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Abstract

This paper discusses the need for multi-cultural methodologies that develop knowledge about the maternity experience of migrant women and that are attuned to women's maternity-related requirements under multi-cultural conditions. Little is known about the transition to parenthood for mothers in a new country, particularly when the country is New Zealand. This paper will challenge the positivist hegemony of previously completed research on migrant women by reflecting on my own experience as a researcher grounded in a broadly-based, pluralistic set of critical epistemologies that allowed me to uncover the issues and contexts that impacted on the experience of migrant women. It concludes by proposing that, where research occurs with minority groups, multiple research strategies are incorporated in order to prevent the reproduction of deficiency discourses.

Keywords

Migration, Motherhood, Methodology, Reflexivity, Methodological Pluralism, Goa (India) and New Zealand

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Motherhood, Migration and Methodology: Giving Voice to the "Other"

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This paper discusses the need for multi-cultural methodologies that develop knowledge about the maternity experience of migrant women and that are attuned to women's maternity-related requirements under multi-cultural conditions. Little is known about the transition to parenthood for mothers in a new country, particularly when the country is New Zealand. This paper will challenge the positivist hegemony of previously completed research on migrant women by reflecting on my own experience as a researcher grounded in a broadly–based, pluralistic set of critical epistemologies that allowed me to uncover the issues and contexts that impacted on the experience of migrant women. It concludes by proposing that, where research occurs with minority groups, multiple research strategies are incorporated in order to prevent the reproduction of deficiency discourses. Key words: Migration, Motherhood, Methodology, Reflexivity, Methodological Pluralism, Goa (India) and New Zealand

Introduction

In the following paper, I foreground and problematise my epistemological concerns as an insider studying my own culture in New Zealand but as an outsider situated within the academy. I was born in what was then Tanganyika and is now Tanzania into a Catholic family originating from Goa. Goa is located on the south west Coast of India and has an area of 3,701 square kilometres and a primarily agrarian economy with, more recently, a tourism and service industry (Mascarenhas-Keyes, 1979). Goa was renowned as a port as far back as the third century BC, when Buddhism was spreading through India. It was a Portuguese colony from 1510 until 1961, at which time Goa was liberated/invaded by the Indian army. There remains a tension between what has been called "Goa Indica" or Indian Goa and "Goa Dourada", which is the Westernised and colonial Goa used to sell tourism (Routledge, 2000). On May 31, 1987 Goa became the 25th state in the Republic of India (Newman, 1999). The Portuguese colonisation of Goa was a catalyst that led many Goans to become a mobile population. My family's migration history began with my great-grandfather leaving Goa to work in Burma. Subsequently, both sets of grandparents migrated to Tanganyika with their families

When I was two my family moved from Tanzania to Kenya and as a result of these experiences I became exposed to multiple heritages and languages, including Maragoli, Swahili, Konkani, and English. Then in 1975, as a result of the unease resulting from the expulsion of "Asians" (meaning people from Bangladesh, Pakistan, and India) from Uganda in 1972 and the process of " Kenyanisation", where Kenyan's were privileged over others my parents decided to migrate to New Zealand (Gracias, 2000).Settling in New Zealand was difficult financially, socially, and emotionally. In East Africa there had been a very strong Goan and Indian symbiotic community that

provided cultural links. Despite being "foreign" there was a sub-culture in East Africa that was supportive and understood by Africans. In New Zealand we were different again, but less well understood.

I have named these migration sites to locate my research, this paper and myself geographically and historically to show how my identity has been shaped by colonialism. As Hall (1996) observes, all writers speak from a particular place and so it is important that they locate their own experiences and culture in their writing. I do not claim that there is anything essentially "Goan" about my own identity or experiences. Indeed they are a *melange* of African and New Zealand cultures underpinned by a reminiscence of the multiple influences of Goan culture, itself a rich blend of Hindu, Muslim, Buddhist, Jain, and Portuguese (Gracias, 2000). This discussion has also raised the issue of language. English is the language of my intellectual make-up but not my emotional make up (Rao, 1995). English is not my first language, it is not even my second but my third language, yet in this paper I must, to paraphrase Rao, attempt to convey in a language that is not my own, the spirit that is my own.

My interest in the area of migration and motherhood developed as a result of a number of incidents in my clinical practice that perturbed me. Contemplating a career in midwifery, I took a break from mental health nursing to work in the maternal health area for one year. New Zealand's migration policy had recently changed leading to a more culturally diverse population. I observed colleagues struggling with providing appropriate care for mothers from the new immigrant and refugee communities. It appeared to me that the concept of "cultural safety" (Ramsden, 1997), that was embedded in nursing and midwifery education did little to prepare nurses and midwives for working with the new populations. Despair at the quality of care I was able to offer women and their families, led me to return to mental health and work on the newly established maternal mental health team. On this team, the majority of referrals were from white middle class professional women who did not reflect the diversity I had seen in the maternal health setting. I wondered what resources migrant women used if they were experiencing postnatal distress and were not using mainstream mental health services. I also questioned the range of treatment options that was offered in mental health settings, which were largely constructed around a "talking cure" when many of my cultural peers clearly desired practical assistance in the absence of support networks. These experiences led me to question to what extent the health care that was provided to migrant women was therapeutic. Moreover, I began to question whether existing knowledge that informed clinical practice was adequate.

I decided to research the motherhood experiences of migrant women from Goa. I felt that the birth of a child would provide an apposite set of circumstances for understanding the appropriateness of various research methodologies to represent the experiences of different women. One of the most culturally and spiritually significant events for women (Khalaf & Callister, 1997), the transition of motherhood is often validated through ritual. Studies show that cultures that have supportive rituals for new mothers have lower rates of postnatal depression (PND) and that women in Western countries are at high risk of developing PND (Stern, 1983). It is often assumed that because the physiology of childbirth is universal that all mothers experience the transition to parenthood in the same way (Sawyer, 1999) but how childbirth is "conceptualised, structured and experienced" (Stewart & Jambunathan, 1996, p. 319) varies from culture to culture. Moreover, little is known about how the

transition to parenthood changes following migration for migrant mothers in New Zealand.

The postpartum mood disorders have been divided into three main categories according to severity (Affonso & Domino, 1984; Arizmendi & Affonso1984; O'Hara & Zekoski, 1982). The mildest form is "the blues", seen in the first week postpartum, lasting between a few hours to a few days and characterised by sadness and tearfulness. It is thought to be physiologically based (Pitt, 1968). Puerperal psychosis, the most severe form of postnatal distress is rare occurring in 1 in 1000 births, but is highly incapacitating and can include such experiences as hallucinations and mania (Cutrona, 1982; Hapgood, 1988). The most common form is postnatal depression (PND) which is important because of its high incidence (Kumar, 1984) and often-long duration (O'Hara & Zekoski, 1982). PND is characterised by a prolonged lowness in mood, a decreased interest in activities, fatigue and disturbances of sleep and appetite (Pitt, 1968). The prevalence is difficult to ascertain because depressed post partum women may feel that they have to minimise their negative feelings because our culture depicts the birth of a child as a highly positive event (Beck, 1992; Whiffen, 1992). It is estimated that PND affects up to twenty percent of mothers (Brockington, 1982; Kumar, 1984; McGill, Burrows, Holland, Langer, & Sweet, 1995; O'Hara & Zekoski, 1982; Pitt, 1968) However, only 2-4% are identified as depressed by health professionals. This identification is even more problematic where linguistic and cultural barriers exist. Furthermore, research has shown that there is a reluctance to seek help for PND as depressed post partum women often feel that they have to minimise their negative feelings or experience shame, fear or embarrassment (Beck, 1993). When mothers eventually do access health professionals, often-unhelpful responses and inappropriate treatments are advocated (Beck, 1993; Gruen, 1989; McIntosh, 1993), so that many women remain untreated and undiagnosed.

This paper attempts to illustrate the need for further research relating to motherhood in a new country. It will present an argument for the use of alternative research frameworks that are able to more appropriately articulate the experiences of women from migrant communities. I will do this by briefly describing four discourses that have shaped knowledge development and representations of migrant women in the health care system. These are the biomedical discourse, "woman-centred" discourse, migration discourse, and the deficiency discourse. The impact of such discourses in guiding the responses of health providers to the needs of migrant mothers are then reviewed which have been unwittingly exclusionary, pathologising, and homogenising. The responses add weight to concerns that health services do not meet the needs of migrant mothers and alternative strategies are discussed that could counter the assimilationist, sexist, and ethnocentric assumptions of prevailing discourses and create new discourses or discursive spaces. This paper points to the need for a new research agenda to inform practice in the maternity arena because of the inadequacy of the four prevailing discourses to bring about valid representations of minority women. This research agenda could incorporate methodological pluralism and reflexivity.

Discourses are "socially and culturally produced patterns of language, which constitute power by constructing objects in particular ways" (Francis, 1999, p. 383) and as such a person or group can be positioned as powerless within one discourse whilst positioning themselves as powerful in another. In the section that follows I will briefly explore the prevailing biomedical, midwifery, migration, and deficiency discourses that impact on the representations of migrant women as passive, invisible, backward, pathological and emotional (Dossa, 2001; Jiwani, 2001).

Reproduction is a key site for the regulation of women through two discourses derived from the disciplines of medicine and midwifery (Marshall & Woollett, 2000). The former biomedical discourse has been constructed as rational and scientific with more status than nursing or midwifery, which are associated with emotional qualities such as caring (Aitchison, 2000). According to Smith (1992), biomedical discourses position women as having limited agency and emphasise pathology, despite pregnancy being a major life event that most women go through without long-term difficulties. Kitzinger (1992) argues that medicalised discourses have transformed pregnancy into an objective observable process through technology where the woman bearing the child takes second place while the foetus is monitored and its growth recorded and supervised. According to Kitzinger, the woman is ritually dispossessed of her body during pregnancy as doctors take charge, asserting that they know more about her body than she can herself and that her body is a barrier to easy access to the foetus. Kitzinger concludes that the mother can risk no longer feeling like she has made her own unique baby. "Woman-centred" discourses construct mothers as consumers, who take responsibility for themselves and their babies (Marshall & Woollett, 2000). A discussion with regard to the attitudes of midwives towards Asian women later in this chapter, however, reveals equally pathologising constructions of migrant women.

"Other" Mothers

Motherhood occurs in "specific historical contexts framed by intersecting structures of race, class, and gender" (Collins, 1998, p. 231), however Woollett and Nicholson (1998) argue that the dominant beliefs about parenthood come from white, middle class parents, researchers and policy makers rather than from poor families or ethnic minority communities. Women who do not fit within the dominant cultural subject positions are at risk of being pathologised as "other" mothers on the basis of class, colour, ethnicity, race, sexual preference, education, employment, or disability (Jolly, 1998).

DeBeauvoir (1949) originally applied the term "othering" to describe a process whereby people define who they are by contrasting self with others and historically this term was used regard to the relationships between men and women. Using the term more broadly, Aitchison (2000, p. 135) defines "othering" as being "characterised by dualisms, this process inevitably defines norms and deviants, centres and margins, cores and peripheries, the powerful and powerless". The process of othering can occur in many contexts and usually refers to exclusion of a minority group by a dominant group on the basis of difference (Johnston, 1998). The creation of an "other" necessitates the creation of a "same", the latter being accorded greater status and power (Aitchison, 2000). The "other" is seen as lowly and unsophisticated in contrast to the dominant group, whose members are seen as civilised and superior (Johnston, 1998). Ganguly (1995, p. 1) argues that minority women have been conceptualised as others in two ways. The first is the "exotic other" of esoteric foods, culture, clothing, beliefs and practices and the second is the "oppressed other", seen in the conception of a homogenous "third-world" woman. The binary categories implicit in the process of "othering" obscure the diversity that exists within groups; assuming homogeneity where it does not necessarily exist.

Racialisation is an othering process that is implicit in the deficiency discourse (Torres, Mirron, & Inda, 1999), which posits that colonised people are lacking in qualities valued by the colonising society (Horsfall, 2001) and forms one of the main

axes of subordination and domination (Bottomley, 1992). In this context, representations of minority women have reinforced prevailing stereotypes of migrant women as passive, backward and oppressed by their patriarchal cultures. The implications of these stereotypes for care delivery are discussed with more vigour later in this paper.

Migration as Masculine

A fourth site of discourse that surrounds migrant women constructs them as passive appendages to men in the migration process, ignoring the complexities of women's motives and their active role in the decision making process (Kofman, 1999; Leckie, 1989). Differences between male and female migrants have tended to involve simplistic comparisons rather than examining the complex interrelations involved (Hondagneu-Sotelo, 1999).

There has been a paucity of research undertaken on women's experiences of migration and, prior to the mid-1970s, women were invisible in studies of international migration (Kofman, 1999). Leckie (1995) suggests that the dearth of literature on women migrants in New Zealand is due to gender biases in historical and social research and a profusion of generalisations and misinformation. However, Abusharaf (2001) suggests that this neglect is due in part to the historical view of women travelling alone as being unimaginable and a threat to family and community. In Europe, Kofman (1999, p. 271) suggests, increasing attention is being paid to the experience of women migrants as a result of increasing interest in "women's position in society, the feminisation of the foreign population, the increasingly visible economic presence of immigrant women, and the production of knowledge by immigrant women about themselves."

In contrast with male migrants, whose main aim is to maximise economic gains, women have been seen as passive, migrating for emotional and personal reasons or as "dependents," moving in the roles of wife, mother, or daughter of male migrants and only worthy of consideration in their role in the private sphere (Zlotnik, 1995). This role often encompasses the maintenance of identity of migrant communities as "cultural custodians" (Hondagneu-Sotelo, 1999, p. 571) or fostering the integration of the family. Bottomley (1994) concurs, stating that early studies presumed that the roles of migrant women included continuing tradition and maintaining home life while remaining separate from the public sphere of work and politico-economic process.

The positioning of migrant women within prevailing discourses has resulted in their construction as deficient, backward, passive and without agency (Arisaka, 2000). This section highlights how responses from health professionals toward migrant women are commonly based on two interrelated discourses, namely the pathologising discourse of the medical model and the deficiency discourse that is embedded within an ideology of assimilation that views adaptation as a one way process. Immigrants are expected to reject their own ways in order to fit into the host culture, whilst the dominant group's ways remain unchanged. Implicit in these discourses is the requirement that those who enter the health setting must give up their power to be a "good patient" since both are based on hierarchies that originate from the mechanism of "science" and have the power to classify based on a modernist philosophical position of Western thought as universal (Arisaka, 2000; Nicholson, 1993).

Jayasuriya (cited in Fuller, 1997) observes that society is comprised of heterogeneous groups that have the right to access health care services that meet their

specific needs. However, it is more common for services to be constructed according to the needs of the dominant group based on an assumption of homogeneity with the occasional concession to cultural difference (Fuller, 1997).

Barclay and Kent (1998) note the hegemony of the health system, observing that the needs of NESB mothers have been ignored by society and health professionals and suggesting that the care given to such women can be ritualised, professionally dominated and inappropriate. Responses from western workers to traditional postpartum practices range from "at best insensitivity and at worst derisory" (Barclay & Kent, 1998, p. 6). Both Barclay and Kent (1998) and Fraktman (1998) contend that the focus on pathology and crisis within the health care system marginalises migrant mothers such that they are labelled in discriminatory ways that result in stereotyping and their differences are rendered into deficits. Fitzgerald et al. (1998) state, however, that the real debate is not whether distress exists but rather how it is expressed and categorised and, secondly, whether a particular explanatory model should be predominant and common human experiences and responses pathologised. According to Fitzgerald et al. (1998, p. 21), the key issue is: "How can we best understand and respond to culturally influenced and contextualised experiences in meaningful and useful ways?"

Stereotypes can provide a frame of reference for appropriate behaviour towards new people, however individuals can also be rendered invisible and stigmatised as a monolithic group by the imposition of a stereotype (Banister & Schreiber, 2001). This is because people "tend to be better informed about the dominant discourse(s) that pervade other cultures than the multiple positions that individuals in those cultures occupy; thus they tend to over-generalise or "stereotype" the behaviours they see or hear about" (Ryan, 2001, p. 198). Stereotypes are based on what is considered the norm or *modus operandi* of the dominant group (Fuller, 1997) and this norm is based on a hegemonic notion of "normal" behaviour against which behaviour is compared. In Western culture "normal" reproductive behaviour is socially constructed in much the same way as the enactment of the "sick role" which typically requires cooperation and a belittling of discomfort (Goffman, 1969 cited in Bowler, 1993). The sick role and what is considered normal reproductive behaviour were significant aspects of a study by Bowler (1993) of Asian women's experiences of health care by midwives in the United Kingdom. Bowler researched the types, effects, and impact of stereotyping by observing and interviewing midwives and reviewing the literature.

In this study, midwives used stereotypes to pitch their interactions and make assumptions about appropriate care and service delivery (as other health professionals do). Bowler's (1993) findings revealed that midwives saw Asian women as demanding, having a low pain threshold, lacking in a maternal instinct, being difficult to communicate with, and lacking in compliance with preventative care and family planning. They were also seen as abusing services by having large families and having unrealistic expectations. Midwives did not acknowledge the positive characteristics of Asian women such as their abstention from smoking and alcohol. Bowler recommended midwives have education that challenges racist attitudes and the hegemony of the Western medical system. Similarly, a study by Day (1992, p. 23) found that Asian women were frequently seen as "oppressed by their role as mothers, suffocated by domesticity and lacking independence." These views are not limited to the maternal area, Wheeler (1994) asserts that the psychiatric literature also holds stereotypical views of minority users as problematic and different rather than diverse and rich. Labelling people rather than assessing their individual needs can be

marginalising and discriminatory, particularly when labelling occurs within a deficit framework rather than on strengths and competencies as seen above.

Many health professionals would be shocked to be called racist, yet Bowler's (1993) study highlights the incongruencies prevalent in the behaviour of health professionals. In the study, midwives paradoxically held stereotypes of Asian women yet saw themselves as sympathetic toward them. The notion of institutionalised racism holds a possible explanation for this incongruence. This is where health workers see western health practises as superior and come to expect minority women to assimilate to these practices (Marshall, 1992). Ng's (1995, p. 133) concept of commonsense racism and sexism could also be useful for explaining the behaviour of the midwives, as it refers to "those unintentional and unconscious acts that result in the silencing, exclusion, subordination and exploitation of minority group members." Another explanation for the behaviour is the notion of hegemony, as in the inability to see other ways of doing things. Hegemony occurs when dominant groups are able to gain control of culture with the consent of the majority of the population so that it appears natural and commonsensical (Cupples, 2001). Hegemony is not a monolithic process, however, and can be modified or contested by competing groups including subordinated groups. As a hegemonic device, the "deficiency discourse" (Dossa, 2001, p. 40) individualises problems and ignores structural factors thus maintaining the dominance of whites in the racial hierarchy and minimising the impact of a racist society on migrant women. Ganguly (1995) on the other hand argues that framing barriers as structural, political and social, reinforces the stereotypes of migrant women as passive and traditional who lack skills or strengths.

The ethnocentric and stereotyping behaviour of health professionals has also been called into question by Foss (1996) with regard to the care given by public health nurses. Foss accuses the research to date of being "Eurocentric" and reductionist because of the focus on the mother. Foss argues that public health nurses base standards of what good parenting is (as defined by the dominant culture) on personal belief, interpretations and stereotypes based on professional experiences with other cultural groups. Foss recommends a new framework be developed to: assess "normal" behaviours and cultural variations in immigrant populations; investigate immigration related health problems; and that nurses avoid judging parenting by the standards of the country of residence.

Ethnocentrism is also evident in incidences of culture clash, where the beliefs and practices of women from "traditional societies" clash with the Western medical model. A study by Nahas, Amasheh, and Hillege of Middle Eastern women in Australia (1999) found that NESB women felt pressured by health professionals to change their beliefs and customs when what the women wanted to do was follow their traditional practices. One of many areas of culture clash is the notion of postpartum rest; in traditional societies, the family supports the woman to have a rest period in which to recuperate. In modern societies however, women are expected to be independent with mothercraft as soon as possible (Bowler, 1993). Bastien (1992) argues that in modern societies, postpartum rest is often seen as a sign of weakness and passivity whereas in other cultures it is sees as the expression of reverence for the transition and rite of passage that women have undergone. It is inevitable the ability to rest will be lost when a woman migrates to a modern society where it is not valued or there are no structures to support it and there is pressure to assimilate into that society.

So far, the discussion has focused on the responses of health providers that marginalise migrant women. The responses reflect the ideology of assimilation, where adaptation is viewed as a one-way process. Assimilation demands that immigrants

change to fit into the host culture by rejecting their own ways, with no corresponding demand for change on the part of the dominant group, therefore the dominant group's ways remain the same (Fuller, 1997). A further area where the notion of assimilation is embedded is in terms of service development. In the main, migrant women have little input into services that are supposedly meant for them. Wheeler (1994) observed that minority users of mental health services have little control over resources that are thought to be necessary for their health, by providers, who are in the main white and do not reflect the population for whom they are caring. Wheeler suggests that this creates an unequal and oppressive relationship.

To summarise, the challenges that face migrant women in the health system are related to the concepts of racism, assimilation, ethnocentrism and hegemony, which result in migrant women being stereotyped and pathologised, having their needs ignored and not having input into services.

Need for a New Research Agenda

Active intellectual work is needed to develop worldviews that differ from the prevailing worldviews of Western academia. For researchers of colour this means having to become epistemologically bi-cultural in order to survive (Scheurich & Young, 1997). The "outsider within" position (Collins, 1990) position is developed by members of minority groups who are required to have fluency with practices of the dominant group in order to survive in that society but also have knowledge of their own contexts. This makes them able to relate to two sets of practices and in two contexts, although there might equally be a sense of being an outsider or of lacking fluency in both contexts (Narayan, 1992).

The "outsider within" position provides a useful stance for accommodating the range and acknowledging the limits of the multiple identities of the researcher and how the interplay of these identities can be used to interpret the experiences of participants and the research dynamics (Collins, 1990). The "outsider within" position that Collins (1990) describes has the ability to be both inside and outside of what is being researched so as to understand both. This position provides a platform for critically examining the limits of dominant approaches when attempting to understand the experiences of marginalised groups. Such a tension can provide a means for new knowledge systems and insights to be created. Kaomea (2001) adds that the reconciling of this "outsider within" tension might occur through the development of hybrid methodologies that would in my case speak to both Western and traditional ways of knowing. In this vein Bailey (1998) proposes two advantages of knowledge that is generated from "outsider within" locations: Firstly, it creates a new focus on the experiences of marginalised groups that have been overlooked by other epistemological projects and secondly, it provides knowledge for those in the centre to develop new understandings about their relationships with marginalised people from their own perspective. For the marginalised group, the outsider within position provides a means for capturing the complexities of their lives and for naming or voicing concerns that are taken for granted or hidden by a community (Smith, 1998).

Being an ethnically diverse researcher with insider or emic status might not minimise or prevent the researcher colluding with the dominant group either, particularly if as Waitere-Ang (1998) cautions, the researcher is working within a Eurocentric paradigm, leading to a situation that Ladson-Billings (2000) terms "epistemic limbo." Narayan (1992, p. 266) reasons that, "there is rarely a dialectical synthesis that preserves all the advantages of both contexts and transcends all their

problems." Ladson-Billings (2000) concludes that the purpose of discussion of racialised discourses is to not just colour the academy, nor is it to dismiss the work of European or American scholars but to define the limits of prevailing standards of scholarship. This is a sentiment with which I agree and again consider that reflexivity can prove to be a useful strategy in advancing this agenda.

Moving Forward

There are particular historic and social influences that impact on the life and health of many migrant women that are difficult, even impossible and certainly inappropriate to describe from a Western epistemological standpoint. Researchers attempting to understand the complexity of social worlds could use a variety of analytic angles on data and become familiar with a range of interpretive approaches (Taylor, 1998). Ladson-Billings and others (2000, p. 260) propose "developing a different epistemological frame to describe the experiences and knowledge systems of people outside the dominant paradigms." This development of an alternative epistemological frame will be described in the following section.

Multiple Methods and Methodologies

Little has been written about the extent to which methodologies can be mixed in qualitative research, despite the common occurrence of this practice. Lowenberg (1993) proposes that the interest in multiple methods is due to the shift toward less structured research, related to the influence of feminist and post-modern approaches. In contrast, Lowenberg argues that nursing research has moved towards being more structured and technical. She states that three trends are concomitant with the former shift to less structure. These are the increasing acknowledgment of multiple realities and the ambiguity and complexity of every day life that have led to the blurring of methods and methodologies. Second, is the importance of locating the researcher in the research and, third, the demand for reflexivity. Each of these trends will be described in the following section.

There is a close relationship between the various qualitative methods. Some authors contend that it is inevitable that pluralism occurs for "philosophical and pragmatic" reasons (Johnson, Long, & White, 2001, p. 243). Triangulation can be defined as the use of two or more theories, methods, data sources, analyses or investigators (Shih, 1998). The two main purposes of triangulation are the production of findings that are convergent or complementary. Convergence refers to confirmability and is more commonly used in regard to qualitative research that has been used as an adjunct to quantitative research while complementarity refers to completeness, which enhances the understanding of a phenomenon. Completeness is the most common goal of triangulation and was used as such here. Fine, Weiss, Weseen, and Wong (2000, p. 119) argue that deliberately using "different methodologies will illuminate different understandings" and add depth. This notion of illumination and reflection is supported by Wadsworth (2000) who contends that research must reflect the complexity and unknowability of the world or otherwise risk being incomplete. In relation to nursing, Maggs-Rapport (2000) says that using multiple methods that lead to completeness is vital if nursing is to consider itself a holistic discipline. However, Allen (2000) refers to another form of triangulation where intellectual ideas are interrogated with personal experience so that both emotional and rational facets can be reconnected as tools for generating rigorous data.

This also termed reflexivity. This form of triangulation significantly alters the meaning of "analytic rigour", moving it beyond the meanings given to the term within either methodological triangulation or analysis triangulation. This strategy is equally applicable to research that uses multiple or single methodologies.

Two significant research strategies have been incorporated into this chapter in order to achieve complementarity or completeness and prevent the reproduction of pathologising and deficiency discourses. The first is a self-reflexive process, which I have used to articulate the tensions and contradictions that I have dealt with in my epistemologically bicultural position. Writing myself reflexively into the text achieves several functions, the first is to add explanatory richness to the data in my research position as an "outsider-within" and secondly, positions me in the research and allows me to reflect on how I might be implicated in the maintenance of discourses that could be marginalizing to the participants. The second research strategy that has been used in this chapter is that of within methods triangulation, or methodological pluralism, using precepts of grounded theory and postcolonial feminism. Postcolonial feminist perspectives are derived from post-structuralist and feminist theories, which seek to dismantle hegemonic discourses through the displacement of dominant discourses by marginal epistemologies that engage and challenge them (Brooks, 1997). A limitation of feminism is that it does not represent the interests of all women and a limitation of postcolonial writing is that it tends to represent gender-based worldviews. Therefore a combination of both was required to complement grounded theory. It was hoped that triangulating the three methodologies would help me to meet the research aims and examine the intertwined social processes of colonialism, sexism and marginalisation. Moreover, tenets of postcolonial knowledge production have been used that incorporate the notion of decolonisation by resisting imperial cultural analysis and developing other forms of analysis that combine multiple practices (Jaber, 1998). Thus, this research has used triangulation, comprised of my reflections, the participants' voices and a commentary on the social, cultural, political and economic contexts that surround the lives of the participants, in order to build a multi-dimensional picture. These tools are used to explore the discursive constructions of migrant women and to engage with discourses that stereotype and homogenise their experiences so that they are not reproduced. However, there are levels of reflexivity and purely reflecting on one's experience doesn't necessarily result in creating change. More than a dear diary outline of events, reflexivity requires one to stand outside one's own experiences and interrogate one's role, values, beliefs, and assumptions underpinning one's participation in the research.

Reflexivity and Positionality

It is important to analyse not just the content of the knowledge that is produced through research, but also the process in which research is conceived, produced and justified as knowledge. This is because research is "an active process, engaged in by embodied subjects, with emotions and theoretical and political commitments" (Gill, 1998, p. 24), that have an impact on the process. The narratives used by participants reflect both their social location and the cultural resources that they have access to, and will also have an impact on the process (Jackson, 1998). As a researcher, the choice of methodology and the research design are influenced by one's own identity and "we inevitably bring our biographies and our subjectivities to every stage of the research process, and this influences the questions we ask and in the ways in which we try and find answers" (Cameron, Frazer, Harvey, Rampton, &

Richardson, 1992, p. 5). Researchers also have a pivotal role in shaping the research encounter through the theoretical, ontological, personal and cultural frameworks that they hold (Luttrell, 2000). The question is how can they faithfully represent the voices of the researched? Lamb (1989) suggests that a process of critical thinking using reflexivity can be utilised to consider the reciprocal influence of the researcher and their participants.

England (1994) states that research is incomplete until it has included an analysis of the researchers role in creating the research. Locating the researcher as a participant in the dynamic interrelationship of the research process can assist the reflexive researcher to develop an awareness of how their presence affects not just the outcomes of the research but the process as well. Nurse researchers like Koch (1998) suggest that incorporating a reflexive account of the process can enhance rigour, validity and the ethics of research. Reflexive researchers need to reflect on their multiple positionings and identification with groups, the political implications of their work, and the context of unequal power relations, so that they can produce research that is both plausible and reflects better the voices of those being researched (Easterby-Smith & Malina, 1999). Yet, as England (1994) contends, the research relationship is intrinsically hierarchical and being aware of power inequities and being reflexive is not sufficient of themselves to resolve this. However, in the case of this research, the notion of reflexivity has been deployed out of the recognition that a balance between research that is both plausible and reflective of those being researched is not to be found anywhere.

To emphasise how social position, personal histories and lived experiences matter in the constitution and application of scientific knowledge, Allen (1999) gives two examples: the first, of a nurse in China and a nurse in the United States identifying different features of Thai culture or childbirth service planners; and the second, substance abuse service planners picking out different features of Inuit culture. The different discourses would construct different "Thai" and "Inuit cultures". Allen (1999, p. 228) argues that diversity of standpoint is not the problem, the problem is not being explicit about the standpoint, in particular when the writer is "from a cultural position that has exploited or colonized the culture being written about." There is a need for honesty about the particular distortions that will impact on the research as a result of the researcher's particular socio-cultural positioning. Moreover, the need to be constantly reflexive about processes, data collection, analysis and relationships is more imperative for those positioned as insiders, with additional responsibilities to their communities (Kiro, 2000; Smith, 1999).

According to Hamberg and Johansson (1999), as individuals we have multiple identities that can be used, not used, highlighted and minimised depending on the situation and these have consequences for the type of data that will be collected. The authors recommend using the word position rather than roles because of the constitutive nature of discourse. For example in the research that I conducted, I positioned myself and was positioned by the participants as Goan[1], woman, researcher, and nurse. All the positions reflected different discourses, which then meant different reactions for different positions triggered during the interview. In the Goan migrant woman position I hoped that being an insider would mean that women would talk more easily to me because I had had similar experiences. I could then recognise and affirm the issues. In the researcher position, I had to ultimately interpret what the participants said. There is also the tension of knowing that I am going to be engaging

[1] Goa is a former-Portuguese colony on the south-west coast of India.

people without a voice in research and then reporting the findings from my privileged position of conference attendee and academic writer.

Personal Experience of Incorporating the Proposed Strategies

Reflexivity can be used in varying contexts and with different aims, to enhance the credibility and rigour of the research process as well as make transparent the positionality of the research. Francis (2000) recommends reflexivity as a tool for exploring one's own position in discourses as well as appraising how one contributes to their maintenance. Self-conscious writing has therefore been employed in my research as a way of breaking or disrupting hegemonic practices (Asher, 2001). I kept a journal of my feelings and perceptions following each interview. It was important for me as a researcher to be aware of my own values and issues and a type of self-assessment and supervision process seemed to be a way of clarifying my part in the process. What I was able to uncover were some of my assumptions in my socialisation as a mental health nurse/therapist. In this position I had an implicit expectation of participants using the research process, as a cathartic and emotional experience, which was challenged. This expectation meant that I perceived participants as dependent on a more powerful other (the researcher) to put in a process that "allowed" them to "reflect properly" on their experiences as in this example from my own field notes:

> [Name] needed more prompting than I expected and also kept things lighter than I had anticipated. I guess because in the past I have seen women who were much more emotional and open in my role at maternal mental health. She made some of her own connections so hopefully she got something out of it as well. Prior to turning the tape off she became more open and humorous.

I e-mailed a researcher in another city for feedback about this comment and my foray into reflexivity. She challenged me, saying that I had an assumption that experiences around motherhood require a cathartic process and that this is the best response to "issues". She also challenged me for colluding with the notion that women are fundamentally emotional in nature. This example implicated me in my own position in and perpetuator of the subjugating and pathologising discourse of the medical model within psychiatry, which is considered by many as a traditional, socially unjust epistemology and paradigm. Friere suggests that dialogue is central to the reflective process (Freire, 1972). I had always viewed myself as someone well versed in the literature around the subjugating and pathologising nature of the medical model from both cultural and feminist viewpoints. However, until I was challenged by my "critical friend" I had failed to recognise that I was equally embedded in the same system. The question for me is whether I would have recognised the dissonance between my so-called feminist ideals and my psychiatric world view by undertaking a solo journaling journey or whether dialogue with someone trustworthy yet critical was required. I suspect the latter had a far more powerful and immediate effect.

In common with the health services and providers that participants looked to for services, the academy can also reflect a structural hierarchy based on race, class, and gender. The traditional power, authority, and positioning of these institutions is maintained by implicit ideological beliefs grounded in western superiority that can define what is "normal" and exclude "others" through the creation of boundaries. A

strategy for challenging these systems of domination and subordination is through developing alternative frameworks and ways of knowing that are inclusionary and interdisciplinary. Research using such strategies can provide a more complete understanding of a minority group that is cognisant of multiple identities.

Participants in the research exemplar came to New Zealand to improve their lives and accepted the global western discourse that saw New Zealand as a place of democracy, prosperity, equality and freedom, and the places they had left behind as backward, traditional, and in need of Westernisation. Goan women expected acceptance, equality, and integration but found themselves "othered", despite giving up elements of their culture to fit in. They found that their lives in New Zealand were marked by constant negotiation and adjustment. The findings show how Goan women took an active part in contributing to the socio-cultural life of New Zealand and subverted and resisted the deficiency discourse.

The significance of health professionals that emerged in the research exemplar demonstrates how a variety of strategies can be used to enhance the delivery of health care to migrant groups. Beneficial strategies included respect for different beliefs, an awareness of participant's preconceptions about the perinatal process and the recognition of the importance of extended family. Whilst it was not the focus of this exemplar to identify how health professionals might advocate for their clients, strategies that were directed toward the participants rather than the system and structural change were seen by the participants as supportive and helpful, repositioning them as empowered. Cultural safety, which encapsulates a range of strategies from sensitivity, safety, and decolonisation, offers a useful starting point for health care delivery for migrants in New Zealand. Although this concept has been devised to provide a vehicle for minority groups and Maori to influence nursing care, it has been utilised primarily in the care of the latter and further research about the applicability of cultural safety within migrants' communities is advocated.

A challenge remains about how to report findings of such research, this was made easier through the reflective nature of this paper where publishing excerpts of my journal and bringing me into the text was a parallel process of the research and considered acceptable. Attempting to produce a "regular" research account would have resulted in having to use conventional journal writing structures that privilege the product and method rather than the process.

Conclusion

All scholars occupy a particular social location and theories derived from that location might not be inclusive of voices from the margins, where culture or ethnicity are defining dimensions of the experience of being in the world. Culture is not an objective phenomenon awaiting discovery but is socially constructed. Moreover, cultures are discursive objects, existing in and through the expressions given to both the values and material aspects of social life. The deficiency discourse, as one such item in contemporary western medical culture (as represented in this research) can construct migrant women in ways that pathologise, generalise, homogenise, marginalise, and deem inferior according to a hierarchy.

The research position of "outsider-within" is not of itself a guarantee that stereotyping or other exclusionary processes will not occur, particularly if the researcher is working within a Eurocentric paradigm. Hence it is necessary to avoid the reinforcement of prevailing and widely accepted patterns of domination and colonial practices that can be embedded in institutions. To do this I have articulated

my standpoints, positionings, and identities through a self-reflexive process that locates me as a researcher in the discourse. This process of reflexivity has required the triangulation of intellectual ideas with personal experience and with research findings so that the emotional and rational aspects are reconnected as tools to enable a rigorously reflexive interpretation of data. This has been written into the text in order to add methodological rigour and contextual richness. The deployment of several types of triangulation such as *within methods triangulation* and *analysis triangulation*, drawing upon feminist and post-colonial perspectives has been used in my research. The purpose of the triangulation has been to critique the dominant discourse of deficiency that surrounds migrants and is a remnant of colonial practices that continue to have an impact on the "othering" of visibly different migrants. Participants' responses have also been deliberately situated into larger historical and societal contexts so as to avoid creating or perpetuating stereotypes.

The overall aim has been to improve the quality of understanding about the construction of knowledge in trans-cultural situations. The micro level of emotional experience and social location and the macro level of social, economic and political structures have provided a form of triangulation that enriches the data collected, as has the use of methodological pluralism. Both strategies create new discursive spaces for representing difference and de-centring hegemonic discourses. However, these strategies have limitations; privileging ones own reflexivity can be flawed if there is no critique. My experience suggests that the critical support of another reader who is willing to challenge can add depth and grounding to reflexivity. Reflexivity demands critical self-awareness and a willingness to be transparent and challenge one's own epistemological and ontological assumptions and these are often firmly held. The way forward is challenging, however, it is hoped that this paper contributes to the debate on culture and identity within the academy and the health care system in New Zealand. It is my hope that this paper advances the discussion on what it means to construct knowledge of social practices within a multiethnic environment in order that that the voices of minorities can be heard.

References

Abusharaf, R. M. (2001). Migration with a feminine face: Breaking the cultural mould. *Arab Studies Quarterly, 23*(2), 61-86.

Affonso, D. D., & Domino, G. (1984). Post partum depression: A review. *Birth: Issues in Perinatal Care & Education, 11*, 231-235.

Aitchison, C. (2000). Poststructuralist feminist theories of representing others: A response to the 'crisis' in leisure studies' discourse. *Leisure Studies, 19*(3), 127-144.

Allen, D. G. (1999). Knowledge, politics, culture and gender: A discourse perspective. *Canadian Journal of Nursing Research, 30*(4), 227-234.

Allen, K. R. (2000). A conscious and inclusive family studies. *Journal of Marriage and the Family, 62*, 4-17.

Arisaka, Y. (2000). Asian women: Invisibility, locations, and claims to philosophy. In N. Zack (Ed.), *Women of color and philosophy: A critical reader* (pp. 219-223). Malden, MA: Blackwell Publishers.

Arizmendi, T. G., & Affonso, D. D. (1984). Research on psychosocial factors and postpartum depression. *Birth: Issues in Perinatal Care & Education, 11*, 237-245.

Asher, N. (2001). Beyond "cool" and "hip": Engaging the question of research and writing as academic self-woman of color other. *Qualitative Studies in Education, 14*(1), 1-12.

Bailey, A. (1998). Locating traitorous identities: Toward a view of privilege-cognizant white character. *Hypatia,13*(2), 37-42.

Banister, E., & Schreiber, R. (2001). Young women's health concerns: Revealing paradox. *Health Care for Women International, 22*, 633-647.

Barclay, L., & Kent, D. (1998). Recent immigration and the misery of motherhood: A discussion of pertinent issues. *Midwifery, 14*, 4-9.

Bastien, A. P. (1992). Postpartum rituals: Honoring the mother. *Midwifery Today, 22*, 32-33.

Beck, C. T. (1992). The lived experience of PPD, a phenomenological study. *Nursing Research, 41*(166-170).

Beck, C. T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing research, 42*(1), 42-48.

Bottomley, G. (1992). *From another place: Migration and the politics of culture*. Cambridge: Cambridge University Press.

Bottomley, G. (1994). Living across difference: Connecting gender, ethnicity, class, and ageing in Australia. In N. Grieve & A. Burns (Eds.), *Australian women, contemporary feminist thought* (p.59-69). Sydney, Australia: Allen and Unwin.

Bowler, I. (1993). 'They're not the same as us': Midwives' stereotypes of South Asian descent maternity patients. *Sociology of Health & Illness, 15*(2), 156-178.

Brockington, I. F., & Kumar, R. (1982). *Motherhood and mental illness*. London: Academic.

Brooks, A. (1997). *Postfeminisms: Feminisms, cultural theory and cultural forms*. London: Routledge.

Cameron, D., Frazer, E., Harvey, P., Rampton, M. B. H., & Richardson, K. (1992). Introduction. In T. Crowley, T. J. Taylor, & M. Williamsburg (Eds.), *Researching language; Issues of power and method* (pp. 1-29). London: Routledge.

Collins, P. H. (1990). *Black feminist thought*. Boston: Unwin Hyman.

Collins, P. H. (1998). Shifting the centre: Race, class and feminist theorising about motherhood. In L. J. Peach (Ed.), *Women in culture: A womens studies anthology* (pp. 231-244). Boston: Blackwell.

Cupples, J. (2001). Disruptive voices and boundaries of respectability in Christchurch, New Zealand. *Gender Place & Culture: A Journal of Feminist Geography, 8*(2), 189-205.

Cutrona, C. E. (1982). Non-psychotic postpartum depression: A review of recent research. *Clinical Psychology Review, 2*, 487-503.

Day, L. (1992). Women's oppression: Race, class and gender. In M. Langan & L. Day (Eds.), *Women, oppression and social work; Issues in anti-discriminatory practice* (pp. 12-32). London: Routledge.

DeBeauvoir, S. (1949). *The second sex*. Harmondsworth, England: Penguin.

Dossa, P. (2001, August). *Narrative mediation of conventional and new paradigms of "mental health": Reading the stories of immigrant Iranian women* (Document No. 01-16). Vancouver: Research on immigration and integration in the metropolis.

Easterby-Smith, M., & Malina, D. (1999). Cross-cultural collaborative research: Toward reflexivity. *Academy of Management Journal, 42*(1), 76-92.

England, K. V. L. (1994). Getting personal: Reflexivity, positionality and feminist research. *Professional Geographer, 46*(1), 80-89.

Fine, M., Weiss, L., Weseen, S., & Wong, L. (2000). For whom? Qualitative research, representations, and social responsibilities. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 107-133). Thousand Oaks, CA: Sage.

Fitzgerald, M., Ing, V., Heang Ya, T., Heang Hay, S., Yang, T., Duong, H., Barnett, B., Matthey, S., Silove, D., Mitchell, P., & McNamara, J. (1998). *Hear our voices: trauma, birthing and mental health among Cambodian women.* Paramatta: Ausmed.

Foss, G. F. (1996). A conceptual model for studying parenting behaviours in immigrant populations. *Advances in Nursing Science, 19*(2), 74-87.

Fraktman, M. G. (1998). Immigrant mothers, what makes them high risk? In C. G. Coll, J. L. Surrey, & K. Weingarten (Eds.), *Mothering against the odds, diverse voices of contemporary mothers* (pp. 85-108). New York: Guildford press.

Francis, B. (1999). Modernist reductionism or post-structuralist relativism: Can we move on? An evaluation of the arguments in relation to feminist educational research. *Gender and Education, 11*(4), 381-393.

Francis, B. (2000). Poststructuralism and nursing: Uncomfortable bedfellows? *Nursing Inquiry, 7*, 20-28.

Freire, P. (1972). *Pedagogy of the oppressed*. Harmondsworth: Penguin.

Fuller, J. (1997). Multicultural health care: Reconciling universalism and particularism. *Nursing Inquiry, 4*, 153-159.

Ganguly, I. (1995). Exploring the differences: Feminist theory in a multicultural society. *Hecate, 21*(1), 37-52.

Gill, R. (1998). Dialogues and differences: Writing, reflexivity and the crisis of representation. In K. Henwood, C. Griffin, & A. Phoenix (Eds.), *Standpoints and differences: Essays in the practice of feminist psychology* (pp. 18-45). London: Sage.

Gracias, F. (2000). Goans away from Goa: Migration to the middle east. *Lusotopie 2000*, 423-432.

Gruen, D. S. (1988). *The new parent: A spectrum of postpartum adjustment*. Minneapolis, MN: International Childbirth Education Association.

Hall, S. (1996). New ethnicities. In D. Morley & K.-H. Chen (Eds.), *Critical dialogues in cultural studies*. London: Routledge.

Hamberg, K., & Johansson, E. E. (1999). Practitioner, researcher, gender conflict in qualitative study. *Qualitative Health Research, 9*(4), 455-467.

Hapgood, C. C., Elkind, G. S., & Wright, J. J. (1988). Maternity blues phenomena and relationship to later postpartum depression. *Australian and New Zealand Journal of Psychiatry, 22*, 299-306.

Hondagneu-Sotelo, P. (1999). Introduction: Gender and contemporary U.S. immigration. *American Behavioural Scientist, 42*(4), 565-576.

Horsfall, J. (2001). 'Difference' and nursing research. *Contemporary Nurse, 6*(1), 40-46.

Jaber, N. (1998). Postcoloniality, identity and the politics of location. In R. D. Plessis & L. Alice (Eds.), *Feminist thought in Aotearoa, New Zealand* (pp. 37-43). Auckland, New Zealand: Oxford Press.

Jackson, S. (1998). Telling stories: Memory, narrative and experience in feminist research and theory. In K. Henwood, C. Griffin, & A. Phoenix (Eds.),

Standpoints and differences: Essays in the practice of feminist psychology (pp. 45-65). London: Sage.

Jiwani, Y. (2001). *Intersecting inequalities: Immigrant women of colour, violence and health care*. Vancouver, British Columbia, Canada: Simon Fraser University.

Johnson, M., Long, T., & White, A. (2001). Arguments for British pluralism in qualitative health research. *Journal of Advanced Nursing, 33*(2), 243-249.

Johnston, P. (1998). Maori women and the politics of theorising difference. In R. D. Plessis & L. Alice (Eds.), *Feminist thought in Aotearoa, New Zealand* (pp. 29-37). Auckland, New Zealand: Oxford Press.

Jolly, M. (1998). Other mothers: Maternal 'insouciance' and the depopulation debate in Fiji and Vanuatu, 1890-1930. In K. Ram & M. Jolly (Eds.), *Maternities and modernities; Colonial and postcolonial experiences in Asia and the Pacific* (pp. 177-213). Cambridge, United Kingdom: Cambridge University Press.

Kaomea, J. (2001). Dilemmas of an indigenous academic: A native Hawaiian story. *Contemporary Issues in Early Childhood, 2*(1), 67-82.

Khalaf, I., & Callister, L. C. (1997). Cultural meanings of childbirth; Muslim women living in Jordan. *Journal of Holistic Nursing, 15*(4), 373-388.

Kiro, C. (2000, Summer). Maori research and the social services/Te puawaitanga o te tohu. *Social Work Review*, 26-32.

Kitzinger, S. (1992). *Ourselves as mothers.* Auckland, New Zealand: Transworld.

Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing, 28*(4), 882-890.

Kofman, E. (1999). Female 'birds of passage' a decade later: Gender and immigration in the European union. *The International Migration Review, 33*(2), 269-299.

Kumar, R. R., K. M. (1984). A prospective study of emotional disorders in childbearing women. *British Journal of Psychiatry, 144*, 35-47.

Ladson-Billings, G. (2000). Racialized discourses and ethnic epistemologies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 257-279). Thousand Oaks, CA: Sage.

Lamb, G. S., & Huttlinger, K. (1989). Reflexivity in nursing research. *Western Journal of Nursing Research, 11*(6), 765-772.

Leckie, J. (1989). From race aliens to an ethnic group-Indians in New Zealand. In M. C. Howard (Ed.), *Ethnicity and nation building in the Pacific* (pp. 169-198). Tokyo: The United Nations University.

Leckie, J. (1995). Silent immigrants? Gender, immigration and ethnicity in New Zealand. In S. W. Greif (Ed.), *Immigration and national identity in New Zealand* (pp. 50-76). Palmerston North, New Zealand: Dunmore Press.

Lowenberg, J. S. (1993). Interpretive research methodology: Broadening the dialogue. *Advances in Nursing Science, 16*(2), 57-69.

Luttrell, W. (2000). "Good enough": Methods for ethnographic research. *Harvard Educational Review, 70*(4), 499-523.

Maggs-Rapport, F. (2000). Combining methodological approaches in research: Ethnography and interpretive phenomenology. *Journal of Advanced Nursing, 31*, 219-225.

Marshall, H. (1992). Talking about good maternity care in a multi-cultural context. In P. Nicholson & J. Ussher (Eds.), *The psychology of women's health and healthcare* (pp. 200-224). Basingstoke, United Kingdom: Macmillan.

Marshall, H., & Woollett, A. (2000). Fit to reproduce? The regulative role of pregnancy texts. *Feminism and Psychology, 10*(3), 351-367.

Mascarenhas-Keyes, S. (1979). *Goans in London: Portrait of a Catholic Asian community*. New Mills, UK: Evans of the Kinder Press.

McGill, H., Burrows, V. L. B., Holland, L. A., Langer, H. J., & Sweet, M. (1995). Postnatal depression: A Christchurch study. *The New Zealand Medical Journal, 108*(999), 162-165.

McIntosh, J. (1993). Postpartum depression: A women's help seeking behaviour and perceptions of cause. *Journal of Advanced Nursing, 18*, 178-184.

Nahas, V. L., & Amasheh, N. (1999). Culture care meanings and experiences of Postpartum depression among Jordanian Australian women: A transcultural study. *Journal of Transcultural Nursing, 10*(1), 37-45.

Narayan, U. (1992). The project of feminist epistemology: Perspectives from a non-western feminist. In A. M. Jaggar & S. R. Bordo (Eds.), *Gender/body/knowledge: Feminist reconstructions of being and knowing* (pp. 256-269). New Brunswick, NJ: Rutgers University Press.

Newman, R. (1999). The struggle for a Goan identity. In N. Dantas (Ed.), *The transforming of Goa* (pp. 17-43). Goa, India: The Other India Press.

Ng, R. (1995). Teaching against the grain. In R. Ng, P.Staton, & J. Scane (Eds.), *Anti-racism, feminism, and critical approaches to education* (pp. 129-153). Westport, CT: Bergin & Garvey.

Nicholson, P. (1993). Motherhood and women's lives. In D. Richardson & V. Robinson (Eds.), *Introducing women's studies* (pp. 201-223). London: McMillan.

O'Hara, M. W., & Zekoski, E. M. (1982). Postpartum depression: A comprehensive review. In I. F. Brockington, & R. Kumar (Eds.), *Motherhood and mental illness* (pp. 17-63). London: Wright.

O'Hara, M. W., Neunaber, D.J., & Zekoski, E. M. (1984). A prospective study of postpartum depression. *Journal of Abnormal Psychology, 93*, 158-171.

Pitt, B. (1968). Atypical depression following childbirth. *British Journal of Psychiatry, 114*, 1325-1335.

Ramsden, I. (1997). Cultural Safety: Implementing the concept: The social force of nursing and midwifery. In P. T. Whaiti, M. McCarthy & A. Durie (Eds.), *Mai i rangiatea* (pp. 113-125). Auckland, New Zealand: Auckland University Press and Bridget Williams.

Rao, R. (1995). Language and spirit. In B. Ashcroft, G. Griffiths & H. Tiffin (Eds.), *The post-colonial studies reader* (pp. 296-297). London: Routledge.

Routledge, P. (2000). Consuming Goa: Tourist site as dispensable space. *Economic and Political Weekly*, 2647-2656.

Ryan, C. (2001). Considering our otherness: A discursive practices approach to cultural identity in the professional writing classroom. *Issues in Writing, 11*(2), 191-217.

Sawyer, L. (1999). Engaged mothering: The transition to motherhood for a group of African American women. *Journal of Transcultural Nursing, 10*(1), 14-21.

Scheurich, J. J., & Young, M. D. (1997). Coloring epistemologies: Are our research epistemologies racially biased? *Educational Researcher, 26*, 4-16.

Smith, J. (1992). Pregnancy and the transition to motherhood. In P. Nicholson & J. Ussher (Eds.), *The psychology of women's health and healthcare* (pp. 175-200). Houndmills: Macmillan.

Smith, L. (1999). *Decolonizing methodologies research and indigenous peoples*. Dunedin, New Zealand: University of Otago Press.

Smith, L. T. (1998, July 1998). *Towards the new millennium: international issues and projects in indigenous research.* Paper presented at the Te Oru Rangahau, Maori research and development, Massey University, Auckland, New Zealand.

Stern, G., & Kruckman, L. (1983). Multi-disciplinary perspective's on post-partum depression: An anthropological critique. *Social Science Medicine* (17), 1027-1041.

Stewart, S., & Jambunathan, J. (1996). Among women and postpartum depression. *Health Care for Women International, 17*, 319-330.

Taylor, J. Y. (1998). Womanism: A methodologic framework for African American women. *Advances in Nursing Science, 21*(1), 53-64.

Torres, R. D., Mirron, L. F., & Inda, J. X. (Eds.). (1999). *Race, identity and citizenship: A reader*. Boston: Blackwell.

Wadsworth, G. (2000). Hearing midlife voices: Assessing different methods for researching women's experiences of menopause and midlife. *Women's Studies International Forum, 23*(5), 645-654.

Waitere-Ang, H. (1998, July 1998). *Methodological vertigo: The researcher as socio-historically constructed phenomenon.* Paper presented at the Te Oru Rangahau, Maori research and development, Massey University, Auckland, New Zealand.

Wheeler, E. (1994). Doing black mental health research. In H. Afshar & M. Maynard (Eds.), *The dynamics of race and gender, some feminist interventions* (pp. 41-63). London: Taylor and Francis.

Whiffen, V. E. (1992). Is post partum depression a distinct diagnosis? *Clinical Psychology Review, 12*, 485-508.

Woollett, A., & Nicholson, P. (1998). The social construction of motherhood and fatherhood. In C. A. Niven & A. Walker (Eds.), *Current issues in infancy and parenthood* (Vol. 3, pp. 1-15). Oxford: Butterworth-Heinemann.

Zlotnik, H. (1995). The south-to-north migration of women. *The International Migration Review, 29*(1), 229-240.

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