressive symptoms. They found that 33% of women at five

months postpartum and 38% at nine months postpartum have higher depressive symptoms. The same research study showed 21 to 53% of Mexican-American mothers experience significant depressive symptoms in the early postpartum period (four to six weeks).

Lack of financial resources may exacerbate the effects of postpartum depression among low-income families, particularly Mexican women (Gress-Smith et al., 2011). Mothers who experience a high prevalence of PPD including stress and SES may affect birth outcomes or infant's health (Gress-Smith et al., 2011). However, Gallo et al. (2013) posited that stress is a hypothesized pathway in SES, but empirical data is inconsistent regarding that hypothesis. In contrast, Dolbier et al. (2012) and O'Mahony et al. (2013) both found data consistent with Gress-Smith findings concerning SES exacerbating postpartum depressive symptom, low birth weight, and infant health (Gress-Smith et al., 2011). An empirical evidence regarding SES among African-American women, non-Hispanic White women, and immigrants living in Canada were found consistent with evidence from the United States (Dolbier et al., 2013; O'Mahony et al., 2013). Gallo et al. (2013) examined SES, education, and domain-specific chronic stressors, stressful life events, perceived stress, and stressful daily experiences in 318 Mexican-American women between 40 and 65 years of age. They found that women with higher income reported lower perceived stress and fewer low-control experiences in everyday life.

SES has played a major role in an individual's well-being (Woolf & Braveman, 2011). For minorities, it has formed one of the health disparities, particularly among Mexican community (Gallo et al., 2012; Gallo et al., 2013; Jimenez et al., 2012; Wilson,

Brown, & Bastida, 2015; Woolf & Braveman, 2011). Liu (2012) noted that "globalization" refers to a dominant and driving force that is shaping a new form of interconnections and flows among nations, economies, and peoples. Economic globalization is a powerful force that can overcome challenges through cultural globalization, improve educational outcomes, communications, technology, and health care services (Liu, 2012; Russell, 2013). However, socioeconomic and education are the strongest variables to reduce health disparities among low-income communities (Ogbonnaya, 2014; Belestrini, 2014). Countries like India, China, Germany, and Japan have invested in higher education, improved their economic downturn, promoted a system of individualism among the youth, and adopted the concept of cultural globalization in order to increase capital and compete in today's world (Balestrini, 2014; Liu, 2012; Ogbonnay, 2014; Russell, 2013; Sharma, 2014).

Education

A study showed that Mexican women's PPD is associated with a lack of education (Dolbier et al., 2013). Predictors like such as stigmatization, acculturation, discrimination, and micro-aggressions in public schools were also linked to Latina's depression symptoms (Callister et al., 2012; Casanova, 2012; Dolbier et al., 2013; Walker et al., 2012). According to Walker et al. (2012), education can be a measurement of SES that predicts depression in minority populations. Gress-Smith et al. (2011) noted that low income might exacerbate the symptoms of PPD. Many studies showed that lack of education, low-income status, and employment could greatly influence the development of PPD among minorities (Dolbier et al., 2013).

Guerrero and Singh (2013) conducted interviews among 27 out of the 35 Mexican women in a nonprofit organization regarding low educational attainment (LEA). Guerro and Singh (2013) found 11% in that population had only completed third grade, 30% had only completed the sixth grade, 25% had completed higher than the 10th grade but lower than high school, and 26% had completed high school or GED (general equivalency diploma). According to Guerrero and Singh (2013), the average age of participants was 47.6 years old. Before working for the organization, 51% of the women were unemployed, and 49% of the women employed earned from $51 to $350 per week. Furthermore, the researchers noted, all employees except the supervisors made minimum wage and worked 32 hours per week, which estimated as $232 per week. To some extent, low educational attainment and low-income linked to depression in Mexican women (Hernandez & Organista, 2013). However, other studies found women who have not gotten their GED were more likely to miss medical appointment/treatment (Hernandez & Organista, 2013).

Despite predictors or factors that have been linked to PPD, little is known in existing literature about Mexican women with PPD. It is important to acknowledge that education is one of the most important features that society needs to overcome their social issues. According to Sharma (2014), education is the backbone of every society to sustain economic growth. Furthermore, Ogbonnaya (2014) noted a community is a bond of people in personal relations whose well-being must be protected and promoted. Education can help the low-income family move from poverty level to a higher living standard (Gilead, 2012).

Attachments made using familyism, national culture, or family orthodoxy are falling short of helping the Mexican community overcome their challenges in the United States. For example, Ojeda (2011) noted Mexican-American women who reached their academic goals were more satisfied with their lives. Additionally, Strand (2012) noted educated children could rise out of poverty and that lack of education weights children's progress. The United States promotes uniqueness or individualism instead of collectiveness (Liu, 2012; Russel, 2013). This supports the importance of focusing on education as it can help individuals overcome issues related to low-income, inability to acquire health insurance, and poor health outcomes, including PPD. Thus, lack of education and income put minorities at higher risk regarding their health. An extensive study conducted found that high school drop-out rates (17.6%) are highest amongst Latino students (U.S. Department of Education, 2011). Education can make individuals become self-sufficient, independent, and contribute to both a community's and an individual's well-beings (Guerrero & Singh, 2013; Russell, 2013; Sharma, 2014).

Social Support

Social support is one of the strongest type supports that an individual can possess at time of depression or stress (Wang et al., 2014). Wang et al. (2014) posited that social support plays a significant, regulating effect on the relationship between stress and depression, and is an important environmental resource. By definition, according to Wang et al. (2014), social support is the care or help from others that an individual can feel, notice, or accept. In the Hispanic culture (particularly Mexicans), social support has played a major role (Callister et al., 2011). It has found that Mexican women looked for

help from their family members in Mexico rather than seeking help from health care professionals in the United States (Callister et al., 2011). It has found the lack of social support in the United States attributed to PPD in Mexican women (Callister et al., 2011). Wang et al. (2014) noted a strong social support system can provide protection for individuals under stress and can increase the likelihood of individuals attaining a positive emotional experience. In an interview conducted by Callister et al. (2014), a 27-year-old Mexican mother of four kids said the following:

> It is hard because there is only us here, my husband and I. It is hard if you do not have the family with you and not having someone to help you out. I did not have anyone to support me. What am I supposed to do? I had to press forward.

Another study found that Latina girls are more likely to drop-out of school due to lack of social support (McWhirter, Valdez, & Caban, 2013). A study on social support documented that parent and teacher support for a Latina is linked with school engagement (McWhirter et al., 2013). Lack of social support can complicate the mother's health and the infant or the family in a whole (Corrigan, 2015). Therefore, it is important for health care professionals to do health assessment needs (HAN) or certain types of screening during the pregnancy period in other to prevent depressive symptoms. For minorities, it becomes more complicated for women to assess health services or mental health services at times of pregnancy. In the United States, the literature showed that minorities received less attention when provided health services (Guerrero & Kao, 2013).

In Mexican culture, it becomes an obligation, or Mexican orthodoxy, for a woman to adhere to the national culture and take the good care of the family, thus, the influence

of prenatal care during the women's pregnancy or after childbirth rest upon the family support, including father's child (Gress-Smith et al., 2011). The construct of prenatal care or maternity care is related to family members' support (Gress-Smith et al., 2011). Furthermore, Gress-Smith et al. (2011) added that familyism values are also related to *marianismo,* a construct that sets forth gender-specific role expectations regarding the centrality of motherhood and childcare in the lives of Hispanic women. Empirical studies showed that social support associated with less prenatal depression symptoms and contributed to enhancing both mother's and the child's well-beings (Evans, Donelle, & Hume-Loveland, 2012; Gress-Smith et al., 2011). Research studies also found countries like Chile and Taiwan revealed that immigrants who live outside of their native countries experienced lack of a social support during prenatal or postpartum depression period (Chien, Tai, & Yeh, 2012; Quelopana, Champion, & Reyes-Rubilar, 2011).

A research study found that familyism plays a vital role in Mexican families (Guerrero & Singh, 2013). For example, Guerrero and Singh's (2013), research found that some Latinas feel pressured to consider their family's needs before their own and to make career choices based on how those choices would affect their family's well-being. The family needs should be balanced, and culture should also interplay with those needs during the family's existence (Guerrero & Singh, 2013). Mexican women can make substantial strides in their income through education if Mexicans culture and values are not considered obstacles (Guerrero & Singh, 2013). However, Mexican women's PPD is complex and requires extensive analysis to reduce their risk of PPD in the United States. Other studies have been focused on factors like stigma, national culture (*Marianismo, El*

apoyo), life satisfaction, and Mexican women's depression symptoms as related to social cognitivism (Casanova, 2012; Ojeda & Navarro, 2011; Pina-Watson et al., 2014).

Discrimination

Chou, Asnaani, and Hofmann (2012) noted the perception of being discriminated against could contribute to negative health consequences. A research study showed that discrimination had impacted the health of Latinos in the United States (Molina, Alegria, & Mahalingam, 2013; Rosenthal et al., 2015). It has found that discrimination contributed to both African-Americans and Hispanic disparities of health (Molina et al., 2013; Rosenthal et al., 2015). The literature agreed that social stressors, stigmatization, psychological factors and discrimination could affect both mental and physical health (Chou, Asnaani, & Hofmann, 2012; Molina et al., 2013; Rosenthal et al., 2015). A study showed women's experiences of discrimination during pregnancy can affect both the infant's health and the family (Chou et al., 2012; Rosenthal et al., 2015). According to Rosenthal et al. (2015), changes in experiences with discrimination may also vary according to factors such as age, race/ethnicity, nativity, and SES. Rosenthal et al. (2015) stated some theories suggest that Black and Latina women in the United States may experience heightened discrimination during pregnancy and postpartum because of group stereotypes related to sexuality and motherhood.

Intimate Partner Violence

Intimate partner violence (IPV) is a serious health issue in the United States and is found to be associated with perinatal or PPD symptoms, particularly among Mexican women (Cummings, Gonzales-Guarda, & Sandoval, 2012; Jackson et al., 2015).

According to Jackson et al. (2015), IPV includes physical, sexual, emotional, and/or psychological abuse and threats of harm, as well as financial abuse, controlling behavior, and coercion between current and former spouses and dating partners. Jackson, et al. (2015) found 1.5 million women in the United States experienced IPV and IPV was linked to 2,340 deaths. In addition, one in four women experiences violence from a male partner at some point during her life (Jackson et al., 2015). In a research study on intimate partner violence conducted by Arizona State University found 13.1% of the Mexican American women experienced intimate partner violence (IPV) in Maricopa County before pregnancy and 11.3% had IPV during pregnancy (Jackson et al., 2015). It has been documented that women born in the United States were more likely to report IPV than foreign-born women (Jackson et al., 2015). The same study indicated that women who reported higher general stress and lower social support were also more likely to report IPV. The study posited that a high level of IPV predicted PPD symptoms (Jackson et al., 2015).

Unintended Pregnancy

In Los Angeles, California, a study conducted by Martin and Garcia (2011) examined the relationship between IPV and unintended pregnancy among Mexican women. The research study showed that 44% of women reported the unintended pregnancy. Women who did not plan to get pregnant are more likely to experience physical abuse from their intimate partners (Martin & Garcia, 2011). In addition, the same literature found that 53% of women did not report physical abuse during pregnancy and only 11% reported abuse before pregnancy. The research study also found

unintended pregnancy among Latinas accounted for 76% of pregnancies (Martin & Garcia, 2011). IPV recognizes as a widespread health issue in the United States which requires public healthcare professionals to emphasize on demographic, psychological social factors, and adhere to utilize effective theory or model in order to prevent intimate partner violence (Cummings, Gonzales-Guarda, & Sandoval, 2012; Shorey et al., 2012; Jackson et al., 2015). However, Martin and Garcia (2011) noted, in addition to physical and sexual abuse, IPV often entails emotional abuse, intimidation, financial control, coercion, threats, and isolation. According to empirical studies, there is a strong relationship between unintended pregnancy and intimate partner violence (Martin & Garcia, 2011).

Interpretive Descriptive Qualitative Approach

The purpose of conducting this research study was to seek an understanding of the PPD among Mexican women in Maricopa County. I used a hermeneutic philosophical approach to interpret and explored PPD from the participants' lives experience (Creswell, 2013; Vandermause & Fleming, 2011; Thorn, 2016).

According Creswell (2013) and Thorn (2016), qualitative research methods begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem). This study aimed to explore the knowledge of PPD from the participants who experienced this condition, participant-observer, and with the intent to use the qualitative research method of interpretive descriptive approach, including both philosophical assumptions and interpretive frameworks (Creswell, 2013; Thorn, 2016).

The four philosophical assumptions (Creswell, 2013) (ontological, axiological, epistemological, and methodological) will play major roles in this literature and may contribute to help gain maximum knowledge in the research (Creswell, 2013).

Summary

Research on PPD was essential and important. It has many indicators or variables that need to be taken into consideration, especially when it comes to diagnosing patients who were experiencing postnatal, prenatal, or PPD. Empirical studies analyzed the causes and effects of pregnant women of having depression before and after giving birth to their newborn babies.

Little was known about the impact of various social factors on infant's health and Mexican women depressive symptoms. Therefore, research was needed to assess additional information about PPD in Mexican women. According to Gress-Smith et al. (2011), children of depressed mothers are at increased risk of behavioral, cognitive, and social impairments. However, the extant literature did not address statistics, location, or demographic analysis among Mexican women suffering from post-partum depression. Thus, additional data was required including race, income, color, and geographic zone.

For Mexican women, PPD was prevalent and associated with Mexican beliefs and values, such as *marianismo, machismo,* and *caballerismo*. These terms found as barriers for Mexican women to be treated for mental health or depression in the United States. Despite other factors, such as SES, social support, discrimination, and education, Mexican culture represented one of the barriers to treat Mexican women with postnatal, perinatal, and PPD. However, the main focus of this study was to explore the perceptions

about PPD and various social factors from Mexican women, in Maricopa County, by using a qualitative research method with one-to-one interviews to collect data.

In chapter three, I focused on the proposed research method. Chapter 3 contained the research methods, designs, theoretical frameworks, and philosophical assumptions.

Chapter 3: Research Method

The purpose of this qualitative interpretive descriptive study was to explore experiences Mexican women in Maricopa County have with PPD and their perceptions of factors such as low-income, cultural beliefs, intimate partner violence, social support, and healthcare services. Additionally, I explored barriers that may prevent Mexican women in Maricopa County from receiving diagnostic care for PPD.

In this chapter, I explain the methodological approaches I used to address my research questions and present details of the research design and rationale, the elements of a philosophical hermeneutics interview, participant selection, recruiting procedures, sampling strategy, data collection, coding, research questions, and the interview protocol.

Research Design and Rationale

Qualitative research is the research design of choice when exploring the depth rather than the breadth of scientific inquiry. My use of qualitative research methods provided me with more details about participants' experiences and perceptions than could a quantitative or mixed methods approach (see Madrigal & McCain, 2012). In addition, as qualitative research provides flexibility during the research process, I was able to learn from the participants' experiences in various ways while in a naturalistic setting (see Creswell, 2013; Madrigal & McCain, 2012). In this interpretive descriptive qualitative study, participants had the opportunity to share knowledge based on their own experiences regarding PPD. Madrigal and McCain (2012) posited the rule of thumb of research, hearing a statement from just one participant is an anecdote; from two, a coincidence: Hearing it from three participants, makes it a trend. During the qualitative

research process, it was important to focus on individual aspects of the setting, considering not only the current environment but also how the participant's past experiences were contributed to their knowledge. For example, Creswell (2013) noted qualitative research consists of a set of interpretive material practices that make the world visible. These practices transform the world into series of representations, including field notes, interviews, conversations, photographs, recordings, and memos of self (Thorn, 2016).

The research questions that guided this study as follow:

RQ1- What perceptions do Mexican women with PPD, in Maricopa County, Arizona have regarding low-income, cultural beliefs, and intimate partner violence?

RQ2-How do Mexican women with PPD, in Maricopa County, Arizona perceive social support and healthcare services before and after childbearing?

RQ3-What are the experiences among Mexican women of PPD?

RQ4- What barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD?

I chose an interpretive descriptive approach for my qualitative research as I aimed to seek understanding of the lived experiences of Mexican women who have experienced PPD. After analyzing five qualitative approaches of inquiry suggested in Creswell (2012), I chose interpretive description as the most suitable approach given my topic of inquiry (see Thorn, 2016). According to Thorn (2016), the motivation behind interpretive description is explicitly to strengthen qualitative research by realigning it with the epistemological underpinnings of the applied disciplines for which it has been

used. Interpretive description is a philosophical perspective that helps researchers to explore and understand everyday experiences without presupposing knowledge of those experiences. Thorn posited that interpretive description born out of observing the attributes and qualities that make for high-quality qualitative studies for the applied world regardless of the tradition in which they claimed to have been conducted. However, interpretive description could help researchers engage in extensive interviews by using the lens of the researcher's philosophical orientation. From my standpoint, I believe interpretive description helped me understand PPD in a larger sense and contributed to data saturation. Since qualitative research begins with assumptions, it becomes imperative to bring my personal assumption (s) concerning how to perceive knowledge from this present study. As a researcher, it was my understanding of the PPD that helped me collect empirical data from the participants' past experience.

Role of the Researcher in Data Collection

According to Xu and Storr (2012), becoming a qualitative researcher, requires a new way of thinking about what constitutes evidence. My role as a researcher in this study was important, and I kept my focus on the participants' experience, payed attention to details, and collected extensive data through various techniques. Furthermore, I was a research instrument in this study (see Xu & Storr, 2012). For example, according to Xu and Storr, in my role as a research instrument, I must be fully aware of how my ontological and epistemological position underpins the research. As a research instrument, my position was pluralistic in this study. Therefore, my skills and level of understanding in ontology and epistemology enhance the quality of this study, as a

participant-observer, and influence data analysis (see Xu & Storr, 2012). Xu and Storr argued that observation is one of the most common and most demanding qualitative research methods.

However, I collected the vigorous data in this study, and I used my tacit knowledge of the focus of the research as well as the research process. Ontology, the nature of reality regarding both participants' experience and their national culture, required me to explore knowledge and seek understanding in participants' cultural background, their values, and the impact of social support. As I had previously described in Chapter 2, social support has been linked to the experience of PPD in Mexican women (Callister et al., 2011; Corrigan, 2015; McWhirter et al., 2013). Researchers have suggested that lack of social support can complicate the health of the mother, infant, and family (Corrigan, 2015). This was where ontology and epistemology interplayed in this study. Further, in Mexican culture, *el apoyo* or support, compassion, and love for family member, axiology, are considered as cultural values for Mexican's society. These philosophical assumptions must be understood and considered while I acted as the research instrument collecting intuitive data through in-depth and unstructured interviews (see Creswell, 2013). In addition, Creswell (2013) argued that the researcher frames the study within the assumptions and characteristics of qualitative research by evolving with the evidence, evaluating multiple realities, and focusing on participants' views.

Researcher's Background

While focusing on participants' views, as immigrant, I also brought my background and personal interest in this study. For example, when I came to the United

States in 1992, acculturation, social support, immigration status, college education were considered as challenges to maintain my social well-being. It was a challenge for me to embrace acculturation. I did not have enough English to perceive and overcome my language barrier. It took me over 14 years to receive my citizenship and later on decided to go to school. In my personal history as an immigrant, I had experienced demographic and psychosocial issues similar to those experienced by the Mexican women I included in this research. Researchers have a personal history that situates the interpretation of data collected through inquiry. They have an orientation to research and a sense of personal ethics and political stances that inform their research (Creswell, 2013). I am not Mexican, though as a Haitian, I too come from a third world country.

In my community, particularly the Haitian community in Palm Beach County, Florida, I encountered the same psychosocial factors. Thus, conducting this research among Mexican women can help me address health disparities and many other research topics in my community as well. This was my motivation and personal interest for conducting this research framed by theory and the extant literature. As a healthcare practitioner, I recognized that an understanding of social issues among minority groups, such as Mexican women, may guide efforts to promote social change and reduce health disparities among that population.

Immigrants who choose to immigrate to the United States bring their values, beliefs, and culture with them. When I came to the United States in 1992, I came with traditional care originating within my family. In Haiti, as in Mexico, the majority of residents do not have access to both private and public health (Tappero & Tauxe, 2011).

In Haiti, my sister experienced depression while carrying her first baby. That depression was associated with two factors insurance and SES. As I lived in the same house with my sister during that time, I observed the phenomenon, her depression, from beginning to end. My brother-in-law and my mother were seeking family support or traditional care (self-treatment) to help my sister overcome her depression.

I chose to conduct this research among Mexican women rather than in the Haitian community to decrease my personal bias and increase the accuracy, trustworthiness, and reliability of my observations. However, this research serves as a model or sample to conduct future research topics in the Haitian community regarding health care disparities. Haitian and Mexican communities are not different when it comes to cultural values and beliefs. Despite my personal interest on promoting social change in this population, I kept my focus on the participants' experience to gain extensive knowledge regarding the phenomenon. At the same time, it was also important to select qualified participants, that is, participants meeting the inclusion criteria who can provide accurate information about the phenomenon. Participants were not been forced to provide information regarding the events experienced. Therefore, the implication was to explain to participants the purpose of this study, the outcomes for conducting this research, and the main objective to promote social change among Mexican women population in Maricopa County.

Participant Selection

According to Reybold, Lammert, and Stribling (2012), qualitative researchers are encouraged to think critically through their selection choices before and during the research process and remain mindful that participant selection is the foundation for data

collection and analysis process. I selected Mexican mothers who experienced PPD, from Maricopa County (see Callister et al, 2011; Gress-Smith et al., 2012; Maricopa Integrated Health System, 2014). My selected participants lived in the same county (Maricopa) and belonged to the same ethnic population, Mexican women. Selecting participants in this manner is a homogenous group (Amanda, 2011). Both geographic and demographic characteristics are important factors in the selection of participants in the research study (Amanda, 2011; Creswell, 2013). In an effort to gather extensive information from the participants in regards to PPD, a sampling strategy that matches the study setting was chosen.

Sampling Strategy

Criterion sampling is a combination of elements that is associated with the sampling (Creswell, 2013; Thorn, 2016). Creswell (2013) noted it is essential that only participants who experienced the phenomenon are studied. Choosing applicants who have experience the same phenomenon, the same culture, are of the same ethnic group, and live in the same geographic location is known as criterion sampling (Creswell, 2013).

For my sampling strategy, I used the following inclusion criteria:

- Sample size of 10
- The age of the participants is from (18--30) years of age
- Form of the interview: One-on-one/ unstructured interviews
- Gender: female participants only
- Educational level: from seventh to 12th grade or higher
- Geographic location: Maricopa County, Arizona

- Subgroup: Mexican women
- Phenomenon experienced: PPD

I chose 10 participants among Mexican women who have experienced PPD. Because to create data saturation, collecting data from the sample size of 10 and using philosophical hermeneutics, One-on-one/unstructured interviews are effective to gain extensive knowledge about this research study. In Maricopa County, the Mexican population is the largest subgroup from Spanish population. However, I did not speak Spanish. Therefore, I selected participants who speak English for this study. I also hired a bilingual Mexican woman who can interpret from both languages, English and Spanish. The recruitment candidate must

- Have resided in Maricopa County at least five years
- Possess a bachelor's degree or higher
- Have 3-5 years of experience in interpreting Spanish and English
- Produce a signed and notarized letter confirming she is qualified to interpret English and Spanish
- Have children and have experienced postpartum depressive symptoms

Instrumentation

Procedures for Recruitment, Participant, and Data Collection

Participants were recruited on the streets in Maricopa County. Before collecting data from participants with interest, participants had been asked to read and signed a consent form before participating in the study, and the participant Interview protocol form was completed. Participants received a $25 gift certificate after the interview.

Data Sources

Data sources were included the following: the participant-observation, unstructured interviews, documents, field notes, and tape recording. As I elected to use a qualitative approach to my research, I identified when I reached saturation. Data sources, software, analysis, and diagrams, as well as saturation, were dictated data collection.

According to Jacob and Furgerson (2012), skilled interviews can gain insight into lived experiences, learn the perspectives of individuals participating in a study, and discover the nuances in stories. Jacob and Furgerson (2012) noted at the procedural level of interviewing, to prepare scripts of what will be said at the interview and the conclusion of the interview, prompts to collect informed consent, and prompts to remind about the information that is needed.

Philosophical Hermeneutics Interview

Hermeneutics interviews are used as a philosophical technique to collect data from participants' experience (Vandermause & Fleming, 2011). According to empirical research studies, this philosophy is useful for data interpretation (Borren, 2013; Glaeser, 2014; Rytterstrom & Arman, 2012; Vandermause & Fleming, 2011; Wolff, 2014). This was allowed me to describe the phenomenon and helped me interpret the data collected in this study. These two methodologies were used extensively to create data saturation and empowered the research study as awhole. In 1859-1939, Edmund Husserl, the founder of philosophical hermeneutics invented this philosophy as a new method of inquiry to conduct research (Vandermause & Fleming, 2011). As an investigator of this research study, I engaged participants in a conversation related to PPD. Thus, everything that was

discussed or shared during the hermeneutics interview was correlated with the research questions. Vandermause and Fleming (2011) stated the goal of the investigator is to co-create the findings with the participant through an engaged conversational process, which they refer to as the fusion of ideas. In Table 1, I shared the required Hermeneutic interview skills I was incorporated into my research methods.

Table 1

Hermeneutics Interview Skills

Element	Skill
Setting the tone of the interview	Welcome participants
	Use pseudonyms
	Allow for an unstructured interview
Conducting the interview	Use open-ended questions
	Use care framing the questions
	Use incomplete sentences
	Observe body movements
	Look for assent
	Look for participant's affirmation
	Do not stop participants while they are sharing experience
	Engage in active listening
Evaluating the interview	Use observations
	Question my understanding

Unstructured Interviews

The purpose of using an unstructured interview in this study was an unstructured interview was leaving space for each participant to openly share their past experience without complexity. Furthermore, an unstructured interview was allowing me to ask different questions to different participants (Dana et al., 2013). Many scholars believe that unstructured interviews are one of the best approaches to gathering data from the

participants (Dana et al., 2013). On the other hand, the literature also mentioned that unstructured interviews remain a ubiquitous and even predominant tool for many screening decisions. My understanding of this research topic and the participants 'cultural background were helping create a comfort zone for each participant to express themselves about their past experience. Therefore, I proposed the anonymous face-to-face interviews instead of using focus groups in this study.

Face-to-Face Interviews

Gathering information from underrepresented minority can be a challenge for the interviewer (s). For example, cultural background, religious belief, sexism, and other complex issues may impact data saturation. Therefore, in this present study, I conducted anonymous face-to-face interviews in other to create the comfort of anonymity for each participant. As a male interviewer, it is important to understand the participant's cultural background, religious beliefs, political affiliation, immigration status, and any other sensitive issue, especially sexism, in other to avoid incongruent data. For instance, according to Banda and Oketch (2011), understanding people's culture can elevate someone to a strong position from which he/she can communicate effectively and successfully in social circumstances. My cultural background and this population's background are similar. However, the focus of this interview was not based on my national culture rather on the participants' past experience which also linked with their cultural beliefs.

Data Analysis Plan

The research questions that guided this study as follow:

RQ1- What perceptions do Mexican women with PPD, in Maricopa County, Arizona have regarding low-income, cultural beliefs, and intimate partner violence?

RQ2-How do Mexican women with PPD, in Maricopa County, Arizona perceive social support and healthcare services before and after childbearing?

RQ3-What are the experiences among Mexican women of PPD?

RQ4- What barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD?

These questions addressed through qualitative research methods. My interview questions in (Appendix C) were designed to query the participant's experience, postpartum depressive symptoms, participants' native culture, and effects and causes that may have led to the participants' experience of the PPD.

Data Software

I chose NVivo software, version 11, to organize my data. NVivo was designed to assist researchers in organizing data and importing documents from both internal and external data sources (O'Neill, 2013). I used NVivo to assign codes and nodes, visualize the data using charts, and attribute value to my observations and recorded materials (O'Neill, 2013).

Data analysis. According to Creswell (2013), data analysis in qualitative research consists of preparing and organizing the data, which includes text data as in transcripts, or image data as in photographs for analysis, then reducing the data into themes through a

process of coding and condensing the codes. The process was completed through representations of the data in figures and tables, as well as through discussions. According to O'Neill (2013), NVivo allows the researcher to move data from lower order themes that involve descriptive and topic issues to higher order aspects of themes concerned with the analysis and drawing conclusions. O'Neill describes the four stages of analysis through which NVivo can help a qualitative researcher. These include

1. Descriptive: entering data sources into NVivo
2. Topic: Organizing and coding data
3. Analytic: Analyzing and querying data
4. Conclusion: Drawing answers from data

In Figure 1, I present my data analysis strategy.

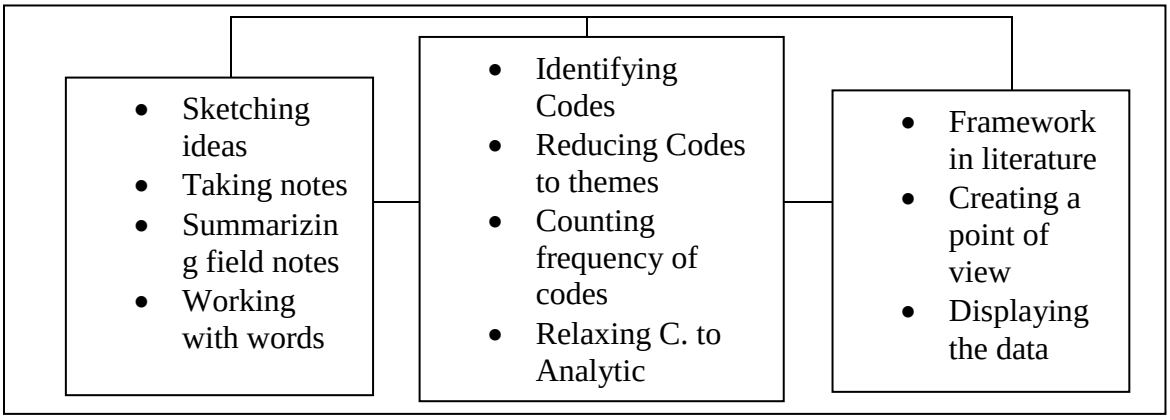


Figure 1. Data analysis strategy.

After completing the one-on-one interview, I ensured evidence of quality, trustworthiness, and credibility regarding the data I collected using scientific knowledge. According to Giorgi (1997), to be scientific, knowledge must be systematic, methodical, general, and critical. I was evaluated data using a systematic process

Coding and codes. After collecting my data on the participants' experience through the one-on-one interview, field notes, participant-observation, documents, gestures, physical appearance, body movement, and language expression, I used NVivo software to code the information. According to Gibbs et al. (2012), coding is the process of combining the data for themes, ideas, and categories. The Center for Evaluation and Research (n.d.), states that codes serve as a way to label, compile, and organize data. Furthermore, the Center for Evaluation and Research noted it is important to think about the big picture or develop the storyline before beginning the process of data coding. To describe what I observed, heard, and understood from the participants in a coherent manner, I used a storyline.

The Center for Evaluation and Research (n.d.) posited the rule of thumb for coding is to make the codes fit the data, rather than trying to make your data fit your codes. One of the ways to ensure this is through grounded codes. These require me to ensure my bias is kept aside from what needs to be coded. It is important to code the data without allowing my preconceptions or beliefs concerning the participants' experience to influence my decisions. Setting aside my presupposition, and background regarding the phenomenon, I created grounded codes (Gibbs et al., 2012).

In order to keep my coding consistent, I will need to use constant comparison (Gibbs et al., 2012). According to Gibbs et al. (2012), every time I select a passage of text (or its equivalent in video, etc.) and code it, I should compare it with all those passages I have already coded that way. This strategy was made the coding more effective and relevant. In addition, I used line by line coding. The purpose of line by line coding is to

summarize what has been written; as the researcher, I selected the code that was related to each sentence or phrase after looking for key words, terms, or themes (Gibbs et al., 2012). I focused on keywords not only to ensure saturation but also to make my coding effective and accurate. For example, Gibbs et al. (2012) suggested the following outcomes for qualitative researchers regarding coding and codes:

- Indigenous categories (what the grounded theorists refer to as in vivo codes)—terms used by respondents with a particular meaning and significance in their settings.
- Key-words-in-context -look for the range of uses of key terms in the phrases and sentences in which they occur.
- Compare and contrast: Ask questions. For instance, what is this about? How does it differ from the preceding or following statements?
- Searching for missing information—essentially try to get an idea of what is not being done or talked out, but which you would have expected to find.
- Metaphors and analogies—people, often use metaphor to indicate something about their key, central beliefs, about things and these may indicate the way they feel about things too.
- Connectors—connections between terms such as causal (since, because, as, etc.) or logical (implies, means, is one of, etc.)
- Pawing (i.e. handling)—marking the text that has not been coded at a theme or even not at all. Underline, use colored highlighters, run colored lines down the

margins to indicate different meanings and coding. Then look for patterns and significances.

As I analyzed the data collected, I revised my codes. I understood every code used to organize and describe the data in the context of the proposed study. I assured that codes are not overstated or theory-laden. Therefore, it was important for me to take notes while coding; I examined meanings, especially among participants who experience a different culture than I. Coding data were created clarity, effectiveness, and improved quality and trustworthy concerning the phenomenon.

Issues of Trustworthiness

Qualitative studies may have biases because some researchers collected information intentionally with personal feelings and interest. Compared to quantitative studies, qualitative studies are lacking when it comes to supporting evidence with numbers. On the other hand, quantitative studies show weaknesses when it comes to studying complex issues, for example, social factors and psychological factors. Therefore, qualitative researchers choose this approach when an issue needs to be comprehended and solved among a population who has experienced the phenomenon.

I chose qualitative research methods in this study, due to social factors that are linked to Mexican women PPD in Maricopa County. To ensure integrity in this study, I took all necessary care and used NVivo software management, version plus 11, to analyze data collected from participants. The one-on-one interview was digitally recorded and transcribed in English. I was the only person to conduct the interviews with the 10 participants. Despite my personal experience in PPD, I put aside my personal experience

while interviewing participants. Before analyzing and transcribing the information collected from the participants, participants were received a copy of the transcripts in order to assure credibility and transparency in this study.

Saturation.

To achieve data saturation, data were collected from the 10 participants who were been interviewed to gather information regarding the phenomenon. There was no new information collected during the coding process after the interview. Habersack and Luschin (2013) agreed that the point of data saturation is an assumption that data collection is a capture of everything important in a study.

Transferability.

This research study was transferable to other settings or other communities with PPD. The social factors that are linked in Mexican women with PPD are also associated with other health issues among the underrepresented communities, in the United States. As a researcher, I conducted other research studies at a later date with the intention of using these study results to create generalizability for studies in the future (Ihantola & Kihn, 2011).

Dependability.

During the interview process, I used an audit trail, (i.e.), focusing on my interview notes, participant-observer notes, journals, and any written documents or drafts that were constituted an audit trail in to create dependability (Carlson, 2010).

Confirmability.

The 10 participants who interviewed were Mexican women with PPD. As a researcher, my biases, viewpoints, or personal experience with PPD were set aside. During the interview process, in order to create accuracy and credibility, participants' answers and feedback confirmed the results and created confirmability in this study. According to Houghton, Casey, Shaw and Murphy (2013), researchers closely link confirmability to dependability in referring to the neutrality and accuracy of the data.

Ethical Considerations

This qualitative study was designed to identify social factors among Mexican women with PPD and utilized philosophical hermeneutics interview to gain an understanding about PPD in Mexican women living in Maricopa County. In this study, participants were given careful consideration regarding the possible emotional impact that might occur during the interview process. In addition to the consent form, participants were advised that their confidentiality was secure. All interview information, recordings, written data or documents provided to me, as a researcher, were confidential and stored in a locked safety box for security purposes; participants were also informed that data will be destroyed after five years. Participation in this study was voluntary, and participants may withdraw from this study at any time during the interview.

Summary

The goal of my research was to explore and extracted extensive knowledge from the participants' experience using qualitative research methods. My methods include the use of interpretive description and the philosophical hermeneutic interview process and designed to address my research questions and contribute to the body of knowledge on

Mexican women experiences of PPD. I determined that this study design was appropriate for my research as it was generated more data and allowed me to contribute to the current understanding of PPD. In this chapter, I described the proposed qualitative research method that I used to collect data while acknowledging and setting aside my background experience to limit bias. Chapter 4 provided the results of this study.

Chapter 4: Results

The purpose of this qualitative interpretive descriptive study was to explore what experiences Mexican women in Maricopa County had with PPD and their perceptions of factors such as low-income, cultural beliefs, intimate partner violence, social support, and healthcare services. Additionally, I explored barriers that prevented Mexican women in Maricopa County from receiving diagnostic care for PPD.

The research questions that guided this study as follow:

RQ1- What perceptions do Mexican women with PPD, in Maricopa County, Arizona have regarding low-income, cultural beliefs, and intimate partner violence?
RQ2-How do Mexican women with PPD, in Maricopa County, Arizona perceive social support and healthcare services before and after childbearing?
RQ3-What are the experiences among Mexican women of PPD?

RQ4- What barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD?

In this chapter, I present the data and findings that were collected for this interpretive descriptive qualitative research study. I first describe the setting in which the study took place and participants' demographics. Then, I describe the data collection and data analysis procedures before presenting the results of this study.

Data Setting

Before recruiting 10 qualified participants, I conducted a field trip to the Mexican communities in Arizona, particularly Maryvale and South Phoenix where many low-income families live and may experience PPD (see Gress-Smith et al., 2012). I walked in

both areas simply to observe the population I wanted to study. I saw young Mexican mothers walking on the streets often with three kids or more. I also walked into some of the Mexican restaurants and food markets to observe public activities. This typical approach gave me a comprehensive knowledge regarding Mexicans social activities in these areas. For example, Creswell (2013) noted a qualitative researcher engages in a series of activities in the process of collecting data. This approach was insightful before I scheduled my first interview. I did not discuss the field trip with participants.

Mexican women may not share their experiences with strangers, except to healthcare professionals or family members. In Mexican culture, it is shameful and shows low self-esteem to talk about social factors that are related to Mexican women postpartum depressive symptoms. Despite the challenges, I talked to 20 prospective participants and 10 agreed to participate in the study. I explained the reason for conducting this study and shared with them the implication of positive social change that the study can bring to reduce postpartum depression in the Mexican community.

Once participants agreed to participate in this research study, I ensured participants met the eligibility criteria for the study. Eligibility requirements were: (a) self-identified as Mexican women, (b) lived in Maricopa County, Arizona, for at least five years or more, (c) between the ages of 18 and 30, and (d) experienced depressive symptoms before or after childbirth. For privacy, interviewees chose the interview site and all interviews were conducted with no interruptions.

Demographics

In the United States, among other ethnic groups, Hispanic subgroups constitute about 50.7 million, and the Mexican subgroup represents 65% or 33 million (Luecken, Purdom, & Howe, 2009). In Arizona, the Mexican population represents the largest ethnic group (Gress-Smith et al., 2012). Researchers have shown that in Maryvale and South Phoenix, Arizona, 31% of Mexican Americans live below the poverty level (Gress-Smith et al., 2012, Luecken et al., 2009). Gress-Smith et al. (2012) found that in Maricopa County, 74% of participants were from Mexico, 42% did not complete high school, 71% primarily used the Spanish language, and SES was considered one of the prevalent factors of PPD among Mexican women. The demographics for my study are presented in Table 2.

Table 2

Participant Interview Profiles	
Age range	18 to 30 (middle-aged)
# of participants	10 participants
Ethnic group	Mexican women
Geographic location	Maricopa County, Arizona
Marital status	
• Married	4 participants (P1, P2, P3, P4)
• Divorced	3 participants (P5, P6, P7)
• Single	3 participants (P8, P9, P10)
Employment status	
• Full-time	5 participants (P4, P5, P7, P9, P10)
• Part-time	2 participants (P1, P2)
• Unemployed	3 participants (P3, P6, P8)
Educational background	
• 7 grades	4 participants (P3, P5, P7, P8)
• 10 grades	4 participants (P4, P6, P9, P10)
• 12 grades	2 participants (P1, P2)

Data Collection

This study was approved by the Walden University Institutional Review Board (# 03-22-18-0457705). As participant-observer, I focused on participant's experience simply to gain extensive knowledge regarding the PPD. Data collected include: one-on-one unstructured interviews, field notes, body movements, and document review. Each one-on-one interview was conducted using the same initial interview. All 10 participants received and signed the informed consent before starting the interview. Once written informed consent was received, the interview began and each participant was told that the interview was being recorded. Each participant received a copy of transcript of the interview to review for accuracy. Each interview took approximately 1 hour and participants answered all interview questions with confidence and with no distractions. Transcripts are currently being stored on my password safety box for 5 years.

The sensitivity of this study, as well as Mexican native culture and personal beliefs, made it difficult to recruit qualified participants. As a result, it took longer than expected to recruit 10 participants or (Mexican women) who were willing to share their experiences. Despite the challenges with recruitment, 10 Mexican women were recruited over 4 months, and a diverse range of personal experiences from the recruitment process were collected. The point of collecting insightful data occurred when interviewees started to answer interview questions. In answering questions, participants showed their understanding about PPD, social support, SES, intimate partner violence, and unintended pregnancy.

Data Analysis

After completing the unstructured interviews with each participant, I transcribed the interviews into a word document. The data analysis began with the member-checking. All 10 participants reviewed the words document and agreed with the transcripts. After that, I inserted the word document into the NVivo software management; then the process of coding continued. Through the NVivo version plus, I used automatic coding. This procedure facilitated110 codes. In order to eliminate redundancy, I selected the most useful codes from the 110 codes. Next, I organized the codes by categories and themes. For each category of codes, I assigned one theme--based on the meaning of each category of codes. All seven themes selected were found compatible with the research questions listed in this literature. I assumed that NVivo software would make valid decisions regarding codes and themes.

Despite the quality of qualitative software management, a researcher should know what to code and how to code the data. According to Stuckey (2015), the software cannot be a substitute for learning data analysis methods because the researcher must know how to create codes and analyze the data. It took me days to determine how to interpret and code the data. The NVivo software arranged the data but did not help me understand what appropriate codes to choose and how to select the themes. I developed all seven themes below through the data collected from each participant and aligned with the research questions. I documented all data collected from all 10 participants--because if there was a misinterpretation, I would refer back to the document in other to ensure the appropriate interpretation of what the participants were intended to convey.

Table 3

List of the initial codes of themes

PPD Community Support

- Anti-depression (drugs)
- Social-network groups
- Food-stamp
- Housing program
- Medicaid
- Diagnostic (test for PPD)
- Childbirth (education)
- Breastfeeding
- Providers
- Nutritional

Financial Problem

- Low-income
- Education
- Cost of Living
- Hopeless
- Unsecured

Family Support

- Cooking
- Cleaning
- Role
- Self-care
- Love
- Strengths
- Compassion
- Sympathy
- Blood
- Trust
- Solidarity
- Together

PPD Life Experience

- Depression
- Anxiety
- Fear
- Loneliness
- Guilt
- Sleeping
- Lost control
- Scare
- Vomiting
- Family History
- Embarrassing
- Exhausted
- Terrible
- Complicated
- Motherhood

Dysfunctional Relationship

- Prison
- Cheating
- Domestic Violence
- Police
- Jealousy
- Separation
- Stress
- Hypertension
- Strong Man
- Divorced

Mexican Cultural Orthodoxy

- Core values
- Cultural Beliefs
- Latino professionals
- Traditional Care
- Obligation

Immigration or Political Factors

- Discrimination
- Illegal status
- Immigrant
- Communication
- Ethnicity
- Transportation

Evidence of Trustworthiness

Credibility.

Credibility in a qualitative study is based on the type of protocol and the methodology that a researcher is choosing to collect data from his or her participants. To ensure credibility in this study, during the interview process with the participants, I bracketed my biases and personal life experience apart and focused on what participants had to say regarding their lives' experiences before and after childbearing. I used one protocol for all ten participants, and I presented myself as a participant-observer in other to pay attention to details during the entire data collection process. I read the interview questions with a clear voice. Some participants asked me to repeat some interview questions, and participants responded with confidence and not been forced to say things that they were unwilling to answer. Each participant received one-hour timeframe, according to the data protocol. After I transcribed the data into the word document, I asked the participants to review the word document. In other words (member-checking), to ensure that credibility in this data collection was accurate (Creswell, 2013). All ten participants reviewed the word document transcribed and agreed with no comments.

Transferability.

In regards to transferability, this sample study results can be used to conduct further studies among other ethnic groups, in the United States, who have experienced postpartum depression. Geographically speaking, results from other populations might explain different scenarios regarding postpartum depression. Therefore, as a qualitative

researcher in this particular study, generalizability cannot guarantee until further studies are conducted by other qualitative researchers.

Dependability.

Dependability is this study aligned with a field trip. First, during the recruiting procedure, I walked in both areas simply to observe the population I wanted to study. Second, I used an audit trail, (i.e.), focused on my interview notes, participant-observer notes throughout the interview process. Third, I used member-checking. After transcribing the data into the word document, all participants reviewed the data and agreed with the word document; I followed the interview protocol to ensure dependability. A qualitative researcher should ensure dependability based on good-notes keeping and focus on the effectiveness of data collected from the participants to attract the audience toward the research study (Miles & Huberman, 2012).

Confirmability.

To ensure confirmability in this study, I set aside my personal biases. All ten participants provided their responses to all interview questions and not been coerced in providing irrelevant answers. The data was purely focused on each participant's experience. Once I reached saturation, I conducted the data analysis by using an inductive approach and concluded with the themes and codes through an NVivo software management. Further, my research committee members reviewed the data and provided feedback for corrections and consistency. After making corrections without altering the content of the information provided by participants, I proceed with the data results.

Data Collection

Four research questions guided this study. The findings for each research question are discussed based on the participant responses to the specific interview questions associated with each research question.

RQ1- What perceptions do Mexican women with PPD, in Maricopa County, Arizona have regarding low-income, cultural beliefs, and intimate partner violence?

Responses from the following 4 interview questions were used to answer research question one.

IQ2. What are your thoughts about low-income and the role it has with PPD?

P001, low-income is no good. I work as a dishwasher. My income is insufficient to raise my two kids. To raise kids, it is expensive. I struggle to pay my bills because I am making low-income. I believe low-income can affect a family's life and especially our kids.

P002, I think getting ready financially before having kids is extremely important. I think the financial problem was the reason for my PPD. My boyfriend and I were not prepared financially to have a baby. That is the reason that my parents were not happy with me. I was making low-income. Now I go back to school. I want to be a nurse.

P003, I think income plays a major role during the post-partum depression. Lack of money can create stress and can affect the women health conditions and the child. My husband and I were working hard to save money before we had our first child. When I was pregnant, I was unable to work because I had pain. My

husband worked two jobs. P004, it is expensive to raise kids in the United States than Mexico. Because in Mexico, we have family support and the cost of living is cheaper than the United States.

P005, low-income families are struggling to take care of their kids because they do not make enough money. It is hard to give our kids a good education if we do not make good money. I know it is not easy for everybody to get good jobs. It is required a good education, to get a good job. That is right, as low-income family or mothers, we struggled and depressed when having kids. I have to agree that PPD is connected with low-income for some women.

P006, I believe minority groups including Mexicans are struggling with their relationship due to the financial situation. Low-income issue can affect family's well-being. Low-income plays a significant role with PPD. I should agree with that. Even though I did not experience PPD, and I financially ready before and after my baby delivery. As far as I know, low-income is definitely a problem for low-income family during PPD period.

P007, I was young when I was pregnant. I had no money to take care, my baby. I learned from my mistake. I believe that my PPD related to my financial situation at the time of my pregnancy and after my delivery.

P008, I think everybody should know that low-income can affect an individual's life or family's well-being. I am Mexican. I know there is many Mexicans families are facing financial challenges with their kids because they cannot

respond to their kids' demand. Therefore, low-income creates stress and distress. I believe that is where, sometimes, PPD takes place.

P009, I would say that low-income is not the only reason for women to have PPD. I have to agree that it is essential to be financially secure before having kids. Today, to raise kids, it cost a lot of money. Lack of financial stability can definitely exacerbate PPD symptoms and even create divorce into relationship during pregnancy and after childbirth.

P010, I was a single mother during my second child. I was under low-income. It was very difficult for me to pay my bills. I divorced, and my spouse fled to Mexico. I agree that low-income can affect an individual's life, especially women. I did experience that. I was depressed, unsecured and hopeless during my PPD period.

IQ3. What are your thoughts about intimate partner violence and the role it plays with PPD?

P001, my ex-husband went to prison. He was cheating on me, and he and I fought. Seven weeks after the baby born. He and I were arguing, and he had beaten me up. I called the police. They took him to prison. It was not my intention to call the police. He was taking care of all the bills. He had a business. He was making good money. I was scared to death. I was afraid to die. I had no choice, rather than to call the police.

P002, my boyfriend and I were fighting a couple of times when he and I lived together. The reason that happened because I caught him cheats on me with other

women. I hate him. I am a jealous woman. He was not caring. He refused to stop cheating. For that matter, he and I separated. I was pregnant before he left. That might be the reason that I had PPD. I was young when I was pregnant but did not know if domestic violence could affect women's health.

P003, intimate partner violence is not a good thing in a relationship. Nobody knows when it is going to happen. Sometimes, it could be stress or jealousy. Intimate partner violence can create a dysfunctional relationship and affect both the mother and the child. It could happen to me, but I tried hard to avoid it.

P004, I never had domestic violence with my husband. To my understanding, I think the reason I had PPD because my husband deported to Mexico. I had no support.

P005, my husband and I never had domestic violence. He and I had arguments couple of times. I tried to stay away from him when having arguments. He has hypertension. He is a good husband. I do not want that happen. Because both of us want to give our kids good education and trace good examples, as much as for our kids. In my community, people fight all the times. That is no good. When fighting, most of the time, men went to jail or prison.

P006, I do not think it is a good idea to have violence domestic, especially at times of pregnancy, no. It is dangerous. First, my husband is a strong man. I am too small and too weak to fight. I can talk. I can say things to him but no physical fight.

P007, I think lack of financial support can lead to domestic violence and PPD. My sister was fighting with her boyfriend because he refused to get a job. My sister had stress and having high blood pressure after childbirth. Compared to my situation, my boyfriend was not present during my pregnancy and did not support me with the baby financially. Intimate partner violence is very common among Mexican community, particularly in Phoenix.

P008, I tried to avoid domestic violence in my relationship. I know it is very common in my community. Therefore, I do all my best to avoid it. My husband likes his family. From my understanding, women can find themselves in domestic violence due to jealousy and other family issues.

P009, I am a member of postpartum depression support group in Phoenix. Some group members experienced intimate partner violence. As a result, they affected by postpartum depression before and after delivery. I think IPV is a serious health problem in our community. I did have IPV once. That was before I married. In addition, I hope not to have it again.

P010, from my experience, I think intimate partner violence plays a role with PPD because before I divorced my ex-husband, my PPD related to intimate partner violence.

IQ4. What are your thoughts about your culture and taking on the culture of other groups of people? Do you think it plays a role with PPD?

P001, I like my culture, and I like who we are, as Mexicans. I think other groups of people should like their culture as well. Mexican people like their core values.

We like to help our family members when there is a need. PPD might play a role when it comes to our core values, maybe regarding whom we are, and in what we believe as Mexicans.

P002, I born in the United States. I grew up in both cultures. I like both cultures. Yes, I think of some points, our Mexicans beliefs are playing a role with PPD. Some of Mexican friends and family who moved from Mexico to the United States do not like conventional care. I think it is a problem for healthcare providers. My family loves self-care rather than seeking conventional care instead.

P003, Mexicans are proud of their culture. We take pride of whom we are, and nobody can separate us despite good and bad times. I do not need to know anything about another people's culture. I do not care about care about what other groups think about my culture. P004, in Mexico, family support plays a vital role in Mexican families. Mexicans' family social support culture is related to our core values. Our core values represent strengths, compassion, love, and keeping us united as a family.

P005, as Mexicans, we adhere to practice our native culture or Mexican orthodoxy. Our orthodoxy is our cultural beliefs.

P006, for some Mexicans, especially those who moved from Mexico to immigrate in the United States might find it difficult to adapt to American culture.

P007, we are very strict when it comes to defending our cultural beliefs and not being influenced by other people's cultures.

P008, in Mexico, Some Mexican people do not have access to healthcare. It is too expensive for low-income families to pay for insurance, or unless they work for the government in other to qualify for government insurance. That is right self-care becomes popular among some Mexican families. Mexicans national cultural beliefs become a barrier for healthcare providers to treat Mexican women who suffered PPD. I acknowledge that barrier. Therefore, we are experiencing more problems than other ethnic groups.

P009, Mexicans culture is very complicated. It is a plethora. I would say it is related to Mexican's orthodoxy. Mexicans' culture is different from other populations' cultures. Despite other types of care in Mexico, we have (for women), traditional midwives care, Temazcal (sweat bath care), hot-cold duality (hot or cold), and Naturaleza which encompasses all other types of care in Mexico and based on family's beliefs. I truly understand why it is complicated for Mexican women to be treated or received diagnostic care for PPD in the United States. I do agree that it is our culture problem.

P010, I am a Mexican culture believer. I do think that our culture defines us. It makes us feel different. It makes us feel like Mexicans. No matter what other people say about us, we are who are. I do not know if our culture plays a role in PPD. From my standpoint, my PPD was not my culture but my divorced.

IQ5. How do you think that Mexican national cultural beliefs contributed to Mexican women's postpartum depression, in Maricopa County?

P001, I do not think our national cultural beliefs are the unique factors contributed to our postpartum depression. Our PPD is related to lack of access to health services or maternity care in Maricopa County.

P002, I do think that everybody has a cultural belief and that should not be used as stigmatization regarding Mexican women postpartum depression. That is my opinion. I think what needs to be done is to identify the fundamental problems and reduce the Mexican women's postpartum depression in Maricopa County.

P003, I know some healthcare professionals are using our cultural beliefs as factors concerning Mexican women postpartum depression instead of finding solutions to solve the problem.

P004, some Mexicans women do not trust doctors. We believe in our traditional care instead. I believe what healthcare professionals need to do is to learn our cultural beliefs in other to treat postpartum depression problem among Mexican women in Maricopa County. I know it is not easy because our Mexican national culture beliefs are complicated.

P005, I know the problem exists when it comes to maternity care in Maricopa County, but we need more Latino doctors. We need Latino professionals who understand our cultural beliefs and our traditional care system. It is hard for people who do not speak our language and know our culture to treat us. It is complicated and challenging.

P006, postpartum depression among Mexican women is not just Mexican national cultural beliefs but other factors like socioeconomic problems, transportation,

social support, legal document issue and lack of access to the public healthcare system.

P007, when it comes to Mexican national cultural beliefs, maternity care is related to Mexicans core values. For some Mexicans, particularly those who raised in rural neighborhoods, Mexican women, attached themselves with traditional care rather than conventional care. Therefore, family care or family traditional care is preferred instead. It is a challenge for us, as Mexicans, to follow conventional care system in the United States, even though we have recognized the challenges it represents for healthcare professionals.

P008, I do not think our cultural beliefs contributed to our post-partum depression. I think socioeconomic status; lack of insurance and ethnicity have considered the main problems. P009, I think our healthcare professionals in Maricopa County need to address other problems that are associated with Mexican women postpartum depression not just focus on Mexican national cultural beliefs.

P010, based on my experience, my PPD had not related to Mexican national cultural beliefs. Healthcare providers, in Maricopa County, should not just focus on Mexican national cultural beliefs but should also look at other factors that might be associated with Mexican women PPD

RQ2-How do Mexican women with PPD, in Maricopa County, Arizona perceive social support and healthcare services before and after childbearing?

Responses from the following 4 interview questions were used to answer research question two.

IQ6. What information and services are provided to you, while living in Maricopa County, Arizona, regarding childbearing and PPD?

P001, during my PPD experience, I had diagnosed for PPD. My doctor prescribed me anti-depression drugs for my depressive symptoms and referred me to a social network group in the Mexican community in Maricopa County. I was lonely. I felt depressed at that moment. After a couple of months, both my baby and I were feeling well. I had a good time and good experience with the social network group.

P002, I received tremendous support from my doctor. She is a female doctor. She was excellent. She told me she had experienced PPD with her first child. She understood what I had experienced. My doctor referred me to a postpartum program at Banner Health hospital in Phoenix and to a therapist. I was not working. I had no money. I did apply for food stamp, housing program, and Medicaid and been approved for all those benefits. Now I have a good job. I can take care of my daughter and myself.

P003, I was vomiting and depressed; three weeks after childbearing, then I called my doctor. He prescribed me some medications. He said it was not a major PPD the fact that I alerted him immediately. After taking medications for about four weeks, I was feeling good. I had my husband support, as always. He is a good husband.

P004, I had to follow a postpartum visit through Women's Care Clinic at Maricopa Medical Center in Phoenix for eight weeks, and my doctor prescribed me some medications.

P005, I had family support. My husband and my mother were supporting me all the way. P006, I was seeking family support throughout my pregnancy and childbearing, not professional support.

P007, I received a diagnostic test for PPD, and my healthcare providers scheduled me on PPD visit for six weeks.

P008, I received support from my friends, family members and healthcare professionals at St-Luc Hospital in Downtown Phoenix. I had to follow a postpartum visit for eight weeks. My doctor also prescribed me some anti-depression drugs.

P009, I was a member of a Mexican women postpartum group and participated in a nurse home visiting program for women from Nurse-Family Partnership. I was not alone. I had family support.

P010, when I was pregnant, my husband was in Mexico. I had depression at that time. My healthcare provider had told me that I should keep my postpartum visit appointment. I received childbirth education and prenatal care from Maricopa Integrated Health System Hospital. I was scared. I thought something would happen to my baby or me. All my family members were in Mexico. I had no family support. I talked to myself I said I made a bad decision to come to the United States. I had my baby delivery at Maricopa Integrated Health System

Hospital. They took care of my baby and me. They connected me with women's group network. It was a good social network support.

IQ7. What are your thoughts about the social support and healthcare services that are available and after childbearing in Maricopa County?

P001, I received social support from health care providers, but it was not the same as Mexican family social support. When I had my second child, I had no family support because all my family lived in Mexico. It was hard for me during my PPD period. I was not qualified for health care benefits because I did not have legal documents during my second child. I received a free postpartum visit, and I signed up with a postpartum women network. It was supportive and helpful.

P002, social support is essential during PPD period. My friends supported me but not my family. I qualified for government insurance and housing program. I received a free postpartum visit, food stamp, and dental care.

P003, I think without social support and health care services, women PPD would be worse. I thanked God that my family supported me before and after childbearing. I became a member of the Nurse-Family Partnership in Maricopa County after childbearing. This organization designed for women who have their first baby in Maricopa County.

P004, before and after childbearing, my husband was not here because U.S. Marshal Border deported him to Mexico and some of my family members were not living in Phoenix. I did not have family social support, but I did receive support from healthcare providers and from my Mexican friends in Maricopa. I

qualified for Medicaid and received breastfeeding support and been connected to postpartum women network in Phoenix.

P005, I think women need social support during their PPD period. If I did not have social support and access to health care services, my baby and I could have died. My family had supported me, my husband was a great supporter, and my doctor was a great supporter.

P006, in the Mexican community, social support considered the number one priority, especially during PPD period or social problems. I think as a community, we should support our family and our neighbors at times of suffering. Before and after my childbearing, healthcare services were available to me, but I had insurance. I was able to afford maternity care expenses. My family were available to help me with some cleaning, cooking, and baby stuff.

P007, social support is a good thing. My PPD would be worse without social support. My parents did not support me because they said I was too young to have a baby. My parents said I suppose to finish college before having a baby. I had friends' support and community including my health care providers. I surrounded with many helps. I received food nutritional support for my baby, free postpartum visit, nursing visit and I was qualified for Medicaid.

P008, women should not wait until childbearing to seek social support. I think they should seek social support during the pregnancy. There are a lot of social services and healthcare services in Maricopa County not just for PPD women but also for women who do not experience PPD. It is important to know what is

available and what is not. That would help women prepare better for their new motherhood experience. I know sometimes, it is hard for illegal immigrants to qualify for government services, but they can seek family and friends support during their PPD. I had friends and family members who were supported me emotionally and financially before and after childbearing.

P009, social support is definitely good for pregnant women. I think social support reduces stress and anxiety. When I was pregnant, my boyfriend was a great supporter. He called off at work when I was seek. My sister also came in to help me with cleaning, cooking.

P010, PPD is a complicated health problem for women. I think social support plays a significant role before and after childbearing. To me, it is an obligation for postpartum depression, women, to have social support and have access to health care services. However, unfortunately, minorities do not receive the same treatment as the majority does. During my pregnancy and after childbearing, I received family and friends' social supports. In Maricopa County, healthcare services are available for people who have legal status. It was a challenge for me because I was not qualified for government benefits during my PPD period.

IQ8. How do you think social support in Mexico differs from that of the United States?

P001, social support in Mexico is different from that of the United States. In Mexico, Social support is associated to Mexican national cultural beliefs. It becomes an obligation in our culture to support family members at times of

suffering. Here, I see some people do not care. Everybody is taking care of his or her own business.

P002, in the United States, some non-profit organizations are helping families at times of suffering or with social problems Compared to Mexico; social support is most likely depending on family, not non-profit organizations.

P003, social support among Mexican people is bidding all Mexican families together. In the United States, social support is relying on societies, governmental and non-governmental institutions. For Mexicans, social support is about caring and supporting family members at times of suffering.

P004, in Mexico, living in family is the source of creating trust and solidarity among family members. Mexicans are considered social support as a strategy to bring emotional support and material support to family members. At times of social needs and suffering, people need people. That is the way we see social support.

P005, in Mexico, we see social support as a basic care to support family. In the United States, sometimes, social support is about your money, your house, your job, and your class.

P006, social support, in Mexico, is associated with Mexican root, Mexican blood. Compared to the United States, social support.

P007, compared to the United States, it is hard to find family's support—because everyone is busy. Everyone is taking care of his own business.

P008, social support plays a significant role in Mexicans' culture. Social support is in our blood. We like helping each other. In Mexico, if there is a problem among family, all family members will bring their support to solve the problem.

P009, in Mexico, we have the best social support. Social support is nothing more than showing love, compassion, and sympathy for one another. Money is necessary, but money is not everything.

P010, nobody has time to help those who are in needs. Lack of social support creates stress; it makes our problems more difficult to solve. Living in Maricopa County changes our culture structures. We seek social support from professionals instead which is hard sometimes. We trust our family values. Our social support is relying on family members, not strangers.

IQ10. Thinking about yourself, what was your perception about receiving diagnostic care for PPD during pregnancy from healthcare providers?

P001, as a Mexican woman, I believe in my national cultural beliefs. There is many stigmatizations about Mexican women's postpartum depression. I was afraid of receiving diagnostic care for PPD simply because of stigmatizations. Some healthcare practitioners are focusing on our cultural beliefs and social problems. For Mexican women, it is embarrassing to talk about Mexicans personal problems.

P002, I was 18 years old when I was pregnant, and was my first child. My perception about receiving diagnostic care for PPD from healthcare providers was not telling me that I am at risk of being losing my baby. I read a lot of bad news

about pregnant women. I was scared to die or losing my baby. Fortunately, there were no other health issues after being receiving diagnostic care for PPD rather than been treated for PPD.

P003, I was afraid to die. I thought health care providers would tell me bad news about my life or my baby.

P004, my perception was on PPD treatment. I asked myself. What healthcare providers should tell me to do? What kind of treatments should they provide me? If I do not have money to buy medications for PPD what would happen to me? I asked myself these questions before receiving diagnostic care for PPD because I was scared.

P005, my perception was focusing on PPD treatments and making sure that my baby is in good health condition. I think receiving diagnostic care for PPD is a right decision for all pregnant women. Because receiving diagnostic care for PPD is allowing women to take-care themselves before and after childbearing.

P006, my perception was on what I would do after receiving diagnostic care for PPD. I think healthcare providers should also focus on PPD preventions not just on treatments for PPD. What should women do to prevent PPD?

P007, my perception was on the cost for receiving diagnostic care from healthcare providers. Fortunately, my maternity care cost covered under the government health insurance program.

P008, my perception was receiving diagnostic care for PPD from healthcare providers. In addition, I also think, healthcare providers should advise postpartum

depression women what they should do and not to do after receiving diagnostic care for PPD. Receiving diagnostic care for PPD is not the end of all.

P009, my perception was on my family's beliefs concerning my PPD treatments. Compared to the United States, in Mexico, women PPD treatments are based on Mexican national cultural beliefs but not based on conventional care.

P0010, my perception was to see if my baby and I were in good health conditions. If PPD diagnostic care revealed a health problem within me and my baby, then the healthcare providers would prescribe medications or would suggest me to seek other health care professionals for PPD treatments.

RQ3-What are the experiences among Mexican women of PPD?

Responses from the following interview question were used to answer research question three.

IQ1. What is your understanding about post-partum depression (PPD)?

P001, I know PPD is all about women's health problem. Women can feel depressed, anxiety, fear and loneliness when having a baby. I had my first child in Mexico. Fortunately, I did not have any health problem. I had my second child born here (in Phoenix, Arizona). I had been depressed. I believe that happened because I had no family members with me.

P002, I was 18 years old when I was pregnant. My boyfriend who got me pregnant left me. I had anxiety. My family did not support me. My parents did not like my boyfriend. I felt guilty. It was a terrible moment that I ever experienced in

my life. I had no money to support myself. I applied for food stamp, housing program, and insurance. I thanked God because I was qualified for those benefits.

P003, I think PPD is a life-changing experience for women. When I was pregnant, everything was fine. I did have my family support. I did follow my doctor's appointments. Three weeks after delivery, I started vomiting. I was unable to sleep. I felt guilty. I lost control of my life. My doctor prescribed me some medications. After taking medications for about three months, then I felt normal again.

P004, in my third child, I had PPD. My husband deported to Mexico. Because he had been caught doing drug. My baby was five weeks old, that time. That is how I knew about PPD. I had to follow PPD appointments for a couple of months. It was a problematic experienced.

P005, I think PPD is a serious health problem for women. I had PPD symptoms five weeks after my delivery. I thought I was going to die. It was my first child. My mom told me she had PPD when she had her first child, which was my brother. I thought my PPD related to my family history.

P006, PPD is a very health common problem among women, particularly among Latina's community. I have friends who had PPD. I have two kids. I did not experience PPD.

During my second baby, I had trouble sleeping for about two weeks. I learned a lot from my friends regarding PPD; I thanked God I did not experience significant depressive symptoms before and after my both deliveries.

P007, I think PPD is a global health problem for all women, especially for young mothers. I was 17 years old when I was pregnant. I was not ready for it. I was embarrassed, depressed and exhausted. I felt lonely. My parents abandoned me because of what happened to me. It was a terrible experience.

P008, I am a nursing student, from my understanding, PPD can affect both the mother and the child. It is essential for women to be prepared emotionally and mentally regarding PPD symptoms. Despite the financial support, maternity care and family support, women can still experience PPD no matter what.

P009, I think PPD is a somber moment. Both my husband and I were so happy to bring our first child on earth. He and I prepared everything for our baby. There was no financial problem. Everything was fine. After delivery, my life changed completely. I was entirely a different person. I cried every day. I felt nothing. I hate life. I thought I did something wrong. To me, PPD was a bad experience.

P010, I think PPD is a complicated health issue for women during pregnancy and after childbirth. I had PPD in my second child. I believe my depression related to my divorced. It was a terrible moment and a difficult life experience.

RQ4- What barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD?

Responses from the following interview question were used to answer research question four.

IQ9. What barriers do you think prevent Mexican women, in Maricopa County, Arizona, from being diagnosed and getting care for PPD?

P001, I think there are a couple of barriers, for example; health insurance, discrimination, and illegal status. For illegal immigrants, it is difficult to apply for government insurance.

P002, I think stigmatization from healthcare providers regarding PPD in Mexican women considered one of the barriers. Healthcare providers are talking too much about our postpartum depression. Mexican women like privacy.

P003, Mexican national cultural beliefs are the barriers because, for Mexicans, family care considered the primary care to treat PPD women instead of using conventional care.

P004, lack of trust and privacy are the barriers. Our PPD problems are personal and sensitive to us. We do not want to talk about it.

P005, we do not want to talk about PPD with other people rather family members. We know it is a problem, but we merely want to keep it private.

P006. I think the barriers are lack of money to buy insurance, sometimes, and family culture.

P007, there are no barriers. I think Mexican women know what to do to treat their postpartum depression. I do know if pregnant women do not have insurance, legal document, transportation, and communication problem that might be the barriers.

P008, I think the barriers are probably motherhood problem or lack of English to communicate or uncomfortable to talk about postpartum depressive symptoms.

P009, I think the barriers are about Mexican cultural beliefs. In our culture, we believe in traditional care instead of conventional care. Secondly, there are other

reasons for that. For instance, those who do not have insurance and financial support are challenging to seek diagnostic care in Maricopa County. Furthermore, issues like legal status, for some of us, and lack of understanding about the United States healthcare delivery system are considered as common factors to receive PPD treatments.

P010, I think for young Mexican mothers, barriers are multiple, for example; lack of family support, lack of knowledge in becoming a new mother, no insurance, low-income, and transportation problem.

Research Question 1

What perceptions do Mexican women with PPD, in Maricopa County, Arizona have regarding low-income, cultural beliefs, and intimate partner violence? Empirical studies showed socioeconomic status affected low-income families and a predictor of health issues (Afable-Munsuz et al., 2013; Dolbier et al., 2013; Gallo et al., 2012; Gress-Smith et al., 2011, & O'Mahony et al., 2013). All ten participants, in this study, were sharing the negative impact of low-income during their PPD before and after childbearing. For example, one participant reported "low-income is no good. I work as a dishwasher. My income is insufficient to raise my two kids. Participant continued. To raise kids, it is expensive. I struggle to pay my bills because I am making low-income. Also, another participant noted "I think getting reading financially before having kids is extremely important. I think my financial problem was the reason for my PPD. Based on the participants' answers, low-income is associated with Mexican women PPD in Maricopa County, Arizona.

Cultural Beliefs.

Mexicans like their culture and believe in their culture orthodoxy. One participant answered: I like my culture, and I like who we are, as Mexicans. I think other groups of people should like their culture as well. We like our core values. We like to help our family members when there is a need. Another participant noted, “we are very strict when it comes to defending our cultural beliefs and not being influenced by other people’s cultures.”

I am, too, an immigrant like Mexicans. I agree individual should like his/her native culture. In the meantime, it is required bi-culturalism when living in a foreign country simply to increase the knowledge of capacity regarding social activities, education, learn the language, access to transportation, etc. The concept of Adaptation should be considered as a body of knowledge for immigrants. Garret and Wrench (2012) noted that culture could be seen as the network of values, social relations and practices that are inscribed and deployed through discourses.

Intimate partner violence.

According to Jackson et al. (2015), intimate partner violence includes physical, sexual, emotional, and psychological abuse and threats of harm, as well as financial abuse, controlling behavior, and coercion between current and former spouses and dating partners. In this study, some participants experienced IPV during their ex-spouse relationship. All ten participants showed their concerns regarding IPV among Mexican’s community in Maricopa County, Arizona. One participant answered: my boyfriend and I were fighting a couple of times when he and I lived together. The reason that happened

because I caught him cheats on me with other women. I hate him. I am a jealous woman. He was not caring. He refused to stop cheating. For that matter, he and I separated. Another participant noted "I tried to avoid domestic violence in my relationship. I know it is widespread in my community. Therefore, I do all my best to avoid it. My husband likes his family. From my understanding, women can find themselves in domestic violence due to jealousy and other family issues." Based on participants' answers, in this study, it is clear to acknowledge that IPV considered one of the factors that are associated with Mexican women PPD.

Research Question 2

How do Mexican women with PPD, in Maricopa County, Arizona perceive social support and healthcare services before and after childbearing?

PPD women should have social support from their healthcare providers, communities, and families in other to reduce their PPD symptoms. It has reported that social support is essential for PPD depression women before and after childbirth. All ten participants, in this study, shared their good and bad experiences regarding social support during PPD period. For example, one participant noted "I received social support from health care providers, but it was not the same as Mexican family social support. When I had my second child, I had no family support because all my family lived in Mexico. It was hard for me during my postpartum depression period. Mexicans believe in family support not just during PPD period but also social concerns or other health issues. Many participants outlined family social support among Mexicans plays a significant role during the PPD period.

On the other hand, despite family social support, many participants explained the social support that they received in Maricopa County, Arizona during PPD period was supportive and helpful. For example, one participant reported “I received tremendous support from my doctor. She is a female doctor. She was excellent. She told me she had experienced PPD with her first child. She understood what I had experienced. My doctor referred me to a postpartum program at Banner Health hospital in Phoenix and a therapist.”

Participants in this study explained their perceptions about receiving diagnostic care for PPD in Maricopa County, Arizona. In this study, some participants believe receiving diagnostic care for PPD would change their Mexican cultural beliefs. Other participants worried about the cost of receiving diagnostic care for PPD because lack of health insurance is considered one of their challenges. For example, one participant noted “my perception was on the cost for receiving diagnostic care from healthcare providers. Fortunately, my maternity care cost covered under the government health insurance program.” I assume that Mexican women who do not qualify for government health insurance and making low-income have a hard time for receiving diagnostic care for PPD. If that were the case, Mexican women PPD factors would continue to affect Mexican women’s well-being in Maricopa County, Arizona. One participant reported “my perception was on what I would do after receiving diagnostic care for PPD. I think healthcare providers should also focus on PPD preventions not just on treatments for PPD. What should women do to prevent PPD?”

Research Question 3

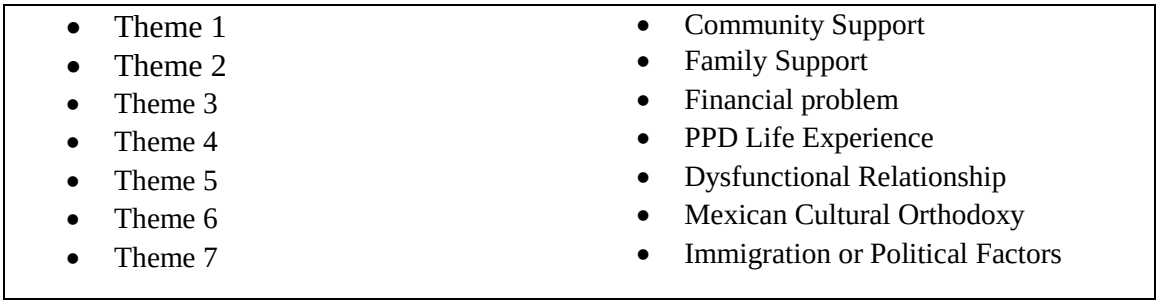
What are the experiences among Mexican women of PPD? PPD is a common health problem among Mexican women (Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2011). PPD among Mexican women is associated with multiple factors (Bobo et al., 2014; Gress-Smith et al., 2011). Some Mexican women do not feel comfortable to talk with anyone about their PPD experienced except the healthcare professionals or family members. In this study, participants were acknowledged and agreed that PPD is a common health disparity among Latinas. One participant reported "It is essential for women to be prepared emotionally and mentally regarding PPD symptoms. This participant surprised me with this particular answer because knowing both emotional and mental symptoms from PPD would help women better prepare to reduce PPD consequences and effects before and after childbearing. Despite the Latinas understanding of their PPD health issue, PPD remains a fundamental health problem among Latinas. One of the participants noted "I know postpartum depression is all about women's health problem. Women can feel depressed, anxiety, fear and lonely when having a baby." All ten participants explained their understanding about PPD and experienced PPD symptoms before and after childbirth.

Research Question 4

What barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD? According to all ten participants in this study, multiple barriers prevent Mexican women in Maricopa County, Arizona from receiving diagnostic care for PPD. Experiencing barriers during PPD period could exacerbate PPD

symptoms. One participant reported lack of trust and privacy are considered as barriers. It seems that Mexican women do not trust their healthcare providers regarding PPD treatments. But participant did not elaborate about the trust. If there is no trust between the patient and healthcare providers, it would be difficult for healthcare providers to deliver quality care to patients. There must be privacy between both parties (the patient and the healthcare professional), but the patient should feel free to explain to healthcare providers regarding their symptoms or health problems. Another participant reported. I think there are a couple of barriers, for example; health insurance, discrimination, and illegal status. PPD women should have access to health services or having health insurance before and after childbirth. The process of maternity care should start with health insurance (Grussu & Quatraro, 2004; Kim et al., 2012; Liberto, 2012). Chou, Asnaani, and Hofmann (2012) noted the perception of being discriminated against could contribute to negative health consequences. Additional barriers are noted by participants. For example, barriers like illegal status, motherhood, low-income, transportation, and cultural beliefs.

Figure 2. The 7 themes characteristic of the PPD experience.



Community Support

PPD women should seek community support during PPD period not just from family members. In this study, participants expressed their gratitude about social support that they had received from healthcare providers in both Maryvale and South Phoenix during their postpartum depression period. Community support plays a significant role in individuals' well-being. Also, government officials should create a facility to help community members gain access to health services, education, jobs, and transportation to reduce social factors that can impact the community's well-being negatively. Therefore, the positive social change of this study is improving the lives of the new Mexican mother and their families through policies and practices. According to Glantz, Rimer, and Viswanath (2008), empowerment is an action-oriented concept whit a focus on removal of barriers and on transforming power relations among communities, institutions, and government agencies.

Family Support.

In Mexican community, family support is reliable and trusted upon family members. This kind of support helps the family be united at times of social needs or health issues among family members. The research study showed that Mexicans looked for help from their family members rather than healthcare professionals in the United States Callister et al., 2011). One participant reported, in this study, my family supported with cleaning, cooking and shopping at times of my PPD. In an interview conducted by Callister, et al. (2014), a 27-year-old Mexican mother of four kids said the following: It is hard because there is only us here, my husband and I. It is hard if you do not have the

family with you and not having someone to help you out. I did not have anyone to support me. What am I supposed to do? I had to press forward. Compared to the United States, family support in Mexico is found more supportive, heartfelt and enthusiasm, according to participants in this study.

Financial Problem.

Lack of financial resources may exacerbate the effects of PPD among low-income families, particularly Mexican women (Gress-Smith et al., 2011). Most of the participants in this study expressed their concerns about the financial problem that they experienced during the PPD period. Researchers found that women with higher income experienced less stress and fewer challenges during their daily lives (Dolbier et al., 2013; O'Mahony et al., 2013). A participant noted "I work as a dishwasher. My income is insufficient to raise my two kids". SES is associated with Mexican women PPD in Maricopa County, Arizona. Improving the life of a family through empowerment, social inclusion, health services, and education may reduce health disparities, especially among underrepresented ethnic groups in the United States.

PPD Life Experience.

PPD is a life-challenging experience for women and can affect both the mother and the child (Abbasi, Chuang, Dagher, Zhu, & Kjerulff, 2013). In this study, one participant noted "I think PPD is a life-challenging experience for women. When I was pregnant, everything was fine. I did have my family support. I did follow my doctor's appointments. There weeks after my delivery, I started vomiting. I was unable to sleep. I felt guilty, as a mother. I lost control of my life. My doctor prescribed some

medications." Another participant reported "I know postpartum depression is all about women's health problem. Women can feel depressed, anxiety, fear and loneliness when having a baby." It has been reported that 10-15% of women develop some depressive symptom after childbirth (Gress-Smith et al., 2011; Pooler, Perry, & Ghandour, 2013).

Dysfunctional Relationship.

PPD is associated with a dysfunctional relationship among Mexican women in Maricopa County. Some of the participants divorced or separated because their spouses have been deported to Mexico or went to prison regarding violence domestic. One participant in this study reported "My boyfriend, and I were fighting a couple of times. The reason that was happening because I caught him cheats on me with other women. For that matter, he and I separated. Intimate partner violence is one of PPD social factors among Mexican women in Maricopa County. Jackson et al. (2015) noted 1.5 million women in the United States experienced IPV. In a research study on IPV conducted by Arizona State University found 13.1% of the Mexican-American women experienced intimate partner violence in Maricopa County, Arizona, and 11.3% had IPV during pregnancy (Jackson et al., 2015). Based on participants' responses in this study, a dysfunctional relationship can lead to more social problems, for example, kids grow up with no father in the house, family income reduces, and kid's education is found under risk of educational attainment.

Mexican Cultural Orthodoxy.

Mexican cultural orthodoxy is a cultural belief that makes all Mexicans feel proud of whom they are as a people, despite all social problems and political outcomes they are

facing in Mexico and the United States, Mexicans are attaching with their cultural values. Garrett and Wrench (2012) noted that culture can be seen as the network of values, social relations and practices that are inscribed and deployed through discourses. One of the participants reported, “We are very strict when it comes to defending our cultural beliefs and not being influenced by other people’s cultures.” I live in Maricopa County for about eight years. I know this population. They like their culture, for example, Mexican food, tacos. They like having a party or family reunion. One day, my Mexican neighbor invited me to his kid’s baptism party. I did not go because I am not Catholic. A participant noted “our core values represent our strengths, compassion for one another and love each other. Today, cultural diversity can help reduce a lot of society’s problems. Many countries are embracing cultural diversity or cultural globalization. As Liu (2012) noted, cultural globalization is not about the homogenization of national culture but the inseparable interconnections among different national cultures as well as the increasing consensus about and consciousness of global issues. I am Haitian and like my national culture alike Mexicans. However, I have embraced bi-culturalism. Bi-culturalism or cultural diversity can help individuals reduces their social factors and live a better life.

Immigration or political factors.

In this literature, I tried to avoid politics because the study focused on postpartum depression, not on illegal immigrants. However, participants also expressed their concerns about lack of legal documents that were affected their social lives in Maricopa County Arizona. One participant stated “It was hard for me during my postpartum depression period. I was not qualified for health care benefits because I did not have legal

documents during my second child. As I reported in this literature, in chapter three; it took me over 14 years to receive my citizenship and later on decided to go to school. As an immigrant, I have experienced demographic and psychosocial issues similar to those experienced by the Mexican women, except I had the work permit. I had access to apply for jobs and driver's license. Illegal status can create stress and affects an individual's well-being, especially women.

Summary

In this chapter, data collected by using an unstructured interview. I chose ten qualified participants who have experienced postpartum depression before and after childbearing. Geographically, I selected participants in Maryvale and South Phoenix, Arizona. In this study, I followed the protocol and both IRB and NIH instructions. Participants chose the time and location that they felt safe and also for privacy concern. Each participant answered all ten interview questions and not been forced by the interviewer to change the meaning of what interviewee has been intended to say. After collecting the data from all ten participants, I transcribed the data into an NVivo software management, version plus. I used automatic coding. This procedure facilitated 110 codes. In other to eliminate redundancy, I selected the most useful codes from 110 codes. Each category of codes was assigned to one theme. I developed each theme based on the meaning of each code and participants' responses, according to ten interview questions. The participants' PPD experience consists of seven themes: PPD community support, family support, dysfunctional relationship, PPD life experience, Mexican cultural orthodoxy, financial problem, and immigration or political factors.

The study findings revealed that social factors associated with Mexican women postpartum depression in Maricopa County, Arizona. The responses given by all ten participants during the interview are aligned with all four research questions in the study. The participants agreed that intimate partner violence, national cultural beliefs, health services, low-income, and barriers were associated with their postpartum depressive symptoms in Maricopa County, Arizona. For example, participants mentioned lack of health insurance, illegal status, transportation, and national cultural beliefs were considered as barriers for not been diagnosed for postpartum depression in Maricopa County. Chapter five includes my interpretations of this study findings, study's limitations, social change, and recommendations for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative interpretive descriptive study was to explore what experiences Mexican women in Maricopa County had with PPD and their perceptions of factors such as low-income, cultural beliefs, intimate partner violence, social support, and healthcare services. PPD is a prevalent health issue among women particularly among minority groups in the United States. This study was conducted because among minority groups, Mexican women have the highest PPD rate; this prevalence is associated with a plethora of indicators or variables (Bobo et al., 2014; Gress-Smith et al., 2011). The findings of this study revealed that Mexican women experienced PPD before and after childbearing.

The participants in this study affirmed that SES, intimate partner violence, Mexican national cultural beliefs, social support, and discrimination were associated with their postpartum depressive symptoms before and after childbearing. The participants agreed that their core values, cultural beliefs, illegal status, transportation, and lack of health services in Maricopa County, Arizona were barriers that prevented them from receiving diagnostic care for PPD. Effective healthcare policies and practices can implement by healthcare practitioners along with cultural knowledge to reduce Mexican women PPD in Maricopa County, Arizona.

Interpretation of Findings

The data that I collected from all 10 qualified participants during one-on-one unstructured interviews confirmed that PPD is a prevalent health issue among Mexican

women in Maricopa County, Arizona. The responses from participants revealed that low-income, social support, intimate partner violence, Mexican national cultural beliefs, discrimination, and lack of access to health services in Maricopa County, Arizona affected their well-being before and after childbearing. During the interviews, the participants also confirmed that lack of public transportation, illegal status (undocumented immigrants), spouse deportation to Mexico, boyfriends or husbands who went to jail or prison, and getting divorced were related to their postpartum depressive symptoms before and after childbearing. Researchers have shown that predictors such as acculturation, unintended pregnancy, micro-aggressions in public schools, and lack of education have been linked to Latina's depression symptoms (Callister et al., 2012; Casanova, 2012; Dolbier et al., 2013; Walker et al., 2012). Participants in my study did not report education, unintended pregnancy, micro-aggressions in public schools, and acculturation as factors that impacted their lives before after childbearing. The findings confirmed that social support is considered one of the Mexicans' strongholds, in Mexican national culture. A previous study suggested that social support is one of the strongest types of support that an individual can possess at the time of depression or stress (see Wang et al., 2014).

> One participant in this study reported: "In Mexico, living in a family is the source of creating trust and solidarity among family members. Mexicans are considered social support as a strategy to bring emotional support and material support to family members. At times of social needs and suffering, people need people. That is the way we see social support." All the participants in this study confirmed that

> Mexican national cultural beliefs were linked with Mexican women PPD in Maricopa County, Arizona. One participant reported: "We like our culture and like who we are, as Mexicans. I think other groups of people should like their culture as well. Mexican people like their core values. We like to help our family members when there is a need." In Mexican culture, it becomes an obligation or Mexican orthodoxy for women to adhere to the national culture and take the excellent care of the family. Thus, the influence of prenatal care during the women's pregnancy or after childbirth rest upon the family support (Gress-Smith et al., 2013).

Researchers have identified that cultural globalization is essential for individuals to surpass their challenges (Liu, 2012). According to Liu (2012), cultural globalization is not about the homogenization of national cultures but the inseparable interconnections among different national cultures as well as the increasing consensus about the consciousness of global issues. Furthermore, Garrett and Wrench (2012) noted that culture can be seen as the network of values, social relations and practices that are inscribed and deployed through discourses.

The responses from participants regarding low-income confirmed that lack of financial resources was associated with Mexican women PPD. The finding of this study is consistent with research studies on a low-income family. Many research studies have illustrated that SES is related to Mexican women PPD (Afable-Munsuz et al., 2013; Dolbier et al., 2013 & Gallo et al., 2013). One participant noted: "I think getting ready financially before having kids is extremely important. My boyfriend and I were not

prepared financially to have a baby. That is the reason that my parents were not happy with me. I was making low-income. Now I go back to school to become a nurse." Lack of financial resources may exacerbate the effects of PPD among low-income families (Gress-Smith et al., 2011).

One empirical study showed a strong relationship between unintended pregnancy and intimate partner violence (Martin & Garcia, 2011). The study findings confirmed that some participants experienced intimate partner violence in their relationship. For example, one participant noted: "I tried to avoid domestic violence in my relationship. I know it is prevalent in my community." Jackson (2015) posited that a high level of intimate partner violence predicted postpartum depression symptoms.

The study disconfirmed that unintended pregnancy, education, and acculturation, were not associated with Mexican women PPD in Maricopa County, Arizona. Contrary to the existing literature, for example, researchers have found unintended pregnancy among Latinas' population accounted for 76% (Martin & Garcia, 2011). Dolbier et al. (2013) also showed that Mexican women's PPD is associated with a lack of education. The participants in this present study did not mentioned unintended pregnancy and education as factors that impacted their PPD symptoms before and after childbearing.

The United States Department of Health and Human Services (2012) indicated that health-related quality of life is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. The theoretical framework for this study, Engel's model, stated (2012) that factors (e.g., biological, psychological, and social) are all interconnected in promoting health or causing disease.

In this study, Engel's (2012) biopsychosocial model explains that women may experience PPD from biological, psychological, and social factors. Thus, I found that PPD in Mexican women is associated with social factors. Researchers have shown that social factors such as SES, cultural beliefs, social support, and acculturation are associated with the development of PPD among Mexican women in Maricopa County (Gress-Smith et al., 2012; D'Anna-Hernandez et al., 2016). Therefore, the findings in this study are aligned with Engel's biopsychosocial model. Engel has recommended that clinicians explain PPD in women through biological, psychological, and social factors.

Limitations of the Study

A limitation of this study is that geographically and considering other Mexican women subgroups, PPD may have different impacts on other groups based on age category, educational attainment, a family with higher income, single parents, and low self-esteem. Furthermore, the study limitations such as choosing one homogenous group, such as demographic, age group (18-30 years old), geographic locations and using an unstructured interview are considered as potential weaknesses in this research. A homogeneous group among Mexican women can be diverse, in terms, of age group, SES, educational attainment, and parenthood or adulthood--the ability to have kids. Women in these categories may have a different understanding of PPD. Further, Mexican women who were born in the United States, who grew up as Americans rather than Mexicans, who were educated, and experienced less economic problems may also have a different understanding of PPD. Ramsauer et al. (2015) showed that women with PPD can be attributed to parenting stress and maladaptive parenting. Another research study revealed

that anxiety and stress levels were related to PPD, especially with women who had the cesarean delivery (Clout & Brown, 2015). Thus, different groups of Mexican women may have a different understanding about PPD depending on life experiences before and after childbearing.

Recommendations

This research study was conducted with Mexican mothers and excluded other Hispanic subgroups, for example; Puerto Rican, Dominican, and Cuban mothers. This study was also limited regarding the research approach, sample size, and biological and psychological factors. Finally, this study was limited among Latina mothers regarding educational achievements and higher income level. Therefore, I recommend further research with a larger sample size and using a different research methodology. For example, in this study, I used an interpretive descriptive qualitative study. I recommend a case by case study approach instead. Compared to qualitative research methods, I recommend researchers to use mixed-methods research to extend the PPD study among all Hispanic subgroups. For future research study in PPD among Mexican women, I have suggested researchers use different patterns or look at different perspectives, for example, Mexican women with higher income, educational attainment, geographic locations, bi-culturalism, and different approach of methodology. These outcomes may generate different results.

For future research study, I recommend quantitative research methods. By using quantitative research methods, researchers would be able to test the hypotheses to see what relationship exist between the constructs or variables within PPD among Mexican

women or Hispanic subgroups. I would be interested in conducting a study measurement regarding the effect of stress or anxiety before after childbearing. I would also recommend researchers to conduct a pilot study that would help researchers enrich the literature through data saturation regarding the subject study. Lastly, I recommend researchers to use phenomenological approach. Using a phenomenological approach, researchers would increase data saturation through multiple-interview settings per participant. The aim of using a phenomenological approach, researchers would gain extensive knowledge through the participant's life experience.

Implications for Social Change

This research study was about PPD in Mexican women living in Maricopa County, Arizona. A positive social change implication that could result from the findings of this study is to encourage healthcare practitioners to implement more effective policy and practice changes through community empowerment, health education, and early diagnostic testing to reduce PPD in Mexican women. I propose healthcare policy and practice change for Mexican women, particularly in Maricopa County, Arizona. Health disparities show significant gaps between the ethnic and the majority populations. Healthcare policy and practice should include access to healthcare coverage for the low-income family, free diagnostic tests for women with PPD, and access to adequate education for ethnic groups. Healthcare practitioners should be culturally competent, especially among Hispanic subgroups. Learning more about Mexican national cultural beliefs or Mexicans' orthodoxy could enhance healthcare practitioners' understanding regarding PPD in Mexican women. As, the United States is one of the most diverse

countries, healthcare practitioners should embrace cultural knowledge and competence to deliver quality care to individuals with a multi-cultural background.

Furthermore, to empower minority or ethnic groups such as Mexican women with PPD, it becomes imperative for healthcare providers or healthcare practitioners to adopt a community-based participatory approach to empower the community with useful tools to overcome health disparities. Devia et al. (2017) suggested that principles of community-based participatory approach (CBPA) include, building on strengths and resources in the community; facilitating collaborative and equitable partnerships; engaging in power-sharing processes that attend to social inequities; fostering co-learning; and capacity building among all partners. A practical implementation of social change cannot be implemented without social inclusion. One of the key factors for social inclusion could be community empowerment through CBPA. Using community empowerment to enhance community's well-being (Minkler, 2012) is essential to promote social change and reduce social factors that are associated with Mexican women PPD (Callister et al., 2012; Dolbier et al. 2013; Gress-Smith et al., 2011; & Wang et al., 2014).

Conclusion

I conducted this study among Mexican women with PPD in Maricopa County, Arizona. The results of this study confirmed that Mexican women experienced PPD before and after childbearing through multiple social factors. Compared to previous studies and methodologies, this present study focused on social factors and used qualitative interpretive descriptive approach to explore what experiences Mexican women in Maricopa County have with PPD and their perceptions of factors such as low-

income, cultural beliefs, intimate partner violence, social support, and healthcare services. Based on the data collected through one-on-one unstructured interviews, participants agreed that the social factors mentioned above affected their well-being before and after childbearing. This present study recommends a different approach or different methodologies to increase the body of knowledge in the future research study regarding PPD. To alleviate PPD among Mexican women in Maricopa County, PPD should be addressed adequately through healthcare policy and practice. Healthcare policy and practice should include access to healthcare coverage for the low-income family, a free diagnostic test for women with PPD, funding resources, and access to public transportation, especially for single mothers.

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Appendix A: Participants' Interview Protocol

Date:_____

Time of Interview:_____

Place:_____

Interviewer (Name and Title): _____

Interviewer Affiliation Organization:_____

Participant (Name and Title):_____

Participant Affiliation Organization:_____

Was informed consent formed obtained prior to interview? □Yes □ No

Required signatures including consent formed? □ Yes □ No

Appendix B: Interview Questions

IQ1. What is your understanding about post-partum depression (PPD)?

IQ2. What are your thoughts about low-income and the role it has with PPD?

IQ3. What are your thoughts about intimate partner violence and the role it plays with PPD?

IQ4. What are your thoughts about your culture and taking on the culture of other groups of people? Do you think it plays a role with PPD?

IQ5. How do you think that Mexican national cultural beliefs contributed to Mexican women's PPD, in Maricopa County?

IQ6. What information and services are provided to you, while living in Maricopa County, Arizona, regarding childbearing and PPD?

IQ7. What are your thoughts about the social support and healthcare services that are available and after childbearing in Maricopa County?

IQ8. How do you think social support in Mexico differs from that of the United States?

IQ9. What barriers do you think prevent Mexican women, in Maricopa County, Arizona, from being diagnosed and getting care for PPD?

IQ10. Thinking about yourself, what was your perception about receiving diagnostic care for PPD during pregnancy from healthcare providers?