



The experience of postnatal depression in West African mothers living in the United Kingdom: A qualitative study



Philippa L. Gardner, Clin Psy D (Doctor), Penny Bunton, Clin Psy D (Doctor), Dawn Edge, PhD (Doctor), Anja Wittkowski, Clin Psy D (Doctor)*

University of Manchester, School of Psychological Sciences, 2nd Floor, Zochonis Building, Brunswick Street, Manchester M13 9PL, United Kingdom

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ABSTRACT

Objective: to explore the lived experience of postnatal depression (PND) in West African mothers living in the United Kingdom (UK).

Design: using a qualitative design, semi-structured interviews were undertaken. Interpretative Phenomenological Analysis (IPA) was used to explore and analyse the data.

Setting: community health services within inner-city suburbs in Manchester, England.

Participants: six West African mothers (Nigeria=3; Ghana=3), who were experiencing low mood in the postnatal period.

Findings: five overarching themes emerged: (1) conceptualising PND, (2) isolation, (3) loss of identity, (4) issues of trust and (5) relationships as a protective factor. Women exhibited symptoms of PND but did not regard it as an illness. In their view, postnatal depression and distress resulted from social stress. Participants stated that their cultural background made it difficult to disclose feelings of depression thus adversely influencing their help-seeking behaviour.

Key conclusions: this is the first study to investigate the experiences of West African mothers with PND who live in the UK, and how they perceive and make sense of their experiences. The themes generated add to the body of existing research on PND in Black and ethnic minority populations and offer insight into the lived experience of West African women residing in England. Such insights are vital in order to deliver effective, culturally sensitive care.

Implications for practice: these findings have implications on how services should be designed to increase their accessibility to African women, by using a community psychology approach alongside systemic and group interventions. Challenges to help seeking and language used to describe experiences are considered.

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Introduction

Postnatal depression (PND) generally begins within four to six weeks after childbirth (Robertson et al., 2004). According to the International Classification of Disorders (ICD-10, World Health Organisation (WHO), 1992), symptoms include low mood, tiredness, lethargy, insomnia, forgetfulness, irritability and poor functioning. As a serious public health problem (WHO, 2000) PND can lead to enduring mental illness for women (National Institute for Clinical Excellence (NICE), 2007) and have serious psychological consequences for their families (Murray and Cooper, 1996).

Cultural diversity within the UK has grown, with the 2001 UK census indicating that 9% of the total population of England was from ethnic minorities, with Black African communities making up

1.0% (Office for National Statistics, 2005). Within the UK, minority populations report higher levels of psychological illness, yet their rate of accessing services is poor (National Institute for Mental Health in England, 2003).

Research conducted in the UK has found that being a mother from an ethnic minority background significantly increases the risk of developing PND (Onozawa et al., 2003). However, Bashiri and Spielvogel (1999) suggest that the identification of PND is more complex when working with women from other cultures due to somatisation and acculturation issues.

Few studies have investigated the experience of PND in migrant women living in the UK. Qualitative studies have mainly focused on women from Bangladeshi and Asian backgrounds (Parvin et al., 2004; Wittkowski et al., 2011). Isolation and language difficulties have been identified as key cultural issues among migrant mothers experiencing PND; with a lack of practical and emotional support, due to the lack of extended family networks, a further issue among migrant populations (Templeton et al., 2003; Parvin et al., 2004; Wittkowski et al., 2011).

* Corresponding author.

E-mail address: anja.wittkowski@manchester.ac.uk (A. Wittkowski).

As there are no existing studies on the experience of PND in West African women living in the UK, this qualitative study was undertaken with the aim of improving understanding of African women's experiences of PND. Such insights are essential for the delivery of effective, culturally sensitive care.

Method

Design

A qualitative design, using semi-structured interviews and Interpretive Phenomenological Analysis (IPA) was used because it aims to understand the unique lived experience of the phenomenon in question (Smith and Osborn, 2008).

Recruitment and participants

Ethical approval for the study was granted by the local Research Ethics Committee (LREC), the Trust's Research and Development Department and the University's Ethics Committee.

Participants were recruited through specialist National Health Service (NHS) provision for children under five in Manchester. All participants had been referred to one of two commissioned parenting groups: (1) *'Baby first year and you'* for mothers with low mood and anxiety who were referred by General Practitioners, Health Visitors and Midwives or (2) *'Baby first year'*: a self-referred group for mothers wanting support and information on child development.

Inclusion criteria for participation were: (a) 18 years or older; (b) considering themselves to be of Black West African origin; (c) being able to understand and speak English; (d) having had a baby in the past 24 months and (e) having a score of 10 or above on the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987). Women from other African backgrounds were excluded in an attempt to increase the homogeneity of the sample.

Potential participants were identified and then approached by the Assistant Psychologist, Clinical Psychologist and Family Support Worker who facilitated the two commissioned parenting groups. Once they consented to take part, they were assessed and interviewed by the first author.

Measures

Validated measures were used to verify PND:

1. The EPDS (Cox et al., 1987) is a 10-item, self-rated questionnaire used for the identification and screening of PND. A score of 10 has been recommended as a cut-off for community PND screening (Cox et al., 1993). The EPDS has been validated within West African populations (Uwakwe and Okonkwo, 2003). It has good psychometric properties.
2. The depression module of the non-patient version of the Structural Clinical Interview for DSM-IV (SCID) (Spitzer et al., 1992) was used to assess depressive episodes and verify diagnosis. The SCID is a semi-structured interview developed for assessment of Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) axis I, a dimension of DSM-IV that refers to the principle clinical disorders diagnosed in adults.

Interview procedure

All semi-structured interviews were conducted in either participants' homes or in community locations of their choice. Written informed consent was obtained from each participant before they completed the EPDS and were interviewed. The SCID was

completed at the end. All interviews lasted between 55 and 85 minutes (mean=60). They were digitally recorded, anonymised and transcribed.

Interview schedule

The interview schedule was piloted on one West African mother who had experienced PND in the past. The schedule was adjusted according to feedback from the interviewee and research team. It covered four broad areas: (1) understanding of experience and the cultural descriptions of experience; (2) support following birth; (3) feelings towards self and others and (4) factors which led to experiences. Questions were open-ended to encourage mothers to develop and elaborate their experiences.

Data analysis

After transcribing individual interviews verbatim, each transcript was read whilst listening to the audio-recordings and reread repeatedly. Observations and recollections of the interview experience were recorded in written field-notes.

Emergent themes were developed and connections across themes were made. Higher-order themes were identified and named when a theme emerged in the majority of transcripts (Smith et al., 2009). Following initial analysis, associations between themes were further explored by revisiting transcripts and constructing diagrams.

Validity and reliability

The study was conducted using established standards for the conduct of good qualitative research (Elliot et al., 1999). Validation methods included regular supervision within the research team and individual supervision of PG by DE (an expert in this methodology) to ensure transparency in procedure, on-going critique of the work and detailed examination of similarity and difference, convergence and divergence among themes and cases. Final themes were agreed, supported by participants' responses.

Findings

Six Black West African mothers (aged 22–36 years) took part in the study. Three were born in Nigeria and three in Ghana. The number of children in each family ranged from one to three. Four mothers were married and living with their partner; two were single parents. The sample size was deemed sufficient given the analysis required (Smith and Osborn, 2008).

As participants did not refer to their experience as 'depression', the term 'distress' was used to remain close to their self-reported experiences.

IPA was used to facilitate the development of five core themes that describe the experience of PND in West African mothers. These were: (1) conceptualising PND, (2) isolation, (3) loss of identity, (4) issues of trust and (5) relationships as a protective factor.

Each theme consisted of a number of subthemes. Fig. 1 provides a diagrammatic summary of themes and their proposed connections.

Conceptualising postnatal depression

This theme related to participants' conceptualisations of PND and their descriptions of how they understood and experienced it within a West African context. Four sub-themes emerged and describe how women's understanding of PND can contribute to distress, and how these experiences can impact on participants'

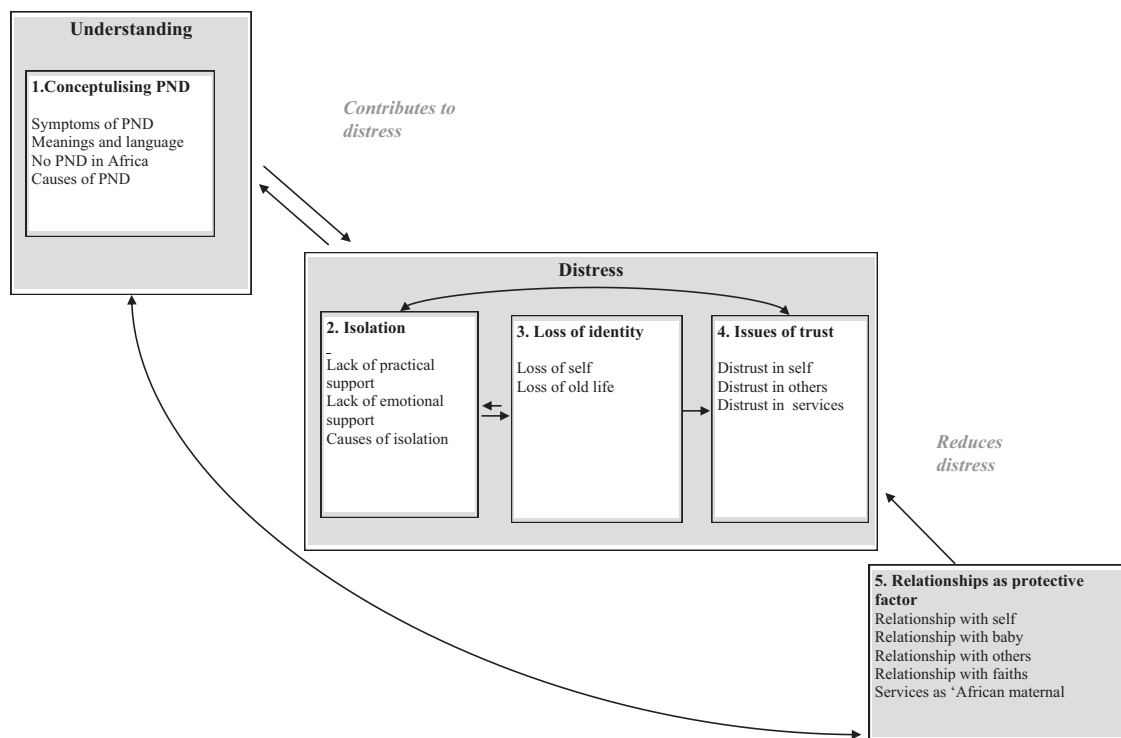


Fig. 1. Summary of themes and proposed connections.

understanding. Although participants experienced symptoms of PND, their conceptualisations differed to Western views, attributing it to social stress instead.

Symptoms of postnatal depression

Participants described feeling irritable, struggling with lack of sleep, becoming over-emotional and crying. Lack of self-confidence and being overcritical were further descriptions of experiences. One participant described feeling overwhelmed and had thoughts of self-harm. These symptoms are consistent with ICD-10 criteria for PND (WHO, 1992).

I snapped all the time, unnecessary things would just get on me and I would just fly up – Participant 1 (Severe Depression)

Dying..... taking my life.... Ending it up. I was.... the time it was the peak of the stress I felt like just disappearing into thin air... – Participant 5

Meanings and language

Most participants did not describe their experiences using the word 'depression' and did not view their experience as an illness. The language and the words they used to describe their experiences were often termed 'stress':

You just see yourself doing things..... just see yourself talking to yourself, having different thoughts, hearing voices.... ... I mean those are all symptoms that I was stressed. – Participant 5

The above quote describes how the participant felt as if she was looking at herself from an outside view, behaving in unfamiliar and unexpected ways. The word 'stressed' is used to describe feeling tense, under pressure and depressed.

No postnatal depression in Africa

In their descriptions of their experiences, it was noteworthy that participants viewed PND as occurring mainly in the UK and not often within African contexts. They attributed their distress to isolation and lack of support. One mother was able to compare her experience of having a baby in Nigeria and a baby in the UK; for her PND only existed in the UK and not in Nigeria. The symptoms of PND were regarded as being context-specific:

I don't experience anybody having it [PND in Nigeria]. Cause I don't have it. I don't have it in Nigeria. I did not have it in Nigeria.....I never knew it exist... you understand? Until I come to this place [UK]. – Participant 1

Causes of postnatal depression

Participants attributed causes of PND as social in origin reporting a lack of support within the community:

I think it is about the stress..... and the [lack of] community..... – Participant 5

Participants described how the causes of PND were seen to differ across contexts and cultures. Within West African countries, distress after childbirth was attributed to cultural norms: participants described mothers as unhappy, if they did not produce a male heir. Unhappiness was also caused by not being able to provide for your baby and worries over the baby's health and the family's financial status. Overall, participants felt that their experiences in the UK were different to the experience of mothers in Africa. Postnatal distress in the UK was attributed to a lack of support, isolation and not having their African family living nearby.

Participants' experiences of distress were described through the themes of isolation, loss of identity and issues of trust, which are discussed in the following sections.

Isolation

One of the recurrent themes among participants was characterised by feelings of isolation and lack of support. Three sub-themes emerged which described lack of practical support, lack of emotional support and lack of professional support as causes of isolation. Participants described how within collectivist African culture, mothers and babies are cared for by their families, neighbours and friends. Living in the UK meant the majority of mothers did not have access to this support network.

Lack of practical support

Mothers described differences in levels of practical support in Africa and the UK. According to the mothers in this study, in Nigeria and Ghana, family members help to do household chores, they cook for the mother and take care of the baby, the stress and 'pressure' of being a new mother was alleviated by the support of the extended family, described in the following quote:

You are attached to the family house you are not on your own, they make meals for you... in fact you actually don't do anything. They bathe the baby for you, they help you out with everything until you are fine. And you are ready to go back to work or whatever it is you are doing so... the pressure is very low in Africa, it is not like that here. – Participant 4

In contrast to experiences in West Africa, African women in the UK described feeling isolated during the postnatal period. One woman described being an 'island on your own', indicating feelings of isolation and the need to survive alone:

Well I have nobody, it's just like you are an island on your own. I have got nobody to help me. – Participant 5

Lack of practical support for participants was experienced as particularly isolating due to perceived cultural expectations of support from the extended family and community during the postnatal period.

Lack of emotional support

Participants described feelings of loneliness and not having others to talk to. One participant described how her husband did not understand what she was going through, instead showing a lack of empathy and sensitivity, which left her feeling more alone:

Even when you are living with somebody, that person doesn't know you are even going through it. Oh..... buying a can of beer or something and give me it.... and [saying] 'let's drink together'.... That's not keeping me company! Or him sitting on his laptop while I am here with the baby, he's not keeping me company 'cause he is not talking to me..... – Participant 1

The above quote demonstrates that the participant's expectations of support from her husband were not met. 'Company' for her was about talking, listening and being emotionally available and not just being physically present in the room. It seemed she was emotionally dependent on him because she lacked a wider social support network in the UK.

Lack of professional support

Participants also described feeling let-down by professionals, as their perceived level of support did not meet their needs:

After you came back from the hospital you have visitors.... you have midwife coming... oh that is good! Those are a good period but when everybody stop coming you are on your

own...then the door close and nobody comes again.... Oh God..... It feels very bad..... So it's not nice.... We need more support. We need more support.... Even if it is just once a week people come to your house to see you. – Participant 2

The above quote demonstrates the comfort gained from the immediate support offered by services, this can be seen as a supportive period mirroring that experienced in West Africa where 'visitors' attend to you at home. This is in stark contrast to when 'the door closes' and women feel rejected, isolated and alone, which may lead to feelings of frustration and distrust in professionals.

One participant also described her experience of changes within the NHS and changes with how mothers and babies were supported, which resulted in her feeling stressed and frustrated:

Nowadays people are complaining..... and when I had my second child I find out that things have changed. You be pressing the buzzer [in the hospital] but some of them will not attend to you. So it makes you so stressed and mad and so.... when I had my first child, what I know is they provide you with a lot of stuff but nowadays when you go there you have to take your own stuff, ... that's one thing people are complaining about as well. – Participant 6

Causes of isolation

Participants indicated that a major cause of isolation was being unable to share their problems with others. Mothers would avoid talking about their problems and this would contribute to feelings of isolation. This meant that at times mothers minimised their experiences and struggled to express how they were feeling:

I don't talk, if I am hurt I won't say it. I haven't got any friends.... So I keep myself to myself and then that's it – Participant 2

Other causes of isolation were due to financial and social difficulties. High levels of deprivation meant that mothers were sometimes unable to access practical and emotional support due to financial constraints, which made it difficult for them to commute or even communicate by telephone:

Yeah I know help is at hand..... but look at me! This house - I don't have landline. I have a phone. I have no credit on that phone. Even if I am in trouble, who am I going to call? – Participant 1

Loss of identity

Loss of identity was a further theme that described participants' distress; two subthemes of 'loss of self' and 'loss of old life' emerged.

Loss of self

Participants described a loss of their old self, not feeling happy within themselves and mourning the loss of the person they once were. In this context, mothers described how their appearance was different since the birth of their baby and how this was affecting how they viewed themselves, which led to feelings of low self-esteem:

Oh God..... I hate myself. I really, really hate myself. I put on weight, because... and I am always very very conscious of my body. Always you looking at yourself in the mirror and you just don't like what you see. – Participant 1

For the participant above, the meaning of the body was significant, having a baby meant that her physical appearance changed, she was constantly 'looking at' herself which may indicate a critical view of herself and of who she had become:

Ever since I have been in this country I have never been myself. I know me, I know the 'me' in me. So I have never been like that since I had my baby. – Participant 5

The above quote describes a sense of really knowing the self before childbirth and when living in Africa. 'Know the 'me' in me' indicates a level of confidence and self assurance that has disappeared since the birth of the baby and when living in the UK. 'Never been myself' suggests a great loss of who she once was.

Loss of old life

Participants described loss of their old lives and yearning for old familiar routines that they had before the baby. Having a baby meant that they could not do the things they used to do, such as going out shopping on their own, this was particularly pertinent for first-time mothers, who had greater difficulty adjusting to motherhood:

Everything needs to change, my former life needs to change to a 'mother life' now so.... It's not what I used to be...it is not an easy something – Participant 4

One participant talked about the loss of her old life in Africa, having fled Nigeria in fear of her life. This traumatic experience caused her to mourn the loss of her old life, her home, her country and cultural identity. She wanted to go back to Nigeria so she could get her 'soul back'.

Loss of old life meant that the practical and emotional support that was available to participants in their home country was not available to them in the UK, which led to feelings of isolation. The 'loss of self' also could have had an impact on how participants viewed themselves and others, which could lead to difficulties in trusting others.

Issues of trust

One of the main themes throughout participants' accounts was a lack of trust in others; which often resulted in relationship difficulties.

Distrust in others

One participant described marital difficulties after discovering that her husband had another family that she was unaware of. She felt let down and lied to; this left her feeling alone, sad and frustrated. Within some African cultures, polygamous marriages are culturally acceptable (Fatoye et al., 2006). However, for this participant, her husband's belief in having more than one partner resulted in issues of trust within the marital relationship that she believed caused her distress in the postnatal period.

Distrust in others was also described by another participant, who had socially isolated herself from the Ghanaian community. Cultural traditions and the importance of being married meant that she had had difficulties relating to single Ghanaian women. She decided to avoid these women, which meant that her wider social support network had decreased:

Sometimes when you are married, it's not good for you to have single people as a friend 'cause some of your friends are bad they can just snatch your husband away... you know out of hatred.... they just hate you just like that because you are married. – Participant 6

The above quote illustrates the importance of marital status in the West African community and the complex dynamics between married and single women. The complexity of West African cultural social systems could cause further difficulties for women who already feel isolated.

Fear of stigma

Participants described distrust of others and they therefore could have chosen not to present emotional problems to health professionals and others within the community for fear of being stigmatized. There may be stigma around mental health difficulties resulting in mothers not wanting to talk about difficulties. One participant described a lack of trust in her church community for fear of stigma. Those who did wish to discuss their problems, described wanting to talk to professionals because they were considered the 'source' of support and help, with conversations being confidential:

I didn't just..... open up totally..... to them. I wouldn't want to.... You know it's like an African community and I felt you know.... If one person knows about it, 2 people know about.... 3 people knows about it..... so I just cut off. um.... I know it's just the stigma.... It's just you know oh... look at the girl.... I think it's just, it's just that I don't want the stigma to just keep following me around. – Participant 5

This participant described how stigma would 'follow me around', suggesting that it would be something that she could not escape from. Stigmatisation may be a central concern for West African mothers, adding to their reluctance to talk to others about their difficulties.

Relationships as a protective factor

In contrast to being a source of stress, relationships also provided a source of support and protected mothers against feelings of distress. Participants described how relationships helped them to overcome difficulties and improve mood.

Relationship with self

Keeping busy and going back to work provided ways in which participants were able to cope with difficult feelings. Finding inner strength and wanting to better their lives and provide for their families helped participants to overcome challenges:

For me when I am down, I just want to do something, go out for window shopping or sometimes tidy the house. But the best thing for me is to go out..... What I did, I went out and I got a salary – a shop, I start working and all of a sudden it took my mind off it. – Participant 2

Relationship with baby

Participants described how their relationships with their babies helped to improve their mood and that within African culture; babies are a source of pride. For mothers who described feeling very isolated, their relationship with their baby was a positive one that they could reflect on. Participants did not attribute their distress to attachment or bonding difficulties with their babies:

There are so many things that she does that just make me you know, forget my sorrows, forget the pains I am going through. – Participant 2

The above quote illustrates the ability for the mother and infant relationship to act as a distraction from painful feelings, observing

the baby's behaviour and their development helps the participant to forget her feelings of sadness.

Relationship with others

Two participants had family in the UK, so they had support in caring for their baby. The West African tradition of the extended support network was able to provide practical and emotional support to the mother. Relationships with other African mothers provided additional sources of information, support and reassurance:

Any little problem I had I used to call my friends,..... [I would] say this is what has happened..... then they say 'ok it's a normal thing', it happens to [them] - just advice from other parent. - Participant 4

Relationship with faith

A number of mothers attributed recovery from distress to their spiritual and religious faith. Prayer and their relationship with God were seen to provide support, companionship and motivation to recover:

.... it was my belief and faith in God, cause I kept praying, my church prayed for me at all times and all that..... and I believed that I would be well again, it was in my head.....so it was..... my faith in God - Participant 6

Services as African maternal figure/African community

Participants described not having their extended family support system around them. Mothers may then become reliant on services to provide this support. Engagement with services helped to protect mothers from distress. Participants described how within West African culture, a woman's mother or mother-in-law would spend two to three weeks with her and the new baby. This tradition is used to help support women during the postnatal period. During this time, older generations spend time passing down knowledge of parenting and provide practical support, which allows new mothers to recover and adjust. Expectations of services can be seen as somewhat different in West African mothers to mothers from Western cultures, who may expect only their partners to offer support.

Services can be seen as replacing this maternal figure, helping to provide support in caring for new-borns by providing time, expertise and care. A lack of this support can be viewed as a mismatch with cultural expectations and can intensify feelings of being let down.

All participants within this study were recruited from mother and baby groups. For those mothers who were feeling particularly isolated, these groups provided not only a source of support and knowledge but also gave women a sense of community, which is embedded within collectivist West African culture:

..... [when you start going to the group] you know that you are not alone. So many mothers are going through what you are going through. And some are even MORE than yourself..... [I think] there should be a gathering for mothers..... So you can chat with another mother..... it does help. - Participant 1

Discussion

Five main themes emerged regarding the experience of PND in this sample of six West African mothers living in the northwest of England: (1) conceptualising PND, (2) isolation, (3) loss of identity,

(4) issues of trust and (5) relationships as a protective factor. Some of the identified factors were similar to those presented in the literature on PND in migrant populations including issues of isolation, noted in South Asian (Wittkowski et al., 2011), Bangladeshi (Templeton et al., 2003; Parvin et al., 2004) and Chinese mothers (Lam et al., 2012). While the findings highlight some similarities in PND experiences, some factors were culturally specific. Women exhibited symptoms of PND but did not regard it as an illness, termed 'depression'. This observation has also been made in Ethiopian women (Hanlon et al., 2009) and African Caribbean women living in the UK (Edge and Rogers, 2005).

For our participants, PND did not exist in West Africa, they described their distress after childbirth as a product of social stress, largely due to lack of practical and emotional support and on dysfunctional/difficult relationships. Interestingly, participants viewed psychosocial coping strategies as being particularly useful. Interventions for PND were described as social, emotional and practical support from partners, family and services. Having someone to talk to and the importance of religious faith and relationship with their baby were expressed as a remedy for PND. These findings suggest that the western biomedical model may not be the most appropriate model to understand PND in African women, because this may neglect spiritual or cultural expressions.

One of the main themes throughout participants' accounts was a lack of trust in others, which often resulted in relationship difficulties. Lack of support and relationship difficulties have been found to be risk factors for PND in general, in African women (Sawyer et al., 2010) and other migrant cultures living in the UK (Parvin et al., 2004; Wittkowski et al., 2011). In the UK, participants described having to cope on their own with distress during the postnatal period, due to the lack of extended family networks, this is in stark contrast with participants' perceptions of the postnatal period in West African countries, and is similar to findings in Bangladeshi migrant women in the UK (Parvin et al., 2004).

Findings suggest that woman may choose not to present emotional problems to health professionals and others within the community for fear of stigma, consistent with previous findings (Lewis, 2004). Although women may feel sad and depressed, their cultural background has an influence on help-seeking behaviour and their experience of services (Edge, 2011). They may conceal their distress, because admitting to having a problem may be a sign of failure (Nahas and Amasheh, 1999; Nahas et al., 1999; Edge and Rogers, 2005).

Relationship with healthcare services was a further important finding. The West African tradition of the extended social network caring for the mother and baby was not experienced in the UK, yet services could be viewed as 'maternal African figures', replacing this level of support. If the level of care did not meet expectations, it led to cultural dissonance in expectations of services. Small et al. (2003) describe how immigrant women are less likely to experience care that gave them what they wanted. Research with Bangladeshi women living in the UK reported similar findings in how cultural expectations of care are mismatched with women's experiences (Parvin et al., 2004).

Limitations

A number of limitations need to be acknowledged. As all participants had received treatment, involvement with services will inevitably have influenced participants' experiences. Additionally, although the official language in Nigeria and Ghana is English, a further limitation was only interviewing women who spoke English. Finally, although the EPDS (Cox et al., 1987) has been validated in West African populations (Uwakwe and Okonkwo, 2003), there may be some difficulties in accurately

detecting 'PND' symptoms. Clifford et al. (1999) have demonstrated that the EPDS does not reflect the understanding and perceptions of women from BME groups, while Hewitt et al. (2010) report that the use of the EPDS is less specific and sensitive to the needs of African women.

Implications for practice

The results have important implications for developing appropriate services and clinical interventions.

Challenges to help-seeking

Professionals need to be made aware of the reasons why women may not disclose psychological problems. Conceptualisation of PND may be different in West African women compared with Western views of PND; women may not recognise their experiences as an illness that they need help for. There may be issues around stigma within the West African community, with women minimising distress for fear of being seen as a failure (Nahas et al., 1999). Further difficulties are that those women, who want help, might not be able to access services due to social and financial difficulties. In order to overcome these challenges, services and statutory organisations should work within an out-reach model of service delivery.

Not saying the right words

Health professionals need to be aware of and recognise subtleties in language used to describe PND in the West African community. Women who present to services may not use the words 'depression' to describe depressive states and may therefore not be identified as depressed by GPs and midwives. Patel et al. (2002) argue that culturally appropriate terminology for depression should be identified and its use may improve recognition and help with interventions.

Configuration of services

A community psychology approach could be considered when working with West African women. Fundamental to this approach is working at a broader level to reduce inequality and build social systems that enable and empower communities (Orford, 1992). Psychological services should be accessible and responsive to clients' needs. Services should be planned proactively and collaboratively with West African women and offer integrated pathways of care, where community groups, voluntary organisations and members of the religious community can refer to services. Emphasis should be on prevention of difficulties and women should be reassured of confidentiality, as this was a concern of West African women. Expectation of services should be discussed and made explicit to overcome any issues of cultural dissonance in expectations. As some professionals may not feel equipped to meet the culturally specific needs of minority groups (Edge, 2011), joint working with ethnically sensitive community services (such as African Caribbean Mental Health Service) would be important, especially for new immigrants.

Group interventions

Individual therapy for PND in West African women may be seen as less effective, because women often attribute their emotional distress to social difficulties. Within collectivist societies, such as those in West Africa, group intervention is often the most culturally appropriate, partly to enable women to develop social

support networks. Social interventions and systemic approaches may therefore be more appropriate.

Future research

Future studies could aim to look at women's perceptions of appropriate care and their experiences of current provision. Additional research could investigate West African women's expectations and understanding of professional roles and how this may impact on help-seeking and engagement with services.

Conclusion

This is the first study to investigate the experiences of West African mothers with PND who live in the UK, and how they perceive and make sense of their experiences. The themes generated add to the body of existing research on PND in Black and ethnic minority populations and offer insight into the lived experience of West African women residing in England. Such insights are vital in order to deliver effective, culturally sensitive care.

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