

**An investigation into how first generation Nigerian mothers  
living in the UK experience postnatal depression: *An  
interpretative phenomenological analysis***

A thesis submitted in partial fulfilment of the requirements for the Professional  
Doctorate in Counselling Psychology of London Metropolitan University

By

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**Declaration**

I hereby declare that the work submitted in this thesis is the result of my own investigations, except where otherwise stated.

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## Abstract

**Background/Objectives:** According to census statistics of the United Kingdom (UK), people who identify as black Africans are now the largest black community group in Britain as opposed to those who identify as African Caribbean (ONS, 2015) and 2.3% of UK immigrants are Nigerian-born (Migration Observatory, 2017). Previous research reported that BME mothers in the UK do not access clinical and psychological services. Whilst there are a few studies exploring BME mothers' experiences of Postnatal Depression (PND), there has been no research to date that has exclusively investigated the 'lived' experiences of the First Generation Nigerian Mothers (FGNMs) in relation to PND. This study is the first to investigate FGNMs' postnatal depression experience in the UK. The study aimed to explore how FGNMs living in the UK experience PND, their experiences of available resources/treatment and the way they manage and cope with postnatal depression.

**Design/Method:** A verbatim account of semi-structured interview data was analysed using Interpretative Phenomenological Analysis (IPA). The participants included six FGNMs aged between 30 and 45 who reported being formally diagnosed with PND by their GPs.

**Findings:** Three main themes were generated in the process of the analysis: Sociocultural Factors (this talks about cultural expectations, perceptions of PND and adjusting to a different culture), Neglected Nurturer (this discusses the experiences of treatment) and Loneliness and Coping (this refers to lack of support and explores how PND was managed).

**Conclusions:** The study suggests that the FGNMs encountered difficulties with their diagnosis, treatment and access to service for PND. All mothers felt a sense of cultural pressure and expectation to present as strong and resilient which impacted on early help-seeking. The mothers narrated concerns and negative experiences about how they were treated by healthcare professionals when they sought help and how their psychological needs were neglected, which contradicts previous research suggesting that BME groups do not seek support and are hard to engage. These findings could promote understanding and inform professionals about how to better support these mothers.

**Implication for clinical practice:** The findings of the study suggest the need for healthcare professionals to provide equal and unbiased services and follow guidelines for care and referral in order to effectively treat the FGNMs. There is also need for a culturally-specific and psychosocial intervention rather than a predominantly medical model for supporting the mothers.

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**I dedicate this research to the loving memory of my late mother Mrs Regina Elenjamu Enatoh who would have been so proud to see me qualify as a counselling psychologist**



## **Reflexive Statement Part 1**

I am a Nigeria-born mother and I did not know anything about PND until I came to the UK. Although I had antenatal classes during my two pregnancies in Nigeria, PND was never mentioned or discussed as part of the topics. My initial interest in researching the topic of PND started after encountering a Nigerian lady who suffered with postpartum (post-puerperal) psychosis here in the UK. This inspired me to undertake a topic for an intervention proposal assignment during my undergraduate studies that looked into how to educate pregnant and child bearing British-African women on preventing PND. In my research, I realised that I could not find any specific literature relating to Nigerian mothers' experience of PND albeit there were very few on African and Asian mothers, hence 'British-African women'. Quite surprisingly, many years later there was still very limited research on the topic of PND and none about the specific experience of Nigerian mothers in the UK, informing the choice of topic and sample for this research.

In addition, on reflection after my intervention project and the knowledge I derived about PND, I believed that I may have experienced or suffered with PND in ignorance as the changes and feelings new mothers experience are regarded as normal after giving birth in my Nigerian culture. I have decided to undertake this topic in order to understand how FGNMs living in the UK experience and manage PND including their experiences of available treatment and to uncover any support needs.

As a trained counsellor, I have had the opportunity to observe the benefits of psychological treatment/interventions but in my five years of practice as a volunteer counsellor in a mental health counselling service, I did not work with any African or Nigerian women and this prompted my concern and curiosity about how African mothers particularly Nigerians, manage their mental health issues in general and specifically PND. I believe that researching the experience of PND in this population would be beneficial to counselling psychologists and other health and social care professionals in understanding the views of this group of mothers and their possible support needs which may help in informing evidence-based practice work with them.

I grew up in Nigeria with strong cultural beliefs and values about motherhood. In Nigeria, a period of childbirth is generally a time of celebration, entertainment, joy and respite for new mothers. When I had my two children, my mother came to live with me for a period of six months each time after giving birth. I had support and help from friends, relatives, neighbours and church members. Nigeria is a communal society in which help is available from everyone around and this can help new mothers to cope but may represent a barrier to recognising PND.

Nigeria is a multicultural, multi-ethnic and multi-religious nation. Nigerian families, particularly the Christian families like mine, believe in prayers. We pray against difficulties and challenges (psychological or physical) instead of seeking formal help/support. Diagnoses are commonly avoided, believing that symptoms will naturally go away or that the body will heal itself. Certain health conditions are

believed to be demonic and therefore prayer was the only option. In my experience sometimes this works, other times it makes people more vulnerable and can lead to death.

As a first generation Nigerian woman, counsellor and now a trainee psychologist who is passionate about people getting psychological support/help, I am aware that I hold a particular viewpoint which I would endeavour to acknowledge and make transparent during my research process. In order to manage my impact on the research process I would implement a number of reflexive practices. I would keep a reflective journal throughout the process to enable me to explore my assumptions and bracket them in order not to impinge on the study. For example, being aware not to hold the belief that Nigerian women do not seek psychological help because they did not access the service where I worked for five years. In addition, I would be aware not to assume that Nigerian women will cope with prayer or that they may deny the reality of mental health issues (Kasket, 2013; Smith, Flowers & Larkin 2009).

I would construct my interview questions in a way so that they are not leading questions and be aware of my interpretations during the data analysis process. I would ensure to stay with the subjective experience of my participants and use supervision and peers review to explore my assumptions and interpretations. I would keep a reflective journal to acknowledge and manage any influence of my own experience and perspective on the research topic.

I am aware that conducting my study with fellow Nigerians may raise some challenges such as the participants over identifying with me and vice versa which may impact the way I manage the interview sessions. Thus, the need to be professional and focused will be taken seriously. A likely advantage however, may be that my participants would feel comfortable to narrate their experiences without restrictions to a fellow first generation Nigerian mother. This may allow them to manage any issues with shame or stigma about their experiences.

Gunaratnam (2003) suggests that similarity in cultural and ethnic background of a researcher and participants is an important factor in conducting research. This is because it helps in eliciting rich data, particularly when researching a phenomenon that requires significant cultural considerations such as PND. I hope that my research will highlight the lack of research exploring the FGNMs' experience of PND in the UK and help in recognising an ethical need to give voice to this under-studied population.

## **1. Introduction**

First generation refers to immigrants who were born in another country and have become residents or citizens in a new or second country after relocating (United Nations Educational, Scientific and Cultural Organization 2017). For the purpose of this research, unless otherwise stated, the term ‘first generation Nigerian mothers’ is used to describe Nigerian-born women who are now residents in the UK following their relocation.

In the UK, the term black minority ethnicity is a general term used to categorise people from South Asia, the Chinese, Black Africans (which includes Nigerians), African Caribbean and non-Europeans (Bhopal, 2004; Pelle, 2013). According to the UK 2011 census statistics (ONS, 2011), BME population in the UK makes up 9% of the total population with the black African population making up 1.0%. The 2015 census statistics documented that people who identify as black Africans are now the largest black community group in Britain as opposed to those who identify as African Caribbean (Office for National Statistics (ONS) (2015).

It is documented that about 2.3% of UK immigrants are Nigerian-born (Migration Observatory, 2017). The largest concentration of Nigerians live in Peckham, South-East London and the 2011 census documented 7% of the Nigerians living in Peckham as Nigerian-born. Despite this high population rate, very little is known in research about Nigerians living in the UK, suggesting that adequate attention has not been given to exploring information about this group and it is unclear why such a

substantial/large population seems poorly researched in the UK. However, this present study may help to give this group a voice and highlight their experiences with a possibility to foster the future provision of tailored and evidence-based support.

Nigeria is a multi-ethnic nation with over 250 ethnic groups and spoken languages. It is one of the largest and the most populated nation in Africa, the country is rich in culture, tradition and customs. The social role of women in Nigeria differs according to religious and ethnic background. Lack of formal education for women and early teenage marriages are common in the north, within Muslim families and in the rural areas. However, the proportion of women at university in the 1980s rose to one-fifth of university places doubling the proportion of the 1970s (Tuwor & Sossou, 2008).

Research in the 1980s indicated that only the daughters of business and professional elites had the opportunity to be educated beyond primary school and in almost all cases, courses and professions were chosen by the family for the women. The rate of women's education and employment has seemingly increased in the last few years, particularly in the southern part of the country and so, women are now occupying professional and some political positions (Falola, 2001).

Nigerian women do not culturally have equal rights to men and there are explicit gender defined roles; for example, cooking and looking after the needs of the children are believed to be women's role while the men are expected to financially provide for their families. Culturally, Nigerian men (particularly the first generation

Nigerian men) do not undertake household chores or support their wives with childcare activities. This is largely acceptable but sometimes results in neglecting the social and emotional needs of their families (Falola, 2001).

A study conducted in Nigeria focusing on Nigerian mothers' experiences of PND reported that the women experienced PND at a rate similar to the ones reported in other women across the globe (Adewuya et al. 2005). However, according to the researchers, the phenomenon of PND is poorly understood by Nigerian mothers. This finding may be translatable to Nigerian-born women living in the UK. FGNMs are currently under-represented in research literature of PND in the UK and their needs remain unexplored. This research will therefore investigate how the FGNMs experience PND and available treatment. It will also explore how they managed and coped with the challenges particularly as research reports that they do not readily seek help with their mental health issues (Lewis & Drife, 2004; Dennis & Chung-Lee, 2006).

A comprehensive strategy for a systematic literature search was employed in this current study. Databases including PsychINFO, EBOSCOhost, ScienceDirect, CINAHL Plus, MedLine and PubMed were accessed for published articles, journals and papers that are presented and referenced throughout this study. Different combinations of search terms were used including 'Nigerian women/mothers', 'First generation', 'Mental Health', 'Postnatal Depression', 'Postnatal depression in Ethnic

Minority Women', 'African Women', 'Black, Asian and Minority Ethnic', 'Resilience', 'Perception' and 'Stigma'.

In addition, journals considered to include relevant information to the current study were specifically searched. These included 'Journal for Mental Health', 'Mental Health and Culture', 'Ethnicity and Health', 'Nursing Research and Practice', 'International Journal of Mental Health', 'Counselling Psychology Review'. Furthermore, due to limited research in the UK exploring PND within this population, studies conducted in the USA and elsewhere have been included within the literature review to complement studies found in the UK.



## **2. Literature review**

This chapter presents research literature on the general understanding of PND. The section looks at the definition and prevalence of PND. It discusses the impact and risk factors, assessment and diagnosis including the exploration of the treatment and access to services by BME population. In addition, the chapter presents the gap in literature of PND in the researched population and aims to outline the theoretical and empirical research findings related to PND in FGNMs.

However, since there are no specific studies exploring the experience of this particular population in relation to PND, the literature and research findings on the experiences of BME and specifically African mothers of PND will be discussed in an attempt to capture the experience of a subgroup of FGNMs. The summary of the research and identified knowledge gap from literature is discussed followed by the discussion of the relevance of the research topic to counselling psychology and then the presentation of the research aims and questions.

### **2.1 Definition and prevalence of PND**

Postnatal depression also known as postpartum depression is a severe mood disorder that globally affects many mothers following childbirth. Howard et al. (2014) defines it as a non-psychotic depression occurring during the first six months postpartum and can persist for long periods (Goodman, 2004; Crotty & Sheehan, 2004). The DSM-5 defines postpartum onset as within four weeks of delivering a child and perinatal period is defined as from conception to one year after birth (DSM-5, 2010).

Postpartum is known by the American Psychiatric Association (APA, 2013) ‘as a major depressive disorder, characterised by depressive mood such as decreased energy and cognitive difficulties. The prevalence rate ranges between 10 to 15% (O’Hara & Swan, 1996; Yoshida et al. 2001; Leahy-Warren & McCarthy, 2007). Lewis and Drife (2004) report that one in ten mothers experience PND in the UK. The most current report by the Charity for children suggests a higher rate of three in ten mothers in the UK (Charity for Children, 2019), signifying a serious clinical issue for practitioners providing care for these group of mothers.

## **2.2 Impact and risk factors for PND**

Research evidence suggests that PND has a profound impact on the maternal health and well-being of new mothers (Boath, Pryce & Cox, 1999; Goodman, 2004; Howard et al. 2014). It has been found to affect mothers in the areas of social functioning, economic productivity and quality of life (Chisholm et al. 2003; Bauer, Knapp & Parsonage, 2016). Though PND is not a terminal illness, it is suggested to have the capacity to destroy marriages, ruin careers and can result in suicide (Appleby, 1991; Appleby & Turnbull, 1995; Shapiro, 2019). PND has been found to account for up to 20% of deaths in the postnatal period with thought of self-harm ranging from 5 to 14% (Oates, 2003).

A recurring depressive episode in new mothers has been found to be harmful to children (Lovejoy et al. 2000; Milgrom, Westley, & Gemmill, 2004; Kingston & Tough, 2014). It has equally been found to lead to emotional, interpersonal,

behavioural and cognitive problems in later life of the children (Miller 2002; Grace, Evindar & Stewart, 2003; Hay et al. 2010; Pearson et al. 2013) and can negatively impact the wider family (Ballard et al. 1994; Murray, 1992; Beck, 2002; O'Connor, 2002; Goodman, 2004; Paulson & Bazemore, 2010). Unlike the baby blues, a milder mood interruption within the first ten days after giving birth may go away without treatment. PND does not go away on its own; it can last for many months if left untreated (Grigoriadis & Romans, 2006; O'Hara & Wisner, 2014).

A number of factors have been suggested to trigger PND. Any woman may develop mental health problems during pregnancy and in the first year after giving birth, however, risk factors are important. Factors including extreme stress, traumatic events (such as exposure to domestic violence, gender and sexual based), antenatal anxiety, traumatic birth, major life events, past history of mental illness, natural disasters, low social support, low income, young age and first time motherhood are recognised as increasing risk factors for specific perinatal disorders (Robertson, et al. 2003; Milgrom & Gemmill, 2014; Campbell et al. 1995).

According to literature, risk factors for postnatal depression in the general population of mothers often include unplanned or unwanted pregnancy, history of mental health problems and history of childhood abuse and neglect. Others include domestic violence, history of miscarriage, inadequate social support and alcohol or drug use. Interpersonal conflict, single marital status and low income are also indicated (O'Hara & Swain, 1996; Beck, 1996; Beck, 2001; Cryan, et al. 2001; Robertson, et

al. 2003). A family or personal history of bipolar significantly increases the risk of postpartum psychosis (Jones & Craddock, 2001).

Risk factors specific to BME mothers includes cultural factors such as expectations, language problems/barriers and family/marital conflicts. Others include violence, unemployment, accommodation issues and racial harassment (Williams & Carmichael, 1985; Cox, 1999; NIMHE, 2003; Onozawa et al. 2003; Templeton et al. 2003; Lewis & Drife, 2004; Goyal et al. 2006; Brookes et al. 2015). Studies also indicated increased socio-economic and acculturation stress as risk factors predisposing BME mothers to developing PND (Martinez, 2006; Berry 2001; Leidy et al. 2010).

Others identified factors include gender of the baby and role of mother in-laws (Patel, Rodrigues & DeSouza, 2002; Das et al., 2003; Wittkowski et al. 2011). However, a number of researchers (O'Hara & Swain, 1996; Elliot et al. 2000; Holopainen, 2002; Lindahl, Pearson & Colpe, 2005; Shapiro, 2019) suggest that psychosocial factors including lack of social support, stressful life events and marital conflict have been highlighted as the most significant risk factors that contribute to developing PND by these mothers.

Studies conducted on the specific risk factors for PND in African American women, suggest that a common theme of low income, isolation, lack of social support were identified (Sejourne et al. 2011). Additional risk factors include education level, maternal age and interpersonal violence. Sociodemographic factors, discrimination

and lack of help with childcare were reported as additional issues that may influence the onset of PND among the African American mothers (Siefert et al. 2007; Broomfield, 2014).

Studies conducted with black African mothers suggest that although some risk factors associated with these mothers are similar to those identified in developed countries, there are some important differences in some of the risk factors identified in them (South African mothers). These include exposure to extreme societal stressors during pregnancy (such as danger of being killed or witnessing violence) and difficult relationship with partners (Ramchandani, Richter, Stein & Norris, 2009). Another study conducted by Wittkowski, Gardner, Bunton and Edge (2014) exploring risk factors for PND in Sub-Sahara African mothers, indicated the influence of traditional African value systems (extended family influence), extreme antenatal exposure to societal stress and the impact of adhering to cultural traditions as contributing factors to developing PND.

Issues around social exclusion, deprivation and relationship complexities are reported as risk factors that influence the development of PND in black African mothers living in the UK (Babatunde & Moreno-leguizamon, 2012). Additional risk factors for this population include missing family members, isolation and loss of identity. Others include issues with lack of help with childcare, housing issues, frustration and loneliness (Gardner et al. 2014; Dei-Anane et al. 2018). According to studies conducted in Nigeria, the risk factors predisposing Nigerian mothers to

developing PND include obstetric risk, employment status, pregnancy complications and sociodemographic factors (Adewuya et al. 2005; Eke & Onyenyirionwu, 2019).

The current study is set to explore the experience of PND in first generation Nigerian mothers living in UK. As there are no specific studies exploring the experience of PND in this population, the risks factors that influence the onset of PND in these mothers remain unknown in research. The current study may be able to highlight the risk factors predisposing this specific population to developing PND whilst exploring their experiences of PND.

There are wide-ranging symptoms of PND including loss of appetite, agitation and anxiety, insomnia, irritability and lack of concentration. There could be suicidal thoughts, self-harm or harm to the baby in extreme cases, such as postpartum psychosis (Appleby & Turnbull, 1995; Howard et al. 2014). A study by Misri, Kostaras and Kostaras (2000) suggests that new mothers get confused and are left feeling upset and guilty when they do not experience instant bonding with their babies. However, many mothers believe that these feelings will go away and therefore fail to seek support that they might need. The authors argued that there may be misinterpretation and inability to distinguish between depressive and after birth symptoms such as anxiety and tiredness.

### **2.3 Assessment and diagnosis of PND**

In the UK, Health Visitors (HVs) are the primary healthcare professionals who assess and support women with PND. While some studies claim good outcomes (Cullinan, 1991), more recent studies suggest that practitioners lack the skills to accurately identify PND in BME women and adequately support them (Taylor, 1997; Elliott et al. 2001; Almond & Lathlean, 2011). Others suggests improved professional training for practitioners and a more coordinated multi-agency approach in order to effectively support new mothers and to possibly reduce the risk of developing PND (Elliott et al. 2001; Edge, 2010).

Historically, there has been a lack of integrated physical and mental health care for women during pregnancy and in the weeks and months following birth as well as lack of specialist perinatal mental health services to support women who become unwell after delivery a child. The NICE guidelines and more recent studies suggest that all mental health professionals working with mothers in the perinatal period should be perinatally competent (Rosan & Grimas, 2016).

The Edinburgh Postnatal Depression Scale (EPDS) is the most universally used instrument to identify PND (Cox, Holden & Sagovsky, 1987; NICE, 2007). The scale is self-rating questionnaire with ten points and above being the recommended cut-off point for diagnosing PND and major depression (Hewitt et al. 2010). Primary care professionals work to detect PND by recognising the symptoms or screen women with this standardised instrument, but researchers have argued that this scale

often failed to identify PND particularly amongst BME mothers resulting in many PND cases in this population being undetected and therefore untreated (Boath & Henshaw, 2008; Edge, 2010).

Although the EPDS has been translated into different languages, studies that have used both the translated and English versions of the EPDS with women from minority cultures have disputed its validation in identifying PND within these different communities (Bashiri & Spielvogel, 1999; Edge, 2010). Research suggests that the language used by BME women in describing PND complicates the use of EPDS when working and identifying PND within the population (Bashiri & Spielvogel 1999; Watson et al. 2019).

This may be due to the Western language used in describing PND and it is possible that the BME mothers do not have a language that describes PND in the way it is described by the EPDS even when translated. It may also be an issue around shared reality, that is, the differences in the way the Western society and the BME communities perceive and understand PND (Watson et al. 2019).

In addition, implicit or unconscious bias of health care professionals has been found to impact health care assessment and diagnosis, particularly within the BME groups. Unconscious biases involves actions or attitudes outside conscious awareness that leads to negative assessment of a person based on characteristics such as gender and race. In a systematic review study by FitzGerald and Hurst (2017) the findings provided evidence suggesting that health care professionals displayed unconscious



bias toward patients. All the studies reviewed by the researchers found a significant correlation between unconscious bias and low quality of care. The evidence suggests that healthcare professionals exhibit the same levels of unconscious bias as the wider population. The need for health care professionals to address the role of unconscious biases is emphasised in disparities in health care service provision (FitzGerald & Hurst, 2017).

Other evidence by studies using Implicit Association Tests (IAT) suggests that these disparities in outcome may in part be due to social biases that are primarily unconscious. Cognitive load associated with clinical practice are suggested to activate these biases in some individuals, however, measures such as counter-stereotypical incentives and targeted experience with minority groups identified in other fields has been recommended to be adapted for use within healthcare settings (Byrne & Tanesini, 2015).

#### **2.4 Treatment and access to services**

The National Institute for Clinical Excellence (NICE) (2007) and the World Health Organisation (WHO) (2014) classified PND as a serious public health problem that can lead to lasting mental health difficulties for new mothers and leads to psychological morbidity in the postnatal period. In order to reduce psychological morbidity in the perinatal period for women, research suggests the provision of support during pregnancy to facilitate early detection, prevention and treatment of depression after childbirth (Elliot, 1989; Elliot et al. 2000; Holopainen, 2002; Oates,

2003). The National Collaborating Centre for Mental Health, (2004) and NICE, (2007) suggest strong evidence for the efficacy of psychological treatments for PND such as Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT). However, the effectiveness of this treatment for ethnic minority mothers is uncertain. Specialist perinatal mental health services, Improving Access to Psychological Therapies (IAPT) team and the Community Mental Health Teams (CMHTs) are part of the teams that currently provide perinatal services to new mothers for up to one year after giving birth (Nice CG192, 2014). In the UK, specialist perinatal mental health service has received attention and commitments in terms of both funding and treatment target. However, it is reported that the provision of support is still falling short of demand in some areas. Many mothers are at risk of not having adequate specialist community perinatal mental health support and as such, medication is the dominate treatment option for most mothers prescribed by GPs.

The objective of the NHS Five Year Forward View implementation is to improve the provision of specialist mental health support across the UK by 2020/2021. This will include increasing access to specialist perinatal community teams and providing additional mother and baby units. This would allow at least an additional 30,000 women each year to receive evidence-based community treatment when needed by 2023/24 (NHS England, 2016; National Collaborating Centre for Mental Health, 2018).

NICE guidelines (NICE, 2016), recommended the importance of equality in service provision that promotes good mental health, prevents the escalation of problems and supports early access to treatment. The guidelines suggest that routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. In addition, according to NICE, general practice, maternity and health visiting services have frequent contact with the mother, baby and family during the perinatal period and are well placed to provide support, make initial assessment and refer onwards if problems are identified (NICE, 2016).

As one of the aims of this research is to investigate the treatment that is available to the FGNMs, it could help to identify how the FGNMs experience these available treatments particularly, as literature suggests that BME mothers do not readily seek professional help (Lewis & Drife, 2004; National Institute for Mental Health in England (NIMHE), 2003; Hamilton et al. 2011).

In addition, Anand and Cochrane (2005) suggest that BME mothers have a tendency not to report or talk about their depressed feelings and such unwillingness or reluctance may be a potential barrier to seeking professional help. As a result, research into BME mothers' experiences of available treatments, particularly the FGNMs, could explore these barriers in more depth and could help to inform improvements around engaging this group in evidence-based, effective treatments.

However, there is an ongoing argument suggesting that the healthcare needs of the BME population in the UK are not adequately addressed by the healthcare system, particularly in the area of providing services that are sensitive to their cultural, ethnic and religious needs (Hussein, 1995; Williams, Turpin & Hardy, 2006; Evandrou et al. 2016). BME communities are reported to continue to experience inequalities within the UK mental health system despite major government policy initiatives (Grey et al. 2013; Wallace et al. 2016).

Additionally, research suggests that racism may be one of the reasons for inequalities in healthcare service provision. Alleyne (2009) argues that whether racism is experienced as a one-off encounter or an ongoing experience, it can be damaging to the wellbeing of an individual. Others concluded that disparities in providing healthcare services are universal and pronounced among ethnic minorities (Williams & Mohammed 2009; Sondik et al. 2010).

Giuliano et al. (2000) suggests that people from ethnic minority communities have been historically underrepresented in health research and others argue that race is the basis of historical and continuing discrimination within the UK, and the impact of this has been hypothesised by scholars (Vernon, 2011; Hall, 2018). According to Andrews (2016) the impact of racialisation permeated by institutional racist structure is impactful on ethnic minorities attempting to navigate a discriminatory landscape.

There are cultural differences within ethnic minority communities regarding the way mental health is perceived, acknowledged and accepted. Although there is global

stigmatisation associated with mental health, research suggests that raising awareness of this context has often been situated within dominant white and Eurocentric backdrop (Grey et al. 2013; Sewell 2012). Research also suggests the importance of addressing this imbalance to ensure that people from all sectors of the society are represented equally in reflecting mental health illness as a problem that affect all types of people regardless of race, class and religion (Glover & Evison 2009; Vernon, 2011).

However, Jones (1994) previously suggested that perception and attitude towards mental health problems/illness in different cultures affects their access to service and help seeking attitude. Others suggest the role of two cultural perspectives; individualistic and collectivistic culture (Shikh & Hatcher, 2004; Ghosh, Chakrabarti, Chakraborty & Biswas, 2013). In addition, Thaker (2008) suggests three cultural values that influence immigrants' health behaviours; high level of family involvement during treatment, personal relationship with healthcare professionals and valuing alternative medicine.

Similarly, research suggests that difficulty in managing mental health problems within the BME population in the UK is due to stigma around mental health issues (Cox, 1999; Link & Phelan, 2001; Knifton, 2012). The findings from this present research may be able to provide insight into these arguments and generate better understanding of the position of this population being researched and how they may be best supported.

Whitton, Warner and Appleby (1996) suggests that for PND to be readily treated, women themselves need to be more able to recognise the challenges and make the decision to seek help, however, NICE (2014) suggests that increased recognition and understanding about available treatments should be achieved through antenatal education and regular post-natal screening for depression by which PND can be identified in large numbers of women who cannot themselves identify the illness. The current study could shed light on the FGNMs engagement with available services and how to possibly improve service design and delivery to better engage the group.

### **2.5 Gap in literature on PND in the researched population**

Available studies have reported that first generation immigrants are at higher risk of mental health problems, such as depression, anxiety and post-traumatic stress disorder, compared to the general population (Cox, 1999; Norredam et al. 2009; Abebe & Hjelde, 2014; Straiton, Reneflot & Diaz, 2014; Close et al. 2016; Watson et al. 2019). However, studies exploring the experiences of first generation population have focused on issues including the impact of acculturation (Mavreas et al. 1989), their economic situation (Algan et al. 2009), substance use and violence among first generation youth (Harrison, Sutton & Gardiner, 1997; Pottie et al. 2015), social exclusion (Laura & David, 2016) and racism (Hunter, 2008; Krieger et al. 2005).

The bulk of the studies exploring health problems amongst this population have heavily focused on health issues, such as psychotic disorder, sickle-cell anaemia,

coronary heart disease, diabetes and cardiovascular diseases (Enas et al. 1995; Alexander, 1999; Bourque, Van der Ven & Malla, 2011). Evidently in the UK, no studies have specifically explored the ‘lived’ experiences of PND in FGNMs, suggesting an underrepresentation of this population in existing literature of PND in the UK.

## **2.6 Literature review on PND in BME mothers**

The literature on new mothers’ mental health indicated that PND severely affects women from BME groups and that they are more susceptible than white British mothers to developing PND (Williams & Carmichael, 1985; Cox, 1999; NIMHE, 2003; Onozawa et al. 2003; Templeton et al. 2003; Lewis & Drife, 2004; Brookes et al. 2015; Goyal et al. 2006).

Studies exploring the experience of PND within the BME communities suggest that lack of awareness of symptoms, lack of support, including language problems are important mediating factors predisposing the BME mothers to developing PND (Templeton et al. 2003; Lam, Wittkowski & Fox, 2012; Babatunde & Moreno-leguizamon, 2012, Wittkowski et al. 2011). This is hypothesised to affect the way they experience PND, it affects their interpretation of the signs and creates a barrier in seeking formal help (Hobfoll et al. 1995; Bashiri & Spielvogel, 1999; Amankwaa, 2003; Templeton et al. 2003).

Studies also show that BME mothers suffer from increased socio-economic related stress which has been found to negatively affect their quality of parenting during the

postnatal period (Martinez, 2006; Leidy Guerra & Toro, 2010). Berry (2001) and Leidy et al. (2010) both suggest that ethnic minorities experience stressors that are specific to their minority/migration status, such as acculturation stress and racism that are directly related to their immigration history. Acculturation stress results from a reaction to events occurring during the process of acculturation, such as missing family members, discomfort with unfamiliar norms and lack of social support, which may trigger PND.

In addition, the gender of the baby has been found to be a risk factor specific to BME women in developing PND. Many of the BME communities are said to prefer male children for different reasons, for example in Indian culture one of the reasons is due to high cost of dowries for girls (Patel, Rodrigues & DeSouza, 2002; Das et al. 2003). The role of cultural practices is also reported to play an important role in the postnatal period for minority ethnic women including 'doing the month' which is a Chinese traditional rite in which new mothers have to follow some restrictive prescription of remaining indoors without engaging in any duties for a month after giving birth as well as following a strict diet (Heh, Coombes & Bartlett, 2004).

One way to define culture is as a learned and accumulated experience of a person that is socially transmitted. It involves values, beliefs, norms, and ways of living by a group of people that guides their thinking, decisions and action in certain ways (Matsumoto, 1999). The cultural aspect of an individual's social system has been



found to have significant impact upon their emotional life (Lazarus & Folkman, 1987; Fernando, 2010; Bracken et al. 2012).

Troyna et al. (1993) report that BME mothers tend to focus on their families and communities for support needs. Generally, BME individuals are reported to be less likely to access services for mental health problems which are reported as consequences of how mental health is perceived by these different communities.

In support of the above, a study by Amankwaa (2003) conducted among African-American women who experienced PND in the past, reports that the women managed their depression by relying on faith and counsel of family members for support. The women believed in living up to the image of being 'strong black women' and described their depression as a 'weakness'. The participants were also reported to believe in the myth that PND was an illness/condition suffered only by 'white women'.

The researcher concluded that these beliefs and rituals widely held by the African-American mothers contribute to worsening their PND and may have prevented them from seeking professional help. Although the study is relevant to understanding how some minority ethnic groups managed PND, the study was exclusively/explicitly focused on the cultural impact of PND. In addition, the study was conducted in America and so the findings may have selected applicability to the experience of BME populations in the UK.

In exploring the experiences of PND in BME women in rural Wiltshire UK, Templeton et al. (2003) found that the women did not generally like to talk about their PND and to seek professional help due to misinterpretation of the signs/symptoms of PND. Stigma attached to mental health issues and specific views on childcare were reported as notable barriers to help seeking by the participants. Issues with isolation, frustration and loneliness were reported as factors contributing to PND. In addition, the women were said to report that language barriers and low number of BME professionals working with them was a hindrance to expressing their feelings.

However, the study did not aim to investigate the participants' experience of treatment and how they managed and coped with PND. In addition, the findings cannot be a representation of the experience of the BME mothers in the UK due to the rural geographical location where the research was conducted. Therefore, more research is required to explore how BME mothers experience PND and available treatment including how they manage and cope with the challenges.

A qualitative study by Wittkowski et al. (2011) found that the experiences of South Asian mothers were complicated by predisposing and perpetual cultural, religious and familial factors than those reported in Western mothers. The mothers found adjusting to married life difficult and felt disempowered by their 'in-laws' believing that they dictated how to look after their babies and perceived that this related to their experience of depression. The women were reported to internalise feelings and

believed that the available services might not meet their cultural and religious needs. This was due to fear of being discriminated against both because of being Asians and experiencing PND. These preconceived concerns meant that the participants turned to faith and religious practices to cope with PND. Shame, loneliness and being misunderstood by healthcare practitioners were also reported barriers to help-seeking by this group of mothers.

The strength of the study is that even though English-speaking participants were recruited, the interviewer understood languages spoken by these women making it possible for the participants to express some terminologies in their language. However, the study focused on the participant's understanding of PND, the impact of cultural norms, beliefs and the help-seeking behaviour rather than their experience of PND and of available treatment. Therefore, more research is needed to understand individual BME community's experiences of PND and how they experience available resources/treatment.

A study by Edge, Baker and Rogers (2004) investigating the prevalence of depressive symptoms during and after pregnancy in African Caribbean women compared to white British women living in the same geographical location as well as the black Caribbean women's beliefs about perinatal depression and their attitudes to help-seeking, employed a mixed method of investigation and found that the black Caribbean mothers were not treated at equal rates as the white British mothers

(inequalities of service provision), despite the black Caribbean mothers reporting higher levels of self-reported risk factors.

Although the EPDS scores for the Caribbean mothers were less than the threshold during pregnancy, they scored above the threshold on the EPDS at an equal rate as the white British mothers after giving birth, suggesting that both Caribbean and British women suffer PND at a similar rate. The qualitative findings of the study suggest differing attitudes, beliefs and associated help-seeking practices by the Caribbean women from those previously reported. However, the study did not explore how the mothers experienced, managed and coped with their PND. Thus, a more specific exploration of how BME groups experience PND is required.

A study by Lam, Wittkowski, and Fox (2012) exploring the experiences of PND among both Chinese-speaking and bilingual mothers, found isolation and conflict as main stressors that contributed to developing PND. The bilingual women expressed more conflict which related to traditional cultural practices, cultural differences with peers and the role of their mother-in-law. The Chinese-speaking mothers were reported to suffer more isolation after giving birth when they failed to receive support from family members and the available services due to language barriers.

The study further showed that the bilingual Chinese women found available charitable community support at the Wai Yin Women's Centre (a centre for new immigrants and values for Chinese Culture) very helpful, while those who did not speak English were restricted from accessing services due to both cultural norms and

language problems. However, although the study is relevant in highlighting the views of some of the participants about available support, this support were not formal support or treatment offered by healthcare professionals. Therefore, more studies investigating the experiences of formal support by BME mothers are needed.

## **2.7 Literature review on PND in African mothers living in the UK**

In searching for specific and related research, only very limited studies were found exploring PND experiences of African mothers living in the UK, suggesting a clear gap in UK research on this topic within the African community particularly the FGNMs.

Babatunde and Moreno-leguizamon (2012) investigated the cultural influence and perceptions of PND in African immigrant mothers and found that half of the participants did not understand the signs and symptoms of PND. The women also concealed symptoms of PND due to the stigma attached to mental health problems. The participants were reported to perceive the symptoms as something else in their daily lives even though the symptoms they narrated were consistent with the criteria for PND (such as irritability, lack of sleep and thoughts of self-harm). The study also showed that despite prolonged visits and contact by HVs, the signs of PND in these women were not identified.

The researchers pointed out that the participants were women who identified themselves as 'Africans'. Although a large number (11 out of 17) of the participants were identified as Nigerian women, it is not possible to identify the data belonging to

the Nigerian mothers. Thus, it could be argued that nothing is known about the experience of PND in first generation Nigerian mothers from the study. In addition, the study aimed to explore daily and cultural issues of PND, therefore, more studies are needed to specifically understand Nigerian mothers' experience of PND and how they manage and cope with the challenges.

Gardner et al. (2014) examined the lived experiences of West African mothers living in Manchester, UK, in relation to their perceptions of PND and found that loss of identity, isolation and trust issues were main factors contributing to PND. However, the participants related relationships with their babies as protective factors (babies were culturally described as a source of pride and helped to improve the moods of their mothers). The mothers expressed believing that PND only existed in the UK and not in Africa. This perception was hypothesised to contribute to their inability to acknowledge their symptoms as constituting PND.

The women also kept symptoms of PND private and secret which was thought to inadvertently impact upon their help-seeking attitude. However, although three of the participants were Nigerian-born women, it is not possible to identify data belonging to them; as a result, the findings in the study cannot be viewed to represent the experiences of PND in FGNMs in the UK.

A recent study by Dei-Anane et al. (2018) conducted in London, UK, investigating the perception of PND by Ghanaian migrant mothers identified two main themes - perceptions of Ghanaian mothers during the postnatal period and coping strategies

for dealing with stress during postnatal period. The study suggests that the mothers experienced infant temperament, lack of support and housing problems as stressors. In addition, the mothers were reported to express reluctance in seeking formal support because of lack of trust of the professionals who worked with them and increased stress as a result of lack of family support. The women sought help from friends and faith leaders instead. The researchers suggest the need for health professionals to clarify their roles to mothers and take the measure to assist migrant mothers on all aspects that influences their PND experience, particularly as they are a subsystem of their larger family in the UK. However, as the study did not evidence the experience of formal support by the mothers, more studies investigating the experience of available support are needed, particularly that of the FGNMs.

## 2.8 Information table of the qualitative studies reviewed

Names of authors and year of publication	Location of Study	Aim of study	Sample Characteristics	Sampling	Method of Analysis	Identified Themes
Templeton, Velleman, Estrada and Milner (2003)	Wiltshire, United Kingdom	To Describe the experiences of women with current and past experience of postnatal depression in black and minority ethnic communities	Six women from a variety of minority ethnic groups took part in the study. They were classed as Bangladeshi, Indian, other Asian and 'other'	EPDS threshold was used for entry into the study	Thematic analysis	'Issues specific to pregnancy and birth (including postnatal depression)'; 'Issues specific to primary health care'; 'Issues relating to culture'; 'Other issues'
Witkowska, Zuzak, Glendenning, and Fox, (2011)	Manchester, United Kingdom	The experience of postnatal depression in South Asian mothers living in Great Britain	Ten South Asian mothers (1 <sup>st</sup> and 2 <sup>nd</sup> generation mothers) Children aged 2-3 months at the time of interview	Participants were recruited through health visitors and midwives. EPDS used to determine depressive symptoms	Grounded theory	'Internalising misery'; 'Others will judge me and I feel on my own'; 'I talk to my health professional and they don't understand'
Edge, Baker, and Rogers, (2004)	Manchester, United Kingdom	Qualitative aim: To explore black Caribbean women's beliefs about perinatal depression and their attitudes to help-seeking	A purposive sample of 12 black Caribbean women interviewed when their babies were between six and 12 months old	Caribbean and British women. The Census data were used to target the participants	Mixed method (Qualitative and quantitative)	Qualitative findings: 'Factors which mediate between adversity and diagnosis with depression'; 'Factors which influence help-seeking for depressive symptoms'
Lam, Witkowska, and Fox, (2012)	Manchester, United Kingdom	Exploring postnatal experiences of Chinese women including the factors that	Eight Chinese mothers (1 <sup>st</sup> and 2 <sup>nd</sup> generation mothers) Chinese-speaking and bilingual mothers	The EPDS and its Chinese version were used as a descriptor for the	Constructivist grounded theory	'Isolation'; 'Conflict'; Chinese-speaking mothers felt more isolated, bilingual mothers
Babatunde and Morenolegumason, (2012)	South East London, United Kingdom	Daily and cultural issues of PND in African women immigrants and the nuances and complexities present in PND	African immigrant women Married and single mothers		Thematic Analysis	'Response to pregnancy'; 'Emotional feelings before the birth of the baby'; 'Emotional feelings after the birth of the baby'; 'Social support or the lack of it'
Gardner, Bunton, Edge and Witkowska, (2014)	Manchester, United Kingdom	Experience of PND in West African mothers living in the UK and how they made perceived and sense of their PND	Six Black West African mothers aged 22 – 36, African born (Nigeria and Ghana) Number of children in each family ranged from one to three		IPA	'Conceptualising PND'; 'Isolation, loss of identity, Issues of trust Relationship with the baby as a protective factor'
Dei-Akane et al. (2018).	London, United Kingdom	Perceptions of Postnatal Depression during Postnatal Periods	The original study interviewed 25 Ghanaian Migrant Mothers living in the UK. Mothers who were 18-45 years of age and have given birth in the UK		Thematic analysis	'Perceptions of Ghanaian mothers during the postnatal period'; 'Coping strategies for dealing with stress during postnatal period'

## **2.9 Summary of the literature review**

The literature review failed to find an exclusive and specific literature and studies exploring the ‘lived experience’ of the FGNMs. Available literature and studies suggests that BME women are at a higher risk of developing PND than the general population and they are underrepresented in research and services engagement (Lewis & Drife, 2004; NIMHE, 2003; Cox, 1999; Onozawa et al. 2003; Goyal et al. 2006; Templeton et al. 2003). The reviewed studies suggests that a predisposition not to report or talk about depressed feelings, misinterpretation and lack of acknowledging symptoms, language barriers and the stigma associated with mental health problems amongst other factors are possible barriers to seeking professional help/support by BME mothers (Williams & Carmichael, 1985; Jones, 1994; Anand & Cochrane, 2005; Babatunde & Moreno-leguizamon, 2012; Lam, Wittkowski & Fox, 2012).

Issues including socio-economic and acculturation stress, isolation, loneliness, unemployment, cultural conflict and loss of identity were key risk factors specific to BME and African mothers in developing PND. Additional factors included lack of social and family support for the women whose close relatives do not live in the UK, issues with childcare, housing, social exclusion and low income. The majority of BME mothers managed and coped with PND with faith, prayer and relying on their families and communities for support (Troyna, Hatcher & Gerwartz, 1993; Onozawa et al. 2003; Wittkowski et al. 2011; Gardner et al. 2014; Dei-Anane et al. 2018).



Evidence from the reviewed studies suggests that some of the BME mothers lacked awareness of available treatment/services. Those who were aware of available services could not access them due to personal circumstances and constraints (Templeton, 2003). Others have a preconception that the available services would not meet their cultural and religious needs; hence they did not access available services (Wittkowski et al. 2011). Overall, very limited set of studies were found exploring the experience of PND in BME women in the UK.

It was noted that these limited available studies largely focused on the risk factors for PND for mothers, their perception of PND, cultural impact and help-seeking behaviour of the population. These studies also concentrated on exploring the experiences of Asian women, particularly south Asians, Bangladeshi and Indian mothers. Therefore, very little is known about the experiences of African women, particularly Nigerian mothers in relation to PND in the UK.

Thus, studies contributing to an in-depth and specific experience of this population (FGNMs) and the topic of PND will be of great interest and necessity to contribute and develop knowledge and inform evidence-based clinical practices. The proposed research hoped to provide a significant contribution to understanding and meeting the unique needs of this under-researched population and to give them a voice to express their experiences of PND including any treatment and support needs they may have.

## **2.10 Relevance of the research topic to counselling psychology framework**

The Division of Counselling Psychology expects topics chosen by researchers to have relevance in counselling psychology (DCop 2005, p.6). The current study is specifically and highly relevant to counselling/clinical psychology and other related health and social care professions. Researchers have suggested psychosocial and cultural understanding and support for PND (Elliot, 1989; Elliot et al. 2000; Holopainen, 2002; Oates, 2003; Wittkowski, Patel & Fox, 2017).

Pharmacological interventions are the main treatment offered for postnatal mental health, but PND is situated in psychosocial context, it is a period involving role transition and major life changing experiences. Change is an inevitable component of the process of childbearing particularly in becoming a first time mother which is a major developmental transition of adulthood (Harwood et al. 2007; Darvill, Skirton & Farrand, 2010). PND involves relationship issues and women's role/inequality, understanding the context of events, issues with loss, relationships and the promotion of equality is very important to counselling psychology. Fundamental to the philosophy of counselling psychology is its value of agency of human beings within a relational and psychosocial context (Milton, Craven & Coyle, 2010).

Postnatal period can involve loss of self-image and vulnerability for mothers, particularly first time mothers (Campbell et al. 1995) which have been found to be one of the risk factors for developing PND and these are issues that can be effectively resolved relationally. Counselling psychology can help mothers

diagnosed with PND manage their difficulties and challenges and help them come to terms with their new role/identity as well as manage the losses inherent in the transition of becoming a mother. Thus, it can be argued that PND is heavily embedded in psychosocial influences and solutions.

Bassey and Melluish (2013) suggest that psychotherapy plays an important role in the process of psychological treatment which has been found helpful in treating PND. Research indicates that psychological and social support facilitates the transition to motherhood (Bloomfield et al. 2005; Leahy-Warren, McCarthy & Corcoran, 2012; Nicholson, 2014). The ability as a new mother to successfully navigate this transition is influenced by the beliefs of the individual mother and these factors can impact the maternal wellbeing and mental health of new mothers (Choenarom, Williams & Hagerty, 2005). Therefore, appropriate psychosocial intervention is required to enable new mothers to effectively manage postnatal difficulties and challenges.

The birth of a child most often evokes the feelings of joy and happiness for new mothers and families, but less attention is paid to the fact that PND is also present for many new mothers (Gavin et al. 2005). The conflict between the reality of depressed mood that many of the new mothers actually experience and the expected positive emotions can be confusing, overwhelming and need exploring with new mothers.

In addition, women have been reported to value relational support over medication, for example, the women in the study by Di Mascio et al. (2008) found it essential for

their feelings to be validated and social support comprised a vital factor for their recovery from PND. Similarly, women with PND expressed preferring talking therapy to antidepressants after receiving both interventions (Appleby et al. 1997). Further, The National Collaborating Centre for Mental Health, (2004) and NICE (2007) both suggest strong evidence for the efficacy of talking therapies for treating PND. Similarly study by Hadfield and Wittkowski (2017) evidenced the effectiveness of psychotherapy in treating PND.

Turpin and Coleman (2010) suggest the necessity for practitioners working with women postnatally to be psychologically and culturally competent. Within this context, cultural competence concerns providing appropriate care to diverse community groups which is a basic value of counselling psychology in practice.

The current study hoped to address the gap in research and aimed to increase awareness of the psychosocial needs of the population being researched in counselling/clinical psychology practice and in other health and social care professional practices. Farooq and Abbas (2013) suggests that conducting research is one important means/ways of giving ‘voice’ to groups that are underrepresented in literature which is one of the aims this current study set out to achieve.

In view of the fact that no research has specifically explored the FGNMs experiences of PND, it seems important and relevant for counselling/clinical psychologists to understand the experiences of this population in order to develop evidence-based interventions that would meet their unique needs.

A humanistic value of counselling psychology in research is about responding to and expressing the voice of the participants through genuine inquiry (Cooper, 2009). This will be achieved by the use of IPA. IPA is a qualitative method committed to exploring how individual participant make sense of their 'lived' experience (Smith et al. 2009). It is particularly useful when researching topics that are under-studied and in which issues relating to sense making and identity are important (Smith, 2004).

Another important value in counselling psychology is to engage with the subjectivity, values and beliefs of the people involved in the research (DCoP, 2005, p1). In order to investigate and make sense of the understanding derived, the researcher must engage with the subjective experience of the participants. The attempt to explore the lived experiences of the FGNMs living in the UK with PND promotes these values and the wish to understand the perspective of this population within a qualitative approach that allows their voice to be heard incorporates the values in counselling psychology.

Further, counselling psychology seeks to always work in ways that empowers individuals (DCoP, 2005, p2). Thus, exploring PND within this population whilst understanding and validating their unique, in-depth experiences and possible challenges and difficulties will serve to empower them. As there are no research studies found either in the UK or elsewhere specifically exploring the experience of PND within this particular population, it is believed that the findings that will be

derived from the present study may be of great value to the relatively new and developing counselling psychology profession /discipline.

Given the complex and diverse experiences of BME mothers in relation to PND and the emphasis of counselling psychology on researching and projecting the voice of under researched populations, the experience of the FGNMs and their access to available treatment would seem to be a particular interest that is relevant to counselling psychology and other health and social care profession. This research also aimed to cultivate a more nuanced understanding of this particular group of mothers and should inform evidenced based practice work with them.

### **2.11 The research aims and questions**

The current study aimed to gain knowledge and understanding about the ‘lived’ experiences of PND of the FGNMs, their experience of ‘available resources/treatment’ and how they ‘managed’ and ‘coped’ with PND. The study also aimed to aid professionals to develop tailored and specific interventions that would effectively meet the needs of this specific group. In the light of this, the following questions are proposed to be addressed:

- How did first generation Nigerian mothers living in the UK experience postnatal depression?
- How did first generation Nigerian mothers living in the UK experience available treatment/resources?
- How did first generation Nigerian Mothers living in the UK manage and cope with postnatal depression?

### **3. Methodology**

This chapter discusses the rationale for employing a qualitative methodology and Interpretative Phenomenological Analysis whilst considering its theoretical underpinning and relevance within this present study and counselling psychology framework. Other potential qualitative methods that were discounted are discussed and the epistemological position that was taken by the researcher is clarified. The process for recruiting participants and materials is described. Ethical approval and considerations are presented, and then qualitative validity and the analytical process of conducting the research are detailed and described, before addressing methodological reflexivity.

#### **3.1 Rationale for qualitative methodology**

A qualitative methodology was selected using the research aim and questions as a guide (Willig, 2001). Qualitative research aims ‘to understand and represent people’s experiences as they encounter, engage and live through situations’ (Elliot, Fischer & Rennie, 1999, p.216). In contrast, quantitative research is concerned with testing hypotheses through measurement of variables and identifying causes and effects relationships (Smith, Harre & Van Langenhove, 1995; Willig, 2001).

A qualitative method of inquiry allows for an in-depth investigation of phenomena such as mothers’ experiences of PND, which are not easily quantifiable. A fundamental objective of this study was to explore the depth and complexities of FGNM’s experiences therefore, a qualitative methodology was chosen above a

quantitative method because quantitative research does not offer insight into the personal 'lived' experience of participants and thus, cannot be used to explore personal meanings.

### **3.2 Introduction to IPA and its theoretical underpinning**

IPA is a qualitative approach committed to detailed exploration of how people make sense of their lived experiences. According to its founder, Smith (1997), IPA is distinguished as 'an attempt to unravel the meanings contained in participants' accounts through an interpretative process of engaging with the texts and transcript' (p.189). Thus, IPA focuses on the detailed understanding of lived experiences, the meaning this hold for individuals and how this informs how they make sense of their lived experiences (Smith & Osborn, 2008). It also requires embracing a phenomenological attitude by the researcher which requires taking a reflexive stance. This means making a conscious effort to be open to how others see their world and striving to see the world in a fresh new way (Husserl 1927 cited in Smith et al. 2009).

The theoretical underpinning of IPA, according to Smith (2007), is based on three components, phenomenological (the study of experience), idiographic (concerned with individual account of a meaning of an event) and hermeneutics (theory of interpretation). Phenomenology is concerned about exploring people's subjective experiences. IPA is phenomenological because it 'is devoted to the investigation of how people make sense of their major 'lived experiences' (Smith et al. 2009, p.1). As such, IPA is consistent with the aim of this study and the research questions that



aimed to explore and understand how FGNMs diagnosed with PND make sense of their experiences.

The idiographic component of IPA is characterised with concerns to detailed exploration and understanding with the particular individual (Smith & Eatough, 2006). IPA is committed to detailed investigation of a single case with each experience separately valued before making a more generalised appraisal across cases. The use of small sample size with IPA allows for this process enabling the researcher to get as close as possible to the general experience (Smith & Osborn, 2008).

The exploratory, inductive and flexible features of IPA mean that it can be used to examine under-studied areas of research (Smith et al. 2009), in this case FGNMs and PND. IPA is committed to valuing people as individuals who are distinct from one another. This characteristic overlaps with the values of counselling psychology and corresponds with its philosophy that values idiosyncratic experiences ‘as valid in their own terms’ and seeks ‘to engage with subjectivity’ (BPS, 2005 p. 1-2).

The theory of interpretation involves a double hermeneutics in which the researcher is trying to make sense of the participant who is trying to make sense of their personal world (Smith, 2004). This means two levels of interpretation are involved which relates IPA to interpretative philosophy (Palmer, 1969: Smith, 2007). This approach is distinct to IPA because it allows the researcher to develop an analytical representation of the participant’s account which may go beyond their own sense-

making (Smith et al. 2009). Smith and Osborn (2008) accentuate IPA as a dynamic process in which the researcher adopts an active role in trying to acquire an insider's perspective on the participant's world.

### **3.3 IPA and relevance to counselling psychology framework**

The theoretical requirement of IPA lies in the holistic understanding of an individual, assuming a concrete connection between the language, feelings, thoughts and physical being of the person (Smith & Eatough, 2006). This holistic notion of IPA relates it with humanistic psychology (Graham, 1986). Thus, fundamental to IPA is its value of agency of human beings within a relational and social context (Smith et al. 2009) and this emphasis is consistent with the philosophy of counselling psychology (Milton, Craven & Coyle, 2010).

IPA and counselling psychology practice are theoretically related in the positioning of the participants in research and clients in clinical practice as experts in their experiences. As noted by Milton, Craven and Coyle (2010), counselling psychology in practice involves paying attention to how clients experience an event whilst being sensitive to their psychosocial context.

### **3.4 Why not a different qualitative methodology?**

A rationale is presented in this section for choosing IPA over two other types of qualitative analysis that were considered as possible alternatives but were discounted: Discourse Analysis (DA) and Grounded Theory (GT).

Discourse Analysis (DA) was another methodology that was considered, but discounted because it is concerned with how people describe their experience or construct social reality through the role of language (Crossley, 2000). Although IPA is interested in language, it does not solely assume language as the only tool necessary to construct reality (Smith & Eatough, 2006). IPA aims to obtain an insider's perspective in understanding how people perceive and make sense of the phenomenon under study. By contrast, rather than aiming to produce knowledge of a phenomenon, DA aims to examine how language is used to accomplish social, personal and political projects. As the focus of the present study is on the participant's phenomenological experience and not the role of language in understanding their experiences, IPA was considered favourable.

Grounded Theory (GT), developed by Glaser and Strauss (1967) is another qualitative approach that explores lived experiences like IPA (Smith et al. 2009). However, it was not considered particularly relevant in this study. IPA is concerned with small number of participants allowing for a detailed analysis of the participants' experience and engages with existing theoretical frameworks (Smith et al. 2009).

In contrast, GT is concerned with generating theories to provide explanation in understanding of the phenomenon under investigation and seeks to identify and integrate categories of meaning to a larger sample (Willig, 2008). In addition, rather than interpreting the data, GT methodology analyses the data to construct theories of basic social processes of the phenomenon. Therefore, GT was not considered to be

the most appropriate methodology to address the study's research questions because the study is specifically concerned in capturing the subjective experiences of women with PND rather than developing a theory from their experiences.

### **3.5 Epistemology and ontology**

The researcher adopts a critical realists' epistemological position. Epistemological stance/position refers to the researcher's theoretical position (Willig, 2008). Thus, researchers select methodologies not only based on how it fits their research purposes but mirrors their personal viewpoint on how reality can be known (Etherington, 2004). In conducting this research it was important for me to reflect on the reason a qualitative and phenomenological method and approach particularly fitted with my research and with me as a person.

I recalled when I was first introduced to research methods at under-graduate level; I was immediately drawn towards qualitative research methods because of the ability of this method to generate understanding of individual perspectives and viewpoints of events. As a person, I have come to value diverse viewpoints particularly lived experience in making decisions.

The process of understanding the way people make sense of the world and their experiences are significant to qualitative investigations (Willig, 2008). Thus, my epistemological standpoint has been informed by my long standing interest in lived experiences, the theoretical concept I have adopted as a practitioner and researcher, aligned me with the IPA approach. This has guided my decision making regarding

the method and approach used in this study. Etherington, (2004) noted that the researcher's opinion and perspective are often enhanced through personal history, enabling them to emotionally and empathically connect with others. This draws upon the critical realist position or epistemology (Madill, Jordan & Shirley, 2000).

In viewing epistemological perspectives as a continuum, critical realism sits at the middle with the positivist approach at one end and social constructionism at the other end. IPA sits between critical realism and social constructionism. Realists argue that knowledge is completely subjective and internally constructed (i.e. there is only one reality), whereas critical realists believe that there is more than one reality, whilst some experiences are in some ways real to us, these realities can only be partially known and are socially constructed (Oliver, 2012).

Thus, this study is also located within a social constructionist position in terms of ontology, i.e. the standpoint about the way of knowing being intersubjective (Haniff & Paszter, 1999). This is a way of the researcher making subjective interpretation of the subjective narrative of the participants. That is me as the researcher trying to make sense of what my participant is trying to make sense of, which is related to the double hermeneutic component of IPA.

Social constructionists view reality as being developed through social interactions between people (DenZin, 1992), in other words, the ontology determines the epistemology - the way we construct experiential meaning determines what we know. In addition, the standpoint is in consensus with CoP concerned with 'not

assuming the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (BPS 2005, p1-2). Furthermore, the focus of meaning making by IPA is considered to be compatible with critical realist position (Reid, Flowers & Hammersley, 2005).

### **3.6 Procedures**

#### **3.6.1 Recruitment**

Different avenues were used to advertise recruitment for participants due to difficulty in finding respondents with relevant and similar experience. This enabled access to additional participants who were interested and met the criteria for the study. Recruitment Posters (Appendix D) were displayed at parenting centres, GP surgeries, and organisations and social groups attended by Nigerian mothers across different counties and cities in the UK. Other avenues were social media and perinatal clinics. During this time, one of the recruitment criteria (years of experience of PND) was discovered to be too restrictive and therefore an amendment to ethics was applied for to broaden this recruitment criterion.

On receiving the ethics amendment, the recruitment process continued. Five other African mothers showed interest but failed to meet the required criteria; these women were from other African countries/nationalities - Ghanaian, Kenyans and Ugandan mothers. Two participants who met the criteria and agreed to participate later dropped out, resulting in extension on the recruitment period. The poster included brief information about the research and some of the inclusion and

exclusion criteria. Individuals were advised to contact the researcher directly via phone or email to express their interest and willingness to take part in the study. Upon initial contact by interested individuals, the participant's information sheet (Appendix E) containing detailed information about the study was emailed and they were advised to contact the researcher if they needed to clarify anything or had any questions before considering to take part in the study.

Further to this and with individuals' continued interest, the informed consent forms were emailed and a convenient date and venue for the interview were arranged via telephone and confirmed through emails. Participants were recruited mainly through organisation and social groups attended by Nigerian mothers, only one participant was recruited through words of mouth. The specific details of the recruitment organisations/groups will not be provided in order to protect participants' identities.

### **3.6.2 Sampling**

The study sought to recruit participants using purposive homogeneous sampling as well as snow-ball technique. This is a method that involves the researcher making contact with a person known to fit the research criteria and then making contact with others through the initial contact (Atkinson & Flint, 2001). Based on the recommendation for sampling for IPA studies (Smith & Eatough, 2006; Smith & Osborn, 2008), for the recruitment strategy to be effective it is important that participants are recruited from a closely defined group for whom the research questions will have relevance and subjective significance (Breakwell, Hammond,

Fife-Schaw & Smith, 2006). It can be argued that the ‘belonging’ to an ethnic group holds subjective meaning to the individual concerned. Thus, participants who met pre-determined criteria based on experiential knowledge (Smith et al. 2009) were recruited. This also allows the research questions to be adequately answered, enabling an insight into idiosyncratic and subjective interpretation of individual experiences (Smith & Eatough, 2006).

### **3.6.3 Inclusion and exclusion criteria:**

The participants were required to be Nigerian-born women who now live in the UK, those who have given birth in the UK and with a history of PND diagnosis and treatment experience. They were required to speak fluent English, because language is considered to represent an important aspect within qualitative research (Smith et al. 2009). The richness and meaning of language may be put at risk if an interpreter is used or when the researcher is unable to understand, interpret and transcribe data supplied by participants. Therefore, this was set as an inclusion criterion.

Moreover, mothers who were below eighteen and above fifty-five years of age were excluded from taking part in the study because actual PND experience may fall short because having a child at a younger or older age may present its own unique challenges that might interfere with precise experience of PND. In addition, below eighteen years of age may require parental consent.

Mothers were also excluded if they were asylum seekers and if they were having problems with social services regarding their children. Mothers with challenging or



unwell babies/children were also excluded because it was considered that these difficulties and challenges may interfere with accurate experience of PND.

### **3.6.5 Data collection**

A face to face, semi-structured interview schedule was used to collect data and individual interview lasted approximately one hour and were recorded with encrypted digital recorder. The interview schedule consisted of open-ended, non-directive questions. Smith et al. (2009) suggests that the use of open-ended questions in semi-structured interviews is flexible providing the participants with the opportunity to narrate their experiences in their own words. Moreover, semi-structured interviews are the recommended data collection method for IPA because it allows flexibility for a dual focus in which the researcher and the participants can follow any avenues that emerge during the interview (Willig, 2013; Smith & Osboorn, 2015). The interviews were guided by the researcher but participant-led in line with IPA principles (Smith & Eatough, 2006).

The interview schedule (Appendix A) was developed through receiving feedback from my academic supervisor and colleagues. The questions were modified following several drafts of the interview schedule, until it reached a satisfactory stage in which it was felt to adequately address the study's research questions. The researcher made notes in her reflective diary, keeping record of non-verbal information, thoughts and observations concerning the interview process to inform the analytic process. The participants were fully debriefed at the end of the interview

(Appendix H). A full detail of the interview process will be discussed later in the ethical considerations section.

### **3.6.6 Materials**

The materials used in the study included a recruitment poster (Appendix D) that was displayed at a number of different organisations, the participants' information sheet and consent forms that were discussed with participants prior to the interview (Appendix E & F). Others included an interview schedule (Appendix A) used in gathering data and a digital voice recorder used for recording the interviews. After each interview, a debriefing form (Appendix H) was given to participants. The Distress Protocol (Appendix G) was adhered to and a verbal debriefing took place.

### **3.7 Ethical considerations**

The study was approved by the Reviewer appointed by the Review Ethics Committee and the Head of Research at London Metropolitan University (Appendix B). All legal and ethical practice guidelines/protocols as proposed by the Code of Ethics and Conduct of the BPS (2009) and the HCPC (2006) were considered in conducting the research. Part of the process of an ethical consideration is to respect the feelings of participants in enabling them to make sense of their experience using a qualitative method.

Ethical consideration is crucial to counselling psychology practice because it helps to rationalise understanding and conduct (Olsen, 2010). As part of the process of the present research, participants were given the opportunity to ask any question from

the onset after receiving the information sheet. This was to ensure that they were fully informed about the study. The consent forms were later emailed with each participant's continued interest.

The participants were informed that they could withdraw from the study at any time before the interview and up to two weeks following the interview without giving any reason. The time limit for withdrawing data supplied was outlined due to the limited timeframe for conducting the study. Although this may appear restrictive due to the sensitive nature of the topic, it was set as a guide rather than a rule. The researcher would not have practically refused the withdrawal of supplied data by participants if any of them had chosen to do so.

The participants were also informed that they had no obligation to take part in the study. They were verbally informed about confidentiality and its limits which were also outlined in the information sheet. They were informed that their identity would remain confidential and the data would be anonymised throughout the research process. They were also informed that the data will be securely stored in a password protected computer (Data Protection Act, 1998 in Redsell & Cheater, 2001) and accessible only by the researcher.

Participants were informed that personal identifying information will be altered and that pseudonyms will be used to anonymise their names. These were made clear in the information sheets provided to participants before data collection. Participants were clear about their right to refuse to answer any question and that they could

pause or stop the interview should they desire to do so. The participants were explicitly aware and informed that the participation was fully voluntary and informed consent was gained from each participant before the interview. Participants were asked to complete a demographic questionnaire (Appendix K) to obtain basic background information.

Considering the nature and sensitivity of PND, when talking about the experience may be an emotional process for mothers, a three step Distress Protocol process (Appendix G) was available which allowed for monitoring non-verbal cues ensuring the safety and wellbeing of participants in line with the BPS code of ethics and conduct (2009). Debriefing procedures were followed after the interviews (Appendix H). Participants were given the opportunity to talk about any feelings and concerns that may have been evoked during the interview with the researcher. The participants were informed that data were being collected as part of a doctoral thesis with a possibility of an eventual publication, in which case the data would be kept for up to a period of five years before being destroyed according to the BPS Code of Ethics and Conduct (2009).

The participants were provided with the researcher's contact details, the contact details of her academic supervisor and a list of available support services they could contact, should they require further confidential support. The interviews were audio recorded with a password protected digital recorder which remained anonymous. All written material (e.g., demographic information, consent form and transcripts) were

securely stored in a locked up personal cabinet and shredded once no longer needed. All recorded materials were transferred and securely stored onto a password protected personal computer following each interview and were destroyed following transcripts that were printed for the analysis of the study. The transcripts were securely locked away and accessed only when required.

### **3.8 Analytical process**

The analytical approach used in this study was informed by IPA process and principles outlined by Smith and Osborn (2003). Individual cases were transcribed and analysed, followed by cross case analysis and final themes translated into a narrative account of the data. The first step was to individually transcribe and analyse the data. The important texts were highlighted and the transcripts were organised with line numbers before making initial notes on interesting and significant features.

The texts were read repeatedly line by line and the recordings were listened to over and over and this was done in combination with making notes in order to contextualise the voice of the participants and fully immerse myself into the subjective world of the individual participant (Smith & Eatough, 2006). The next stage involved movement to a higher level of interpretation as different meanings were reflected upon, putting my pre-conceptions aside and facilitating a more critical engagement. The right-hand margin of the transcript was used to note emerging themes. This stage involves making connections between the exploratory comments

and moving away from the descriptive and interpretative stage of the interview dialogue in an attempt to develop patterns.

The themes that emerged for individual cases were clustered into subordinate themes according to similarities. The work was partly completed by hand and electronically. The next stage was moving into a more theoretical level; Smith et al. (2009) proposed that this stage is like laying each table on a large surface to explore connections and patterns across cases. The reoccurring subordinate themes were grouped together, some were merged into one, others were relabelled and some were removed from the analysis. This is in line with the process of looking for the most prominent themes that answered the research questions and the novel and anticipated areas of mothers' experience of PND. These subthemes were formatted into a table with transcribed verbatim quotation from the participants' transcripts.

Following the analysis of individual transcript, the subthemes across all cases were clustered to produce a table of superordinate/master themes. The final themes were shared with my supervisor and trainee counselling psychologist colleagues to verify the consistency of the themes. This was a vital process of reflecting which helped to enhance the credibility of the themes. The final stage of the analytical process was expanding the identified themes into a narrative account forming the basis of the result of the study. The narrative account is supported by excerpts from participants' transcripts, it presents the subjective sense-making of their experience and the

interpretation by the researcher of this sense-making. Smith et al. (2009) suggests that the analysis is a joint product of the participants and the researcher.

### **3.9 Validity**

The concept of validity is surrounded by a considerable debate because it relates to qualitative and phenomenological studies (Smith et al. 2009). Different views have evolved according to varying theoretical and academic perspectives by researchers. Yardley (2000) considered a pluralistic viewpoint, suggesting that qualitative validity is authenticated through a number of principles including sensitivity to context of existing research and theory, commitment and rigour, transparency and coherence. Sensitivity was demonstrated through attending relevant research workshops and conferences to the subject area of PND and an in-depth literature review.

Yardley (2000) also proposed that validity is demonstrated through commitment and rigour. This was shown through the level of attention that was attributed to each participant and detailed application of IPA guidelines by Smith et al. (2009). I carefully selected a homogenous sample in order to address the research questions. I was personally committed and dedicated to the study, producing the qualitative interview schedule and research questions that were carefully examined by my research supervisor and revised after several iterations drafts (Appendix A). I was open to surprises within my analysis and I ensured that the themes resonate within dataset (Davies & Dodd, 2002).

Further to the above, Yardley, (2000) suggests that transparency and coherence were important in validating qualitative research. This was achieved through a coherent description of the procedural process of the study. I kept a reflexive journal and attended closely to participants' experiential claims, manifesting the interpretative activity of IPA at the same time (Shinebourne, 2011).

The transparency of the study was further demonstrated by providing examples of informed consent forms, marked transcripts, quotes within the analysis section and other documents relating to accountability and reliability (all included in the Appendix section of the thesis). Another principle of validity lies within the impact and importance of the study thus, providing evidence to support usefulness and applicability in professional practice. This will be explored in more details within the discussion section.

### **3.10 Methodological reflexivity**

The interview schedule was constructed to prioritise participants' experience and not to be led or based on my expectations. In working with feedback from my supervisor, I was able to identify and check my presupposition enabling me to update and restructure my interview questions in order not to 'block out the participant voice' (Finlay, 2002a). I was skeptical from the onset about finding participants for my study due to the nature and sensitivity of the topic. Despite the challenges I faced in the recruitment phase which lasted for long period of time, I remained positive in looking for participants.



As my participants were a hard to reach population and the topic considered sensitive, therefore, managing and tolerating uncertainty in the recruitment stage was important for me and in enriching the ‘process of becoming a reflexive researcher’ (Etherington 2004, p. 81). I looked at the literature on hard-to-reach population and sensitive research topics (Liamputtong, 2007; Abrams, 2010) to inform myself of other possible recruitment avenues.

During this process, my research was actively discouraged by a Nigerian GP whom I approached regarding recruitment of participants. He laughed and told me that Nigerian women were ‘resilient and so do not suffer with PND’. This affected my recruitment confidence knowing that this particular GP has practiced in the UK for over twenty years. However, I was able to challenge my doubts and continue with the recruitment process. I later attended a Nigerian women conference at which I spoke about the myth around PND being ‘white’ women’s illness. I was able to recruit one participant at this conference, howbeit other women who indicated interest did not meet the required criteria for recruitment.

In order to facilitate the rigor of the study I attempted to outline the possible impact I had as a researcher on the study (Willig, 2012). Researchers within studies involving participant action research are often situated as insider and outsider, as they conduct research within their own community, workplace or social groups whilst occupying an outside position of the researcher. Dwyer and Buckle (2009) highlight that within

research study, researchers are increasingly making known their membership identity in the communities they study.

I attempted to conduct each interview upholding my professional values (Orlans & Van Scoyoc, 2009) in respecting each participant's unique experience. I consciously 'bracketed' my presuppositions allowing each participant to freely express and reflect on their individual experiences. The interview process were conducted demonstrating CoP values in enabling participants to experience the process 'as empowering and facilitative of understanding and growth' in relation to their PND (Kasket, 2012 p.68).

However, the vulnerability of participants around the topic and the intense emotions it brought up in sharing their experience meant I was very aware not to turn the interview into a 'therapy session' even though I felt encouraged to do so by some of the participants. I identify with some of the mother's experiences, such as the Nigeria intergenerational cultural values regarding the expectation to be a strong and resilient mother and the difficulties in adjusting to an individualist UK culture. Although this has been challenged through my training and practice as a clinician, I reflected on how this may have impacted on the process of my research.

All the participants described the interview as an opportunity to freely speak about their experience and reported finding it therapeutic. Deciding on the venue for the interview was another challenge due to childcare arrangements because some of the participants did not want the interview to take place in their homes. This gave me an

insight into some of the challenges faced by mothers with young children in this country.

My experience of conducting interviews with fellow Nigerian mothers felt like I was giving something to my own community. My participants and significant Nigerian individuals believed in the potential influence of the study within the Nigerian community and other ethnic minority groups in the UK. Although I felt frustrated at the recruitment stage due to reluctance and drop out by some potential participants, the shared cultural understanding between me and the participants made relating, interviewing and understanding the narratives of the mothers much easier. I believe it also made it easier for the participants to freely share their experiences. Following the recruitment process and data collection, the analysis of the data took place. This will be the focus of the following chapter.

#### **4. Analysis/results**

This section presents the participants' profile and the IPA analysis of the findings of the study which emerged from the narrative experiences of the participants of the study. The analysis consists of six transcripts which produced a large volume of data and resulted in three superordinate/master themes and seven subthemes. An example of an interview transcript and emergent themes for all participants is in Appendix I. The raw data are illustrated by verbatim anonymised transcript extracts in italic script. The extracts are labelled according to the interview from which they originated and the relevant page number. The master and their constituent subthemes are summarised in Table 2 below and another table consisting of the master and subthemes with corresponding quotes including page and line numbers from the transcripts of all the participants can be found in Appendix J.

##### **4.1 Participant's profile**

The participants in the study were six Nigerian mothers who self-reported to be formally diagnosed with PND by their respective GPs. They were Nigerian-born mothers who now live and have given birth in the UK. All participants were given a pseudonym in order to maintain confidentiality. Three interviews were conducted at participants' homes at a quiet and private time and in confidential rooms and the other three were conducted in a hired confidential counselling room. The participants lived across England (Three lived in Buckinghamshire, one lived in London and two lived in Northamptonshire) and they were all in employment at the time of the interviews. Two participants moved to the UK to join their husbands, three

participants came to study and one participant relocated with family through the Tier 2 visa for skilled workers. All six participants confirmed being prescribed medication as a form of treatment/intervention. The profile details were obtained at the beginning of the interview. Table 1 below represent the characteristic and demographic information of the participants.

**Table 1: Participant’s characteristics and demographics**

Participant’s pseudonym	Age	Nationality	Marital status	Age of child at the time of interview	Position of Child	Number of Children in the family
Ade	32	Nigerian	Married	Eight	First	Two
<u>Ngozi</u>	45	Nigerian	Married	Nine	Third	Three
Rosemary	40	Nigerian	Lived separately from partner	Eight	Third	Three
Blessing	39	Nigerian	Married	Six	Second	Two
Celia	30	Nigerian	Married	Four	First	Two
Julie	35	Nigerian	Married	Five	Second	Two

**Table 2: Master and related subthemes**

MASTER THEMES	SUBORDINATE THEMES
SOCIO-CULTURAL FACTORS	Intergenerational transmission: cultural expectations and conformity to the primacy of the strong black resilient woman
	Cultural perceptions: shame and stigma
	Transition: adjusting to an individualistic culture
NEGLECTED NURTURER	Experience of treatment: neglected by professionals
	Façades: pretending to be okay
LONELINESS AND COPING	Lack of spouse support
	Self-reliance

**4.2 Master theme 1: Sociocultural factors:** The findings grouped into this theme suggested that FGNMs experienced cultural expectations to maintain a sense of resilience and strength that is highly valued by the Nigerian culture. This master theme is clustered into three subthemes – Intergenerational Transmission: *cultural expectations and conformity to the primacy of the strong black resilient woman*; Cultural Perceptions: *shame and stigma* and Transition: *adjusting to an individualistic culture*. These themes are strongly interlinked, constituting the social and cultural factors/issues that affected the way in which the FGNMs experienced PND.

**4.2.1 Subtheme 1: Intergenerational transmission: *Cultural expectations and conformity to the primacy of the strong black resilient woman*:** All the FGNMs interviewed narrated how intergenerational beliefs and expectations to be strong and resilient affected them postnatally. The theme also shows how the tendency and effort on the part of the women to conform and live up to these expectations denied them the opportunity to express their feelings and share their difficulties. In many cases the women identified and referred to themselves as ‘African women’ and not as individuals, indicating the impact of the beliefs that has been culturally transmitted. For example, Rosemary said:

*‘...as an African woman, we are brought up to be strong; we are supposed to be strong ... there’s that expectation...’ (p 3, line 83-84)*

This excerpt seems to convey Rosemary’s conflict with the cultural expectations and her true desires for support needs. It seems that although she felt vulnerable and needed help and support, she conformed to the cultural expectations and masked her struggles, suggesting the impact of the expectation which may have partly represented a possible precursor to the struggle with PND. Rosemary’s identity as an African woman seemed important and it appeared that her position with the concept also had to do with her family values: ‘*we are brought up to be strong*’. It felt as if she did not want to disappoint her family and she did not want to be seen as unable to cope even though that seemed the obvious case.

All the participants expressed experiencing cultural expectations to overcome any challenges. They voiced that expressing emotional feelings might be regarded as weakness as highlighted by Celia:

*'...you have to be strong, you have to be strong no matter what, you have to overcome any challenges or it's considered as weakness' (p 5, line 165-166)*

Here it appears that Celia laid emphasis on the need to conform to the norms and expectations. There seems to be an indication for rigid conformity to values and strong beliefs here. Celia did not only expect to be strong but also felt that being perceived as not coping will be interpreted as weakness by others. This may have increased her level of struggle and vulnerability.

On the contrary, Julie, one of the participants, revealed that although it was not natural for her to ask for help, which could have been a result of the cultural beliefs and expectations, she was willing to accept available help and support if they were offered:

*'...I could have said something if someone had pushed me or asked about how I was coping, I would have been open to talk about it because I think they would have helped me...' (p2, line 68-69).*

It is interesting to hear what Julie conveyed in the above excerpt, implying the flexibility to receive support, but it was not culturally permitted or normal for her and perhaps for other women in the study to explicitly ask for support. This also



highlights the impact of the expectations which could have encouraged Nigerian women to conceal their vulnerability.

Although some of the participants described their experience of the cultural expectations as ‘pressure’ and ‘irrational’ they seemed unable to break away from the influence. For example Ade said the following:

*‘...so more slowly and gradually I felt I needed to deny myself ... I felt I needed to live a life for people’ (p 5, line 26-27)*

Here, Ade seemed to suggest helplessness about how her struggles were not acknowledged. It seemed as though she did not have the voice and the courage to overcome the pressure and the expectations. This seemed to be due to the influence of the powerful and endearing intergenerational cultural transmission of the notion and expectation to be strong and resilient. It also appeared that everyone around Ade assumed she was coping when she was not as articulated below.

*‘...everyone felt that everything was going on well with me except me (Ade, p2, line 26-27)*

Here, Ade seemed to indicate being alone in a world where no one except herself could feel the possible pain, struggle and the challenges she was experiencing. This could indicate difficulty in receiving support when the struggles are not acknowledged by others. As a consequence, it seems that the majority of the mothers came to a conclusion to get on with their lives as recounted by Julie:

*‘...the expectation on you is that you just get on with it, that’s our culture ...get on with things, you don’t complain’ (Julie, p3, line 84-85)*

This excerpt seemed to suggest that Julie came to a conclusion about the expectations and the need to conform to them. This was substantiated by other women in the study. It seems that Julie adjusted and accepted the situation even though it seems irrational and meant suffering the pain alone or in silence.

The participants also reflected inability to express their concerns and emotional struggles to their immediate families including their mothers who came to support them. However, it seems that although emotional support was not available, the women valued the practical support that was offered as recounted by Celia:

*‘...even when my mum came, I couldn’t tell her what I was going through but I was so happy that she came and she was able to take over to look after the baby and gradually I begin to get myself back yeah’ (Celia, p5, line96-98)*

This excerpt showed how Celia was unable to discuss her emotional struggles with her mother, but she was happy with the practical support that was offered. This may reflect how the inability to talk about emotional struggle links to the expectation to be seen as a strong and resilient woman. Ngozi had a similar experience and explained as follows:

*‘... I don’t want to spoil her joy, so I had to really kind of bottle everything in...the culture I came from or where I grew up, I don’t speak to my mum that freely...about things that are so deep...because she will not understand, it*

*will look like I am 'going mad' when I should be happy...' (Ngozi, p7, line 193-197)*

Here, Ngozi narrated how she did not want to jeopardise the joy of her mother, but rather suffer the emotional pain in silence (*'bottle everything in'*). It seems that the expectation to be happy was not only for the new mother, but for the entire family. The expectation appeared so powerful for Ngozi to equate expressing emotional struggles with a sense of *'going mad'*. It also appeared that Ngozi bottled up things to keep up with the expectations and to be seen as doing okay or copying which was not the case (façade).

**4.2.2 Subtheme 2: Cultural perceptions: *shame and stigma*:** This theme captures another significant experience that was described by the FGNMs. The theme discusses how PND was culturally perceived and how it was associated with shame and stigma. This cultural perception of PND meant that mental health issues including PND were not openly and freely spoken about as described by Ngozi:

*'It is not just something to talk about... when you are expected to be happy nobody will take you serious. I think it's also because I didn't want them to feel as though I wasn't coping, and it wasn't part of our culture also to be talking about things like that' (p5, line 144-146)*

The narrative suggests a link between how PND was perceived in the Nigerian culture and the impact this had on the sufferer. According to Ngozi, because she was

expected to be happy, it was difficult to show or express vulnerability and this seemed to encourage secrecy and shame around talking about the subject of PND.

Blessing similarly describes the impact of the Nigerian cultural perception of PND as follows:

*'...where I came from, depression is not something you can just talk about...because of the taboos that are associated with it, sometimes when people know that you have mental health problems, they will start avoiding you...so the person is like stigmatised and you won't be able to have your confidence in front of people anymore... so ...that's why, so with the way they view it... makes it very difficult ...to open your heart to tell anyone that you are suffering from depression'(P4, line 105-112).*

This excerpt explains the way Blessing experienced the impact of the Nigeria cultural perceptions of PND, the associated stigma and the isolation that was endured including other implications for the sufferers. Blessing describes how depression was perceived as a taboo and spoke about the risk of being isolated/ostracised which she said could lead to loss of confidence. Her narrative inferred a form of discrimination against people suffering with mental health issues which seemed that in order to be socially inclusive, mental health issues are denied or kept secret. It also felt that this had an implication on suffering alone and in silence. Blessing used the word 'heart' here which may indicate the deep seated nature of the concerns for her.

Julie also narrated her experience of how PND was perceived with a slightly different view as articulated below:

*'...anything that has to do with mental health is frowned upon, it is stigmatised where we come from, and it's like because we see our mothers went through it without complaining we should not complain' (Line 139-141)*

The excerpt shows how Julie may have felt helpless but accepting of the cultural perception of PND. She describes how mental health issues were culturally frowned upon and the stigma attached to it. However, Julie seemed to link this to how their mothers in generation past went through it without complaining and the expectation for the following generations to do the same. This inter-generationally transmitted beliefs and expectations may have affected Julie's confidence to express her feelings and struggles. This also seemed to have impacted Ngozi as explicated in the excerpt below:

*'I think my mum ...probably would not understand as...you are expected to be very happy because you are married and you are expected to be very happy because you've had a baby, she will tell me to be strong and mentioned the generations of women in our family who have had children without problems' (Ngozi, p7, line 189-192).*

The account reflects how the perception of PND by the families of the FGNMs may have affected the autonomy and freedom to express negative feelings and struggles. Ngozi narrates in the excerpt about how she was unable to tell her mum about her struggle not only due to the expectations to be happy, but also because she might be compared to the older generations of women who had babies without any struggles or perhaps without expressing any struggles. It seemed that without the

understanding and cooperation of the family members it was difficult for the women to easily make decisions about how to seek help from elsewhere. This may have been responsible for the women interviewed in seeking help at a later stage of their depressed states.

**4.2.3 Subtheme 3: Transition: *adjusting to an individualistic culture:*** All the participants describe how adjusting to an individualistic culture in the UK affected them both socially and psychologically. For some it resulted in feelings of isolation and loneliness and for others it was the loss of the communal life they were used to in Nigeria and comfort zone as described by Ade:

*‘So being isolated from my comfort zone which is Nigeria made things harder. It made access to help more difficult. It made the gap wider for me. Yes, I would say, yes’ (Ade, p6, line 143-144).*

Ade’s narrative suggests the isolation she felt being away from both her family and the Nigerian cultural norms she was used to. This may suggest a sense of discomfort and difficulty in navigating her way around the support system available in the UK. It seems that the differences in the way things are done in Nigeria in comparison to the UK was challenging for Ade which may have made it difficult for her to easily adjust to the system.

Similar to Ade, Rosemary describes the isolation she suffered:

*‘I didn’t have any family in the country, I didn’t really have any friends other than... work colleagues, and so, it was very isolating for me’ (p2, line 34-36).*

Rosemary seemed to suggest in this excerpt how isolating it was for her to live in a new country without friends and families. She seemed to describe lack of social integration and connectedness. It also seems that the cultural differences made it harder for her to form relationships which could be one of the possible root causes for her depression.

Julie, in describing her experience of migrating to the UK in relation to her PND, compares the communal/collectivist life in Nigeria with the individualistic culture in the UK and how this impacted on how she managed with her difficulties and challenges:

*'I guess we come from a very communal culture back home, where...you always have help... there's always an auntie, cousin, someone you are surrounded by, and then you come to a society where it's a very individualistic, everybody keeps to themselves, you can't knock on next door neighbour to say please look after my child, come and help me, so it does involve culture shock' (p3, line 95-99)*

This excerpt suggests how Julie felt about the differences in the two cultures. Her narrative inferred a loss of comfort and social support which is available in the Nigerian culture to new mothers. The excerpt also seemed to capture a significant cultural difference that Julie found very hard to cope and come to terms with. Julie seemed to describe the disappointment of not been able to ask for help from neighbours here in the UK which is available in Nigeria as a cultural shock. It

sounded as though in Nigeria, neighbours are part of the support system, and it seems that the unavailability of such support was significantly difficult for Julie which was equally echoed by some of the other women interviewed.

Blessing likewise described her isolation and loss of comfort that she lacked here in the UK and described her experience as being alone:

*'...coming from a country where there is a close family unit where...most times you see everybody will help you with one thing or the other and then coming to the United Kingdom ...and when you are pregnant and have your baby, you are there on your own'(p1, line 14-17).*

Blessing shared a sense of isolation, loneliness and perhaps a sense of struggle to integrate into an individualistic culture in the UK. It seemed that she struggled with concerns and anxiety about the cultural differences between Nigeria and the UK and seemed to have difficulties adjusting to these differences.

**4.2.4 Theme summary:** The theme 'sociocultural factors' illustrates how the Nigeria cultural and social factors impacted on how the FGNMs experienced PND. This includes the cultural expectations to be strong and resilient and the stigma and taboo associated with PND. It indicated how this encouraged concealing vulnerability and responsible for delayed professional help-seeking/interventions. The Nigerian cultural perceptions of PND were associated with stigma, feelings of shame and isolation and seemed to encourage secrecy about PND. A common



experience of adjusting to an individualistic UK culture seemed to have created significant difficult experiences for the participants.

**4.3 Master theme 2: Neglected nurturer:** This superordinate theme captures the perceived neglect that the participants experienced with different healthcare professionals who worked with them. All the participants believed that support for new mothers from healthcare professionals should be readily available. They reflected on their personal and individual experiences of care and neglect by different professionals, which will be explored in the first subtheme (experience of treatment: neglected by professionals). The response by the participants to their experiences of neglect will be considered in the second theme (façade: pretending to be okay).

**4.3.1 Subtheme 1: Experience of treatment: *neglected by professionals:*** The participants individually narrated their encounter and experiences with the different professionals who worked with them. Below is an excerpt of Ade's comments on her experience and contact with her midwife:

*'I went to see the midwife and I explained to her that I am experiencing these symptoms, instead, she kept on asking about the baby. 'I hope you are not harming the baby' I said no. I told her the only thing is that I am not emotionally attached to her, I might leave her crying for hours, at times I might shout on her...they said I would have to be referred to the GP, I went to see the GP, I was given antidepressants ... but I did not take the medication' (p2&3, line 48-60).*

This narrative seemed to reflect a sense of neglect by the midwife. It seemed that all the effort and courage Ade exerted in going to see the midwife to complain about her difficulties and struggles were disregarded and instead, the focus was directed to whether or not she was harming the baby. This may have been upsetting, disappointing and frustrating for her. Ade may have interpreted the midwife's response and attitude as though the baby was more important than her wellbeing which may have evoked a sense of neglect. Below, Ade narrated her experience with her HV which is why she went to see her midwife:

*'...I couldn't speak to my health visitor because ... I felt she was just going through a checklist...I felt everything was being mechanical. She was using a set of questions; I think she was asking me the wrong questions... I felt she was not empathetic. I felt that distance was there. She was asking me a lot of questions but she wasn't ready to come close. I didn't want her as a friend, I wanted her to lean on I wanted someone that would understand me... not someone who was going through a 'checklist' (p6&7, line 164-170)*

This account reflects Ade's concerns and perception of her HV. It seems that the HV felt duty bound to attend to a 'checklist' which Ade may have seen and regarded as neglectful of her mental health and wellbeing. Ade felt the professional was asking her wrong questions. It appeared that she expected questions related to how she was coping that could have enabled or encouraged her to open up about her struggles. Ade seemed to experience the HV to be distant and unavailable when she perhaps desperately needed someone to listen to her, someone to acknowledge her difficulties

and possibly give professional advice. Ade seemed to have made several attempts to be heard and seems clear about what she wanted but appeared to have a lost voice.

Similarly, Julie narrated her experience about how the practitioners were more concerned about her care for the baby and physical things rather than how she was coping.

*'The nurse come and look at the child, look after how she is doing, how I'm looking after her, they were always enquiring about the child, and yeah but not my mental health, so it's always like your physical health, is your wound healing, nobody asked about my mental health...'(p2, line 65-69)*

This excerpt seemed to represent an expectation that the HVs and midwives as primary health carers have the responsibility to both check on the wellbeing of the babies and how the mothers are looking after the babies as well as care and assess the mother's mental health and wellbeing. This seems to echo the expectations and the NICE guidelines for caring for women postnatally, but this duty and responsibility seemed neglected by the practitioners as described here by the participant. Julie seemed frustrated about the focus of the nurses being only on her care for the baby and her physical wounds. The excerpt also seemed to indicate that the EPDS was not being used by the HVs for these mothers in monitoring PND which is recommended by NICE guidelines. The lack of the use of the EPDS was validated by other women in the study.

In addition, Blessing articulated her experience about how the visiting professionals were habitually concerned about the care of the baby:

*'When the midwife come in, they just want to check on the baby just to make sure the baby is okay, the baby is feeding well on the breast., the baby doesn't have jaundice... they just do their thing and when the health visitor come as well they weigh the baby, so most times the interest is on the baby baby baby, nobody thinks about the mother, yeah so that it the actual experience' (p2, line 40- 45).*

The excerpt seemed to echo a sense of neglect, frustration and disappointment by Blessing in saying: *'nobody thinks about the mother'*. It sounds like Blessing strongly felt like a neglected nurturer here. She possibly could not imagine how the focus could predominantly be on the baby without the professionals asking how she was coping with her new role and demands from the baby. For her it seems obvious that support should be offered or provided to the mother by the professionals, but it seemed she felt unable to ask and possibly internalised her feelings instead.

Rosemary narrates her experience with her GP and explained how her possible preconceived scepticism was confirmed as stated below:

*'So I just thought, I would speak to the GP and see if I'll get anywhere there, so when I saw the GP...I was started on anti-depressants, I had a little chat but there was nothing in terms of... referral to any external services...I was just given anti-depressants, I couldn't tolerate the anti-depressant at all because it made me feel very tired and this wasn't explained to me either...I was just feeling terrible, getting up was a problem and I just felt I can't feel like this because I've got...the children, so I needed to take care of them and*

*I needed to take care of myself, so...I stopped taking the medication within, probably...a week, yeah and I just didn't bother so I just struggled by myself'(p3 &4, line 93-103)*

The excerpt may suggest an interpretation by Rosemary that the GP was probably dismissive or it could have been due to her scepticism before going to the GP. However, she expected to be referred to other services, for example where she would be allocated more time to talk about her struggles. Rosemary seemed surprised being given antidepressants without a choice. It also seemed that she thought as a new mother that the GP would have given her a preference and more time. This unmet expectation may have caused a sense of disappointment and feelings of neglect. It appeared that the antidepressants genuinely had a negative impact on Rosemary. The fact that the GP did not explain how the medication works including possible side effects, meant that she discontinued the antidepressants. Further, Rosemary explains about anticipated benefits of having the opportunity to talk to someone about her feelings:

*'...I think ...sometimes I think, just by talking to people...helps, so I think maybe...if I asked for referral or was referred to an external sources, it would've probably have helped because I think sometimes just talking to other people...helps, it helps because you offload things and it makes you feel okay it doesn't solve the problem but...I think... problem shared can make you feel able to cope and become better' (p6, 169-174).*

Rosemary and some of the women in the study seemed to believe in talking about their problems and struggles rather than taking medication. Unfortunately, such

opportunity or expected referral by their GPs was not available to them. Below Ngozi narrated her encounter with her GP and expressed her surprises:

*‘To be very very honest with you I was so surprised that he just immediately prescribed antidepressants for me, because I wasn’t expecting him to just like hand it to me like that without explaining things or checking if I would take it’ (p3, line 65-67).*

This account seemed to suggest that Ngozi was deprived of her desired agency in her care and treatment choice. The absence of her autonomy and the failure of the GP to explain the function and possible side effects of the antidepressants may have been experienced as disregarding and neglectful. The excerpt also seemed to indicate or highlight the fact that the mothers were diagnosed with PND without due consideration of the context of their difficulties and challenges by the GPs.

Ngozi indicated that she did not take her medication due to personal or cultural beliefs which is similar to how some of the other women in the study viewed medication therapy:

*‘Because I didn’t want to see myself as a junkie, someone that is relying on tablets, I took the medication for a while and...decided not to take it anymore...’ (p2, lines 37-38, Ngozi).*

Ngozi seemed to have a strong view and interpretation about taking medication and the possible side effect. It may sound extreme to think of being seen as a ‘junkie’ for taking antidepressants, but this may have a possible link to both cultural beliefs and lack of explanation of the medication by the GP.

**4.3.2 Subtheme 2: Façades: *pretending to be okay*:** The majority of the mothers interviewed described how they adjusted to their unmet expectations and managed their disappointment by the professionals:

*‘when... you have had the baby, they will come and see the baby and during this time I will put up a smile, I feel like I’m so happy because they are caring for the baby, as soon as they walk out of the door, I go down being unhappy again, wishing that someone could just take the baby’ (p6, line 157-160)*

Here Ngozi seemed to separate herself from the visit: *‘they will come and see the baby’*. The baby centric care offered by the professionals may have informed her decision to step away/back and put up a smile to appear happy. It could be a way of reverting to the culturally expected default behaviour - to be happy as a new mother. On the contrary, it could be denial and unwillingness to talk about her mental health, informed by cultural constraints. However, it seemed that Ngozi was not given the opportunity to talk about her feelings, struggles and need for support.

Blessing conducted herself in a similar manner to Ngozi. However, it seemed that Blessing was reacting to the frustration she felt:

*‘so once they come and the child is okay, they will go and when you know they are coming you just put a smiling face, show them the things they want to see...they come and look at the environment, they look at the baby, and off they go...then when they go, you now have to go back to where you started from, so you hardly see them, you can’t meet them, there is nobody to talk to...’ (p2, line 46-50)*

The excerpt seemed to describe a deeper psychological impact for Blessing. It appeared that she was reacting to the disappointment she felt in the way her feelings and struggles were not acknowledged by the professionals. Similar to Ngozi, she took a back seat by putting on a smiling face during the professionals' visits. It also seemed like a reaction to a sense of helplessness and a possible reaction to an unmet expectation. It is possible that the women accepted the situation as a defeat, hence the decision to put on 'smiling faces' during the professionals' visits or inability to freely express her feelings. This may be a way to cope with the feelings they had towards the professionals and their situations. They may have pretended to be okay to get by with the visits as confirmed by Ade:

*'I would go to the windows opened it and I just wished something would push me down to die... I remember it was December, all snowy, dark, I just opened the window and wanted to jump but I couldn't do it myself and when the health visitor came I will pretend I was okay' (p2, line 45-48)*

Ade reflected on how lonely and difficult it was for her to the extent that she contemplated suicide yet, she seemed unable to talk to the healthcare professional who came through her doors at this difficult time of her life. Ade earlier narrated how she was alone with the baby because her husband worked abroad *'Three weeks after I had the baby my husband travelled to Paris to work so I was left in an empty house, with a baby girl clothed in blue clothes'*.



### **4.3.3 Theme summary**

The Theme: ‘neglected nurturer’ exemplifies the interpretation of the experiences of the participants regarding the perceived neglect of their mental health and the excessive focus on their babies by the visiting professionals (baby centric care). The lack of choice of treatment type and neglect of their desire to be referred by GPs to other supporting services was highlighted. The theme also emphasised the beliefs of the women about taking medication for PND and the interpretation of the possible side effects of the medication. The theme additionally suggested a passive permission by the mothers to allow the professionals to conduct the process of the visits even though it was unsatisfactory and ineffective for them. It emphasises the inability of the mothers to freely express their struggles.

### **4.4 Master theme 3: Loneliness and coping**

This theme discusses the lack of support suffered by the FGNMs, particularly from their spouse. This will be discussed in the first subtheme and coping methods will be analysed in the second subtheme.

**4.4.1 Subtheme 1: Lack of spouse support:** All the participants narrated their experiences of lacking support particularly from their spouses, which for some led to extreme loneliness, frustration and hopelessness and for others it was related to feelings of disappointment and suicidal ideation:

*‘I remember feeling so overwhelmed one day, I was just standing at the window with the baby and I thought to myself I want to jump outside the window with the baby um, then I thought, you know I’ve got a little one,*

*because I held the baby, in my arms and I just thought to myself uhm, I had tears streaming down, it was just a feeling of hopelessness... yeah, especially thinking about uhm, you know wanting to kill yourself but fortunately for me I just thought uhm, what would, how would that impact on my family and who will look after my children...’ (Rosemary, P6, line 181-188)*

The above excerpt pictures the gravity and the negative impact the lack of support from partner and professionals had on Rosemary. It seemed Rosemary suffered overwhelming feelings of loneliness and isolation, leading to extreme thoughts to take her own life. Rosemary summed her experience as feeling hopeless. It appeared that one of Rosemary’s protective factors was concern about her older children and thoughts about the impact her suicide may have on her family. In addition, Rosemary described lack of support from her partner and related it to her predisposing factors:

*‘I couldn’t tolerate my partner because [you know], because I felt he got me into this situation and as a dad to my 2 children he should’ve done something about it...so although he supported financially, I felt it wasn’t enough...’ (P5, line 133-136).*

Rosemary seemed to react strongly to the way she was treated by her partner in explaining the inability to tolerate him. Rosemary had housing problems when she was pregnant (in her third trimester). She blamed her circumstances on the poor relationship and lack of support from her partner. Although her partner was the father to her two children, Rosemary may have found it harder to cope alone because

they did not live together. It also appeared that Rosemary was more interested in physical and emotional support from her partner than financial support.

Similarly, Ade described her experience of lacking support from her husband and the resulting outcome:

*'I couldn't cope with the depression because all I kept on wishing was for me to die. That was all that came to my mind and head. There was no one to talk to and it was just a lot of thought...I would go to the windows opened it and I just wished something would push me down to die... I wanted to jump but I couldn't do it myself...' (P2, line 43-47) 'Three weeks after I had the baby my husband travelled to Paris to work so I was left in an empty house, with a baby...' (P2, line 41-42)*

This excerpt explains a possible sense of abandonment felt by Ade and subsequent suicidal thoughts and attempts. Ade could not act on her persistent and overpowering thoughts possibly because of the thoughts about what might happen to her child. Alternatively, the suicidal thoughts could have been a simple desire for support and lack of companion/isolation she was not used in Nigeria. The loneliness and the lack of support that Ade experienced may have exacerbated her struggle to cope with her PND challenges.

Similar to Ade and Rosemary, Julie described the impact of lack of support from her husband:

*'My husband was away most of the time, he worked away from home, so I was left by myself, with a crying baby...so he wasn't there so he would come*

*home on weekends, [you know], then he would leave again by Sunday, I was practically by myself. I felt lonely and isolated...'* (p2, line 52-56)

This account may suggest that Julie was not happy about her husband working away from home, but it seemed that as she did not have the influence or power to change the situation. She had to manage all alone during the week, although this seemed unpleasant. Being left alone with a 'crying baby' may suggest that Julie had difficulty in knowing how to look after the baby, particularly as a first time mother. This lack of support, loneliness and possible ignorance seems to have made managing her difficulties and struggles more challenging.

In addition, Blessing narrated her experience of lack of support but with a slightly different view and circumstance:

*'...so there is no one to actually help,... because my husband has to work to pay the bills... having a child is supposed to be something that will make a mother happy...[you know ] instead of being happy, one is having low moods, being depressed...I have to wake up many times in the night, I have 1 hour sleep, sometimes 2 hours sleep and with no help at all so it is very depressing... and also at the time I had wanted my mum to come over but the home office wouldn't let her...when I applied, I told them that I had a baby so my mum can come and help but they said there are lots of nannies here, why would I need my mum, so all these things where the things that really, really made me to uhm feel depressed at the time...'*(p1&2, lines 19-35).

This excerpt seemed to expound that although Blessing did not have support from her husband, but she did not blame him because she believed that she husband

needed to work to financially provide for the family. Blessing seemed to have suffered multiple gaps in support, both from the professionals, husband and her mother's denial of entry visa by the Home Office as illustrated in the excerpt. It seemed that Blessing felt very unfortunate and disappointed with the narrative of her experience. She attributed the onset of her PND to these factors and circumstances.

#### **4.4.2 Subtheme 2: Self-reliance**

This theme emphasised how the FGNMs managed and coped on their own in the absence of expected support from the professionals and the lack of social and emotional support from family, particularly their spouses. The FGNMs were adverse to medication therapy which was the only treatment offered to them. The theme highlighted how the women were struggled through their difficulties all alone as narrated by Julie:

*'You stay by yourself, so you cry by yourself you just get on with it...' (p3, Line 105)... 'but my mum came much longer because she is working in Nigeria ...' (p2, line 46-47)*

Here, Julie explained how she struggled through her difficulties, how she got on with things and possibly suffered in silence. Although her mother later came to support, the help did not appear to come at the appropriate time which meant that she went through the most difficult phase of the struggle and difficulties by herself.

Ngozi also recounted how she struggled on her own and managed through the difficulties without support from others:

*'Well, I managed on my own...suffered the isolation and loneliness alone before my mum would come and ... [you know] my mum has her own business so it takes time to prepare to come and when she came she like to go back early' (Ngozi, p5, lines 118 -120).*

Similar to Julie, Ngozi here seemed to describe suffering alone and going through the most difficult and challenging phase of her struggle before her mum came to support. Ngozi highlights suffering with isolation and loneliness and the delayed support from her mother seemed linked with a sense of 'giving up' on others. It seemed to inform the decision to rely on her strength and ability to go through the challenges.

In Rosemary's case, she narrated how she struggled through her situation and difficulties with self-motivation:

*'so ...I stopped taking the medication within, probably within a week, yeah and I just didn't bother so I just struggled by myself and...I think I tried to cope by just trying to get out of the house, [you know] going to the park, and just walking a little bit and just, that it what I did...' (P4, lines 102-105)*  
*'I just felt I can't feel like this because I've got [you know], the children, so I needed to take care of them and I needed to take care of myself...' (p4, lines 101-102)*

Here, Rosemary spoke about how she stopped taking the medication which was possibly due to her belief and view about taking medication as well as her reaction to it. However, she described how she motivated herself and how she was determined

to get better by compelling herself to get out of the house. Rosemary seemed to have developed a stronger resilience because she did not live with her partner. Although her partner was involved in the life of her children, it seemed that Rosemary saw herself as a single mother and took things on board without much expectations of support from the partner. The responsibility to look after her children seemed to be the propelling force for her self-motivation.

Celia, on the other hand, described her experience of juggling things on her own without support:

*'Having a baby abroad (UK) is completely different because you are the mother, you are the wife, you are the maid, you are the cook, you are so many things in one, and it's a lot, it's a lot to cope with but you have to do it alone when there is no help or support...I don't believe medication is the answer (p5, line166-168; 181-183).*

In the excerpt, Celia seemed to compare having a child in Nigeria and in the UK. This may imply the loss of the comfort of having people around to help with childcare as it happens in the Nigerian society/culture. Celia narrated the difficulties of juggling with multiple roles without support. This seems like a very difficult process for her; however, she seemed very self-motivated, resilient and determined with very clear beliefs regarding the role of medication in her difficulties and challenges. She seemed to strongly believe that medication could not provide the physical, emotional and psychological support she needed.

#### **4.4.3 Theme summary**

The theme ‘loneliness and coping’ captures the experience of the lack of support the mothers endured. It highlighted the impact of loneliness and how this led to extreme isolation, frustration and associated suicidal thoughts. The theme centred on how the women managed and coped on their own. It highlights the impact of Nigeria’s cultural gender defined roles in which men are more involved in financially providing for the family and the adverse emotional and social implications of this for the mothers.

The analysis of the data revealed significant difficulties suffered and endured by the participants. This will be discussed and evaluated in detail in the next chapter and will be related to existing literature including the implications of the findings for theory and clinical practice.



## **5. Discussion**

This chapter discusses and evaluates the findings of this study in relation to existing literature and theory. It discusses the implications of these findings for research and clinical practice. The chapter also highlights novel findings and makes suggestions for future research. This is followed with a discussion of the limitations of the study and a final reflection of the research process.

While some of the findings of the study echoed existing literature, some are unique and culturally specific to the FGNMs. The key socio-cultural issues identified in the current study with six first generation Nigerian mothers are reflected in the wider literature. Cultural expectations, perceptions and associated stigma, isolation, loneliness and lack of support have been found to be prevalent among BME groups (Templeton et al. 2003; Wittkowski et al. 2011; Lam et al. 2011; Gardner et al. 2013; Babatunde & Moreno-leguizamon, 2012).

Studies have shown that social norms, expectations and roles are common causes for depression, often exacerbated by culture specific issues (Lasch, 2000; Kirmayer, 2004; Ekanayake et al. 2012). The FGNMs in this study stated that their Nigerian culture placed some specific expectations and responsibilities on them. Such responsibilities include maintaining a sense of resilience, upholding the status of a 'strong black resilient woman' and conforming to this image.

The current study provides some important new insights about how the FGNMs related to the concept of PND. It was found that the need to be strong and seen as

resilient was passed onto the mothers inter-generationally and conforming to these cultural expectations impacted their ability to express their support needs and seek formal help on time. This process could be explained with social identity theory (Tajfel & Turner, 1981) suggesting conformity is a social pressure and influence which affects how people relate and behave within a group or culture, originating from the feeling of acceptance or rejection.

This intergenerational cultural transmission (expectation to be happy as a new mother and resilient) may have pressured the women and seemed to have had a significant impact on their ability to show vulnerability. They minimised related difficulties and demonstrated tendency to deny PND. Another potential issue for the FGNMs could exist around the interpretation of symptoms, suggested by Misri et al. (2000) to disenable new mothers to distinguish between depressive and after birth symptoms such as anxiety and tiredness. As a result, many mothers believe that their feelings and symptoms will go away without treatment and therefore fail to seek support that they might need.

Studies suggest that the Western language used in describing PND makes it difficult for BME mothers to understand and acknowledge PND (Bashiri & Spielvogel 1999; Lam et al. 2011; Watson et al. 2019). Although the majority of the participants were healthcare professionals many of them were ignorant about PND prior to their diagnosis. A study by Adewuya et al. (2005) conducted in Nigeria suggests that the phenomenon of PND is poorly understood by Nigerian mothers. This may also

suggest why mothers in a study by Amankwaa, (2003) with African American mothers believed that PND is only suffered by 'white mothers'. However, it is surprising that the women in this study living in the UK did not know about PND before their diagnosis despite NICE guidelines recommending professionals to discuss emotional wellbeing and identify potential mental health problems in women during routine antenatal and postnatal appointments.

Gavin et al. (2005) suggests that the birth of a child most often evokes the feelings of joy and happiness for new mothers and families, but less attention is paid to the fact that PND is also present for many new mothers. The conflict between the reality of depressed mood that many new mothers actually experience and these positive emotions that the mothers often think they should feel can be confusing and overwhelming. This conflict could have further fed into denying and minimising the presence of PND for the FGNMs.

All the participants in the study reflected on experiencing a sense of isolation and shame associated with stigma relating to how PND was culturally perceived. They suffered with the fear of discrimination and concerns about bringing shame to their families and community as a result of their PND. This finding is in line with previous research such as Wittkowski et al. (2011) and Babatunde and Moreno-leguizamon (2012) suggesting that stigma regarding PND significantly affected South Asian, African immigrant and Bangladeshi women (Templeton et al. 2003). The issue of stigma around mental health problems amongst BME mothers has been

largely identified in literature (Williams & Carmichael, 1985; Cox, 1999; Anand & Cochrane, 2005; Wittkowski et al. 2011; Watson et al. 2019).

Abdullah and Brown (2011) defines stigma as disgracing and devaluing of an individual with mental health problems by the general public. Although the reasons for stigmatisation are inconsistent across cultures, perceived stigma by people with mental health problems/illness is globally reported (Templeton et al. 2003; Alonso et al. 2008). Such stigma should therefore be considered and addressed when working and supporting this particular population postnatally.

Whilst studies (Troyna et al. 1993; Amankwaa, 2003) suggest that BME women feel more comfortable within their families and communities and tend to focus on them for their support needs. This claim contradicts the findings of this current study, from the experiences narrated by the FGNMs, they were unable to rely on their significant others and community for their support needs due to the cultural perception of PND and the cultural expectation to be happy (after giving birth), strong and resilient.

Rüsch et al. (2005) suggests that stigma is associated with shame and can lead to discrimination. This was the experience of the participants in this study and this could have resulted in secrecy, denial about the topic/reality of PND and delay in seeking former support. White et al. (2011) and Edge et al. (2010) suggest that delay in help-seeking has a long-term negative effect and puts a strain on the healthcare system. It has the potential to lead to increased suicidal thoughts, suicide attempts and actual suicide by patients/clients. As result, Goodman, (2004) suggests that early

intervention in treating PND would be of benefit to both the mothers and the care providers and it can be helpful in avoiding the negative impact of PND.

The mothers also said that speaking about their feelings and intimate issues like diagnosis of PND to an outsider is considered as a cultural taboo and it could be perceived as a weakness when disclosed to family members or may be conceived as one losing their mind, '*going mad*'. Therefore the mothers would not readily disclose them to families and healthcare professionals. This echoes studies such as Wittkowski et al. (2011) and Babatunde and Moreno-leguizamon (2012) reporting that African immigrant women concealed symptoms of PND due to the associated stigma which relates to the way PND was culturally perceived.

The participants' interviews revealed the struggle with adjusting to the individualistic UK culture. They highlighted the struggle to identify with two different cultures and to simultaneously balance two different sets of expectations and ways of living. For some of the participants this was said to result in feelings of isolation, loneliness and anxiety, and for others it was the loss of the communal life they were used to in Nigeria. In addition, the participants experience this as a cultural shock and felt removed from their comfort zone. Lalonde and Giguere (2008) discuss some of the conflicts that first generation individuals might face as Western culture emphasises the importance of independence and individual autonomy, whereas Nigerian culture places strong emphasis on communal living (interdependence) and family connectedness. This 'cultural clash' could have

complicated the experiences of the women, suggesting that while communal living by Nigerian women could be helpful in lessening stress or anxiety, it could also pose as a barrier in coping outside such environment and could trigger mental health issues such as depression. This is consistent with a study by Lam, Wittkowski and Fox (2012) suggesting that isolation and cultural conflict were some of the major stressors suffered by the Chinese mothers, triggering PND. In addition, studies suggest that discomfort with unfamiliar norms could trigger depression (Berry, 2001; Leidy et al. 2010).

This tension could have created a sense of frustration, hopelessness and lack of belonging, and undermines the women's sense of self and identity. This clearly highlights the importance of social support and integration. This is very important for clinical practice because the practitioners need to be mindful of how their approach is compatible with the multifaceted and complex issues faced by the FGNMs. The practitioners need to carefully evaluate the interaction and potential conflict between the women's collectivist values and the individualistic and unfamiliar norms in the UK when working/supporting them and to help them in the process of establishing their identity, autonomy, social connectedness and integration.

Research evidence suggests that social integration leads to a better state of mental health and reduces risk of mortality (Seeman, 1996; Horsten et al. 2000). However, a review by Casey (2016) suggests that the UK government has not successfully

ensured that social integration keeps up with the scale and unprecedented pace of immigration. The author reported that some communities have been allowed to increasingly become divided and recognises the problem as failure of collective, persistent and consistent effort of the Government to give the issue the priority it deserves. However, it seems that a collaborative effort is needed to resolve the issue - the role of the Government and the need of the individuals to seek or be willing to integrate.

Notwithstanding, transition has been found to be a difficult experience. For instance, studies on immigration and acculturation suggest that lack of social support and integration could trigger PND (Berry, 2001; Leidy et al. 2010). This finding is consistent with the experiences of the women in this current study – the FGNMs were unable to adjust easily to the unfamiliar norms and suffered associated discomfort such as isolation.

Deaut, (1996) and Van Ecke, (2005) both argued that immigrants suffer with issues of adjustment and adapting into a new culture and this can lead to the immigrants having different self-perception and identity issues. This is consistent with the study by Gardner et al. (2014) suggesting the impact of loss of identity on West African mothers. A recent meta-analysis study by Wittkowski, Patel and Fox, (2017) suggests that immigrant mothers suffer with multiple psychosocial stressors that can predispose them to developing PND, suggesting a psychosocial understanding of

PND. Psychosocial predisposition for PND is evidenced in this study. The mothers suffered with psychosocial issues such as housing issues and lack of support.

A novel finding in this study particularly relates to the unique experience of a sense of neglect expressed by the participants. The participants narrated concerns and disappointment towards the way they were treated and responded to by the professionals they came in contact with. Research suggests that cultural context can play a role in understanding neglect in that what is acceptable for one culture may be considered neglectful in another (Dubowitz, 1999).

This could also be in the form of expectation, such as what is expected in one culture being regarded as neglectful in another culture, particularly when such expectations are not met. Straus and Savage (2005) suggest that neglect centres on social understanding. It could be seen as a failure to act and it occurs over a period of time, often due to lack of clarity as to who should be responsible for such failure. It is based on assumptions about what is contextually normative and this can be affected by individual beliefs and values.

Previous research suggests that BME women do not readily seek help with their mental health problems (Lewis & Drife, 2004; Dennis & Chung-Lee, 2006); others suggest poor service engagement (Hamilton et al. 2011). The findings of this study thus produced a novel and insightful paradox in that the participants expressed seeking support (though delayed) despite cultural constraints, but experienced a



sense of neglect and lack of attention and interest about their mental health and wellbeing by the professionals they encountered.

However, it appeared that the women did not readily disclose their feelings/symptoms. This could be due to the cultural expectations and associated stigma and a culture in which talking about feelings/emotional struggles or intimate issues with an outsider is conceived as a taboo or regarded as weakness, suggesting that asking for support was not natural for these women and so, they were unable to willingly ask for support from the healthcare professionals who worked with them. Notwithstanding, the women narrated encountering professionals who did not engage with them and did not ask them the right questions that could have encouraged them to open up and disclose their support needs. The women were often asked 'how are you' but expected to be asked 'how are you coping?'

The FGNMs recognised that they needed support and were prepared to accept available and appropriate support if offered to them by the professionals regardless of the pressure to conform to their cultural expectations, but the support they needed was not available or provided by the professionals. For example, the EPDS is a universally recommended instrument by NICE guidelines to screen and identify PND in mothers (NICE 2007; NICE, 2011), but none of the FGNMs reported being screened with this instrument by the health visitors, which possibly confirms the neglect perceived by the mothers.

These negative experiences narrated by the mothers were both from the visiting professionals and the GPs. All the mothers voiced baby-centric care by the healthcare professionals which was interpreted across by the women as neglect and lack of concern about their mental health and wellbeing. Some of the mothers recalled putting on a 'smiling face' and appearing to be happy during the professionals' visits, even though they felt dissatisfied with the care and support. This relates to Babatunde and Moreno-leguizamon (2012) reporting that the signs of PND were not identified in the women in their study despite prolonged visits and contact by health visitors. Moreover, Watson et al. (2019) noted that failure by health professionals to identify postnatal depressed women often leads to safeguarding concerns for both mothers and infants.

A number of studies provide evidence in support of family centred care as opposed to baby-centric. For example, Shields and Tanner (2004) suggests the need for necessary emotional support to be applied in family centred care in order to improve treatment outcomes. Therefore, it could be argued that in order to meet the postnatal needs of the FGNMs, a family centred care approach needs to be implemented. This supports the NICE guidelines (NICE, 2016) for treating women during pregnancy and the postnatal period.

The women expressed negative experiences with visits to their GPs. A systematic review by Watson et al. (2019) suggests that fragmented health services and culturally incompetent and dismissive health provision impacts on ethnic minority

mother's ability to receive adequate perinatal health support in the UK. The women in the current study explained that they would have liked to talk through some options such as talking therapy or other forms of support rather than only the medication treatment that was offered.

Their narrative suggested a conflict between the types of support the mothers perceived that they essentially needed and the support that was available to them. Therefore, a care approach that considers the Nigerian cultural views on mental health and the emotional and psychological wellbeing of the FGNMs should be provided or implemented when working with them. Women have been reported to prefer talking therapy, for example, Appleby et al. (1997) reports that women with PND indicated preference to talking therapy rather than antidepressants after receiving both interventions.

Likewise, a study by Di Mascio et al. (2008), revealed positive outcome and recovery from PND with social and therapeutic support and others suggest the effectiveness of psychological therapy for treating PND (The National Collaborating Centre for Mental Health, 2004; Dennis, 2005; NICE, 2007). In addition, more recent studies reported that new mothers valued therapeutic support/relationships (Hadfield & Wittkowski, 2017; Button et al. 2017). Therefore, it is not surprising that the FGNMs wanted this form of support.

It is assumed that GPs as primary care providers prescribe medication as necessary, but at the same time are generally required to refer patients as appropriate, but the

FGNMs interviewed established that they were not referred even though this was their expectation and preference. NICE guidelines advocate service provision that promotes good mental health and prevents the escalation of problems. According to NICE, general practice, maternity and health visiting services have frequent contact with the mother, baby and family during the perinatal period and are well placed to provide support, make initial assessment and refer onwards if problems are identified (NICE, 2014). It is therefore uncertain why this did not apply to the mothers interviewed.

In addition, the majority of the participants mentioned that they were not given a choice in the treatment offered to them. The idea of patient choice or preference for a particular treatment type has been suggested to affect treatment outcomes. The NICE guidelines also suggest that people have the right to be involved in decisions about their care (NICE, 2014). Similarly, a few studies have examined the impact of patient preference in health outcomes both in drug therapy and clinical interventions (Cooper et al. 1997; Bakker et al. 2000; McPherson & Britton, 2001). Therefore, GPs need to strictly follow the guidelines for referral, they need to be contextual in diagnosing ethnic minority women with PND so as to offer the most appropriate and effective treatment option as well as the most suitable and needed interventions.

Clarks et al. (2008) concluded from their study that patients' choice and preference in intervention enhanced physical and psychosocial functioning when women were given the choice of two formats of treatment. Therefore, it could be argued that

giving the FGNMs a choice of treatment could help or be a catalyst for their recovery. The majority of the women further specified that they were not told about the possible side effects of the antidepressants prescribed by the GPs. This was reflected by the participants to result in reluctance in taking the medication and discontinuation by some of the mothers due to perceived fear about the possible negative side effects.

The participants' narrative suggested a sense of helplessness and neglect about how their struggles and challenges were not acknowledged and how they were not heard and listened to by the professionals. Being heard, listened to and understood is a significant relational feature and it is a form of communication considered very essential in human relationships. Humans often have a strong desire to feel listened to and understood and can easily become lonely, miserable and frustrated, or even angry when they do not feel like their point-of-view is being heard. This contributes to the biggest conflict in our relationships and society as a whole (Knapp, Vangelisti & Caughlin, 2005). This is similar to what the participants in this study experienced which was regarded as neglect.

This echoes one of the main themes generated by Wittkowski et al. (2011) in which women revealed that they talked to their healthcare professionals who worked with them, but they failed to understand them. This could lead to withdrawal and distrust of healthcare professionals by women. This have been widely reported by studies within BME women to affect women/professionals' relationship and help-seeking

behaviour. Issues with lack of trust of healthcare professionals were reported by Gardner et al. (2014) to impact on help-seeking behaviours. Similarly, Dei-Anane et al. (2018) reported that Ghanaian women were reluctant to seek support from healthcare professionals due to lack of trust.

The participants further said that they took a back seat and allowed the visits to be conducted at the pace of the professionals and also said that they did not go back to their GPs which may have been related to the disappointment they felt. These behaviours could be a way of reacting to a sense of helplessness and powerlessness. The theory of learned helplessness by Abramson et al. (1978) suggests that a sense of helplessness is a learned behaviour that is conditioned through experiences in which individuals perceive or truly have no control over their circumstances. When people start to perceive or believe that they have no control over what happens to them, they will begin to feel, think and act as if they are helpless. A reformulation of this theory links this sort of helplessness to depression (Miller & Norman, 1979) suggesting that this situation could complicate the experience of PND for these women.

This type of treatment experience could be due to unconscious bias on the part of the professionals that has been found to lead to disparities in service provision. FitzGerald and Hurst (2017) suggest that unconscious bias of healthcare professionals impacts health care assessment, support and diagnosis, particularly

within ethnic minority groups. The authors reported a significant correlation between unconscious bias exhibited by professionals and low quality of care.

Research also suggests that racism may be one of the reasons for disparities in healthcare provision. Within the UK, race is the basis of historical and continuing discrimination and the impact of perceived or actual discrimination and oppression results in despair, loneliness and hopelessness, a thread that ran across many of the participants' experiences. The issues of racism and inequality in service provision have been widely documented in research (Edge, 2004; Glover & Evison 2009; Williams & Mohammed 2009; Sondik 2010; Vernon 2011; Hall, 2018) despite major government policy initiatives (Grey et al. 2013; Wallace et al. 2016). This sort of neglect and unmet expectations experienced by the FGNMs could lead to many of the mothers being ineffectively treated.

This experience has implication for clinical practice in regards to addressing the issues of inequality in service provision in line with the government recommendations on race equality (Race Relations Amendments Act 2000; National Institute for Mental Health, 2003; Department of Health, 2005).

In addition, myths held by professionals about FGNMs could make it difficult to provide the FGNMs with effective treatment. This echoes a personal experience during the recruitment process of this research with a first generation Nigerian GP who laughed at my project when approached for support with potential participants. He stated that Nigerian mothers are resilient and so they do not suffer with PND. It

was concerning that a professional who has practiced for over twenty years as a GP in the UK could hold such a myth. This could make it harder for the FGNMs to be provided with the support they need and could field into the implicit bias of the professionals in providing equal and effective support to the FGNMs.

The mothers narrated lack of support from their families, particularly their spouses and narrated how this impacted their moods and inability to cope, resulting in feelings of loneliness and suicidal thoughts. This is consistent with previous research which found that lack of social and emotional support is a significant factor that triggers PND in new mothers (O'Hara & Swain, 1996; Templeton et al. 2003; Patel, Rodrigues & DeSouza, 2014). Lack of support, particularly from families has been extensively reported to impact BME women postnatally. Gardner et al. (2014) reported that lack of close family support was a major problem for West African women in their study, resulting in a majority of the women managing and coping via faith. Similarly, Dei-Anane et al. (2018) reported that this led to increased stress for Ghanaian mothers.

Valtorta et al. (2016) suggests that loneliness can be an unpleasant emotional response to isolation. It is a complex emotional state that is usually anxiety provoking when there is lack of connection and communication with others (Scott, Klaus & Klaus, 1999). On the other hand, Gjerdingen, Froberg and Fontaine (1991) emphasised the importance of spouse support, suggesting that with spouse support symptoms of depression decreases, mothers experience increased self-esteem and



sensitivity to the child's needs. Previous research has shown that some women find transition to motherhood as a psychological and stressful event (Leahy-Warren & McCarthy, 2007) and that social support can facilitate a positive outcome of this transitional experience (Logsdon & Davis 2003, Wilkins, 2006).

The participant's accounts also illustrated how emotional state was not culturally recognised therefore this support was not available from family members, particularly from their spouses. This could also be due to the influence of cultural gender defined roles that is common in the Nigerian culture. This is where the men believe that it is their role to provide financially for the family with less focus on the families' emotional and psychosocial needs. In addition, it could be the influence of traditional and cultural practice of joy, happiness and celebration associated to giving birth that presents a possible barrier to recognising PND in the Nigerian culture.

The account of the participants indicated multiple gaps in support - from the professionals, families and spouses in particular. Many of the mothers explained how they cried through the difficulties and got on with things on their own. This supports findings by Babatunde and Moreno-leguizamon (2012) about the notion 'that you have to get on with it'. Some of the mothers described how they struggled and juggled between multiple roles.

The mothers explained that the influence of the intergenerational expectations to be able to cope and appear strong and resilient enabled them to go through the difficulties on their own. Although this influence had a negative impact, it seemed to

have enabled the FGNMs to have a strong mind-set and determination to get through the experience without deterioration in the condition of their mental health.

However, the mothers suggested that they would have preferred to be supported and some of them expressed a sense of anger and disappointment about the lack of support they endured. As a result, it would be necessary for the professionals to adequately seek to work and engage with these mothers in a fashion that will enable an empathetic understanding of the difficulties and conflict that these mothers may have to deal with and adequately support them.

The findings of this study could inform professionals including counselling/clinical psychologists working with African mothers about specific types of difficulties and barriers that can be encountered when working with this particular group of women postnatally. The findings also highlight those factors which can be unique to the FGNMs and significant when working with them. Adequate and appropriate support is required to prevent unwarranted negative life threatening impact resulting from the experiences of PND.

### **5.1 Clinical implication and recommendations**

The result of the study has major implication for service in term of decreasing feelings of discrimination and neglect for these FGNMs and the need to provide equal and unbiased support/services that meet their cultural and psychosocial needs. The need for providing cultural-specific support is indicated for the findings. The FGNMs were impacted by intergenerational expectations, culture shock, lack of

spouses' and family support including difficulties in accessing appropriate healthcare support.

While the cultural expectation to conform to the image of a 'black strong woman' had negative impact in admitting PND and seeking help on time, it helped the FGNMs develop a positive mind-set that enabled them to overcome their difficulties. However, the mothers made a few suggestions in relation to how their needs could be better met by services such as asking them direct questions about their mental health and how they are coping, prompting them because talking about emotional issues or owning to mental health difficulties are not natural to them. They also suggested offering them alternative or treatments options.

The factors that appear to contribute to the onset of PND in the FGNMs apart from those highlighted in the general literature on PND are largely related to cultural factors - the impact of intergenerational cultural transmission of expectations to be happy after giving birth and resilient, culture clash/shock on their experience of PND (unfamiliar norms) and lack of specific support from their spouses that had cultural influence were particularly relevant.

The professionals working with these women may need to employ more targeted interventions to help the women to better manage a variety of conflicts associated with their experience of PND. If professionals could understand the issues that the FGNMs face and talk to them about available support and how they can access them, it might discourage the mothers from regarding vulnerability as a weakness; it might

enable them to freely speak about their struggles/difficulties and could help them to engage with available support more readily.

There is implication for regular screening for PND that may enable the mothers to understand and detect PND and encourage early intervention as advocated by NICE guidelines and previous researchers (Whitton, Warner & Appleby, 1996; Elliot et al. 2000; Holopainen, 2002; Oates, 2003; Brookes et al. 2015). However, additional methods could be considered and applied in detecting PND amongst BME mothers, such as rigorous therapeutic assessment/consultations since the EDPS scale is reported to often failed to identify PND in the population (Boath and Henshaw, 2008; Edge, 2010).

The implication for lack of screening and assessment for PND in the FGNMs means that, the mothers and their families are less likely to recognise and acknowledge depressive symptoms that may be present. Therefore, it is important for professionals to pay particular attention to listening and monitoring the new FGNMs and seek to understand their experiences, help them to manage the impact of the conflict of expected positive emotions and the reality of PND in order to provide support that meets their unique needs.

The professionals working with these women may also need to be aware and be sensitive to the fear of discrimination and isolation these women may experience and provide adequate therapeutic support where these issues can be confidentially explored and addressed, particularly as the families and community of the FGNMs

cannot offer this sort of support. In addition, it is important for professionals to build a trusting relationship and seek to engage with the mothers and ask the right questions that would encourage them to open up and disclose/discuss their difficulties more easily.

There is also implication for educating the FGNMs (particularly during the antenatal period about PND) and their spouses about the role and importance of social and emotional support. Integration into the UK culture could be emphasised and the Nigerian men could be encouraged to consider and evaluate the negative impact of the Nigerian cultural gender defined role on the FGNMs. In addition, it would be helpful to explore the impact of the cultural upbringing in the Nigerian culture in which emotional difficulties are concealed.

Perinatal services or other professionals working with FGNMs postnatally could seek to engage with them through their local churches and social clubs/organisations to provide this education and encourage engagement with available services. In addition, support or peer groups tailored and specific to the needs of the FGNMs whereby the issues of stigma could be discussed and reduced through shared stories could be considered.

This sort of support could offer emotional and psychological support that immediate and extended family cannot offer to these mothers. The support groups could also empower and encourage the mothers to share specific transitional experiences with

each other. This type of support has been found to alleviate loneliness and increase self-worth and confidence (Lieberman & Altman, 2004; Haslam et al. 2016).

These groups could be facilitated by BME professionals where possible or by those who are culturally and psychologically competent and willing to work flexibly and liaise with other agencies on behalf of the mothers/parents. The NICE guidelines suggest that practitioners should have cultural awareness and be able to provide culturally relevant information on mental health problems to women in pregnancy (NICE, 2014). An example is a group-based perinatal education programme designed to meet the needs of families from minority ethnic background and a range of disadvantaged parents, developed by the National Society for the Prevention of Cruelty to Children (NSPCC), this programme was found to be effective when evaluated.

Positive outcomes reported by mothers from the programme included increased knowledge about pregnancy and parenting, change in attitude towards gender role and improved relationships with infants and partners. The programme was also reported to be a particularly important source of support for socially isolated parents (Brookes et al. 2015). This type of group could be nationally encouraged to help with the support of this group of mothers. Besides, a perinatal telephone helpline could be a potential support service that may enable FGNMs to speak to perinatal or mental health professionals for support when they cannot physically access support.

In addition, GPs should ensure that they follow NICE (NICE 2014) guidelines in diagnosing FGNMs with PND, considering the context of their presentation and circumstances and taking relevant history into account as well as refer as appropriate. GPs should also offer treatment choice to the FGNMs to allow them to feel heard and valued. As an implication, talking therapy and support groups should be an established form of treatment option on offer and available to all women diagnosed with PND, particularly the FGNMs. In addition, GPs should endeavour to provide psychoeducation to patients around medication, particularly with antidepressants for the FGNMs.

Furthermore, professionals working with these mothers should implement a family-centred care and have cultural awareness as recommended by NICE guidelines (2014) in order to provide effective treatment and support to the FGNMs. This recommendation has also been made by previous researchers (Taylor, 1997; Elliott et al. 2001; Almond & Lathlean, 2011).

This current study supports the need for multi-agency professional support and training programmes including educating professionals in order to be better equipped to support the FGNMs. Such programmes could encompass lectures and conferences on specific ways of integrating aspects of the BME's cultural expectations/norms, psychosocial understanding, addressing implicit biases, issues with racism and possible issues around myths regarding PND into such training programmes.

There is a need for healthcare professionals to consider supporting these mothers to achieve a sense of confidence required to maintain a balanced psychological wellbeing, particularly after giving birth. This is supported by research suggesting that support from healthcare professionals are helpful to new mothers because this could help to reduce the rate of PND and help mothers achieve a high self-esteem and efficacy after giving birth (Misri et al. 2000).

In relation to supporting the FGNMs to have positive experience of available services, a targeted and tailored support that consider their cultural and psychosocial predisposition to PND should be carefully considered in ensuring appropriate and effective support rather than a predominant medical intervention. There is need of healthcare professionals to engage correctly with the mothers, listen and demonstrate interest in their mental health to facilitate disclosure. The FGNMs should be assessed and screened with EPDS when necessary. The need of health professionals to be aware and address any implicit biases in providing support/treatment to the FGNMs and make appropriate referrals are all indicated factors that could enable these mothers to have positive experiences of available resources/treatment.

## **5.2. Evaluation and strength of the study**

The conclusions from this study provide an insight into the FGNMs experiences of PND, but may not necessarily represent the views of all FGNMs. The use of IPA could be considered as a methodological strength of this study because it provided a detailed account of the participants' experience of PND, their experiences of



available treatment and how they individually managed and coped with PND. This contributed to the understanding of the views and support needs for this particular group of mothers in accordance with the idiographic commitment of IPA (Smith et al. 2009).

An additional strength of the study is recruiting participants across different UK counties as well as achieving a homogeneous sample by recruiting only FGNMs with relevant and shared experience. This therefore helped to highlight the salient features in the experiences of this narrow and specific population. Earlier studies had recruited African immigrant mothers (Babatunde & Moreno-leguizamon, 2012) and West African mothers (Gardner et al. 2013). Previous researches were conducted within a particular geographical location in the UK, for example Manchester and London.

An added advantage for the success of recruiting this narrow and homogenous sample could be the fact that the researcher is a FGNM herself. The current study largely recruited participants through organisations and social groups attended by Nigerian mothers across UK cities. A further strength of this study lies in the contribution it makes to existing research knowledge. It is generally believed that BME mothers do not always seek professional help and are difficult to engage, but from this current study it was found that the FGNMs actually sought help and support (though delayed), despite cultural constraints.

A further contribution of the study to existing research knowledge is that whereas previous research suggests that BME mothers turn to their families and communities for their support needs (Troyna, Hatcher & Gerwitz, 1993; Amankwaa, 2003; Gardner et al. 2014), in contrast, the participants in this study revealed that they could not turn to their families and community for support partly due to Nigerian cultural perceptions of PND and associated stigma and partly due to the cultural expectation to be happy post-delivery and resilience. In addition, the myths that African mothers are strong and resilient, particularly in the postnatal period and that PND is only suffered by 'white women' is disputed by the findings of this current study.

### **5.3 Limitations**

This study made several unique and insightful contributions to the existing knowledge base of an under-researched area and population. Whilst this study is original in terms of research questions and findings, it has a number of limitations that can direct future research. Although the sample size of the current study could be perceived as a limitation, it was in line with the recommended use by IPA (Smith et al. 2009). The results of this study were based on the experiences of a small sample size of six Nigerian mothers' accounts and may not be generalised as the experiences of all other FGNMs in the UK because the experiences were idiographic and subjective. However, readers may develop links between the findings, literature and their own experience as Smith and Osborn (2003) suggest that IPA can offer theoretical generalisability as opposed to empirical.

In addition, the experiences were past experience of PND, the age of the children at the time of interview ranged between four and nine and the participants' age ranged between 30 and 45. Therefore accuracy in recalling past experiences could be a limitation of the study. However, research suggests that retrospective reports of pain intensity and quality were consistent with those made while the pain was experienced (Terry, Niven & Brodie, 2007), suggesting that memory of painful event/experience might be quite accurate (Singer et al. 2001).

Furthermore, the insider/outsider position of the researcher was both strength and a limitation to this study. Social bias is primarily unconscious and common to everyone. Therefore this may have impacted the process and influenced the data analysis and write up by the researcher. Asselin (2003) suggests that it is best for an insider researcher to conduct research, particularly data collection and analysis with open eyes and mind, but assume that they know nothing about the phenomenon under study. Although the researcher might be part of the culture under study, they might not understand the subculture. I was particularly mindful of this basic dynamic during the process of my research. However, one's own cultural understanding and experiences cannot be completely blocked out.

#### **5.4 Suggestions for future research**

It might be helpful to build on the findings of the current study to offer a better understanding on how factors such as intergenerational transmission and psychosocial factors can influence the experience of PND. It might be useful to

replicate this study with participants with more recent experience of PND. In order to increase the rate of participation of research in this area, it would be helpful to seek to widen the scope of recruitment to include the NHS.

In addition, future research could consider recruiting participants who are not in the healthcare profession and involve FGNMs who are married to non-Nigerian or to a different generation of spouse. In this study the FGNMs were married to Nigerian men and this was a significant factor in their experience. Those married to non-Nigerians or a different generation of men might have a different experience and this may provide a new insight for future clinical practice and research. A concluding suggestion for future research could therefore be to explore the experiences of FGNMs with more recent PND experience, those married to or in partnership with non-Nigerians or a different generation of spouse and those who are non-healthcare professionals. It might also be insightful to compare the experiences of the first and second generation Nigerian mothers in future research.

## **6. Final reflections**

The process of carrying out this research has been a difficult learning journey of being realistic, becoming totally absorbed and reflecting on the phenomenon of the experiences of how the FGNMS experience PND in the UK. The process of the research taught me to value subjective meanings and interpretations, though the later was a struggle at time due to cultural similarities with my participants. I learnt to value uncontrolled curiosity. I came into this project with my own assumptions about

the experiences of PND of BME and African mothers. Part of the assumptions was that the experiences of this group of women would be difficult and multifaceted. Through the course of conducting the interviews I found a lot to reflect on.

I reflected on my assumptions, beliefs, culture and the potential impact of my preconceptions on the study throughout the research process. This was in personal therapy, with peers and in supervision. I managed to bracket (Smith et al. 2009) my feelings, understanding and personal views as much as possible in order to reduce their influence on the data. This was attended to during the selection and interpretation of the transcript. I discussed my data interpretations with non-Nigerian peers and my academic supervisor in order to monitor and explore my interpretations. The feedback I received suggested that my interpretations were rooted in the accounts of the participants.

I noticed that my participants felt comfortable and passionate about the research, which could have been informed by the shared identity. However, I was aware and concerned about accurately representing their experiences. Qualitative researchers have been observed to struggle with frequent anxiety regarding issues of authentically representing participants' views (Coyle, 2007). Although a more negative experience by the participants was apparent, I appreciated my participants for sharing those experiences which enriched the analytical process.

I struggled with selecting and developing themes as enormous data were supplied by the participants. However, I enjoyed developing the subthemes and the subsequent

superordinate themes of the thesis which were cross checked by my academic peers and supervisors. The process of writing up the analysis was challenging at times, partly due to the shared realities and concerns about being able to block my personal experiences and feelings in order to capture and reflect the authentic accounts of the participants. I utilised my reflective diary, peer support and supervision to increase my awareness of potential biases and to ensure the analysis reflected participant's accounts. In addition, during the discussion of the findings of the study, I remained open-minded as possible and I further realised the importance of having additional knowledge about the FGNMs.

Being an insider I was struck by the participants' accounts of their experiences and how they processed this. As I reflected on this, I realised that I sometimes shared experiences, perspectives and opinions with my participants and at other times I did not. There were times I felt close to tears at the sense of being left unsupported during what were clearly difficult times. For example, when one of the participants disclosed being left alone in an empty house with a baby girl dressed in blue clothes because her husband wanted a male child and how the husband went abroad for work after a few weeks of having the baby. The suicidal attempts expressed and uncontrolled emotions during the interview were painful.

As a FGNM, I became very aware about how I interpreted and made sense of how the participants made sense of their experiences. However, I was surprised about what the data revealed during the research, particularly how the women were not

given option and choice of treatment and how much less interest the professionals showed towards the psychological wellbeing of the mothers. Though understandably this was due to heavy caseloads, but to imagine these mothers suffering the amount of neglect reported was shocking. The findings increased my awareness about the potential challenges about being objective when there are cultural similarities between researcher and participants. I thought at the beginning of the research that the participants would present with support needs, but not with such degree and high levels of negative results. I also thought that Nigerian mothers would generally support themselves with prayer. Unfortunately, only one of the participants disclosed using prayer as a form of support.

My assumption that Nigerian mothers may not like to talk about their psychological problems was influenced by my personal experience and largely by information from literature and research which was disputed by this study. In addition, I thought that the mothers would over identify with me. Whilst there were similarities between my experience and that of the participants, there were distinctive differences in the experiences. For example, I did not have my children in the UK which was a standard criterion for participation in the study.

Although the process of data analysis and writing up the discussion section was challenging and stressful due to the on-going uncertainty and concerns about not misinterpreting the data, it was interesting to immerse myself in the rich experience of the participants and more importantly the opportunity and privilege to give these

mothers a voice in literature. This study has increased my interest in working with mothers postnatally and to pursue my initial interest in educating British-African mothers about PND and subsequent prevention. Perhaps more importantly to advocate the need for perinatal services to be more psychology informed and led with less medical focus.

## **7. Conclusion**

The perspective of the experiences of PND, the experience of available treatment and how mothers managed and coped with PND has not previously been the focus of empirical research. This is the first study exploring the specific experiences of PND in first generation Nigerian mothers and their specific experience of available treatment. The study revealed that the view the FGnMs hold with regards to being strong and resilient was passed to them inter-generationally with expectations to conform to this image and the traditional/cultural expectations particularly within the family and their community.

It revealed the shame and stigma culturally associated with PND suffered by the mothers which was related to how mental health issues were perceived by the Nigerian culture and partly due to the cultural expectation to be strong and resilient. This was found to negatively impact the mothers and affected their ability to freely speak about their difficulties and to seek help on time.

The accounts suggest that the participants' needs were neglected by the professionals. They felt that the professionals were duty bound with 'checklist' and



offered baby-centric care approach, neglecting their emotional and psychological wellbeing. This was reflected to discourage the mothers from speaking to the professionals, particularly the HVs about their difficulties and struggles. In addition, the mothers recounted that they were not given options for alternative treatment as expected and were not given choice in the intervention that was offered (medication treatment).

This unmet expectation and lack of choice in treatment was reflected by the mothers to dissuade them from taking the medication that was prescribed and discontinuation by some of the mothers. This was also related to the perceived fear of possible negative side effects of the antidepressants which some of the women said was not explained to them by their GPs.

The results of the study suggest a mismatch between needing support and difficulties in asking for it. The mothers expected the professionals to ask them direct questions about how they are coping and about their mental health that would encourage them to open up and share their difficulties. Some of the mothers subsequently pretended to be okay by wearing smiling faces to allow the practitioners to carry out their duty even though they felt dissatisfied with the services.

The FGNMs experienced difficulties adjusting to the UK's culture and unfamiliar norms. They suffered with lack of support from their families and spouses in particular which led to extreme loneliness, isolation and suicidal ideation for some of the mothers. The women further described how discussing emotional struggles may

be conceived as one losing their mind or '*going mad*' or perceived as weakness and how they had to rely on themselves and suffered through the difficulties on their own.

The findings of the current study support the notion for cultural and psychosocial understanding and intervention for PND in FGNMs. So far the main primary care treatment for PND is based on medical model which negates the context of how this distress happens. The findings have therefore offered professionals/practitioners a new and useful understanding of the support needs of the FGNMs. This should help professionals and training programs to develop tailored and specific interventions to suit this particular group of mothers.

It is hoped that this study has contributed useful understanding and insight for evidence-based practice for postnatal treatment for this group of mothers by providing information into their postnatal difficulties and challenges, expectations and the type of support that can be helpful and productive for both the mothers and service providers. The interest in conducting this research on the experiences of PND by Nigerian mothers has been of personal importance and I feel this has contributed to my own personal learning and development as a researcher and a counselling psychologist.

## 8. References

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## 9. APPENDICES

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## Appendix A

### INTERVIEW SCHEDULE

Participants are welcomed by researcher and housekeeping rules will be discussed. Information sheet and informed consent are reviewed, distress protocol indicators are observed. Demographic information will be obtained before commencing recorded interview.

### Questions

1. To start with could you tell me a little bit about how you came to live in the UK and how long you have lived here for?
2. Could you describe in as much detail as possible how you experience postnatal depression?
3. Could you tell me the difficulties, if any you encountered with your postnatal depression?
  - What type of support was there for you? If any, how helpful was this?
  - What more could you tell me about this resources?
4. Do you think being a first generation Nigeria mother living in the UK affected your experience? If so how?
5. What would you say was most challenging about your experience of PND?
6. Is there any support you think would have been helpful that was not available?
7. What was your understanding or perception of postnatal depression before you were diagnosed?
8. Is there anything you would like to tell me about your experience that I have not asked which you think is important and relevant to the topic?
9. What has taking part in this interview been for you?

### **Possible prompts to further clarify what is being said or answered by the interviewee**

- Can you tell me a bit more about that...?
- What do you mean when you say...?
- That is an interesting point can you expand more on it?

Thank the participants for their time.



## **Appendix B**

### **ETHICS APPROVAL**

**Angela Loulopoulou** <A.Loulopoulou@londonmet.ac.uk>  
To  
Lydia Ling  
30 Jan at 12:57 PM

Dear Lydia,

Both the Reviewer appointed by the Review Ethics Committee and the Head of Research have approved your Ethics Application proposal. You can proceed with the interviews and data collection for your study.

Kind Regards,

Angela

**Chair of Review Ethics Committee for PG Psychology**

*Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA*

**Principal Lecturer in Counselling Psychology**  
**Programme Director of the Professional Doctorate in Counselling Psychology**  
**School of Social Sciences**  
**Chair of Subject Standards Board for PG Psychology**  
**Chair of Review Ethics Committee for PG Psychology**

## Appendix C

### ADVERTISEMENT LEAFLET

#### **Participants required for a study about postnatal depression**

**Title of research: An investigation into how first generation Nigerian mothers living in the UK experience postnatal depression: *An IPA Study***

My name is Lydia Ling. I am a trainee counselling psychologist at the London Metropolitan University. I am currently conducting a (Doctoral) research to discover first generation Nigerian mothers' experience of postnatal depression (PND) and their experiences of available resources/treatment.

The study aims to gain knowledge and understanding about the experiences of the first generation Nigerian mothers who have been diagnosed with PND. Research on this topic is limited, meaning very little is known about the topic and there seems to be a lack of exclusive research on the lived experiences of Nigerian mothers of PND. My hope in carrying out this study will be to gain a better understanding of the lived experiences of first generation Nigerian mothers and to 'give them a voice' in order to get the support and help they need. Research into a topic like this informs practice in providing appropriate and tailored interventions.

Participants who are willing to share their experience on this topic will take part in an approximately 60 minutes semi-structured face-to-face interview which will be audio- recorded.

If you are interested in taking part in the study or would like to find out more about it, please contact me at: [lsl0031@my.londonmet.ac.uk](mailto:lsl0031@my.londonmet.ac.uk) or alternatively provide your contact to the person who gave you this leaflet and I will contact you with more information and answer any relevant questions to facilitate your decision. You will be under no obligation to take part. My research is supervised by Dr Verity Di Mascio and she can be contacted at: [v.dimascio@londonmet.ac.uk](mailto:v.dimascio@londonmet.ac.uk)

Thank you for taking the time to read this leaflet and for your consideration to take part in the study.

Kind regards

Lydia Ling

Email: [lsl0031@my.londonmet.ac.uk](mailto:lsl0031@my.londonmet.ac.uk)

Phone: 07756 976623

## Appendix D

### RECRUITMENT POSTER

## **Participants required for a study on postnatal depression**

This is a Doctoral research study exploring the experiences of postnatal depression of the first generation Nigerian mothers. First generation is defined as those born in Nigeria and now living in the UK.

## **I would like to listen to you**

### **If you are:**

- ✓ First generation Nigerian mother living in the UK
- ✓ Aged 18-55
- ✓ Have given birth in the UK
- ✓ Diagnosed with PND
- ✓ Have had a form of treatment for PND

Participants who are willing to share their experience on this topic will take part in an approximately 60 minutes semi-structured face-to-face interview which will be audio-recorded.

**If you are interested in taking part in the study or want more information, please contact me:**

**Lydia Ling**

**[ls10031@my.londonmet.ac.uk](mailto:ls10031@my.londonmet.ac.uk)**

**Tel: 077569 76623**

I will provide you with more information about the study and answer any relevant questions to facilitate your decision. You will not be under any obligation to take part.

**This research project has gained ethical approval from the Research and Ethics Committee at London Metropolitan University.**

**PARTICIPANT INFORMATION SHEET**

My name is Lydia Ling. I am a trainee counselling psychologist at the London Metropolitan University. I am carrying out a (Doctoral) research to discover some information about first generation Nigerian mother's experiences of postnatal depression (PND) and their experiences of available resources/treatment.

**Invitation to participate in research study**

I am writing to you because you indicated an interest in sharing your experience of PND and to give you a bit more detail about the study and your involvement. Research in this area and topic is limited, meaning very little is known about the topic and there is a lack of exclusive and specific research on the 'lived' experiences of Nigerian mothers of PND. My hope in carrying out this study is to gain a better understanding of the 'lived' experiences of first generation Nigerian mothers and to 'give them a voice' in literature in order to get the support and help they need. Research into a topic like this informs practice in providing appropriate and tailored interventions.

The research will involve you taking part in a semi-structured face-to-face interview where you would be asked to share your experience of PND and talk about the help that was available to you following your diagnosis. The interview will be audio-recorded and will last approximately one hour, and will be arranged in a confidential setting. The data collected will be kept confidential and stored in a password protected computer that can only be accessed by the researcher and destroyed once the project is completed or after its publication. If you choose to participate you will be asked to sign a consent form, the consent form will be kept separately from the data, and it will only serve to verify that proper consent was obtained. You will be

free to withdraw from taking part in the study at any point before the interview and up to two weeks after the interview without giving any reason. Participation in this research is entirely voluntary.

All personal information about you will be kept confidential and your name will not be used in connection with the results in any way that may otherwise identify you. The data will be completely anonymised, it will be analysed as part of my Doctoral research project and written up into a thesis and/or publication of the study. The voice content of the interview will be solely used for analysing the data by the researcher and will not be heard by any person other than the researcher.

This study has been approved by the Research Ethics Review Panel at London Metropolitan University and will be conducted in accordance with the ethical guidelines provided by the British Psychological Society (BPS). If you have any questions or require further information about the validity of the research please contact me at: [ls10031@my.londonmet.ac.uk](mailto:ls10031@my.londonmet.ac.uk) or alternatively contact my project supervisor Dr Verity Di Mascio at: [v.dimascio@londonmet.ac.uk](mailto:v.dimascio@londonmet.ac.uk).

Thank you very much for your time and interest.

I hope to hear from you soon.

Yours Sincerely

Lydia Ling

**Appendix F**

**INFORMED CONSENT FORM**

**Title of research:** An investigation into how first generation Nigerian mothers living in the UK experience postnatal depression: *An IPA study*

In this research, you will be asked questions regarding your experience of postnatal depression within a voice recorded interview, but before you give your consent for your session to be recorded, it is important that you understand and agree to each of the points stated below.

- I have read the participant information sheet and I understand the nature and described purpose of the research and the procedures to be used.
- I understand my involvement in the research and that my participation is voluntary.
- I understand that my participation is anonymous. My name will not be used in connection with the result, that a pseudonym will be assigned to protect my identity throughout the research and all information that may otherwise identify me will be altered for example, address or friend's names.
- I understand that I can withdraw from the study at any time before the interview and until two to three weeks after the interview without giving any reason.
- I understand that the data I supply will be securely stored and will be destroyed at the completion of the project or may be kept for a period of five years in case the research will be published and will be destroyed after this period. I also understand that only the researcher will have access to the recorded data.
- I understand that the interview may evoke some difficult and distressing feelings for me. I am aware that I will be offered the opportunity to discuss these feelings after the interview with the researcher. I will also be given information on available support services if further support is required.
- I understand that I have the right to obtain information about the result/findings of the study.
- I have had the opportunity to ask questions of the researcher.

**PARTICIPANT SIGNATURE:..... RESEARCHER SIGNATURE :.....**



**DISTRESS PROTOCOL**

This protocol has been devised by a qualified mental health nurse for the purposes of research into PTSD (Cocking, 2008) to deal with the possibility that some participants may become distressed and/or agitated during their involvement in this research. It is not expected that extreme distress will occur in the interviews or that the relevant action will become necessary. However, this protocol identifies three stages of distress that the researcher will look out for and take the necessary action should it arise.

**1. Mild distress:****Signs to look out for:**

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless

**Action to take:**

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

**2. Severe distress:****Signs to look out for:**

- 1) Uncontrolled crying/ wailing, inability to talk coherently
- 2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
- 3) Intrusive thoughts of the traumatic event- e.g. flashbacks

**Action to take:**

- 1) The researcher will intervene to terminate the interview/experiment.
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
- 4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover from PTSD

- 5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
- 6) Details of counselling/therapeutic services available will be offered to participants

### **3. Extreme distress:**

#### **Signs to look out for:**

- 1) Severe agitation and possible verbal or physical aggression
- 2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

#### **Action to take:**

- 1) Maintain safety of participant and researcher
- 2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

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**DEBRIEFING FORM**

Thank you very much for taking part in this study. As you are aware, the research study is a part of a Counselling Psychology Doctorate Project. It was designed to explore how first generation Nigerian mothers living in the UK experience postnatal depression. The experience of postnatal depression in Africans and minority ethnic mothers living in the UK is found to be challenging and complex. Research suggests that minority ethnic individuals are at higher risk of developing postnatal depression due to factors such as acculturation stress, isolation and stigma around mental health problems. Although a few studies have explored these experiences in Black Minority Ethnic (BME) mothers, there seems to be no available studies exploring first generation Nigerian mother's experiences of PND in the UK and more specifically, not much is known about how they manage and experience available treatment. The results from this research may help in informing health and social care practice in the delivery of appropriate and culturally sensitive interventions.

You are welcome to address any concern with me now or please contact me via email on [ls10031@my.londonmet.ac.uk](mailto:ls10031@my.londonmet.ac.uk) if you have any question about the study or if you wish to withdraw.

Please contact my supervisor Dr Verity Di Mascio at: [v.dimascio@londonmet.ac.uk](mailto:v.dimascio@londonmet.ac.uk) if you have any complaints regarding any aspect of the way you have been treated during the course of your involvement in the study.

Also see details of available supporting agencies/services below that can provide confidential advice and support if participating in this study have raised any issues or concerns that you may wish to discuss further. Alternatively, you can speak with your GP who may be able to direct you in accessing available and free local counselling and wellbeing services.

- ❖ **MIND** - provides information and support to help promote understanding of mental health issues. They can be contacted on 0845 766 0163 or accessed via [www.mind.org.uk](http://www.mind.org.uk)
- ❖ **The British Psychological Society (BPS)** - provides details about qualified psychologists trained in a variety of psychological interventions across the UK. They can be contacted on 0116 254 9568 or via <https://www.bps.org.uk>
- ❖ **The Samaritans** offers safe and confidential telephone support for 24 hours a day. Their national help line telephone number is 116 123 or via <https://www.samaritans.org/>

**Appendix I**

**TABLE OF TRANSCRIPT EXCERPTS WITH SOME EMERGING THEMES  
FOR ALL PARTICIPANTS**

**PARTICIPANT 1- ADE**

<b>Transcript excerpts</b>	<b>Line numbers</b>	<b>Initial thoughts</b>	<b>Emerging themes</b>
Everyone felt that everything was going on well with me except me.	17 -18	Expectation to be happy whilst being pregnant	Pressure from sociocultural expectations or  Sociocultural pressure and expectation
I wasn't allowed to talk to people. It wasn't a celebrative approach of receiving help to talk about things like that in my culture.	18 -19	Not allowed to talk to others outside family and in-laws	Secrecy culture
No one really cared about how I was doing or feeling; it was all about the baby	24 - 25	Focus on baby  Lack of attention given to the mother	What about me?  Neglect
I was a new mum to be then so any information I learnt was about looking after baby. Not about how I felt. So more slowly and gradually I felt I needed to deny myself for the baby. I felt I need to live a life for people	25 - 27	Self-denial to please others.  All about the baby what about me? Who cares about my feelings?	Pressure from sociocultural expectations  Conforming to expectation  What about me?

Three weeks after I had the baby my husband travelled to Paris to work so I was left in an empty house, with a baby clothed in blue clothes – alone with the baby. I couldn't cope with the depression because all I kept on wishing was for me to die.	39 - 44	Wishes to die, suicidal thoughts unable to cope with the depression.	(suicidal thoughts)
When the health visitor came I will pretend I was okay, but later I went to see the mid-wife and I explained to her that I am experiencing these symptoms, instead, she kept on asking about the baby. "I hope you are not harming the baby" I said no. I told her the only thing is that I am not emotionally attached to her, I might leave her crying for hours, at times... I might shout on her.	48 - 53	Lack of confidence and acknowledgment to open up to the Health Visitor but summed up courage to go and speak with the Midwife... was disappointed as focus was all on the baby.	Neglected by health professionals
I don't know how I coped in that isolation. All I saw was that my symptoms were getting worse	87 - 88	Symptoms got worse in the midst of the isolation  Symptoms exacerbated by Isolation	Effect of delayed treatment  isolation
Being a Nigerian born living in the UK had an impact on me because firstly I did not understand how the system worked at that time, and I did not understand what was available for me to access and even those available I could not access because I was poorly informed	136 -138	Naïve about how the system works; Not aware of available support; Poorly informed about support services	Support need  Lack of knowledge of support services  Impact of transition to a new society
. . being isolated from my comfort zone which is Nigeria made me . . made access to help . . it made the gap wider for me	143-144	Isolation, Unfamiliar culture and environment impact of transition	Isolation  Impact of transition to a different culture
I couldn't because I felt she wouldn't understand. I felt she was just going through	164 -171	Unable to speak to Health visitor as she	Neglected by

a check list [pause]. . I felt everything was being mechanical. I felt she was using a set of questions, I think she was asking me the wrong questions. I felt she was [pause].... . I felt that distance was there. She was asking me a lot of questions but she wasn't ready to come close. I didn't want her as a friend,... I wanted someone that would understand my background, my cultural background, my religious background. Not someone who was going to click a checklist and work within a particular timeframe.		was detached; uses checklist; set of questions; very clinical approach asking the wrong questions  Desperate to be heard	health visitor
Firstly, I didn't want medication; I was not aware what else was available for me. Secondly, I wasn't morally challenged to seek help. I wasn't challenged, even spiritually. I resorted into prayers, I resorted into self-talk, and I kept on waiting for the time I would forget the experience.	199 -201	Did not want medication  Not spiritually/morally challenged or motivated to seek help; managed with prayers and self-talk strategy	Ignorant about available help  Did not want medication  Coped with prayer and self-talk
...we did not really talk about my feelings, I was just happy to find someone to look after the baby	229 -233	Though emotional issues are not talked about	Stigma around talking about Emotional issues
I did not know anything about it until my GP mentioned it	238	Lack of knowledge	Ignorance about PND

## PARTICIPANT 2 – NGOZI

Transcript excerpts	Line numbers	Initial thoughts	Emerging themes
I came here uhmmmm, all by my own, leaving my parents, my brothers, my sisters, my family behind , coming to this country and errr, to be married and didn't have a lot of friends, I found myself pregnant uhmm because we just got married and then the next thing I had a baby and its hardly anyone in the house	11,12,13,14 and 15	On my own, leaving family in Nigeria to join husband, no friends; lonely at home with baby; husband working	Poor social network Loneliness Isolation

because my husband was always working			
I didn't realise what I was actually going through during the time, I didn't realise it was postnatal depression. I thought it was because I was tired, it was because I wasn't very happy, because I had left my parents at home and there's nobody here	20,21 and 22	Lack of knowledge of PND symptoms; thought it was due to being alone	Ignorance of symptoms
...culturally when you have a baby you invite your mum, either your mum or mother in law to come over and help you with the baby so my mum arrived just few weeks after that and she was able to hold the baby, give the baby a shower, you know, a wash and take care of the baby while I got some rest	40, 41,42 and 43	Mum came to help giving time to recover	Supported by mother
To be very very honest with you I was so surprised that he just immediately prescribed anti-depressants for me, because I wasn't expecting him to just like hand it to me like that without explaining things or checking if I would take it uhmmm,... I didn't know anything about depression at all, he just prescribed these anti-depressants and said I should continue to be on it that they will help me. I think with African women because we are not used to depression the GP should explain things to us to encourage taking the medication. I am not erm, the only one many African women don't like to take medication...	65,66,67,68,69, 70,71,72 and 73	Anti-depressants given very quickly as first course without consent. Mother's prefer alternative treatment but was not available. African women not wanting to take anti-depressants because of side effects	Preferring alternative therapy to medication treatment
...maybe because we didn't know what it was, nobody said anything cause I had never really knew that I would go through depression after having a baby	98,99 and 100	Lack of knowledge about PND	Ignorance about PND
..because when you have baby, it's supposed to be something joyful, something really happy	100 and 101	Having a baby is expected to be a thing of joy.	Pressure from Sociocultural expectation
I was not very happy with my husband, erm mmm I felt like he wasn't giving me the attention that I needed or helping me as much as he needed to because he was always away, uhmmm, I hardly see him,...	102,103, 104 and 105	Lack of attention and support from husband. Feeling of abandonment and loneliness	Lack of support from husband  Loneliness
I was not very happy with my husband, erm mmm I felt like he wasn't giving me the attention that I needed or helping me as much as he needed to because he was always away, uhmmm, I hardly see him,...	102,103, 104 and 105	Lack of attention and support from husband. Feeling of abandonment and loneliness	Lack of support from husband  Loneliness

### PARTICIPANT 3 – ROSEMARY

Transcript excerpts	Line numbers	Explorative comments	Emerging themes
I think it started [you know] by getting low in mood, I just didn't, uhmmm, it was not worth living at one point, because during the period I became homeless which, uhm I think that is where things started actually going wrong uhm, and also relationship problems	13 - 16	Thing went wrong with issue of homelessness and relationship problems	Triggered by social issues
I was very satirical (felt mocked) because I didn't have any family in the country, I didn't really have any friends other than [you know], work colleagues	34 - 35	Felt mocked, lonely, separated from family	Loneliness Isolation Lack of social network
...decided to go and see uhm, the GP during this period, uhm, and I didn't really, get any help	57	GP not helpful as expected	Lack of support from GP
I was basically homeless, and I can't remember what the GP said but it was just, it was just uhm, I just thought to myself, unbelievable, it was like [you know], you are left to be by yourself, there was no help	70 - 72	Felt abandoned and disappointed by the system	Lack of support By the social system and GP
... after the birth actually, I went, I actually	72 - 73	Changed GP	Lack of support by GP
it was difficult for me to get up in the morning and be positive about anything, no energy, and I just felt like I was drowning	75 - 76	Felt like drowning all alone with two little ones	Lack of support alone
I think because as uhm, as an African woman, we are brought up to be strong , we are supposed to be strong [you know], you are not supposed to, there's expectation, yeah, depression doesn't exist, [you know],... I felt that if I come out with uhm, if I express my problems to them it would make me feel weak, so I didn't say anything to them,	83 - 88	Brought up to be strong Perception about PND Weakness not allowed.  Wear a mask to pretend I am okay	Pressure of sociocultural expectations  Denial of depression
They ask if I was breast feeding well and I just thought yeah I'm fine, they were more concerned just about the baby, it was [you know], they didn't they just, [you know] never asked how you are feeling and all that	88 - 90	Professionals more concerned about the baby and not how I am feeling and coping	What about me?  Neglect
I mean I just feel as a nurse I would've been able to pick up myself if a person was alone, I didn't get that, and I think that was also a barrier,	90 - 92	Self-blame Self-expectation as a barrier to help seeking	Barrier to help seeking
I stopped taking the medication within,	102 - 105	I became seriously	Stopped



probably within a week, yeah and I just didn't bother so I just struggled by myself and uhm, I think I tried to cope by just trying to get out of the house, [you know] going to the park, and just walking a little bit and just, that it what I did.		isolated but managed through and coped with self-motivation	medication  Struggled through with self-motivation
so even then there was no interaction, so I was still very isolated uhmmm, I couldn't tolerate my partner because [you know], because I felt he got me into this situation and as a dad to my 2 children he should've done something about it	132 - 134	Isolation Relationship matter angry with partner	Lack of support from partner Isolation
...my symptoms did, it lasted a very very long time, it had an impact on everything I did henceforth, I think as a nurse I did , because uhm, I remember feeling so overwhelmed one day, I was just standing at the window with the baby and I thought to myself I want to jump outside the window with the baby um, then I thought, you know I've got a little one, because I held the baby, in my arms and I just thought to myself uhm, I had tears streaming down, it was just a feeling of hopelessness, uhmmm and I realised and that I was in trouble uhm, that this actually more than baby blues, yeah, especially thinking about uhm, you know wanting to kill yourself but fortunately for me I just thought uhm, what would, how would that impact on my family and who will look after my children.	179 - 188	Overwhelmed Feeling of helplessness Suicidal thoughts and attempts  Protective factors – Children and family	Suicidal thoughts  Ignorance of symptoms
I think just talking about it, its still, it's still very difficult to talk about, coz I'm so, I was just thinking about it, it still makes me very emotional	223 -224	Still very difficult to talk about it, still feels uncomfortable	Lasting emotional impact

#### PARTICIPANT 4 – BLESSING

Transcript excerpts	Line numbers	Initial thoughts	Emerging themes
Coming from a country where there is a close family unit where uhm, most times you see everybody will help you with one thing or the other and then coming to the United Kingdom uhm and when you are pregnant, you are there on your	14 -16	Loneliness, transition from a closed family culture to an isolated environment	Impact of transition from different culture

own			
My husband has to work to pay the bills, so while he's doing that, even when I would need help, [you know], with one thing or the other, that help is not there	22 - 24	Husband not able to help as money is needed from his work husband as he has to provide for the family	Lack of support from husband
Having a child is supposed to be something that will make a mother happy, make someone [you know] feel uhm, fulfilled. But because of all these things that are surrounding one at the time, [you know ] instead of being happy, one now finds herself to be somehow withdrawn	24 – 27	Expectation to be happy after having a new baby	Pressure from sociocultural expectations
... Withdrawn, having low moods, being depressed so that how it came about so the thing is because I have a child and [you know], I don't have any help at all, so [you know] I have to look after her, wake up many times in the night, I have 1 hour sleep, sometimes 2 hour sleep in and out with no help at all so it is very depressing	27- 31	Withdrawn, low mood, depressed, lack of sleep, in need of practical help and support	Condition triggered by social and practical factors
I had wanted my mum to come over but the home office wouldn't let her I did tell them that I had a baby so my mum can come and help but they said there are lots of nannies here,...so all these things where the things that really, really made me to uhm feel depressed at the time	31 – 34	Refusing the mother a visa was seen as very unsupportive and lack of consideration. Home Office lacked understanding and treated case.	Mum denied visa to come to support exacerbated the symptoms and condition
...just realising the fact that [you know], one is going into depression because that's an area that is not talked about an area nobody talk about, it's an area that nobody cares about	37 – 39	Most challenging experience is not being able to talk about feelings and experience due to stigma	Effect of stigma of talking about mental health problem Cultural factor
when the midwife come in, they just want to check on the baby just to make sure the baby is okay, the	39 - 45	All attention on baby. Where is the help and	What about me?

<p>baby is feeding well on the breast uhm, the baby doesn't have jaundice [you know] then they do all the little test, they normally do to check certain things whether the child has a good, [you know] those things, they just do their thing and sometimes when the health visitor come as well they weighs the baby, so most times the interest is on the baby baby baby, nobody thinks about the mother, yeah so that it the actual experience</p>		<p>care for the mother?</p> <p>A cry for help by mother from the professional – not all about the baby</p> <p>Focus on baby</p>	<p>Neglected nurturer</p>
<p>...Because when they come in they don't ask you how do you feel , they don't care about your mental health issue for them mental health is a big, [you know]is something that they still, they don't look into it,....</p>	<p>55 -58</p>	<p>What about my feelings? Not the physical environment</p>	<p>Neglected by professionals</p>

#### PARTICIPANT 5 – CELIA

<b>Transcript excerpts</b>	<b>Line numbers</b>	<b>Initial thoughts</b>	<b>Emerging themes</b>
<p>I didn't realise it was postnatal depression because I was a first time mum, and just thought that what I was going through was normal</p>	<p>13-14</p>	<p>Lack of knowledge of symptoms</p>	<p>Ignorance of symptoms and condition</p>
<p>everybody around me expected me to be happy, to find a way to cope with uhm with having a baby, still being able to receive people, cooking for them and to entertain them, look after my child well, look after my husband well</p>	<p>14 - 17</p>	<p>Pressure from expectation Overshadow with looking after the home and family ignoring the signs and symptoms of PND Symptoms overlooked due to conforming to expectation</p>	<p>Pressure from Scio-cultural expectation  Conforming to expectations</p>
<p>I felt like a tool no longer a person, it was more about waking up then my daughter was woke up, look after her, feed her, bath her, clothe her just look after her then after that</p>	<p>23 - 26</p>	<p>Felt like a tool  Living a robotic routine life</p>	<p>Living a robotic routine life</p>

I had to look after the house, cleaning, cooking, uhm, organising myself to do shopping or anything to do related to the house			
... and I had no one to talk to because there was so much expectation of how a woman especially in the African culture, how a woman should behave, you should still be able to look after your baby, look after your husband, look after your home, look after guests, entertain them even though you are struggling with what you struggling with.	38-42	Isolation No one to talk to social- cultural expectations	Pressure of sociocultural expectation Loneliness
...culture in a sense of from a very young age especially when you reach your teenage age, you are trained in a certain way where you need to prepare yourself to look after a home and it entails many many things, and the first thing you are taught is self-control. You don't have to, you don't have to divulge everything that is wrong, you have to learn to cope with it, so at a very young age, you are taught about coping mechanism, despite your discomfort, you need to find a way to just manage through things, at the end of the day, this how you know a good strong woman	45-51	Influence of cultural training – self coping, resilience, self-sufficient, self-control how to be a good wife and mother, secrecy and getting on with things despite any discomfort Cultural training to be strong and resilient keeping things secret	Secrecy culture  Cultural expectations
... when you have a guest, you are expected to be fed, to be entertained, you have to sit with them, you have to cook for them, you have to offer them drink at the same time you have to be at the kitchen cleaning and cooking, and if your child is crying, you still have to attend to your child. It's a lot to deal with...	58-62	Juggling multiple tasks overshadowing the ability to recognise or detect depression. Entertaining guests, coking and keeping the home together	Conforming to norms and social expectation
...and even when you start talking, the talk is all about the baby as if your life is about the baby and if	84-91	Everyone around interested in the baby apart from	Focus on baby

you want to ask questions but then people's responses just make you realise that nothing really interesting,... but no one really asking you how things are going, are you getting enough sleep, or what do you do to get enough sleep...			What about me? neglect
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**PARTICIPANT 6 - JULIE**

<b>Transcript excerpts</b>	<b>Line numbers</b>	<b>Initial thoughts</b>	<b>Emerging themes</b>
I second guess myself most of the time, but I kept going like a robot, just wake up doing what I could do. I thought my child was sick because she was always crying, I thought it was a cough, asthma, that I must have done something, so uhm.	30 - 33	I second guessed myself most of the time Kept going like a robot I thought the baby was crying because she was unwell	Ignorance
I didn't tell anybody about the problem, about how I was feeling yeah.... Because of the expectation like I didn't want people to think I wasn't a good mother, when you have a baby you should be joyful, you should be happy so, if I complain people would say what do you mean that you are sad or you are not coping? what is there to be sad about, what you will hear will be your mother, your aunties from generations have done it, ...you are just sulking,	33-34, 36-40	Kept difficulties secret due to cultural expectation and fear of been disbelieved and possibly mocked	Pressure from Scio-cultural expectation Hindrance to help seeking
...my husband was away most of the time, he worked away from home, so I was left by myself, with a crying baby and.... yeah, so he wasn't there so he would come home on weekends, you know, then he would leave again by Sunday, I was practically by myself. I felt lonely and isolated.	52 - 56	Lack of support from husband Loneliness isolation	Lack of support from husband Loneliness and isolation
I did have nurses that would look at	65 - 69	Felt her mental	What about

<p>the child, look after how she is doing, how I'm looking after her, they were always enquiring about the child, and yeah but not my mental health, so it's always like your physical health, is your wound healing, nobody asked about my mental health, I could have said something if someone had pushed me or asked about it, I would be open to talk about it because I think they would have helped me.</p>		<p>health was ignored by the nurses. All about the baby Unable to ask for help due to cultural constraint Would open up if asked</p>	<p>me? Feelings of neglect by health professionals  Willing to accept available support if encouraged</p>
<p>...the expectation on you is that you just get on with it, that's our culture [you know], get on with things, you don't complain, what do you mean, they think you are abroad and you having it easy</p>	84 -86	<p>Denial due to cultural expectations Expectation to be strong and resilient expectation to appreciate the privilege of being abroad.</p>	<p>Pressure of sociocultural expectations</p>
<p>...it's not for typical African strong woman (laughs), so you don't think, even in your brain, to give value or voice to it in your head, once it comes you reject it like, not me not me, so you don't even accept it in your brain, because it is associated with something like weakness, so that's why I thought no, not me..</p>	88 - 92	<p>Denial due to false association It is for the weak Misconception of facts about who suffers with PND Unable to show vulnerability due to cultural expectation</p>	<p>Wrong perception of PND due to cultural expectations</p>
<p>I think so because you come from a culture where, I guess we come from a very communal culture back home, where you know you always have help, uhm, there always an auntie, cousin, someone you are surrounded by, and then you come to a society where it's a very individualistic, everybody keeps to themselves, you can't knock on next door neighbour to say please look after my child, come and help me,</p>	95 - 99	<p>Effect of coming from a communal culture to an individualist culture</p>	<p>Impact of transition from different culture</p>

<p>...you know, anything that has to do with mental health is frowned upon, it is stigmatised where we come from... because culturally it is just get on with things... so we coming after that generation to think like them that asking for help is a sign of weakness is not right. So yes it does affect us culturally in many aspects, we believe depression is for people who are not brave enough, we ask why are you feeling depressed?, come on get on with it, stand up and get on with it, stop indulging in silliness that what we say.</p>	<p>139 - 147</p>	<p>Mental health issues frowned upon culturally Resilience promoted Misconception about the realness of PND Lack of understanding and support</p>	<p>Effect of stigma and cultural belief system</p>
<p>Then join a support group, again culturally we also think that's a waste of time, like what are we going to do in a group... ...we believe if we come and talk about it, everybody will know my problems [you know], that's one thing about us, emotionally we can be very secretive</p>	<p>151 -153, 160 - 161</p>	<p>Nigerian women are generally not good at opening up in group setting and finds it difficult to talk about emotional stuff</p>	<p>Secrecy culture  Stigma around talking about Emotional issues</p>
<p>..if I had told some people, I would have had so many people shut me down in my community, maybe criticise me and even stigmatise me, they will say look at her, she says she's suffering, she is sad, she is having negative thoughts, like she's just indulging.</p>	<p>168 -171</p>	<p>Unable to talk about emotional issues due to fear of criticism and stigmatisation</p>	<p>Effect of stigma and fear of criticism</p>

## Appendix J


**TABLE OF MASTER AND SUBORDINATE THEMES WITH CORRESPONDING QUOTES FOR ALL PARTICIPANTS**

Master themes	Subordinate themes	Corresponding quotes and line numbers
<b>SOCIO-CULTURAL FACTORS</b>	Intergenerational transmission: expectations and conformity to the primacy of the strong black resilient woman	<i>'...as an African woman, we are brought up to be strong; we are supposed to be strong ... there's that expectation...'</i> (Rosemary, line 83-84, p3).
	Cultural perceptions: shame and stigma	<i>'...depression is not something you can just talk about...because of the taboo that are associated with it, sometimes when people know that you have mental health problems, they will start avoiding you the person is like stigmatized and you won't be able to have confidence...'</i> (Blessing, line 105-107, 109, p4).
	Transition: adjusting to an individualistic culture	<i>'...I guess we come from a very communal culture back home, where you...always have help, <b>uhm</b>, there always an auntie, cousin, someone you are surrounded by, and then you come to a society where it's a very individualistic, everybody keeps to themselves, you can't knock on next door neighbour to say please look after my child ...so it does involve culture shock</i> (Julie, line 95-99, P3).
<b>NEGLECTED NURTURER</b>	Experience of treatment - neglected by professionals	<i>'...when the midwife come in, they just want to check on the baby, just to make sure the baby is okay, the baby is feeding well on the breast...when the health visitor come as well they weighs the baby, so most times the interest is on the baby <b>baby baby</b>, nobody thinks about the mother'</i> (Blessing, line 39-44, p2).
	Façades: pretending to be okay	<i>'...I will put up a smile, I will feel like I'm so happy since they came for the baby,... as soon as they walk out of the door, I go down being unhappy again, ...wishing that someone could just take the baby away'</i> (Ngazi, line 158-160, p6).
<b>LONELINESS AND COPING</b>	Lack of spouse support	<i>'...my husband was away most of the time; he worked away from home, so I was left by myself... with a crying baby</i> (Julie, 52-53, p2).
	Self-reliance	<i>'...I managed on my own...I suffered the isolation and loneliness alone'</i> (Ngazi, line 118, p3).



## Appendix K

### SAMPLE OF DEMOGRAPHIC QUESTIONS



LONDON  
METROPOLITAN  
UNIVERSITY

Demographic questions

Name: .....

Nationality: .....

Marital status: .....

Age: .....

Qualification: .....

Current employment: .....

How did you come to live in the UK? .....

How long have you lived in the UK? .....

When were you diagnosed with PND? .....

How old was your baby? .....

How old is your baby now? .....

How many children do you have now? .....

## Appendix L

### TEMPLATE OF EMAIL FOR ACCESS TO PARTICIPANTS

#### **Subject: Research study into how first generation Nigerian mothers experience PND in the UK**

Dear...

My name is Lydia Ling. I am a trainee Counselling Psychologist at London Metropolitan University, for my Doctorate project I am investigating how First Generation Nigerian Mothers (FGNMs) in the UK experience Postnatal depression (PND), their experience/access to available treatment and how they manage with the challenges. The statistics according to the 2011 census suggest that people who identify as black Africans are now the largest black community group in Britain as opposed to those who identify as African Caribbean and the majority of Nigerian women are first generation. Research currently indicate that Black and Minority Ethnic (BME) population under-utilise mental health services and they are under-represented in the literature of psychological support. Available studies show that psychological support can be helpful with managing PND. However, there has been no specific research to date on how the available treatment is experienced by Nigerian women and their need remain unexplored.

The aim of my study is therefore to explore the experiences of FGNMs who have experienced PND. The study's objective is to give a voice to the FGNMs so as to highlight their needs and for it to be given attention. The research also hope to provide practitioners with an in-depth understanding of the psychological needs of the FGNMs in order to develop tailored and specific interventions that meet the needs of this group of mothers.

I am seeking to recruit FGNMs who have been formally diagnosed with PND and are willing to participant in face-face interviews that will last approximately an hour. I am contacting you to enquire if you will be able to help in my recruitment process and whether you are aware about other organisations or groups that would be able to help me. I will be happy to share the findings of my study with you once completed and I have the intension of publishing the research results.

I sincerely hope that you would be able to help me in this my endeavour. Please do not hesitate to contact me or my research supervision Dr Verity Di Mascio if you have any questions or concerns about the study.

Yours sincerely

Lydia Success Ling

Research supervisor: Dr Verity Di Mascio

Emai: [v.dimascio@londonmet.ac.uk](mailto:v.dimascio@londonmet.ac.uk)

## Appendix M

### **SAMPLE OF RESPONSE EMAIL FROM APPROACHED RECRUITING ORGANISATIONS/GROUPS**

**Fola Komolafe (FI)** <fola@freshinspiration.org>

To  
Lydia Ling  
14 Dec at 4:37 PM

Dear Lydia,

In respect of our conversation a few months ago and your subsequent email, I can confirm that Fresh Inspiration will be able to support you with finding participants for your investigation. Fresh Inspiration is a registered charity and one of our aims is to empower women to maximise their potential. We work with a diverse group of women and a majority of them are first generation Nigerian mothers.

So we will be pleased to provide support to you, encouraging our group of women to participate in the interviews as deemed appropriate. I wish you all the best in your studies and look forward to working with you on this exciting topic.

Best wishes,  
Fola Komolafe MBE DL CCMi

**Fresh Inspiration**  
(Address deleted)

### Reply from a parenting centre

**Nicola Ritchie** <nicola.ritchie@mkcc.org.uk>

To  
Lydia Ling  
24 Dec at 4:38 PM  
Hi Lydia

Thank you for contacting me regarding the participant request, sorry for my delay in replying to your request. I am happy for you to display your poster at the group and or speak to the ladies, as discussed. There might be a chance of finding suitable participants as we have a few Nigerian mothers attending the group.  
Speak to you soon.

Nicola  
**Nicola Ritchie**  
Address deleted