First-generation Nigerian mothers living in the UK and their experience of Postnatal Depression: An Interpretative Phenomenological Analysis

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Abstract

Objective: Previous studies emphasise the negative psychological and physical consequences of Postnatal Depression (PND) on mothers and children's health. In the UK, around 10-20% of women can be affected by perinatal mental health problems. Minority ethnic groups such as Black African mothers are considered to be at greater risk of developing PND and data estimates that immigrant mothers are twice more likely to develop PND than native mothers. The unique experiences and needs of this culturally diverse group remain little explored in the UK. To address this gap in the literature, this study aimed to explore the lived experiences of First-Generation Nigerian Mothers (FGNMs) who suffered PND, their coping behaviours and treatment experiences in the UK.

Design: Six FGNMs with a previous diagnosis of PND and treatment experiences were purposefully recruited from GP practices and social groups attended by Nigerian mothers in the UK. Semi-structured interviews were analysed using Interpretative Phenomenological Analysis.

Results: Three master and seven subordinate themes were identified: (i) Socio-cultural factors (Inter-generational transmission; cultural perceptions: shame and stigma; transitions: adjusting to a new culture); (ii) What about me? The neglected nurturer (experiences of treatment; pretending to be OK); and (iii) Loneliness and coping (lack of support from partner; self-reliance).

Conclusions: The study provides evidence about the difficulties encountered by FGNMs in relation to PND, including socio-cultural factors, neglect from family and healthcare professionals, and self-reliance as a coping strategy. Contrary to reports suggesting that Black ethnic groups do not seek help for their mental health needs, participants' accounts indicated that their attempts to engage with professionals were met with unsatisfactory responses. The findings of this study highlight the need to address barriers affecting access to services by fostering a patient-centred and culturally sensitive approach in healthcare teams to effectively engage mothers at an early stage in the detection pathway.

Keywords: Postnatal depression; first-generation Nigerian mothers; experience of treatment; Interpretative phenomenological analysis.

Introduction

Postnatal depression (PND) is a debilitating disorder that usually occurs within six weeks after childbirth although symptoms can develop up to twelve months after giving birth (National Health Service [NHS] 2022). In the UK, it is estimated that between 10-20% of women can be affected by perinatal mental health problems during pregnancy and the first year postpartum (Public Health England 2019). The National Institute for Clinical Excellence (NICE) (2007) classified PND as a serious public health problem that can lead to long-term mental health challenges for new mothers and psychological morbidity in the perinatal period. PND has a profound impact on the maternal health and well-being of new mothers, and it can manifest in symptoms of anxiety, low moods, irritability, inability to cope, fatigue, self-blame and feelings of worthlessness, amongst others (Howard et al. 2014, Slomian et al. 2019). It can also lead to emotional, interpersonal, behavioural and cognitive problems in children in later life (Grace, Evindar, and Stewart 2003; Slomian et al. 2019).

The Royal College of Psychiatrists (2018) and NICE (2020) evidence-based guidelines recommend psychological treatments such as Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT) for mild to moderate PND, offered through Improving Access to Psychological Therapies (IAPT) and Perinatal Mental health services. In addition, the National Health Service' Maternity Transformation Programme (NHS 2016) has set up Mother and Baby Units for mothers with severe mental illness to access specialised community perinatal mental health services. Access to early diagnosis and treatment, however, has been suboptimal due to structural barriers affecting both the provision of services and women's help-seeking behaviours. Lack of clinical recognition, poor mental health service coordination in the community, shortage of health visitors and midwives (limited time to build rapport), and delays in referrals have been identified as contributing factors (The Mental Health Taskforce 2016).

More importantly, inequalities in Black, Asian and minority ethnic (BAME) mothers in regard to access to services, experiences with treatment, and health outcomes have been evidenced by the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRCE-UK 2021). The review found that maternal mortality rates were four-times higher for Black women, two-fold higher for Mixed race and for Asian women, in comparison to White women. In addition, the Birthrights' inquiry into Racial Injustice in Maternity Care (2022) focused on the extent of systemic racism in maternity services, identifying the following key issues: lack of physical and psychological safety; being ignored and disbelieved; racism by caregivers; dehumanisation; lack of choice, consent and coercion; structural barriers and workforce representation and culture. Informed by the MBRCE-UK report, the NHS (2021) issued guidance to improve equity for BAME mothers and babies and women living in the most deprived areas, and to improve race equality for staff. Whilst the guidance focuses primarily on physical and severe mental health conditions rather than PND specifically, it is a significant step in the recognition of structural barriers affecting BAME women during the perinatal period.

The experiences of treatment for PND, particularly amongst BAME mothers and how they manage and cope with the illness has been little explored in the UK despite studies suggesting poor engagement with mental health services (Sambrook Smith et al. 2019). On the one hand, the perceptions and attitudes towards mental illness in different cultures may affect the way women interpret and experience PND as well as their coping strategies and help-seeking attitude (Arifin, Cheyne, and Maxwell 2018). On the other, BAME mothers experience stressors that are specific to their minority status, such as acculturative stress and racism that are more directly related to their immigration history and social status (Nilaweera, Doran, and Fisher 2014). In addition, stigma, in its varied forms of internalised, anticipated or treatment stigma, and public or social stigma, has been associated with lack of access to services and as predictable variables of perinatal depression in BAME women in the UK (Amoah 2021). Access to mental health services, as well as effective interaction with health professionals, has been further hindered by women reporting language barriers and low numbers of BAME professionals who they could relate with, impeding women expressing their feelings and symptoms (Button et al. 2017; Sambrook Smith et al. 2019).

The prevalence of PND in migrant women worldwide is estimated to be around 20%, with symptoms twice more likely to occur in this group when compared to non-migrant women (Falah-Hassani et al. 2015). The literature has consistently reported that first generation migrant women are at higher risk of mental health problems such as depression, anxiety, and post-traumatic stress disorder compared to the general population (Norredam et al. 2009; Close et al. 2016), while quantitative UK studies on PND have identified BAME groups and migrant mothers as more susceptible than White British mothers to develop the condition (Onozawa et al. 2003; Moore et al. 2019).

Research exploring the particular experiences of African mothers with PND living in the UK is still limited. A recent cross-cultural survey analysed PND, maternal-infant bonding, parity and social network amongst British, Nigerian, and Nigerian immigrant mothers in the UK, where the latter group had higher PND, less access to psychological services and emotional support, and poor maternal-infant bonding (Afolabi et al. 2020). The authors highlighted the relevance of understanding the experiences and health care needs of Nigerian immigrant mothers in the UK, and the present study aims to fill this gap in the literature. To our knowledge, this is the first study specifically exploring the lived experiences of PND in first-generation Nigerian mothers (FGNMs) in the UK. The study's aims were twofold: 1) To explore how first-generation Nigerian mothers in the UK experience postnatal depression; 2) To investigate how this group of mothers experience available treatment and resources, and how they manage and cope with PND.

Method

Interpretative phenomenological analysis (IPA) was used to collect, analyse, and report the results (Smith, Flowers, and Larkin 2009). IPA was selected over other qualitative methods because of its focus on participants' lived experiences, a perspective that was identified in the literature as in need of better understanding to interpret complex individual experiences of FGNMs diagnosed with PND. Thus, the specific social and cultural contexts of the participants were carefully considered (Smith, Flowers, and Larkin 2009). IPA focuses on the detailed understanding of lived experiences, it helps to produce knowledge from the meaning this holds for individuals and how this informs how they make sense of their lived experiences (Smith and Osborn 2008). Furthermore, IPA is consistent with the philosophy of counselling psychology practice (Milton, Craven, and Coyle 2010), in the positioning of participants in research and clients in clinical practice as experts in their experiences.

The exploratory nature of IPA and its small sample can affect the level of generalisations observed in larger qualitative studies, yet findings from ideographic research in PND can help us refine our understanding of the complex challenges affecting specific BAME groups and along with other research designs, inform the development of more effective interventions.

Sampling and participants

Purposive homogeneous sampling was used to identify Nigerian-born mothers who have had children in the UK, had PND diagnosis, treatment experience, and those who spoke fluent English. This was decided over the use of an interpreter which could affect the meaning and richness of the language. FGNMs hold a unique set of cultural narratives and identities that shape their experience of mothering and responses to distress and were recruited for this unique experiential knowledge (Smith, Flowers, and Larkin 2009). To maintain homogeneity in exploring the intersections between ethnicity and the experience of PND, mothers who were under eighteen or over fifty-five years old, mothers who had asylum seeker status, and those engaged with social services or had a baby or babies diagnosed with serious illness were excluded.

The recruitment strategy used posters displayed at parenting centres, GP surgeries, organisations and social groups attended by Nigerian mothers across different counties and cities in the UK. Snowballing technique was also used to identify potential participants. 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, a participant information sheet containing detailed information about the study was emailed and participants were advised to contact the primary researcher if they had any questions before taking part in the study. Five African mothers from other countries showed interest, but failed to meet the nationality criteria, and two participants who initially agreed to participate later dropped out. Of the 6 participants selected, five were recruited through organisations and social groups attended by Nigerian mothers and one participant was recruited through GP practice using snowballing technique.

The IPA approach requires that participants are recruited from a closely defined group who share a similar experience and for whom the research questions have relevance and subjective significance (Smith and Eatough 2006; Smith and Osborn 2008). Thus, participants who met the predetermined criteria based on experiential knowledge were selected. This also allows the research questions to be adequately answered, enabling an insight into an idiosyncratic and subjective interpretation of individual experiences (Smith and Eatough, 2006). All participants in the study were employed at the time of the interview. Further demographic and characteristic details are presented in Table 1. Pseudonyms have been used to maintain anonymity.

Ethical approval was obtained from London Metropolitan University Research Ethics Committee. All legal and ethical practice guidelines/protocols as proposed by the Code of Ethics and Conduct of the British Psychological Society (BPS) (2009) and the Health and Care Professional Council (2016) were considered in conducting the research. The participants were 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.

The participants were informed that participation was fully voluntary and informed consent was gained from each participant before the interview. Considering the nature and sensitivity of PND, where talking about the experience may be an emotional process for mothers, a three step Distress Protocol process 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, and participants were given the opportunity to talk about any feelings and concerns that may have been evoked during the interview with the first author.

Table 1: [here]

Interviews

A face-to-face semi-structured interview schedule was used to collect the data, and all interviews were conducted by the first author. Three interviews took place at participants' homes in quiet and private rooms, and the other three were conducted in a hired confidential counselling room. The interview schedule consisted of open-ended, non-directive questions. Semi-structured interviews are the recommended method for data collection in IPA approaches because this allows flexibility for a dual focus where the researcher and the participants can follow any avenues that emerge during the interview (Smith and Osborn 2015). The questions for this study focused on the participants' experiences of PND, their views on treatment and support received, and their coping strategies. The interviews lasted approximately one hour and were recorded with a digital recorder.

Analysis

The analytical approach used was informed by IPA's process and principles outlined by Smith and Osborn (2008). This involves individual cases being transcribed verbatim and analysed, followed by cross-case analysis. LL led on the analysis, reading the texts repeatedly line by line and listening to the recordings several times, making notes to contextualise the voice of the participants and fully immerse into the subjective world of the individual participants (Smith and Eatough 2006). The right-hand margin of the transcript was used to note emerging themes which were later clustered into superordinate themes according to intrapersonal patterns of convergence and divergence.

After completing this process for each individual case, further exploration of connections (similarities and differences) within and across cases were traced to develop a master table of themes for the cases in the study (Table 2) with verbatim quotations from the participants' transcripts. LL sought further refinement of master and subordinate themes from VD to verify consistency alongside quotations selected to illustrate each theme. After LL and VD reached consensus on the master table, the final stage of the analytical process involved expanding the identified themes into a narrative account forming the basis of the results of the study. All authors contributed to the final write up of the results, refining extracts used from participants' transcripts, i.e., evidence of their subjective sense-making, and the interpretation by the authors of this sense-making (Smith, Flowers, and Larkin 2009).

The practice of reflexivity is a fundamental component of qualitative research to ensure rigor throughout the qualitative research process (Finlay and Gough 2003). Critical self-reflection was undertaken by the first author (LL) who is a qualified Counselling Psychologist. LL is a Nigerian mother who was unaware of PND until she arrived in the UK. Her initial interest in researching this topic started after encountering a Nigerian mother who suffered with postnatal psychosis in the UK. During the study, LL used a reflective diary, peer support and supervision to increase her awareness of potential biases and to ensure the analysis reflected participant's accounts. In her reflective process, she attempted to 'bracket' her feelings (Smith, Flowers, and Larkin 2009) to establish a balanced view and to adequately represent the participants' negative experiences and barriers encountered. Although LL was aware of the similarities between her and the interviewees, there was also distinctive divergence in their experiences as LL's children were not born in the UK (an inclusion criterion for participation). This enabled her to remain open to the participants' unique experiences.

Results

The analysis generated three master and seven sub-ordinate themes which are summarised in Table 2. The raw data is illustrated by verbatim anonymised transcript extracts. The findings provide evidence to suggest that the FGNMs encountered different types of challenges in relation to their experience of PND in the UK.

Table 2: [here]

Master theme 1: Socio-cultural factors

The findings that constitute this theme indicated 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 a new culture. These themes are strongly interlinked, constituting the social and cultural factors that affected the way in which the FGNMs experienced PND.

Inter-generational transmission: expectations and conformity to the primacy of the strong black resilient woman

All the participants were negatively impacted by the inter-generational belief and expectation to be strong and resilient in their experience of PND. The participants believed that they were brought up in a culture that fostered the need to be self-sufficient and resilient therefore, they felt culturally obliged to show strength and courage in difficult and challenging situations. This cultural transmission seems to impede on the need to be flexible and easily ask for or accept help in times of need by these women. The quote below by Rosemary, one of the participants, captured this expectation:

> ‘As an African woman, we are brought up to be strong; we are supposed to be strong, there’s that expectation’ (Rosemary).

This expectation and cultural influence resulted in conformity by the women, which meant that though they recognised the need for external and professional support, it was not cultural to them to ask for help. There seems to be a belief that bad and challenging situations will go away with time and so, there was reluctance in asking for help. Some of the reasons which led the women to conform to the idea of black and strong women included not wanting to be regarded as weak and not wanting to disappoint family members, as highlighted by Ngozi ‘I don’t want to spoil her Joy’, referring to her Mum. She did not want to spoil the joy of her mum instead, she bottled everything in and suffered her PND in silence.

> ‘You have to be strong no matter what, you have to overcome any challenges or it’s considered as weakness’ (Celia).
>
> ‘I don’t want to spoil her joy, so I had to really kind of bottle everything in’ (Ngozi).

As a result of the inter-generational cultural influence, i.e., the expectation to be strong and resilient, participants lacked emotional support as they were unable to show vulnerability and discuss their struggles with family members.

> ‘Even when my mum came, I couldn’t tell her what I was going through’ (Celia).

However, some of the participants suggested that they could have spoken to external support sources such as healthcare professionals if they were enabled. It seems that the cultural expectation the women endured was a barrier to expressing feelings without being prompted. From the participants’ narrative, they expected the professionals to prompt them by asking questions that could have enabled them to open up about how they were coping.

> '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' (Julie).

Although some of the participants described their experience of the cultural expectations as pressure and irrational, they still seemed unable to break off from its effect, suggesting the strong and negative impact the cultural belief and expectation had on them. For example, Ade narrates her experience as self-resignation, she described a sense of giving up on herself as unable to talk to anyone about how she was feeling, describing a sense of not having a voice.

> 'So more slowly and gradually I felt I needed to deny myself … I felt I needed to live a life for people'.

Ade seemed to suggest a sense of helplessness, not having a voice and courage to overcome the pressure and the expectation to be strong or happy after giving birth to a new baby, she described a sense of being forced to deny her reality. She seemed to be in a world where no one except herself could feel the struggle and challenges she was experiencing.

Whilst Ade was struggling in her inner world as a reaction to her constraints, some of the mothers decided to get on with their lives as an interpretation of the cultural expectation 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'.

The majority of the mothers simply adjusted to the cultural expectation even though it seemed unreasonable and meant suffering the challenges alone and in silence.

Cultural perceptions: shame and stigma

In reflecting on their experiences, participants discussed some of the cultural challenges. PND and mental health issues in general were perceived as a taboo which led the participants to feel shame and become secretive about the topic due to associated stigma, as articulated by Julie and Blessing:

> ‘Anything that has to do with mental health is frowned upon, it is stigmatised where we come from’ (Julie).
>
> ‘Where I came from, depression is not something you can just talk about…because of the taboos that are associated with it, it makes it very difficult …to open your heart to tell them that you are suffering from depression’ (Blessing).

This beliefs and perception about mental health including PND held by the culture of these women meant that they could not openly speak about depressed feelings or acknowledge it. In addition, Ngozi and Celia noted that even when they summed up courage to talk about their depressed feelings, this would not be acknowledged rather it might be regarded as unnecessary attention seeking, therefore the women had to adopt false courage.

> ‘My mother will tell me to be strong and mentioned the generations of women in our family who had children without problems’ (Ngozi).
>
> ‘I think it’s also because I didn’t want them to feel as though I wasn’t coping’ (Celia).

The negative impact of this aspect of the Nigerian culture seemed to have been downplayed by the mothers.

Transition: adjusting to a new culture

All the participants described how adjusting to the UK culture affected them both socially and psychologically. For some, it resulted in feelings of isolation, and for others, it was the loss of the communal and comfortable life they were used to in Nigeria:

> ‘Being isolated from my comfort zone made things harder; it made access to help more difficult’ (Ade).

Ade described the communal lifestyle where they received support from friends and families, particularly as a new mother in her old culture so, being outside this environment had an impact and coping in a different cultural setting was perceived as a barrier.

The participants described the impact of cultural differences (collectivism vs. individualism), Blessing and Julie additionally described their disappointment, surprises, and sense of loss of comfort that was available in Nigeria, but they lacked in the UK:

> ‘Coming from a country where there is a close family unit, where everybody will help you with one thing or the other, and then coming to the United Kingdom …and you are there on your own’ (Blessing).
>
> ‘I guess we come from a very communal society where you always have help, always surrounded by someone, and then you come to a society where it’s very individualistic, everybody keeps to themselves. You can’t knock-on the next-door neighbour to say please look after my child, so it does involve culture shock’ (Julie).

Cultural shock was used to describe this experience by Julie, it was perceived as a loss and disappointment. The lack of this communal lifestyle that was experienced by these women in their own culture may have increased their vulnerability and inability to seek support from professionals.

Master Theme 2: What about me? Neglected nurturer

This theme captures the feelings of the perceived neglect that the mothers 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 is explored in the first subtheme (experience of treatment: neglected by professionals). The response by the participants to their experiences of neglect is considered in the second subtheme (Façades: pretending to be okay).

Experience of treatment: neglected by professionals

The participants explained that they felt neglected by the professionals who worked with them. The narratives suggested that the health visitors and midwives were more focused on the care and wellbeing of the new babies whereas the psychological, mental and emotional needs of the mothers were neglected as narrated by Julie:

> 'They would come and look at the child, how I'm looking after her, they were always enquiring about the child, and not my mental health; so, it's always like your physical health, is your wound healing? Nobody asked about my mental health.

It seems from the excerpt that the mothers expected the focus of care to be on both the mother and the baby, however the participants experienced the professionals to be focused on the baby while neglecting them. This may be more important for these particular mothers as it was already culturally difficult to discuss their struggles and challenges with family members.

The participants also indicated that the healthcare professionals did not listen to their needs, and were not ready to develop a 'professional relationship' rather, they came across as duty bound as articulated by Ade:

> 'I couldn't speak to my health visitor…I felt she was just going through a checklist…she was using a set of questions; I think she was asking me the wrong questions… I felt she was not empathetic. 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 to lean on her, and I wanted someone that would understand me… not someone who was going through a 'checklist'.

Ade sounded desperate and frustrated as she experienced the visiting professionals as behaving in a duty-bound manner. She felt that they did not have time to relate with the mothers at a deeper and curious level in order to enable and empower the mothers to open up, given their difficult cultural constraints. Ade indicated trying hard to have a voice with the professional which she could not have with her family, but she experienced the effort to be met with neglect and apparent rejection by the professionals.

In addition, the participants expressed feeling neglected by their GPs. They were treated with medication which was against their treatment preference. The participants felt disappointed by their GPs and implied that their GPs did not listen enough to their needs. They thought of them as hastily arriving at a diagnosis and prescribing medication without explaining the drug side-effects. This resulted in the participants not taking the medication whilst others discontinued. Some of the participants expected to be referred to specialist services, as they were aware of GPs time-constraints, but this expectation was unmet.

> ‘So, I just thought, I would speak to the GP and see if I get anywhere there, I had a little chat but there was nothing in terms of… referral to any external services…I was just given antidepressants. I couldn’t tolerate the antidepressant at all because it made me feel very tired and this wasn’t explained to me either… I stopped taking the medication, yeah, and I just didn’t bother so I just struggled by myself’ (Rosemary).

The majority of the participants did not take the medication due to personal or cultural perceptions of medication-taking behaviour. Also, the majority of the participants expressed that their GPs did not explain the possible side effects of the antidepressants that were prescribed to them.

> ‘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…’ (Ngozi).

Describing medication taking as being seen as a ‘junkie’ indicates the strong cultural perception of this behaviour and demonstrates poor professional understanding of cultural differences.

Most of the participants also discussed lack of autonomy in treatment decision-making and lack of choice regarding other psychotherapeutic interventions. One participant articulated:

> ‘To be very very honest with you, I was so surprised that he just immediately prescribed antidepressants for me...without explaining things or checking if I would take it’ (Ngozi).

The mothers felt deprived of their agency to be involved in their treatment plan. This lack of autonomy and the failure on the part of the GP to explain the possible side effects of the medication may have accounted for some mothers not taking the medication thereby leaving them without treatment options after overcoming the cultural constraint to seek support. Also, it seemed that some of the mothers were diagnosed with PND without properly explaining their condition to them as described by Ngozi ‘I was surprised that he just immediately prescribed’ medication without explaining things to her.

Façades: Pretending to be okay

The majority of the participants described how they adjusted to their unmet expectations and managed their disappointment with healthcare professionals, for example Ngozi and Blessing noted:

> ‘When they will come and see the baby … 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’ (Ngozi).
>
> ‘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' (Blessing).

The mothers seemed to have taken a back seat to allow the professionals to carry out their duties on their own terms and dealt with this with a sense of helplessness and defeat.

Master theme 3: Loneliness and Coping

This theme captures the experience of lack of support from partner, friends, families, and healthcare professionals. The women also spoke about how they managed and coped with the difficulties and challenges. These experiences broke down into two subthemes, Lack of support from partner; and Self-reliance.

Lack of support from partner

All the participants narrated experiences of lacking emotional support and the majority spoke about lack of both practical and emotional support from families and partners in particular, which for some led to extreme loneliness, isolation and frustration, and for others led to feelings of disappointment, hopelessness, suicidal thoughts and ideation:

> 'I thought to myself I want to jump outside the window with the baby um, then I thought..., it was just a feeling of hopelessness yeah, especially thinking about and wanting to kill yourself but fortunately for me I just thought about the impact on my family and who will look after my children' (Rosemary).

Ade also narrated feeling lonely and suicidal when her husband had to work abroad and her baby was only three weeks old, and she was a first-time mother:

> 'I couldn't cope with the depression; all I kept on wishing was for me to die. There was no one to talk to …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… 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' (Ade).

To be left in an empty house suggested the experience of loneliness and isolation. This loneliness may have exacerbated her inability to cope. Ngozi also commented on her experience of the lack of social and emotional support from her husband and the disappointment she felt about the lack of attention she received from him.

> ‘I was not very happy with my husband…I felt like he wasn’t giving me the attention that I needed or helping me as much as I needed to because he was always away working, … I hardly see him’ (Ngozi).

The lack of attention by Ngozi’s husband was a significant factor that contributed to her struggle to cope which is similar to the experience of other mothers in the study. The phrase ‘lack of attention’ actually meant lack of emotional support in real terms. Some of the mothers did not blame their husbands too much because they believed the husbands needed to go to work in order to provide for the family financially. This is also a cultural factor to the Nigeria families. In the Nigeria culture, men are expected to financially support the family, whereas the wife or mothers are expected to look after the house and the children’s practical needs.

Self-reliance

The participants spoke about how they managed and coped with their conditions in the absence of expected support from professionals and the lack of social and emotional support from others, particularly their husbands/partners. They were averse to medication therapy which was the only treatment offered to them. These experiences reinforced a self-reliance attitude when the expected support was not available and they went through their difficulties on their own, as noted by Julie and Ngozi:

> ‘You stay by yourself, so you cry by yourself, you just get on with it’ (Julie)
>
> ‘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 comes, she likes to go back early’ (Ngozi).

The mothers were faced with lack of timely practical support from their own mothers, for some it was due to the UK entry visa process and leaving their own businesses to travel to the UK. For one of the participants, her mother was denied an entry visa which contributed to developing PND. The majority of the participants suffered this lack of timely practical support, and although they were not expecting psychological and emotional support from their mothers, timely practical support would have been helpful. Rosemary also reported how she struggled on her own and managed through the difficulties and depression without support from others and without taking medication because she could not tolerate it. She described how she motivated herself and how she was determined to get better by compelling herself to get out of the house:

> ‘So,…I stopped taking the medication within, probably within a few weeks, 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 is what I did’. […]
>
> ‘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’ (Rosemary).

Overall, the experiences of the FGNMs appeared complex and multifaceted. The lack of support, the expectations to be strong, and the way PND was perceived by the families and communities of the participants, were all barriers to early help seeking behaviour. However, the attempts made by participants to engage with health professionals were met with unsatisfactory responses, contrary to previous studies suggesting that BAME mothers are less likely to seek help for their mental health problems (Sambrook Smith et al. 2019).

Discussion

The aim of the research was to explore how FGNMs living in the UK experienced PND, their experience of available resources and treatment, and the way they managed and coped with PND. The results indicate negative experiences by the participants with some factors that appear as unique and culturally specific to the FGNMs, a group that has not been the focus of substantial empirical research. Therefore, this qualitative, ideographic study adds depth and detail to existing research on PND in migrant mothers from African heritage living in the UK.

Our findings suggest that FGNMs had to conform to the cultural expectation of being strong and resilient, an expectation that was passed to them inter-generationally, and to which the participants seem to have very little agency but to observe this specific feminine image in interactions with their family. Yet having a conforming attitude did not mean that mothers were unable to recognise their depressive feelings. This is inconsistent with previous studies of PND amongst African mothers that have suggested that women deny their depressive symptoms, regarding them as something else in their daily lives, because they did not believe that PND was an illness suffered by typically strong black women (Babatunde and Moreno-Leguizamon 2012). Furthermore, previous research (Amankwaa 2003; Dei-Anane 2018) suggests that African migrant mothers turn to their family and communities for support needs when postnatally depressed. Yet the latter was not observed in this study. FGNMs were unable to turn to their family and communities for support due to the cultural expectation to be strong and resilient coupled with a broader negative perception of mental health illness in African culture. FGNMs experienced feelings of shame, fear of stigma, and lack of validation of depressive symptoms within their family circles. Being aware of these cultural beliefs meant that mothers were unable to freely speak about their difficulties and to seek timely professional help. Internalised and public stigma can also be compounded by treatment stigma experienced by women from healthcare providers (Watson et al. 2019) leading to a delay in help seeking which could in turn have longer-term negative effects, i.e., severe depression in mothers (Lewis 2007).

Data estimates that immigrant mothers are twice more likely to develop PND than native mothers as a result of shorter length of residency, low income, lack of social support, and poor marital relationship (Falah-Hassan et al. 2015). Whilst mothers in this study did not squarely meet this profile, other factors such as lack of support added nuance to their lived experiences. In this sense, we concur with Afolabi et al. (2020) about the need to disassociate emotional from functional (practical) support. FGNMs endured lack of emotional and practical support from their husbands/partners who had to work to financially provide for the family leading mothers to feel extreme loneliness and having to develop a sense of self-resilience to cope, as narrated by all participants.

Healthcare professionals and mothers' interactions during the postnatal period suggest that mothers' needs were neglected by health visitors and midwives, as these encounters were largely perceived as a 'checklist' approach and baby-centric care with little regard for mothers' mental health needs. More importantly, this discouraged mothers to openly speak to their health visitors about their emotional struggles. This is concurrent with findings from a meta-ethnographic study of migrant mothers in high income countries where healthcare professionals directed their attention only to problems with pregnancy and babies (Schmied et al. 2017); and a meta-synthesis in the UK where the 'tick box' nature of the health visitor's assessment was also highlighted (Sambrook Smith et al. 2019).

Previous research suggests that BAME mothers do not always seek professional help and are difficult to engage (Lewis 2007; Alegría et al. 2008; Hamilton et al. 2011). A novel finding of this work is that the FGNMs sought help and support despite their cultural constraints. Unfortunately, the mothers were not adequately supported by their GPs as pharmacological interventions (antidepressants) were offered as the default option. Similarly, a meta-synthesis about help seeking for perinatal distress has also found that women regarded antidepressants as an unwanted offer alongside fear of addiction (Button et al. 2017). In this study, participants were not offered a referral to an alternative treatment (psychological, talking therapy) nor were they assessed about their beliefs around medications or concerns about side effects. This unmet expectation and lack of choice about treatments meant that many mothers discontinued their medication and were not adequately treated for PND.

A study by Appleby et al. (1997), reports that women with PND preferred talking therapy to antidepressants after receiving both interventions and Lam et al. (2012) also suggest that psychological therapy was helpful with treating PND. In the UK, maternal mental health has progressively been on the public health agenda and the current NHS Mental Health Implementation Plan (2019) aims to improve access to evidence-based psychological therapies for women alongside an assessment of their partners through the specialist community perinatal services. Whilst this is a welcome initiative, it is worth mentioning that the Covid-19 pandemic and social distancing measures had a double impact on mothers' access to services and practical support from family and friends, with a London survey indicating an increase in the incidence of PND to 47.5% (Myers and Emmott 2021). Within a context where Covid-19 has shown to exacerbate health inequalities for BAME groups, it is likely that PND inequalities will persist in a post-pandemic society unless a timely, fair, and comprehensive approach is adopted.

The Patient and Carer Race Equality Framework (National Collaborating Centre for Mental Health, 2018), which aims to identify areas for improvement in mental health services for people of BAME background, is currently being piloted in a number of NHS Trusts. It seems possible that engagement with the lived experiences of mothers diagnosed with PND, as suggested in our findings, would help improved access to services and treatment for postnatally depressed women.

Implications for practice

To our knowledge, this is the first qualitative study using an ideographic approach to explore the experiences of the FGNMs in relation to PND, their treatment experience and how they managed and coped with the illness. The findings for FGNMs have highlighted the centrality of culture in women's experiences of PND as well as in their behavioural responses to depressive symptoms. The fact that research indicates that cultural responses are not uniform across African mothers, nor are the same within the same nationality - when factoring in circumstances such as immigration status, class, language, and social network, amongst others - reinforces the need for healthcare professionals to follow a patient-centred approach to mothers.

Our findings suggest it is important for mothers seeking support to be able to express their emotional struggles and for health professionals to elicit discussions and inspire confidence in available treatments. To facilitate this, training of health visitors and GPs in cultural competence and psychological symptoms is needed to promote active patient involvement, identification of needs, information about risk and benefits of treatments, and timely referrals. This would in turn empower women to make informed decisions about their care and improve treatment retention. Another suitable approach to delivering a person-centred service could draw on developing culturally adapted psychological therapies. Cultural adaptation is a perspective that seeks to modify evidence-based therapies such as cognitive behavioural therapies to service user's language, culture and meanings (Castro, Barrera, and Holleran Steiker 2010).

This approach has proven to work in South Asian women with mild to moderate depression (NICE 2017) and could inform group-based interventions with migrant mothers of the same cultural background suffering with PND. Evidence on the effectiveness of these interventions would be needed. Furthermore, it is important that the culturally adapted psychological therapy is delivered preferably by same ethnic group facilitators.

Considering the negative experiences of FGNMs with PND identified through an ideographic approach, it is hoped that the findings will encourage healthcare professionals to take an individual approach to mothers' needs and be more accepting of women's accounts. It might be helpful to build on these findings to offer a better understanding on how inter-generational beliefs and expectations, acknowledgement of depressive symptoms, and self-reliance can influence the experience of PND and help-seeking behaviours. Equally, it might be insightful to compare the experiences of the first and second-generation Nigerian mothers in future research. This would further inform evidence-based practice.

Strengths and limitations

This study made several unique and insightful contributions to the existing knowledge base of an under-researched population group. Whilst this study is original in terms of research questions and findings, it has a number of limitations. The results of this study were based on the experiences of six Nigerian mothers whose accounts may not be generalised as the experiences of all other FGNMs in the UK as their experiences were idiographic and subjective. Moreover, different interpretations of the experiences could have emerged with a different researcher. The demographic characteristics of the sample indicate that participants were professionals and therefore, it would be relevant to follow this study up with mothers from other SES groups or different migration status.

Conclusions

This qualitative, ideographic study reported findings about the lived experiences of first-generation Nigerian mothers suffering with postnatal depression in the UK. It provides insight into the specific problems underpinning mothers' negative experiences, including socio-cultural factors, neglect from family and healthcare professionals, and self-reliance as a coping strategy. The presence of these interacting factors shaped the experiences of postnatal depression and help-seeking behaviours in this population group. Contrary to a perceived lack of help-seeking behaviour in Black ethnic minority groups, women's accounts indicated that their attempts to engage with healthcare professionals were met with unsatisfactory responses. Although a new plan for extending perinatal mental health services is being rolled out across the UK and should facilitate access to psychological therapies, the findings of this study highlight the need to address barriers affecting access to services, by fostering a patient-centred and culturally sensitive approach in healthcare teams to effectively engage with mothers at an early stage in the detection pathway.

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References

Afolabi O, L. Bunce, J. Lusher, and S. Banbury. 2020. “Postnatal depression, maternal-infant bonding and social support: a cross-cultural comparison of Nigerian and British mothers.” *Journal of Mental Health* Aug; 29(4):424-430. doi: 10.1080/09638237.2017.1340595.

Alegría, M., P. Chatterji, K. Wells, Z. Cao, C.N. Chen, D. Takeuchi, J. Jackson et al. 2008. 2008. “Disparity in depression treatment among racial and ethnic minority populations in the United States.” *Psychiatric services* Nov; 59(11):1264-72. doi: 10.1176/appi.ps.59.11.1264.

Amankwaa, L. C. 2003. “Postpartum depression among African-American women.” *Issues in Mental Health Nursing, 24*(3), 297-316. doi: 10.1080/01612840305283.

Amoah, E. 2021. “Predicting Perinatal Low Mood and Depression for BAME Women - The Role of Treatment, Perceived Public, and Internalised Stigma.” *Diversity and Equality in Health and Care* 18(7): 387-397.

Appleby, L., R. Warner, A. Whitton, and B. Faragher. 1997. “A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression.” *British Medical Journal* Mar 29;314(7085):932-6.doi: 10.1136/bmj.314.7085.932.

Arifin, S.R.M., H. Cheyne, and M. Maxwell. 2018. "Review of the prevalence of postnatal depression across cultures." *AIMS Public Health* Jul 20;5(3):260-295. doi: 10.3934/publichealth.2018.3.260.

Babatunde, T. and C.J. Moreno-Leguizamon. 2012. "Daily and cultural issues of postnatal depression in African women immigrants in South East London: Tips for health professionals." *Nursing research and practice* 2012:181640. doi: 10.1155/2012/181640.

Birthrights. 2022. "Systemic racism, not broken bodies. An inquiry into racial injustice and human rights in UK maternity care Executive summary." Accessed 6 June 2022. https://www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf

British Psychological Society. 2009. "Code of ethics and conduct." Ethics Committee. Leicester: British Psychological Society.

Button, S., A. Thornton, S. Lee, J. Shakespeare and S. Ayers. 2017. "Seeking help for perinatal psychological distress: a meta-synthesis of women's experiences." *The British journal of general practice* Oct;67(663):e692-e699.doi: 10.3399/bjgp17X692549.

Castro FG, M.Jr Barrera, and L.K. Holleran Steiker. 2010. "Issues and challenges in the design of culturally adapted evidence-based interventions." *Annual Review of Clinical Psychology* 6:213–39. doi: 10.1146/annurev-clinpsy-033109-132032

Close, C., A. Kouvonen, T. Bosqui, K. Patel, D. O'Reilly, and M. Donnelly. 2016. "The mental health and wellbeing of first generation migrants: a systematic-narrative review of reviews." *Globalization and health* Aug 25;12(1):47.doi: 10.1186/s12992-016-0187-3.

Dei-Anane, E., A. Afriyie Poku, S. Boateng, K. Osei Poku, E. Amankwa and A. Nkrumah Adasa. 2018. "Perceptions of Ghanaian Migrant Mothers Living in London towards Postnatal Depression during Postnatal Periods." *American Journal of Geographical Research and Reviews* 1:7. doi:10.28933/ajgrr-2018-02-0501.

Falah-Hassani K., R. Shiri, S. Vigod, and C.L. Dennis. 2015. "Prevalence of postpartum depression among immigrant women: A systematic review and meta-analysis." *Journal of Psychiatric Research* Nov;70:67-82. doi: 10.1016/j.jpsychires.2015.08.010.

Finlay, L., and Gough, B., eds. 2003. *Reflexivity: A Practical Guide for Researchers in Healthcare and Social Sciences*. Oxford: Blackwell Science Ltd.

Grace, S. L., A. Evindar, and D.E. Stewart. 2003. "The effect of postpartum depression on child cognitive development and behavior: a review and critical analysis of the literature." *Archives of women's mental health*, *6*(4), 263-274.

Hamilton, S., A.M. Moore, D.R. Crane, and S.H. Payne. 2011. "Psychotherapy dropouts: Differences by modality, license, and DSM-IV diagnosis." *Journal of Marital and Family Therapy*, Jul;37(3):333-43. doi: 10.1111/j.1752-0606.2010.00204.x.

Health and Care Professional Council. 2016. “Standard of proficiency for practitioner psychologists.” London: HCPC.

Howard, L. M., E. Molyneaux, C.L. Dennis, T. Rochat, A. Stein, and J. Milgrom. 2014. Non-psychotic mental disorders in the perinatal period. *The Lancet*, *384*(9956), 1775-1788.

Lam, E., A. Wittkowski, and J.R. Fox. 2012. “A qualitative study of the postpartum experience of Chinese women living in England.” *Journal Of Reproductive & Infant Psychology* 30(1), 105-119. doi:10.1080/02646838.2011.649472.

Lewis, G. ed. 2007. “Confidential Enquiry into Maternal and Child Health (CEMACH): Saving mothers' lives: reviewing maternal deaths to make motherhood safer - 2003-2005.” December 2007. https://www.publichealth.hscni.net/sites/default/files/Saving Mothers%27 Lives 2003-05 .pdf

MBRCE-UK. 2021. “Maternal, Newborn and Infant Clinical Outcome Review Programme.” Accessed 7 December 2021. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

Milton, M., M. Craven, and A. Coyle. 2010. “Understanding human distress: Moving beyond the concept of 'psychopathology' “. In *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*, edited by M. Milton, 57-72. West Sussex: Wiley & Sons.

Moore L, H. Jayaweera, M. Redshaw, and M. Quigley. 2019. “Migration, ethnicity and mental health: evidence from mothers participating in the Millennium Cohort Study.” *Public Health* Jun;171:66-75. Doi: 10.1016/j.puhe.2019.03.022.

Myers S. and E.H. Emmott. 2021. “Communication across maternal social networks during England’s first national lockdown and its association with postnatal depressive symptoms.” *Frontiers in psychology* May 11;12:648002. Doi: 10.3389/fpsyg.2021.648002.

National Collaborating Centre for Mental Health. 2018. “Patient and Carer Race Equality Framework.” Accessed 6 June 2022. https://www.healthylondon.org/wp-content/uploads/2021/05/nccmhpatientandcarerraceequalityframeworknovember2018-1.pdf

NICE. 2007. “Antenatal and postnatal mental health: clinical management and service guidance.” NICE clinical guideline (CG45) no longer available from www.nice.org.uk/guidance/CG45.

NICE. 2017. “Innovative ways of engaging with Black and Minority Ethnic (BME) communities to improve access to psychological therapies.” Accessed 1 October 2021. https://www.nice.org.uk/sharedlearning/innovative-ways-of-engaging-with-black-and-minority-ethnic-bme-communities-to-improve-access-to-psychological-therapies.

NICE. 2020. “Antenatal and postnatal mental health: clinical management and service guidance. 11 February 2020”. https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations - recognising-mental-health-problems-in-pregnancy-and-the-postnatal-period-and-referral-2.

NHS. 2016. “Maternity Transformation Programme.” Accessed 7 October 2021. https://www.england.nhs.uk/mat-transformation/

NHS. 2019 Mental Health Implementation Plan 2019/20 – 2023/24. July2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

NHS. 2020. “Advancing mental health equalities strategy. September 2020”

NHS. 2021. “Equity and equality Guidance for local maternity systems. September 2021.” Accessed 01 July 2022. https://www.england.nhs.uk/publication/equity-and-equality-guidance-for-local-maternity-systems/

NHS. 2022. “Overview - Postnatal depression.” Accessed 7 June 2022. https://www.nhs.uk/mental-health/conditions/post-natal-depression/overview/

Nilaweera I, F. Doran, and J. Fisher. (2014) “Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: a systematic review of the evidence.” *Journal of Affective Disorders* 166:213–226. doi: 10.1016/j.jad.2014.05.021.

Norredam, M., A. Garcia-Lopez, N. Keiding, and A. Krasnik. 2009. “Risk of mental disorders in refugees and native Danes: a register-based retrospective cohort study.” *Social psychiatry and psychiatric epidemiology* Dec;44(12):1023-9. doi: 10.1007/s00127-009-0024-6. *44*(12), 1023..

Onozawa, K., R.C. Kumar, D. Adams, C. Dore, and V. Glover. 2003. “High EPDS scores in women from ethnic minorities living in London.” *Archives of Women’s Mental Health* Aug;6 Suppl 2:S51-5. doi: 10.1007/s00737-003-0006-8.

Public Health England (2019) “Perinatal mental health.” Accessed 28 September 2021. https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health

Royal College of Psychiatrists. 2018 “Postnatal depression.” Accessed 28 September 2021. https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-natal-depression?searchTerms=PND

Sambrook Smith, M., V. Lawrence, E. Sadler, and A. Easter. 2019. “Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK.” *BMJ Open* 24;9(1):e024803. doi: 10.1136/bmjopen-2018-024803.

Schmied V, E. Black, N. Naidoo, H.G. Dahlen, and P. Liamputtong. 2017. “Migrant women's experiences, meanings and ways of dealing with postnatal depression: A meta-ethnographic study." *PLoS One* Mar 15;12(3):e0172385. doi: 10.1371/journal.pone.0172385.

Slomian J, G. Honvo, P. Emonts, J.Y. Reginster, and O. Bruyère. 2019. "Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes." *Women's Health* Jan-Dec;15:1745506519844044. doi: 10.1177/1745506519844044.

Smith, J. A., and V. Eatough. 2006. "Interpretive phenomenological analysis." In *Research Methods in Psychology*, edited by G. Breakwell, C. Fife-Schaw, S. Hammond, and J.A. Smith (3rd Ed.), 322-342. London: Sage.

Smith, J. A., and M. Osborn. 2008. "Interpretative phenomenological analysis." In *Qualitative psychology*: *A practical guide to methods*, edited by J.A Smith, 53-80. London: Sage.

Smith, J.A., P. Flowers, and M. Larkin. 2009. *Interpretative phenomenological analysis: Theory, Method and Research.* London: Sage.

Smith, J. A., and M. Osborn. 2015. "Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain." *British journal of pain* Feb;9(1):41-2. doi: 10.1177/2049463714541642.

Smith, J.A., P. Flowers, and M. Larkin. 2009. *Interpretative phenomenological analysis: Theory, Method and Research.* London: Sage.

The Mental Health Taskforce. 2016. "The five year forward for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England." Accessed 3 October 2021. https://www. england. nhs. uk/ wpcontent/uploads/ 2016/ 02/ Mental-Health- Taskforce- FYFV- final. pdf.

Watson H, D. Harrop, E. Walton, A. Young, H. Soltani. 2019. "A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe." *PLoS One* Jan 29;14(1):e0210587. doi: 10.1371/journal.pone.0210587.