Postnatal Depression in African Mothers

A thesis submitted to The University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Medical and Human Sciences

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Abstract

Postnatal depression in African mothers

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Paper one is a systematic review aimed at improving our understanding of the culturally determined risk factors of postnatal depression (PND) within ‘Sub-Saharan Africa’, by integrating evidence from quantitative and qualitative studies. A mixed-method systematic review approach was employed, nine quantitative and three qualitative studies were quality assessed, synthesised, and integrated. Stressful life events, adhering to cultural values and traditions, the effects of negative cultural perceptions and difficulties within the African extended family system were found to be risk factors for the development and maintenance of PND in Sub-Saharan Africa.

The objective of paper two was to explore the lived experience of postnatal depression in West African mothers living in the UK. A qualitative design using semi-structured interviews with six West African mothers (Nigeria = 3; Ghana = 3) who were experiencing low mood in the postnatal period was undertaken. Participants were recruited from mother and baby groups within the National Health Service. Interpretative Phenomenological Analysis was used to explore and analyse the data. Five overarching themes emerged: (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. Women exhibited symptoms of PND but did not regard it as an illness, with the name ‘depression’. They viewed their emotional distress as a result of social stress, and described feelings of isolation, loss of identity and relationship difficulties. Women’s cultural background influenced their help-seeking behaviour; participants often avoided talking about their feelings and kept their distress to themselves. The findings have clinical implications in how services should be designed to meet the needs of African communities.

Paper three reflects on the process of developing culturally competent research through the development of the current thesis. Suggestions for future research and reflections on the strengths and limitations of the research process are embedded throughout. Clinical implications are discussed with reference to a community psychology model.
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I am particularly grateful to the mothers who gave up their time to participate in the study and for allowing me to bear witness to their personal experiences. A special thanks to my family, friends and peers for their unwavering support and understanding over the last few years.
Literature Review

Culturally determined risk factors for postnatal depression in sub-Saharan Africa: A mixed-method systematic review

Prepared in accordance with requirements for submission to the

*Journal of Affective Disorders (Appendix 1)*

Word Count: 7976
Abstract

Background: Research suggests that African women experience postnatal depression (PND) at a similar rate to that reported in Western countries. If PND is to be better understood in African populations, its risk factors need to be reliably identified. Studies in non-Western countries have found that risk factors are often culturally determined. This review aimed at improving our understanding of the culturally determined risk factors of PND within Sub-Saharan Africa by integrating evidence from quantitative and qualitative studies.

Methods: A mixed-method systematic review was employed. Studies were located through computerised databases such as MEDLINE and through hand searching the reference lists of identified articles and reviews. Nine quantitative and three qualitative studies were quality assessed, synthesised, and integrated.

Results: Quantitative studies indicated that stressful life events, cultural values and the African extended family system, such as in-law and other relationship difficulties, have an influential role in women’s experience of PND. Qualitative studies described the impact of negative cultural perceptions of others and adhering to cultural traditions and values as contributing to the development and maintenance of PND.

Limitations: The small number of studies is a limitation within the available body of research. Search strategies only included English language articles.

Conclusions: Although some risk factors for postnatal depression were similar to those identified in studies in Western countries, important differences exist; most notably the influence of traditional African value systems, customs and antenatal exposure to extreme societal stress. The findings of this review are especially important for the development of a predictive model for PND within Sub-Saharan Africa and when working with migrant Sub-Saharan African mothers.

Keywords: Africa, cross-cultural, postnatal depression, postpartum depression, risk factors
1. Introduction

Postnatal depression (PND) is the most frequently recognised psychological disorder after birth and is defined as an affective mood disorder often occurring in women up to one year after childbirth (Gibson et al., 2009). PND is often characterised by feelings of loss and sadness, insomnia, lack of energy, forgetfulness, irritability and poor functioning (World Health Organisation (WHO) International Classification of Disorders, 10th revision (ICD-10), 1992) and has become a serious public health problem (Stuart et al., 1998; WHO, 2000) that can lead to enduring mental illness for women. Crucially, PND can also have serious psychological and emotional consequences for their families (Cooper and Murray, 1998).

Whilst there is global literature on PND, most research has focused on Western, economically-developed countries, primarily Europe and North America. Prevalence rates of maternal mental health disorders show considerable variation between countries. In Europe and North America, the prevalence of PND is between 10% and 15% (Beck, 2001) but a review of PND in 40 countries found that prevalence rates ranged widely from almost 0% to 60% (Halbriech and Karkun, 2006). The variability in reported PND might be due to cross-cultural variables, reporting style, differences in perception of mental health and its stigma, differences in socio-economic environments (including poverty, levels of social support or its perception, nutrition, stress), and biological vulnerability factors.

There has been considerable research conducted to identify risk factors for PND within European and North American countries. These studies have been summarised into a number of reviews that have found that risk factors for postnatal disorders are predominantly psychosocial (Beck, 2001), socio-demographic (O’Hara and Swain, 1996) and obstetric (Stuart et al., 2001). Women’s experience of PND is often strongly associated with psychosocial difficulties, such as poor social support, poor marital relationship, stressful life
events, past history of psychopathology and psychological disorders during pregnancy (Beck, 2001; O’Hara and Swain, 1996; Lusskin et al., 2007).

So far there has only been one systematic review of studies examining pre- and postnatal psychological wellbeing in Africa, which found that African women experience PND at a similar rate to that reported in Europe and North America, with a prevalence rate of 18.3%. Mixed results in terms of risk factors were highlighted, with lack of support, marital or family conflict associated with poorer mental health (Sawyer et al., 2010). The relationship between obstetric variables and postnatal mental health was inconclusive (Sawyer et al., 2010) and was therefore not the focus of the current review. Although Sawyer and colleagues provided an initial overview, there are major limitations when comparing findings across the whole of the African continent, due to the tremendous diversity of cultures. For this reason, the current review focused on studies undertaken in Sub-Saharan Africa. Sub-Saharan Africa refers to the area on the continent of Africa that lies south of the Sahara, there is thought to be a cultural unity among countries due to common socio-historical experiences and diffusion of similar culture traits through culture contact and acculturation (Diop, 1960). However, it is important to note that countries within this region display diversity in their ethnic and linguistic composition and political structures (Nsamenang, 1993). It is acknowledged that these differences exist and findings should therefore be interpreted with caution.

If PND is to be better understood and treated by clinical or public health interventions, its risk factors need to be reliably identified. Boyce (2003) proposed a psychosocial model to improve our understanding of the origins of PND. However, studies in non-Western cultures, such as India, have found that some socio-demographic and psychosocial risk factors for PND are often culturally determined; these include the influence of polygamy and the disappointment with the infant’s gender (Patel et al., 2002).
Culture is defined as “the learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guides their thinking, decisions and actions in patterned ways” (Leininger, 2001, p.47). To date, there has been no review that looks at distinguishing aspects of African culture regarding risk factors for PND. The objective of this review was therefore to identify the unique cultural risk factors for the development of PND in Sub-Saharan African women, by systematically reviewing both the quantitative and qualitative literature.

2. Method
A mixed-method systematic review was conducted. The mixed-method model integrates quantitative data with the qualitative understanding from people’s lives (Harden and Thomas, 2005). Within this method there are three syntheses. First, quantitative data are quality assessed and synthesised. Second, qualitative studies are quality assessed and themes are synthesised. Third, there is an integration of the two types of syntheses resulting in a single systematic review.

2.1. Search Strategy
A systematic search was conducted to identify quantitative and qualitative studies of PND in Sub-Saharan African women. The process and reasons for exclusion are shown in Figure 1 Electronic literature searches were conducted using the following databases: African Index Medicus (World Health Organisation), Medline, PubMed, PsychInfo, Web of Science and Scopus. The key words used for the search included “Africa” and (“postpartum depression,” or “postnatal depression,” or “depression”). Broad search terms were used to include as many articles as possible because evidence suggests that using electronic databases to search articles in Non-Western countries can be challenging (Betran et al., 2005; Sawyer et al., 2010). These key words returned a large number of citations (2833). However, after screening titles and abstracts many did not fit inclusion criteria. Study type search filters were not used in order to identify quantitative and qualitative studies using the same strategy.
Electronic search strategies were supplemented by hand searching and careful checking of references cited in the identified literature. The search strategy was limited to English language and no date restrictions were applied. Published quantitative and qualitative studies from 1970 to January 2012 were obtained.

2.2. Inclusion and exclusion criteria
After screening titles and abstracts for relevance (inclusion of any risk factors), removing duplicates and hand searching reference lists, twenty-nine studies were identified as eligible for full text assessment. Due to the enormous diversity of African culture, only studies that were conducted in Black Sub-Saharan African countries were included in the literature review. Studies could be cross-cultural but had to include at least one Sub-Saharan African country. Studies had to include risk factors for PND that were clearly defined and participants had to include mothers (See Figure 1). Quantitative studies had to specify both the means of assessment for PND, i.e., self-report or clinical interview and the instrument used (e.g., the name of questionnaire or interview). Qualitative studies had to be empirical and not anecdotal evidence.

To maximise homogeneity of the sample, papers were excluded if the sample populations were from White African populations. Studies with women of dual heritage backgrounds were excluded as it was considered that they were more akin to White European than Black Sub-Saharan African cultures. Asian African samples were also excluded as they were likely to have more in common with Asian than Black Sub-Saharan African cultures. Papers from Arab-African populations were excluded as they are much more closely tied to Southwestern Asia and Europe and deemed to be culturally too distinct from Black Sub-Saharan culture. Furthermore, although there is a high prevalence of HIV in this region, studies including HIV samples were not included in this review, because it would have been too difficult to clarify whether symptoms were associated with PND or the effects of living with HIV.
Eligibility criteria were applied to titles and abstracts. Full reports were obtained for those studies that appeared to meet the criteria or where there was insufficient information. Twelve studies were available for analysis.
Additional records identified through hand searching reference lists (n = 5)

Total records identified through database searching (n = 2833)

Titles and abstracts screened after removal of duplicates (n = 2356)

Records excluded at screening stage as not relevant (n = 2327)

Full text articles assessed for eligibility (n = 29)

Studies included in synthesis (n = 12)

Full text articles excluded (n = 17)

5 studies did not include risk factors

3 studies focused only on Arab African Culture

3 studies focused only on White South African population

2 studies focused on HIV status mothers

2 studies excluded as participants were professionals or family members and not mothers

2 studies could not be located on inter-library loan

Figure 1: Search results: Numbers of included and excluded studies and reasons for exclusions
2.3. Quality assessment

Quantitative studies

The quality of each study was assessed by two independent researchers (Appendix 2). Any discrepancies were discussed and a consensus was reached, disagreements did not affect overall quality ratings. There was an 86% agreement of scores for quantitative studies and a 71% agreement for qualitative studies. The methodological quality of the nine identified quantitative studies was assessed based on a checklist developed by Mirza and Jenkins (2004). This checklist was used in a previous review assessing the quality of studies investigating pre- and postnatal psychological wellbeing in Africa (Sawyer et al., 2010). Eight criteria were assessed and included: (1) clear study aims, (2) adequate sample size, (3) sample representative of population, (4) clear inclusion and exclusion criteria, (5) valid measurement, (6) good response rate, (7) adequate description of data, and (8) appropriate statistical analysis. Studies were given a score of 1 if they met criteria and 0 if they did not, resulting in a total score quality score of 8. Studies were appraised as low quality (0-3), moderate quality (3-5) and high quality (6-8).

Qualitative studies

The methodological quality of the qualitative studies was assessed using criteria developed by Rees and colleagues (2001). These criteria were chosen because they were based on the rationale and assumptions of qualitative research rather than on a checklist of prescriptive technical procedures (Barbour, 2001). The criteria were (1) a focus on African mothers’ lives, (2) explicit account of theoretical framework and/or inclusion of a literature review, (3) clearly stated aims and objectives, (4) clear description of context, (5) clear description of sample and recruitment, (6) clear description of methodology, including data collection analysis methods, (7) evidence of attempts made to establish the reliability and validity of data analysis, (8) inclusion of sufficient original data to mediate between data and interpretation. Details of the quality assessment can be found in Appendix 3. An appraisal system was developed for each of the studies; a mark of A to D was awarded for each of the eight quality assessment
criteria (Rees et al., 2001). The appraisal system was: (A) no or few flaws, (B) some flaws, (C) significant flaws which may affect the validity of the findings, and (D) untrustworthy findings/conclusions. Based on the appraisals of the eight criteria, a final overall assessment was then made for each study, and a grade of A to D was assigned (Appendix 3). All studies were included in the review due to the lack of research in the area.

2.4. Data extraction
The following information was extracted from quantitative studies: country of origin, design, number of participants, location of recruitment, measure of postnatal depression and defined risk factors. Data on country of origin, aims, methods, number of participants, analysis and defined risk factors were extracted from the qualitative studies.

2.5. Synthesis methodology
Quantitative studies
The nine quantitative studies used a cross-sectional design. As the findings do not indicate causality, a descriptive account of the data was used. The risk factors were grouped by individual country.

Qualitative studies
Thematic analysis was used to synthesise the three qualitative studies (Harden and Thomas, 2005). Each study was read several times, noting key themes, concepts, phrases and relationships involving risk factors. Descriptive themes were developed and searched for across studies. Emerging patterns across the studies were synthesised and overall themes were developed.
3. Results

3.1. Synthesis 1: Quantitative studies
The search yielded nine quantitative papers all of which were epidemiological observational studies; seven were cross-sectional studies, one was a cohort study and one case-controlled study. Most studies were of a reasonable quality with moderate to high quality scores ranging from a 5 to 7 out of 8. (Table 1).

Measures
The analysis revealed that measures for PND varied across studies. Three studies used self-report measures, two studies used structured clinical interviews using criteria from the DSM-IV (APA, 1994), ICD-10 (WHO: 1992) and Standardised Psychiatric Interview (SPI; Goldberg et al, 1970) and four studies used a two stage screening process, administering self-report measures, then structured clinical interviews to confirm depression.

One study used the Pitt Depression Questionnaire (PDQ; Pitt, 1968), one study used the Self reporting Questionare-25 (SQR-25; Beusenberg and Orley, 1994), three studies used the EPDS (Cox et al, 1987), one study used Zung’s (1965) Self Rating Depression Scale (SDS) and one study used General Health questionnaire-28 (GHQ-28; Goldberg and Hiller, 1979.) (See Sawyer and colleagues (2010) for a review of postnatal measures validated within African populations.)

Four studies (Nakku et al., 2006; Owoeye, et al., 2006; Abiodun, 2006; Aderibigbe et al., 1993) used a two stage screening process, administering self-report measures, then structured clinical interviews to confirm depression. The Psychiatric Assessment Scale (PAS; Dean et al., 1983), the Present State Examination (PSE; Wing et al., 1974), the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) and criteria from ICD-10 (WHO, 1992) were used.
<table>
<thead>
<tr>
<th>Country</th>
<th>Study</th>
<th>Design</th>
<th>N</th>
<th>Recruited From</th>
<th>Ethnicity</th>
<th>Religion</th>
<th>Measure</th>
<th>Sig. risk factors</th>
<th>Non-sig. risk factors</th>
<th>Limitations</th>
<th>QA</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>Cooper et al (1999)</td>
<td>Cross-sectional study</td>
<td>147</td>
<td>Peri-urban Health centre</td>
<td>Black African</td>
<td>Not stated</td>
<td>SCID (DSM-IV)</td>
<td>Lack of support from husband Unplanned pregnancy Unwanted pregnancy</td>
<td>Infant gender Age Education Marital status Socio-economic status</td>
<td>Cross sectional design therefore cannot imply causation. Depression only assessed at two months postpartum.</td>
<td>7</td>
</tr>
<tr>
<td>Study</td>
<td>Type</td>
<td>Sample Size</td>
<td>Setting</td>
<td>Ethnicity</td>
<td>Maternal Characteristics</td>
<td>Mental Health Instrument</td>
<td>Psychosocial Characteristics</td>
<td>Comorbidity</td>
<td>Quality Assessment Score</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Fatoye et al (2006)</td>
<td>Case-control, cross-sectional study</td>
<td>83</td>
<td>Urban Hospital</td>
<td>Black African</td>
<td>Not stated</td>
<td>Zung's SDS</td>
<td>Polygamy</td>
<td>Age Socio-economic status Education</td>
<td>Did not evaluate number of women already depressed in pregnancy.</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Abiodun (2006)</td>
<td>Cross-sectional study</td>
<td>360</td>
<td>Urban Primary Health Care Centres</td>
<td>Black African</td>
<td>Not stated</td>
<td>EPDS PSE</td>
<td>Age In-law problems (mother/sister/brother) Infant gender Marital status (single or separated) Unsupportive husbands Financial difficulties</td>
<td>Education Occupation</td>
<td>Cannot generalise to rural women. Cross sectional design therefore cannot imply causation.</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Quality Assessment scores:  
0-3 = low  
3-5 = moderate  
6-8 = High
As studies from Sub-Saharan Africa yielded mixed results in terms of risk factors for PND (Sawyer et al., 2010), which is likely to reflect the tremendous diversity of cultures across the continent, it was decided to summarise findings by country. The search yielded nine quantitative studies across three different countries, namely South Africa, Nigeria and Uganda.

South Africa
Two methodologically sound studies were undertaken in South Africa (Cooper et al., 1999; Ramchandani et al., 2009) with quality assessment scores of 7 and 5 respectively. Both studies were undertaken in peri-urban settlements of Soweto and Khayelitsha in a time of particular social and political instability and transition within South Africa (Ramchandani et al., 2009). One major finding was that societal stress, such as witnessing violent crime or being in danger of being killed, was one of the strongest predictors of postnatal depression (adjusted Odds Ratio 2.468 (95% Confidence Interval 1.509, 4.037)) (Ramchandani et al., 2009). The authors concluded that these life-threatening stresses could be of particular importance for pregnant women in societies undergoing major upheaval. Unwanted and unplanned pregnancies were also found to be associated with PND. Lack of emotional or practical support from husbands or partners were also significant risk factors (adjusted OR 1.645 (1.088, 2.488)). Furthermore, family stress and being consistently ‘unhappy during pregnancy’ were associated with PND.

Non-significant associations were found with the infant gender, marital status and socio-economic disadvantage. Socio-adversity was not found to be associated with PND; which is in contrast to what has been found in Western samples (Cooper and Murray, 1998). The authors state that the consistent levels of social-adversity found within these samples made it difficult to identify any causal relationship with PND.

One major limitation of the cohort study by Ramchandani and colleagues (2009) was the high percentage of women who were lost during follow up (35.1%), this is understandable given the turbulent nature of the study setting. A further limitation was that the Pitt Questionnaire (PDQ; Pitt, 1968) has yet to be validated within an African sample and it is unclear how the cutoff score was chosen for this study. However, one strength of the Ramchandani et al. (2009) study was that women were assessed during pregnancy, which allows for differentiation between those women who were depressed during pregnancy and those who developed depression only in the postnatal...
period. Depression during pregnancy has been found to be one of the strongest predictors of PND (Robertson et al., 2004).

One of the main strengths of the study by Cooper and colleagues (1999) was that there was a detailed explanation of the peri-urban settlement and the sampling methods used. However, a limitation was that the study was cross-sectional and therefore not generalisable to other settings and populations within South Africa. A further limitation was that depressive symptoms were assessed only at two months postpartum. Therefore, there is no way of knowing if participants had prenatal depression, or what their depressive states were later in the postpartum period, as women can develop PND up to 1 year after delivery (Gaynes et al., 2005).

**Uganda**

Two studies were undertaken in Uganda, in both rural and peri-urban environments respectively (Cox, 1983; Nakku et al., 2006). The quality of the two studies was good (5 and 6 respectively). The cross-sectional design of both studies makes it impossible to establish predictive validity. Larger numbers of participants would have possibly improved statistical significance of results. Age was found to be a significant risk factor, with younger mothers being more at risk for PND, which is similar to findings in Western cultures (Boyce and Hicky, 2005). Undesired gender of baby was found to be a significant risk factor, as there is an overall preference for male children within patrilineal society where an heir is considered of great importance (Nakku et al., 2006).

Having an unplanned pregnancy was found to be a significant risk factor in women who lived in a peri-urban environment but this association was not evident in women who lived in a rural environment. Child bearing is often seen as desirable in African culture and therefore issues of whether a baby is wanted might not have been found in urban women, this may suggest that the meaning of pregnancy in urban and rural women in Uganda may be different.

Negative life events that occurred in the previous year were found to be significantly associated with PND (e.g., bereavement following the death of a family member). It should be noted that this study (Nakku et al., 2006) was undertaken at a time in Uganda when the prevalence of HIV meant that nearly every family within the study had experienced a death of a family member. This suggests that psychological factors, particularly bereavement, may influence the development and
expression of PND in Uganda. Evidence suggests that negative life events, such as bereavement have been found to be one of the most powerful predictors of PND (Paykel et al., 1980; Brown and Harris, 1978). Non-significant associations were found with unhappiness in pregnancy and low social economic status. Comparable to the studies in South Africa, social adversity was found not to be a significant risk factor.

A limitation of the study by Nakku and colleagues (2006) was that recruitment of the sample took part in a health centre. The authors acknowledge that most women in Uganda do not attend postnatal clinics and therefore recruiting from this setting could have resulted in a highly selected group of participants, making it difficult to generalise the findings to the total Ugandan population. The SRQ measure (SQR-25; Beusenberg and Orley, 1994) that was used has been validated in a primary health care setting in Nigeria (Harding et al., 1980), but had not been used in a Ugandan population.

The strength of Cox’s (1983) study was that women were assessed in pregnancy and the postpartum period. However, data were collected at different time points within the Ugandan and Scottish samples. Scottish mothers were interviewed on four occasions and Ugandan mothers were interviewed on two occasions. In view of the cultural differences between African and UK populations, study results should therefore be compared with caution.

Nigeria

Five studies were undertaken in Nigeria (Ademuya et al., 2005; Owoeye et al., 2006; Fatoye et al., 2006; Abiodun, 2006; Aderibigbe et al., 1993) and recruited from urban maternity hospitals or health centres. The quality of all five studies was moderate to high, ranging from 5 to 6. One of the significant risk factors associated with PND was marital status: women who were either single or within a polygamous marriage were more likely to be depressed. This may suggest an association between PND and a lack of support from a partner, which has also been found in both White Western populations (Forman et al., 2000) and other Black women in the West (Edge, 2007). Polygamous marriages are common practice in Nigeria with an estimate of two in five women in polygamous marriages (Fatoye et al., 2006). New mothers who are looking after the baby are often left to look after themselves and their children as the father spends more time with his other wives.
(Adewuya et al, 2005). Single parenthood can be seen to be socially unacceptable for new mothers, and thus within Nigerian culture it is considered a risk factor for PND.

Rejected paternity was found to be another significant risk factor within the Nigerian sample. Nigerian culture often emphasises the importance of men claiming responsibility for the paternity of a newborn before they are born (Owoeye et al., 2006). Rejected paternity can lead to ambivalent feelings of the father and the community towards the child and mother (Owoeye et al., 2006). Having a marriage contract or a traditional dowry confers men’s legitimacy on the paternity of the newborn (Owoeye et al., 2006).

In-law-relationship difficulties were found to be a further risk factor, either difficulties with the sister-in-law, the brother-in-law or the mother-in-law. This probably reflects the dynamics of the extended family structure within Nigerian culture. The mother-in-law traditionally stays with the family when a new baby is delivered in order to assist with the care of the baby. The dynamics between the mother-in-law and new mother determines if the new mother experiences this as supportive or unsupportive. The mother-in-law can therefore be either a source of stress or support. The importance of the mother-in-law relationship in the context of PND has been found across different cultures, such as within Chinese culture (Chan et al., 2002; Lam et al., 2012).

A number of risk factors were found to have inconclusive associations, such as age of the mother and gender of the baby. Authors found this difficult to explain and it could be that the studies took part in urban and cosmopolitan cities where traditional African cultural value systems are fading. The gender of the baby showed mixed associations with PND; however, the desire to have a male child has been found to be important in studies from Non-Western countries (Makanjuola, 1982; Patel et al., 2002). In the traditional African setting, especially in Nigeria, having a male child helps to stabilise the status of the woman in a marriage. Woman are often blamed for the gender of the baby so giving birth to a female child, especially if it is her first, can be a major source of stress, which can sometimes lead to marital break-up with the husband marrying another wife (Adewuya et al., 2005).

A limitation across all five studies is that they were carried out in urban settings and in some large cities, making it difficult to generalize the findings to rural Nigerian women who may be affected to
a lesser degree by modernism and may follow perceived rituals and customs differently than the women in these studies. Two studies (Aderibigbe et al., 1993; Fatoye et al., 2006) had high attrition rates and the results should therefore be interpreted with caution. Those who dropped out were found to be less likely to have experienced low mood prenatally.

Two of the studies (Adewuya et al., 2005; Fatoye et al., 2006) did not use standardised diagnostic instruments to measure or verify diagnosis of depression. Strengths of the studies included the use of measures validated in Nigeria such as the EPDS (Uwakwe and Okonkwo, 2003). However, not all translations of the EPDS have been validated. A further strength was that all five studies had large sample sizes which increase the power and generalisability of results.

Conclusions

Psychological, social, cultural and demographic risk factors vary across Sub-Saharan Africa. By grouping each of the studies by country, certain patterns emerged. Unique risk factors within Sub-Saharan Africa cultures show that societal stress, such as threat of violence seen in South Africa, and issues of bereavement due to the effects of HIV in Uganda, are important factors to consider when developing a predictive model of PND in Sub-Saharan Africa. Contrary to Western cultures, social adversity was not found to be a major risk factor as many African women struggle with issues of housing and money. Certain cultural values, such as polygamous marriages and the gender of the baby were found to be influential in Nigerian culture. Cultural factors such as in-law-relationship problems and rejected paternity were also associated with PND in Nigeria. Due to the limited number of studies, these findings should be interpreted with caution. They do, however, enhance our understanding of the risk factors associated with PND in Sub-Saharan Africa.

3.2. Synthesis 2: Qualitative studies

Three qualitative studies met inclusion criteria and are detailed in Table 2. These studies were undertaken in Ethiopia (Hanlon et al., 2011), The Gambia (Sawyer et al., 2011) and Uganda (Oates et al., 2004). The quality of these studies was generally good, although there were particular weaknesses in the transparency of the analyses (Appendix 2).
### Table 2: Characteristics and quality assessments of qualitative studies

<table>
<thead>
<tr>
<th>Country</th>
<th>Study</th>
<th>Aims</th>
<th>Methods</th>
<th>Analysis</th>
<th>N</th>
<th>Ethnicity</th>
<th>Religion</th>
<th>Themes relating to risk factors</th>
<th>Limitations</th>
<th>QA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Gambia</td>
<td>Sawyer et al (2011)</td>
<td>Explore woman’s experiences of pregnancy, childbirth, the postnatal period and maternal psychological distress in the Gambia</td>
<td>Cross-sectional study using semi-structured interviews with mothers who had given birth within the previous year</td>
<td>Thematic Analysis</td>
<td>55</td>
<td>Black African</td>
<td>Not stated</td>
<td>Negative cultural perceptions Lack of support Relationship difficulties Unwanted pregnancy</td>
<td>Not representative sample of general population. Method of translation (translation occurred prior to transcription) information could be lost or distorted.</td>
<td>A</td>
</tr>
<tr>
<td>Uganda</td>
<td>Oates et al (2004)</td>
<td>Explore whether postnatal depression is universally recognised, attributed and described. Enquire into perceptions of remedies and services for morbid states of unhappiness</td>
<td>Cross-sectional, cross-cultural study. Focus groups with new mothers, interviews with fathers, grandmothers and health professionals</td>
<td>Textual analysis</td>
<td>Not stated</td>
<td>Black African</td>
<td>Not stated</td>
<td>Lack of support Relationship difficulties Cultural factors</td>
<td>Not representative sample. Small number of informants. Comparison of themes across centres could be controversial.</td>
<td>C</td>
</tr>
</tbody>
</table>

Quality assessment: (A) No or few flaws (B) Some flaws (C) Significant flaws (D) untrustworthy findings/conclusions
Four major themes relating to risk factors for PND emerged from the findings of the three qualitative studies: Lack of support, relationship problems, unwanted pregnancy and cultural factors (Figure 2).

*Lack of support* was a key aspect of maternal accounts. Lack of support from the husband was commonly identified as reasons for distress in the postnatal period. The importance of social support in maternal mental health has previously been demonstrated in Europe, North America and African countries (Beck, 2001; Sawyer et al., 2010).

*Relationship problems* was another theme that emerged. Marital conflict was found to be an issue for many of the women, and was identified as a risk factor for PND in Sub-Saharan African countries (Sawyer et al., 2010). Conflict about sexual activity following delivery was mentioned by Ugandan women as a source of unhappiness following delivery. Infidelity on the part of the husband was identified by Ugandan and Ethiopian women; women reported becoming distressed if their husbands spent all of his time with another wife or started to see another woman. Polygamy was again found to be a cause of distress within the postnatal period. Deficits in the care and recognition received from the woman’s husband were regarded as potent causes of disappointment and distress (Hanlon et al., 2009). Ethiopian women described how women already living in abusive marriages might be at greater risk of depression (Hanlon et al., 2009).

Relationship difficulties with family members were found across the three studies. Ugandan women identified the importance of their relationship with their mothers-in-law, and the mother-in-law’s role as a source of unhappiness following delivery. This cultural factor is also seen in many other cultures throughout the world (Lam et al., 2012; Oates et al., 2004). Delays and difficulties in naming the baby by the partner’s family were seen as a cause of unhappiness in Ugandan women.

*Unwanted pregnancy* was a further theme that emerged from the three studies. The financial strain of having a child was found to be a factor related to distress. Economic strain and poverty interferes with a woman’s ability to engage in acts of reciprocity and decreases avenues of social support (Hanlon et al., 2009). It was acknowledged that a child may not be wanted, particularly if the woman is young, already has too many children, or is having marital problems (Hanlon et al., 2009).
A number of different cultural factors were associated with PND. Negative cultural perceptions were seen as a major risk factor across the studies, how the pregnancy and baby were viewed by others was seen as important. Within the Gambian study (Sawyer et al., 2011), being a single parent and having a baby out of wedlock were seen as socially unacceptable, therefore the stigma associated with being single may contribute to the development of PND.

Having a female baby was seen to be a further risk factor due to the deep-rooted cultural preference for male children in Sub-Saharan Africa (Sawyer et al., 2011). Male babies are seen to confer higher status upon the woman as they inherit the family’s property and wealth (Hanlon et al., 2009). In patriarchal societies male babies continue the family lineage and are often expected to look after their parents. Giving birth to a girl has been identified as a potential risk factor across other African countries; having repeated female babies is seen as diminishing woman’s status and a threat to her happiness in the postnatal period (Hanlon et al., 2009).

Inability to adhere to postnatal traditions was identified as risk factor for PND, especially within the Ethiopian women where the tradition of the postnatal period of confinement exacerbated their pre-existing difficulties (Hanlon et al., 2009). The tradition of postnatal confinement meant that women felt unable to leave the postnatal house for fear of being shamed. Distress during postnatal confinement came from not being able to share their problems with friends of neighbours.

The consequences of not following prescribed practices were also thought to be related to feelings of distress in women. Fear of violating postnatal rituals was a concern in women and postnatal ill health and misfortune were attributed to inadequate adherence to tradition (Hanlon et al., 2009). Within the Ethiopian study, women described how the postnatal women and newborn baby were at risk of spirit attack and bewitchment. Supernatural agents were described as causing disturbance of the postnatal woman’s thinking or behaviour.

Cultural dissonance was found within Ethiopian woman where there was a mismatch between cultural expectations and actual behaviour, and was seen as a stressor which increases the risk of mental distress. When the individual is unable to adhere to strongly held cultural values for whatever reason, cultural dissonance results and can lead to depression (Dressler et al., 2007).
There are a number of methodological limitations within the qualitative studies reviewed. It is important to be cautious when generalising the results to all women within Gambia, Ethiopia and Uganda respectively. The exact number of participants within Oates and colleagues’ study was not reported. Some of the comparisons across cultures can be seen as somewhat controversial and the samples were not considered to be representative of the populations. Oates and colleagues (2004) do not specify how many interviewers participated in the study. There was no mention of steps taken to enhance the trustworthiness and rigor of the study; it is therefore difficult to draw conclusions as to how reliable and nonbiased the study was. Researchers stated textual analysis was used in order to analyse the qualitative data, but no specification of the emerging categories and themes was provided. However, one of the strengths of their study was that transcripts were analysed in original languages before being translated into English, therefore information and meaning were less likely to be lost (Oates et al., 2004).

Sawyer and colleagues (2011) acknowledge that one of the limitations of their study was that women were recruited from health care centres and that this could have affected results, as women who do not have access to health facilities or have had home births are likely to give different accounts of pregnancy and childbirth. Translation occurred prior to transcription, which could have meant that information was lost or distorted. Hanlon and colleagues (2009) acknowledged the effects of religion on their results as potentially limiting the generalisability of findings, as the sample population was predominantly Muslim, whereas Ethiopia has a majority Christian population.

Conclusions
Qualitative studies provide an insight into real life experiences of Sub-Saharan African mothers in the postnatal period. Studies were of good quality but there were limitations in transparency of analysis and methods of translation. By grouping common themes, culturally determined risk factors emerged (Figure 2. Negative cultural perceptions and how others within the community might view the mother and child were seen to be a major influence across studies. Difficulty in adhering to cultural traditions and values and the consequences of not following prescribed practices were likely to increase distress during the postnatal period.
Figure 2: Thematic analysis of risk factors in postnatal depression in Sub-Saharan Africa

- **Negative cultural perceptions:**
  - Baby girl
  - Baby out of wedlock

- **Cultural dissonance**
- **Spirit attack**
- **Rejected paternity**
- **Polygamy**
- **Relationship with Mother in Law**

- **Cultural traditions:**
  - Adhering to cultural traditions
  - Not adhering to cultural traditions

- **Lack of Support**
  - Emotional support
  - Practical Support
    - Economic strain
    - Physical labour

- **Partner support**

- **Unwanted Pregnancy**
  - Economic strain
  - Too many children

- **Relationship Difficulties**
  - Family relationships:
    - Family conflict
    - Mother-in-law

- **Marital relationship:**
  - Negative marital relationship
  - Infidelity
  - Polygamy
  - Conflict about sexual activity
  - Abuse
  - Insufficient care
3.3. Synthesis 3: Integration of quantitative and qualitative studies

The variables that were examined in the qualitative and quantitative studies can be categorised into psychosocial and socio-demographic factors.

*Psychosocial factors*

Psychosocial factors are those pertaining to the influence of social factors on an individual’s mind or behaviour, and to the interrelation of behavioural and social factors (Oxford English Dictionary, 1989). Psychosocial variables appear to play a consistent role in the development and maintenance of PND in Sub-Saharan Africa women. Women with PND are more likely than non-depressed women to report difficulties in their marital relationships (Sawyer et al., 2011; Hanlon et al., 2009; Oates et al., 2004; Owoeye et al., 2006; Ramchandani et al., 2005) and lack of support (Cooper et al., 1999; Abiodun, 2006; Sawyer et al., 2011; Hanlon et al., 2009; Oates et al., 2004). Women who reported family conflict, either with their mother-in-laws, sister-in-law or brother-in-law, were more likely to be depressed (Abiodun, 2006; Oates et al., 2004; Ramachandani et al., 2009). Rejected paternity by the baby’s father (Owoeye et al., 2006) was also found to be a risk factor for PND.

Negative life events, such as bereavement of family members, and societal stress, such as witnessing violent crime, were significantly related to PND (Nakku et al., 2006; Ramchandani et al., 2009). One study reported that women who were depressed were more likely to have suffered from depression during pregnancy than non-depressed women (Ramchandani et al., 2009).

Three studies found a significant association between unplanned pregnancy and PND (Cooper et al., 1999; Nakku et al., 2006; Owoeye et al., 2006). Three studies reported that women identified as having PND were more likely to report and describe that the baby was unwanted compared to non-depressed woman (Cooper et al., 1999; Sawyer et al, 2011; Hanlon et al., 2009). Feelings of cultural dissonance (Hanlon et al., 2009) where a woman’s beliefs or actions are not in line with strong prevailing cultural norms were identified as a further risk factor for PND.
Socio-demographic factors

Socio-demographic factors are those pertaining to sociological and demographic characteristics of mothers and babies. The relationship between age, education and occupation with PND were inconclusive. Marital status was found to be important within Sub-Saharan Africa. Specifically, three studies identified that woman in polygamous marriages were more likely to be depressed than woman in monogamous marriages (Ademuya et al., 2005; Fatoye et al., 2006; Hanlon et al., 2009). Five studies found that depressed woman were more likely to be single or separated (Nakku et al., 2006; Adewuya et al., 2005; Owoeye et al., 2006; Abiodun, 2006; Sawyer et al., 2011).

Infant gender was found to be an inconsistent risk factor; five studies described an association with PND (Nakku et al., 2006; Adewuya et al., 2005; Abiodun, 2006; Sawyer et al., 2011; Hanlon et al., 2009), while three studies reported a non-significant association (Ramchandandani et al., 2009; Cooper et al., 1999; Owoeye et al., 2006).

4. Discussion

The scope of this review was ambitious as the cultures within Sub-Saharan Africa are extremely diverse. However, this is the first review to look at this important developing area of research. This review sought to improve our understanding of the culturally determined risk factors for PND within Sub-Saharan Africa by integrating evidence from quantitative and qualitative studies. It is the first mixed-method systematic review of its kind. The evidence from the nine quantitative studies indicated that stressful life events, cultural values and the African extended family system play an influential role in women’s experience of PND. The review of the three qualitative studies indicated that negative cultural perceptions and adhering to cultural traditions and values as contributing to onset of PND.

Although risk factors for PND were similar to those identified in studies in Western nations such as lack of support, age, antenatal depression, unwanted pregnancy and relationships difficulties (O’Hara and Swain, 1996; Beck, 2001); some important differences exist, most notably antenatal exposure to extreme societal stressors and the influence of traditional African value systems and customs. Lack of partner support was identified as a risk factor; however, it is important to acknowledge that this may only be applicable where partner support is considered a culturally
relevant expectation; a factor not considered in the reviewed literature. A more salient factor might be the importance of women’s perceived support, the fact that subjectively women feel that their needs are being met. It is important to further investigate the different cultural expectations of support to better understand cultural context of women’s lives and the meanings of receiving appropriate support.

Extreme societal stress (witnessing or being in danger of violence) was found to be one of the strongest risk factors for PND in South African women (Ramchandani et al., 2009). While PND research has primarily explored the association between PND risk and proximate stressors, little is known about distal and/or cumulative stress effects. The stress-process model (Perlin et al., 1981) describes chronic stresses as enduring problems, conflicts, and threats that may be encountered on a day-to-day basis (Perlin 1989). Chronic stresses are more likely to be cumulative in nature (e.g., financial difficulties or living in an unsafe neighborhood) and are generally only harmful during their duration (Perlin 1989). With regard to risk factors, the stress-process model posits that stress exposure is cumulative over time and is part of a causal pathway to PND. This stress-process model may be useful in understanding women’s risk of PND in parts of Sub-Saharan Africa where there is a high risk of conflict and threat of violence.

Extreme societal stress may also have wider implications on immigrant and Asylum seeking mothers living in Western countries, professionals and health care services should be aware that societal stress in their country of origin may be influential in the development and maintenance of PND within Sub-Saharan African mothers, and that screening and assessment of PND should take this into account.

Traditional African value systems and customs were further risk factors unique to a Sub-Saharan African context. Polygamy, (Adewuya et al., 2007; Fatoye et al., 2006) rejected paternity (Owoeye et al., 2006), negative cultural perception of others (Sawyer et al., 2011), the threat of spirit attack (Hanlon et al., 2009) and adhering to African cultural traditions (Hanlon et al., 2009) were found to be important risk factors within Sub-Saharan Africa. Polygamy was identified as a risk factor for PND within the reviewed studies. However, this was not unpacked by the studies and, therefore, it was unclear if it was the practice of polygamy or the participants who experienced their polygamous partners as unsupportive as a risk factor to PND. It is also important to note that
polygamy is often considered a protective factor as co-wives can assist new mothers in the care of the newborn and can provide practical and emotional support to the new mother (Hayase & Liaw, 1997).

Cultural traditions can be seen as both an alleviating and an exacerbating factor for PND across cultures (Bina, 2008). In a review examining the impact of cultural factors on PND, Bina (2008) found that if women do not perceive rituals as helpful to them, they can have a negative effect on their postpartum mood. Future studies should explore women’s subjective perceptions of cultural traditions in the postnatal period as fulfilling or not fulfilling their needs.

The lack of association between PND and socio-economic disadvantage was also found across studies. Socio-economic disadvantage can be seen as endemic across Sub-Saharan Africa and therefore may not be a contributing factor to PND within this population. This is in contrast to findings in Western samples, where social-economic disadvantage is considered a significant risk factor for PND (Cooper and Murray, 1998).

Inconsistent findings may reflect differences within cultures across Sub-Saharan Africa (Saywer et al., 2010). Mixed findings within countries may reflect differences across settings, such as urban, peri-urban and rural environments. Future studies could consider the effects of urbanisation on traditional African values and the impact on the postnatal period. Further differences might be explained due to the diversity of Sub-Saharan African tribes and the influence of spiritual and religious beliefs. Only one of the 12 reviewed studies recorded and acknowledged the influence of religion. This is a major gap within the Sub-Saharan African postnatal literature. Religious practices have been associated with a decreased risk of PND symptoms based on the view that traditional religious communities are seen as having a more cohesive social structure, emphasis on rituals, clearer role definitions and more extensive community support (Danker et al., 2000). Future studies could investigate the influence spirituality and religion on the development and maintenance of PND in Sub-Saharan Africa.

Cultural dissonance, where a person’s beliefs or actions are not in line with strong prevailing cultural norms may be an important risk factor to consider in Sub-Saharan African women, especially within cultures were the postnatal period is elaborated (Hanlon et al., 2009) or within migrant populations (Parvin et al., 2004). Due to increased migration of Sub-Saharan African
populations to Western countries, health services will need to be aware of additional risk factors for PND and the implications on screening and the development of culturally appropriate services.

4.1. Limitations and strengths
There were a number of methodological limitations with the studies reviewed. Studies assessed social support only at the postpartum stage, it was therefore difficult to establish whether social support needs preceded low mood or vice versa. People suffering from depression are more likely to perceive a social situation as negative and may therefore express greater need for support (Stuchbery et al., 1998). A further methodological limitation was that in the majority of studies, depression was assessed only after birth. Cross-sectional analyses makes it difficult to conclude whether women had depression in antenatal as well as postnatal period, as depression during pregnancy has been found to be one of the strongest predictors of PND (e.g., Robertson et al., 2004). With the exception of one study, the reviewed studies did not report on the participants’ religious orientation or how this might have affected their experiences of PND. It was also unclear if some of the samples included women who were immigrants, as it would have been difficult to differentiate between problems arising from immigration and challenges arising from PND. In many of the studies the methodology limited the generalisability of findings, as the type of analysis chosen meant that conclusions should be limited to the sample under examination.

A number of limitations to this current review are acknowledged. First, Sub-Saharan Africa is a large geographical area that is culturally tremendously diverse; therefore, findings of this review should be applied with some caution. Second, there are a small number of studies due to the lack of research in the area. Third, the search strategies have not included non-English language studies, as only English language articles were used. Fourth, inclusion criteria could be viewed as somewhat problematic, although dual heritage samples were not included in the review due to the influences of different cultures, their exclusion may have limited results due to the large population of dual heritage (e.g. White African and Asian African) populations within Sub-Saharan Africa. Although studies on women with HIV were not included, because of the difficulties in differentiating causes of PND, it is acknowledged that this may have limited the results of this review given the high prevalence of HIV in Sub-Saharan Africa.
Despite the methodological limitations of the studies reviewed, they contribute to the understanding of Sub-Saharan African culture in relation to PND. The qualitative studies provided rich information on women’s subjective experience in the postnatal period. The quantitative studies demonstrated the association between culturally determined risk factors and PND and provided a more systematic evaluation of this association.

The strengths of this review include the comprehensiveness of the searches, the rigorous synthesis methods used, a second rater to assess the quality of the studies and the inclusion of qualitative research along with quantitative studies to establish not only what studies have found but also the experiences of Sub-Saharan African women.

4.2. Conclusions
The currently available literature has highlighted that stressful life events, adhering to cultural values and traditions, the effects of negative cultural perceptions and the African extended family system are risk factors for the development and maintenance of PND in mothers living in Sub-Saharan Africa. The findings of this review are especially important when looking at a predictive model for PND within Sub-Saharan Africa, and when working with immigrant mothers from these communities in other parts of the world. The lack of research within the region highlights the need for further studies to identify women vulnerable to psychological distress so that health services, interventions and preventative strategies can be developed.
References


Harden, A., Thomas, J., 2005. Methodological Issues in Combining


Main Paper

The experience of postnatal depression in West African mothers living in Great Britain:
A qualitative study

Prepared in accordance with requirements for submission to the
Qualitative Health Research Journal (Appendix 4)

Word count: 7851
Abstract

The objective of this paper was to explore the lived experience of postnatal depression (PND) in West African mothers living in the UK. A qualitative design using semi-structured interviews with six West African mothers (Nigeria = 3; Ghana = 3) who were experiencing low mood in the postnatal period was undertaken. Interpretative Phenomenological Analysis was used to explore and analyse the data. 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, emotional distress resulted from social stress. Women’s cultural background influenced their help-seeking behaviour. Participants often avoided talking about their feelings. These findings have implications on how services should be designed to meet the needs of African women. Such insights are vital in order to deliver effective, culturally sensitive care.

Keywords: African mothers, help-seeking, immigrant, Interpretative Phenomenological Analysis, postnatal depression,
Introduction

Postnatal depression (PND) is the most frequently recognised psychological disorder after birth and generally begins within four to six weeks after childbirth (Robertson, Grace & Wallington, 2004). According to the International classification of Disorders (ICD-10, World Health Organisation (WHO), 1992), symptoms include low mood, tiredness, insomnia, lack of energy, forgetfulness, irritability and poor functioning. PND is a serious public health problem (WHO, 2000) that can lead to enduring mental illness for women. (National Institute for Clinical Excellence (NICE), 2007). PND may also have serious psychological and emotional consequences for their families, including child’s psychological development (Cooper & Murray, 1998). Moreover, failure to identify these women can lead to safeguarding concerns for both mothers and children (Warrington, Wright & Team, 2001; Department for Children School and Families (DCSF), 2010). The Department of Health’s (2008) recent strategy for global health also emphasised the need for better and fairer health care in reproductive and maternal health (Health is Global: a UK Government Strategy 2008-2013).

Whilst there is global literature on PND, most research has focused on Western, countries, primarily in Europe and North America (Gaynes, Gavin, Meltzer, Brody, Lohr, Swinson & Gartlehner, 2005). Prevalence rates of maternal mental health disorders show considerable variation between countries. In Western countries, the prevalence of PND is between 10% and 15% (Beck, 2001) but a review of PND in 40 countries found that prevalence rates ranged widely from almost 0% to 60% (Halbriech & Karkun, 2006). A recent review of PND in eight African countries found an overall prevalence of 18.3%, falling in the upper limits of studies conducted in European and North American countries (Sawyer Ayers & Smith, 2010). According to this review, African Women therefore appear to experience PND at a similar rate to that reported in Western countries (Sawyer et al., 2010), which indicates that maternal depression is not a culture-bound Western phenomenon as previously suggested (Stern & Kruckman, 1983).

Cultural diversity within the UK has grown, with 9% of the total population of England being from ethnic minorities, and Black African communities making up 1.0% (Office for National Statistics, 2001). Approximately 20% of Greater Manchester’s population is from BME groups, many of whom live in Manchester’s most deprived areas (Office for National Statistics, 2001). Within the UK,
minority populations report higher levels of physical and psychological illness, though the rate of
minority populations accessing services is poor (National Institute for Mental Health in England,
2003). It is therefore important that services understand the mental health needs of different
communities.

Research conducted in the UK has found that being a mother from an ethnic minority background
significantly increases risk of developing PND (Onozawa, Kumar, Adams, Dore & Glover, 2003).
Bashiri and Spielvogel (1999) suggest that identification of PND is more complex when working
with women from different cultures, giving examples of somatisation and acculturation as
complicating issues. Emotional symptoms may have different attributions, such as religious or
social interpretations, which may influence where, or whether, help is sought (Parvin, Jones & Hull,
2004; Wittkowski, Zumla, Glendenning & Fox, 2011). There may also be variation in attributions
between recent migrants and those who have lived longer in the UK and have more familiarity with
British culture and health care settings (Kirmayer, Young & Robbins, 1994). Cox (1999) stressed that
culture has to be taken into account when understanding the prevalence and management of PND,
stating that it is important to “include culturally sanctioned postnatal rituals as well as other social
influences that determine the pathway to care and choice of therapy” (p.103).

To date, few studies have investigated the experience of PND in migrant women living in the UK,
these studies are invaluable because they allow exploration of women’s attitudes, perceptions and
emotions during the postnatal period in the context of women’s lived experiences. The qualitative
studies undertaken have mainly focused on women from Asian and Bangladeshi backgrounds
(Parvin et al., 2004; Templeton, Velleman, Persaud, & Milner, 2003; Wittkowski, Zumla,
Glendenning & Fox, 2011). Isolation and language difficulties have been found to be key cultural
issues among migrant mothers experiencing PND (Templeton et al., 2003; Parvin et al., 2004;
Wittkowski et al., 2011), with a lack of practical and emotional support, due to the lack of extended
family networks, a further issue among migrant populations (Parvin et al., 2004; Wittkowski et al.,
2011).

Few studies have investigated the experience of PND within an African context. In a study
undertaken in Ethiopia, participants described problematic ‘distress states’ occurring in the
postnatal period, but they did not consider this to be an illness (Hanlon, Whitley, Wondimagegn,
Alem & Prince, 2009). Risk of supernatural attack and physical harm were concerns for mothers in the postnatal period and would often lead to ‘distress states’ (Hanlon et al, 2009). Difficulties in marital relationships (for example, husband’s infidelity or being in a polygamous marriage) were described as contributing to distress for the postnatal women (Hanlon et al., 2009). In a further qualitative study undertaken in The Gambia, Sawyer and colleagues (2011), found that a child conceived out of wedlock or having a baby girl can be sources of distress because of negative cultural perceptions. The financial strain of having a child and the minimal support from men were further concerns for women (Sawyer, Ayers, Smith, Sidibeh, Nyan & Dale, 2011).

To date, there is no available evidence on the experience of PND in West African women living in the UK, or the implications for treatment within services and service delivery. To begin the process of addressing this knowledge gap, a qualitative study was undertaken with the aim of improving understanding of African women’s experiences of PND. Such insights are vital in order to deliver effective, culturally sensitive care. Findings could provide an awareness of the difficulties this population may have in accessing services and ultimately help to refine psychological interventions that are culturally sensitive.
Method

Ethical approval for the study was granted by relevant NHS, and university ethics committees (Appendix 5).

Design and Method

A qualitative design, using semi-structured interviews and Interpretive Phenomenological Analysis (IPA) was chosen as the most appropriate research methodology for this study. IPA seeks to identify personal perceptions of individuals, rather than an objective record of an experience or state. The aim of this approach is to try to understand the unique lived experience of a phenomenon and the content and complexity of meanings, rather than measuring their frequency (Smith & Osborn, 2008). The aim of the study was to understand the phenomenology of how West African mothers with PND made sense of their experiences and what those experiences meant to them in their specific context. A psychological perspective was taken in order to analyse the meaning of the data in a psychological way (Giorgi, 2008). IPA combines phenomenological with interpretative processes to help understand and uncover meaning of the phenomenon under examination in a social context (Larkin, Watts & Clifton, 2006). This requires the researcher to engage in the process of dual hermeneutics (Smith et al., 2009) where the researcher tries to make sense of the participant who was trying to make sense of their world.

IPA requires researchers to engage in an interpretive relationship with the data to make sense of participants’ personal worlds and lived experiences (Smith & Osborn, 2008). Reflexivity and transparency are key elements of the process (Smith et al., 2009). Reflexivity involves developing an awareness of one’s previous knowledge, values and role as a researcher on the research process, in relation to the methodological approach, data collection, interpretation and reporting (Elliot, Fischer & Rennie, 1999). In order to provide transparency of the study and ‘own one’s perspective’ (Elliot et al., 1999), it is important that the reader is informed about the background of the primary researcher to understand the influences on interpretation of transcripts. The primary researcher was a White British woman who was born and grew up in South Africa and had experience of working within African health care settings. Her personal history of living for 16 years in a culture with Black African women influenced how participants’ language was viewed, understood and
interpreted. Her experience of living in post-apartheid South Africa meant that she had direct experience of the complex effects of colonialism and racism within an African context, and an awareness of the effects of her own race and social class within this context. Her own experience, beliefs and assumptions about African culture influenced the interpretation process. The primary researcher’s personal value system of the belief in others’ voices and their right to be heard, the ethical issues of inequality along with the belief in the empowerment of women, influenced her decision to undertake this research. The primary researcher is also a Trainee Clinical Psychologist with a broad awareness of psychological models and theories and has studied anthropology at degree level. This study was undertaken as part of her clinical training. Her clinical work is mainly influenced by systemic and dynamic approaches. Her clinical training and work in African mental health settings has influenced the way she understood PND and the differences in cultural understanding of mental health difficulties. The research team has expertise in perinatal clinical psychology and perinatal mental health, with a specific interest in minority and marginalised groups.

**Reflective Diary**

The primary researcher completed a reflective diary following each interview. The diary recorded thoughts, feelings and ideas arising from the interviews, alongside observations on the interaction between the participant and the researcher, with particular attention to power issues due to the primary researcher’s own race and social class. This reflexive process was useful in understanding how these factors contributed to how the data was collected and analysed. The reflective diary was used to create an audit trail of the analysis process. The reflective diary was utilized to document potential influence of the primary researcher’s previous personal history in order to address concerns about extracting data that were not present in participants’ accounts but based on the primary researcher’s experience. This is known in phenomenological research as ‘reflective bracketing’ (Smith et al., 2009), which is the active endeavor to not overly allow bias, assumptions, subjective understanding and preconceptions to influence the interpretation of the data during the data collection and analysis process. The influence of the primary researcher being from a privileged population relative to race and social class and the potential for power issues to interfere with the interactions with participants was also documented and reflected on. These reflections included an acknowledgement that some participants might have filtered their responses in an effort to protect themselves and their community from negative characterisations (Gibson &
Abrams, 2003). Alternatively, some participants may have been more willing to explain themselves in detail to someone outside their own cultural identity, because there might be an assumption that the primary researcher lacked an understanding of their worldview and their experiences, thus needing further explanation.

**Recruitment and Participants**

Participants were recruited through a specialist NHS service for children under five in Manchester. Potential participants were identified by clinicians and informed of the study, the primary researcher contacted all participants by phone to answer any questions regarding the study. All participants had been referred to one of two commissioned parenting groups: 1) ‘Baby first year and you’ for mothers who had experienced low mood and anxiety and were referred by GPs, Health Visitors and Midwives and 2) ‘Baby first year’ were self-referred groups for mothers who wanted support and basic information on child development. The groups were strategically located in a city centre location where there was a large immigrant population, low uptake of services and high levels of deprivation (ranked third most deprived ward in Manchester and in the top 1% of most deprived wards in England; Index of Multiple deprivation, 2010).

Inclusion criteria for participation in the study were: a) 18 years or older; b) consider themselves from a Black West African background; c) able to understand and speak English; d) had a baby in the past 24 months and e) a score of 10 or above on the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987) (Appendix 6). Women from other African backgrounds were excluded as they were seen to be culturally dissimilar to West African culture. Homogeneity of the sample was improved by the participants being from a West African background, having had contact with services and by the participants’ shared experience of being mothers experiencing low mood in the postnatal period.

**Measures**

Validated measures were used to screen for PND and to help describe participants’ mood. The EPDS was used as an initial screen for PND prior to interviews and the Structured Clinical Interview for DSM disorders (SCID; Spitzer Williams, Gibbon & First, 1992) (Appendix 7) was completed following the interview so that it did not influence responses or effect engagement with participant.
1. The EPDS (Cox et al., 1987) is a 10-item, self-rated questionnaire used for the identification and screening of PND. A cut-off score of 13 is suggestive of major depressive disorder; however, a lower threshold of 10 is recommended for community screening to ensure identification of all potential PND cases (Cox, Murray & Chapman, 1993). The EPDS has been validated within West African populations (Uwakwe & Okonkwo, 2003), and has good psychometric properties.

2. The depression module of the non-patient version of the SCID (Spitzer et al., 1992) was used to describe depressive episodes. The SCID is a semi-structured interview developed for assessment of DSM-IV axis I diagnoses in adults (Spitzer et al., 1992). It is the standard method to characterize study samples in terms of diagnosis. Participants were categorised as ‘Mild’, ‘Moderate’ or ‘Severe’ depression depending on number of symptoms and level of impairment in occupational functioning, usual social activities and relationships.

**Interview procedures**

All interviews were conducted by the primary researcher in either participants’ homes or in community locations of their choice. Written informed consent was obtained from each participant before the interview (Appendix 8: Participant Information Sheet and Consent Form). Collection of data consisted of a standardised postnatal measure, EPDS (Cox et al., 1987), semi-structured interviews and completion of the SCID (SCID; Spitzer et al, 1992). All interviews were digitally recorded, anonymised and transcribed. Interviews lasted between 55 and 85 minutes, mean interview was 60 minutes.

**Interview Schedule**

The interview schedule was developed through consulting relevant literature and discussion with the research team. The interview schedule was piloted on one West African mother who had experienced PND in the past but was not currently depressed. It was adjusted according to feedback from the interviewee and the research team (Appendix 9: Final Interview Schedule). Questions were open ended to encourage mothers to develop and elaborate their experiences. The schedule 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. Discussion of positive and negative experiences was facilitated through a non-
directive approach; participants were encouraged to reflect on past and present experiences and to describe their thoughts and feelings about their experiences.

**Data Analysis**

After transcribing individual interviews verbatim, each transcript was read whilst listening to the audio-recordings and reread repeatedly. Initial observations and recollections of the interview experience were written down.

Initial comments were made by examining semantic content and language use on an exploratory level. Exploratory commenting included (a) *descriptive comments* which focused on describing the content of what the participant had said, (b) *linguistic comments* focused on exploring the specific use of language, and (c) *conceptual comments* that focused on engaging at a more interrogative and conceptual level.

Next, emergent themes were developed by focusing on discrete sections of text whilst at the same time recalling what was learned through the whole process of initial commenting. This process is known as the hermeneutic circle where “the part is interpreted in relation to the whole; the whole is interpreted in relation to the part” (Smith, Flowers & Larkin, 2009 p.85). (Appendix 10: Anonymised coded transcript).

Connections across themes were made by writing the emergent themes on pieces of paper and grouping them together, allowing spatial representation of how emergent themes relate to each other. Patterns and connections between emergent themes were discovered using two main techniques (1) *abstraction* (themes that had similar meanings or understandings were grouped together under super-ordinate themes) and (2) *Contextualisation* (where connections between cultural and narrative themes were examined). Themes from all interviews were compared and recurrent themes were assembled together as sub-themes within higher order categories. Higher-order themes were identified and named when a theme emerged in the majority of transcripts (Smith et al., 2009). In order to ensure that analysis remained close to the data, the main researcher adopted an iterative stance and revisited the transcripts throughout the process and
referred to analytical memos and reflections that were recorded throughout data collection and analysis.

Following initial analysis, associations between themes were further explored by revisiting transcripts and constructing diagrams. A final diagram was constructed to show connections between themes with the aim of describing participant’s experiences.

Validity and Reliability
The study was conducted using established validation standards for the conduct of good qualitative research (Elliot, Fischer & Rennie, 1999). Validation methods included regular supervision meetings to ensure transparency in procedure, ongoing critique of the work and detailed examination of similarity and difference, convergence and divergence among themes and cases. The analysis of the transcripts was judged to be coherent by an experienced qualitative researcher who oversaw the analysis at all stages and conducted credibility checks on the data. Final themes were agreed and are supported by participants’ responses.

Results
The final sample consisted of six Black West African mothers between the ages of 22 and 36 years, three were born in Nigeria and three in Ghana (see Table 3. The number of children in each family ranged from one to three. Four mothers were currently married and living with their partner and two were single parents. EPDS scores ranged from 10 to 25 indicating that all participants experienced depression; these scores reflect the range of severity of depression from mild (9-12) to severe (above 13). Guided by Smith and Osborn (2008), the sample size was deemed sufficient given the in-depth analysis required for the purpose of this study.
<table>
<thead>
<tr>
<th>Participant number</th>
<th>Age</th>
<th>Country of Birth</th>
<th>Languages spoken</th>
<th>Marital status</th>
<th>Occupation</th>
<th>Duration of time in UK</th>
<th>Immigration status</th>
<th>Age of baby (months)</th>
<th>Gender of baby</th>
<th>Parity</th>
<th>Delivery</th>
<th>Previous mental health difficulties</th>
<th>Input from services</th>
<th>EPDS</th>
<th>SCID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>32</td>
<td>Nigeria</td>
<td>Yoruba, English</td>
<td>Married</td>
<td>Housewife</td>
<td>7 years</td>
<td>Applying for residency</td>
<td>11</td>
<td>Male</td>
<td>3</td>
<td>Natural</td>
<td>Single episode (PND)</td>
<td>Parenting group</td>
<td>25</td>
<td>Severe Depression</td>
</tr>
<tr>
<td>2</td>
<td>36</td>
<td>Ghana</td>
<td>Ga, English</td>
<td>Married</td>
<td>Hairdresser</td>
<td>11 years</td>
<td>Applying for residency</td>
<td>8</td>
<td>Female</td>
<td>2</td>
<td>Natural</td>
<td>None</td>
<td>Parenting group</td>
<td>15</td>
<td>Moderate Depression</td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>Nigeria</td>
<td>Yoruba, English</td>
<td>Married</td>
<td>Housewife/Student</td>
<td>4 years</td>
<td>EU citizen</td>
<td>5</td>
<td>Female</td>
<td>1</td>
<td>Natural</td>
<td>None</td>
<td>Parenting group</td>
<td>17</td>
<td>Mild Depression</td>
</tr>
<tr>
<td>4</td>
<td>22</td>
<td>Ghana</td>
<td>Twi, English</td>
<td>Single</td>
<td>Housewife</td>
<td>2 years</td>
<td>Applying for residency</td>
<td>6</td>
<td>Female</td>
<td>1</td>
<td>C-section</td>
<td>None</td>
<td>Parenting group</td>
<td>10</td>
<td>Mild Depression</td>
</tr>
<tr>
<td>5</td>
<td>28</td>
<td>Nigeria</td>
<td>Yoruba, Ibilo, English</td>
<td>Single</td>
<td>Student</td>
<td>2 years</td>
<td>Student Visa</td>
<td>8</td>
<td>Female</td>
<td>1</td>
<td>Natural</td>
<td>Two episodes (Depression)</td>
<td>Medication; Inpatient treatment; Crisis Team; Parenting group</td>
<td>17</td>
<td>Severe Depression</td>
</tr>
<tr>
<td>6</td>
<td>31</td>
<td>Ghana</td>
<td>Ga, Ashanti, English</td>
<td>Married</td>
<td>Housewife</td>
<td>15 years</td>
<td>Indefinite leave to remain</td>
<td>22</td>
<td>Female</td>
<td>3</td>
<td>C-section</td>
<td>None</td>
<td>Parenting group</td>
<td>10</td>
<td>Mild Depression</td>
</tr>
</tbody>
</table>

EPDS >10 = Probable PND
Participants did not refer to their experience as ‘depression’; therefore, in order to remain close to their experience the term ‘distress’ is adopted throughout the results section.
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
5. Relationships as a protective factor

Each theme consisted of a number of subthemes. Figure 3 provides a diagrammatic summary of themes and their proposed connections.

**Theme 1: Conceptualising Postnatal Depression**
This theme related to how participants conceptualized PND, how they experienced it, described it and understood it within a West African context. Four sub-themes emerged and describe how women’s understanding of PND can contribute to distress, and how experiences of distress can impact on participants’ understanding. Although participants experienced symptoms of PND they did not conceptualise it in the same way as Western views of PND. Participants attributed distress in the postnatal period to social stress.

**Subtheme 1.1: Symptoms of PND**
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

Subtheme 1.2: 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. She saw herself behaving in unfamiliar and unexpected ways. The word “Stressed” is used to describe feeling tense, under pressure and depressed.

Subtheme 1.3: No PND 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.

The distress experienced after childbirth was attributed 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 and felt that PND only existed for her in the UK and not in Nigeria. The symptoms of PND were seen to be somewhat context-specific.

“I don’t experience anybody having it. 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”
– Participant 1

Subtheme 1.4: Causes of PND
Participants attributed causes of PND as psychosocial 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, if women experienced distress after childbirth this was attributed to issues with cultural norms such as preference for a male baby, participants described mothers as unhappy if they did not produce a male heir. Unhappiness was also caused by not being able to feed or 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, this meant it was difficult to understand and to cope with. Postnatal distress in the UK was attributed to a lack of support, isolation and not having their African family. Their understanding of PND contributed to their experience of distress.

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.

**Theme 2: Isolation**

One of the recurrent themes among participants was characterised by feelings of isolation and lack of support. Four subthemes emerged which described lack of practical support, lack of emotional support, lack of professional support and 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 this support and this was a recurrent theme of distress. Lack of support is reflected in different themes as discussed below.

**Subtheme 2.1: 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, which is 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, women 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......I am on my own.” - 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.

Subtheme 2.2: 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 and showed a lack of empathy and sensitivity, which left her feeling more alone and isolated.

“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. The above quote may also demonstrate emotional dependence on her husband perhaps because of a lack of a support network.
Subtheme 2.3. 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 that mirrors that experienced in West Africa where “visitors” attend to you at home. This is in stark contrast to when “the door close” and women feel rejected, isolated and alone. This may come as a shock to women if this is not what they expect. This unpredictable support from professionals may lead to feelings of frustration and distrust.

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

Subtheme 2.4: 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 with others and this would result in feelings of isolation. This meant that at times mothers minimized their experiences and then 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

Theme 3: 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.

Subtheme 3.1: 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 the baby 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.

**Subtheme 3.2: 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 described wanting 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 issues of trust in others.
Theme 4: Issues of trust

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

Subtheme 4.1 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 with husbands taking more than one wife (Fatoye et al., 2006). 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. This participant uses emotive language when describing the difficulties in her relationships with other women as they could “snatch your husband” which would be sudden and unpredictable. “Hatred” is used to describe how others might view her with distain and jealousy. It could be that the complexity of West African cultural social systems can cause further difficulties for women who already feel isolated.

4.2. Fear of Stigma

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

In the above quote the participant describes how stigma would “follow me around” suggesting that it would be something that is permanent that she could not escape from. Stigmatisation may be a central concern for West African mothers that may result in their reluctance to talk to others about their difficulties.

**Theme 5: Relationships as a protective factor**

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

**Subtheme 5.1: Relationship with self**

Keeping busy and going back to work were 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.

Subtheme 5.2: 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. The celebration of having a new baby is reflected in traditions such as the naming ceremonies. These traditions are thought to be a celebration of a new life.

“...... the first one (ceremony) is 7 days and the second one is maybe after 27 days, you know a big party, because Africa we like parties especially in Nigeria...... We normally do it, it's just a tradition......” - Participant 3

For mothers who described feeling very isolated, their relationship with their baby was a positive one that they could reflect on. Participants tended not to 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.

Subtheme 5.3 Relationship with others
Two participants had family in the UK, this meant that they had support in caring for their baby and 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

Subtheme 5.4 Relationship with faith
A number of mothers attributed recovery from distress as a result of 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

As illustrated by the quote above, participants described their relationship with their faith and God, rather than the people within the church community, as a protective factor. As previously described, one participant felt it was difficult to talk to others in the church about her difficulties for fear of others knowing that she was struggling and the feared stigma that may result.

Subtheme 5.5: Services as African maternal figure/ African community
Participants described how living in the UK during the postnatal period was often very challenging because they did not have 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 will 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 have space 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 newborns 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
Figure 3: Proposed links between themes

1. Conceptualising PND
   - Symptoms of PND
   - Meanings and language
   - No PND in Africa
   - Causes of PND

Contributes to distress

Distress

2. Isolation
   - Lack of practical support
   - Lack of emotional support
   - Lack of professional support
   - Causes of isolation

3. Loss of identity
   - Loss of self
   - Loss of old life

4. Issues of trust
   - Distrust in others
   - Fear of stigma

Reduces distress

5. Relationships as protective factor
   - Relationship with self
   - Relationship with baby
   - Relationship with others
   - Relationship with faith
   - Services as 'African maternal figure'/'African community'
Discussion

The experience of PND in this sample of six West African mothers living in the north west of England was complex. Five main themes emerged: (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 such as issues of isolation, which has been found in South Asian (Wittkowski et al., 2011), Bangladeshi (Parvin et al., 2004; Templeton et al., 2003) and Chinese mothers (Lam, Wittkowski & Fox, 2012).

While the findings of this study identified some similarities in PND, there were additional factors that are culturally specific. Women exhibited symptoms of PND but did not regard it as an illness, with the name ‘depression’. This observation has also been made in Ethiopian women (Hanlon et al., 2009) and African Caribbean women living in the UK (Edge & Rogers, 2005). Participants did not refer to their experience as ‘depression’. Therefore, in order to remain close to their experience the term ‘distress’ was adopted throughout the results section. The term PND was used within the discussion section because this is the recognised term used within the international literature, and has been used in Halbriech and Karkun’s (2006) study on PND in 40 different countries as well as within the African postnatal literature (see Sawyer et al., 2010).

The psychosocial model of depression (Brown and Harris, 1978) provides a useful framework to understand the experience of PND in West African mothers living in the UK. This model fosters the notion that expression of depression could best be understood in an environmental and social context. Stresses in the form of life events and chronic difficulties are implicated as aetiological agents in episodes of major depression observed in community samples. Participants viewed the causes of their postnatal distress as psychosocial with particular emphasis on lack of practical and emotional support and on dysfunctional/difficult relationships. For most participants, PND did not exist in West Africa, distress after childbirth such as feelings of isolation, loss of identity and distrust in others, was considered as a product of social stress. Participants also viewed psychosocial coping strategies and interventions 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 express distress in African women, because this may neglect spiritual or cultural expressions which do not fit current categories.

One of the main themes throughout participants’ accounts was a lack of trust in others; which often resulted in relationship difficulties. This is consistent with the interpersonal theory of PND (Sullivan, 1953). Interpersonal theory is based on assumptions that psychological difficulties develop as a result of interpersonal conflicts. This theory would assume that PND develops in response to a women’s struggle with accepting her new role as a mother within her family and perhaps mourning the loss of her old self. Conflict with partners and or/significant others would also be seen as symptoms and maintaining factors of PND. Lack of support and relationship difficulties have been found to be risk factors for PND in African women (Sawyer et al, 2010) and in other migrant cultures living in the UK (Wittkowski et al., 2011; Parvin et al., 2004). 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 Balgladeshi 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 being stigmatized. Lewis (2004) suggests that women from Black and minority ethnic (BME) backgrounds may be undiagnosed with PND because of women’s fear of being stigmatized. Although women may feel sad and depressed, their cultural background has an influence on help-seeking behaviour and their experience of services (Edge, 2011). Participants often avoided talking about their feelings and kept their distress to themselves, admitting to having a problem may be a sign of failure (Nahas & Amasheh 1999; Nahas et al., 1999; Edge & Rogers, 2005).

Relationship with healthcare services was a further important finding; mothers described differences in care in West African countries and within the UK. The West African tradition of the extended social network caring for the mother and baby was not seen in the UK, services could be viewed as ‘maternal African figures’, replacing this level of support. If the level of care did not meet expectations this led to cultural dissonance in expectations of services. Small and colleagues (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 found 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. It would have been useful to collect more socio-economic information on the women sampled because religion, educational level and employment may have impacted on their experiences. Finally, the EPDS (Cox et al., 1987) used to screen participants, was open to criticism. Although the EPDS (Cox et al., 1987) has been validated in West African populations (Uwakwe & Okonkwo, 2003), there may be some difficulties in accurately detecting ‘PND’ symptoms, because West African women view PND as psychosocial in nature, which may not be detected by the current EPDS (Cox et al., 1987). Clifford and colleagues (1999) have demonstrated that the EPDS does not reflect the understanding and perceptions of women from BME groups and Hewitt and colleagues (2009) also report that the use of the EPDS is less specific and sensitive to the needs of African woman.

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

1. Challenges to help-seeking
Professionals need to be made aware of the reasons why women may not disclose emotional and psychological problems. As the findings of this study indicate, conceptualisation of PND (Theme 1) may be different in West African women compared with Western views of PND and 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 (Theme 4), women may be reluctant to talk about difficulties for fear of being seen as a failure or as a sign of weakness (Nahas & Amasheh 1999; 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 (Theme 2). In order to help overcome these challenges, services and statutory organisations should work within an outreach model of service delivery, providing services within the community as well as healthcare settings.

2. 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. As described in the findings, women who present to services may not use the words ‘depression’ to describe depressive states (Theme 1) and may therefore not be identified as depressed by GPs and midwives. Patel and colleagues (2002) argue that culturally appropriate terminology for depression should be identified and its use may improve recognition and help with interventions.

3. 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, such as in the notion of ‘bus-stop therapy’. This term refers to the provision of interventions which are located in the ‘real world’ wherever people feel most comfortable, such as at bus-stops or park benches. Confidentiality should be maintained throughout and location of such interventions should be client-led, to ensure clients feel comfortable with community locations. Services should be planned proactively and collaboratively with West African women and should be partnered with African organisations and community groups. Referral systems should be in place 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 found to be a concern of West African women. Community based interventions should be accessible and aware of issues of confidentiality. 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, 2010), joint working with ethnically sensitive community services (such as African Caribbean Mental Health Service) would be important, especially for new immigrants.
4. Group interventions

Individual therapy for PND in West African women may be seen as less effective, as these 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 (Leong & Wong, 2003), not only due to conceptualisation of difficulties but also 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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Critical Review

Developing culturally competent qualitative research with West African mothers - A reflexive account

Word count: 7415
Introduction

This paper reflects on the process of developing culturally competent research by undertaking a study exploring experiences of postnatal depression (PND) in West African women living in the UK. Suggestions for future research and reflections on the strengths and limitations of the research process are embedded throughout. Clinical implications are discussed with reference to a community psychology model.

Cultural competence has been defined as “.....the capacity to appreciate and understand the rich within-group variability that occurs within any diverse racial/ethnic group. Under cultural competence the [researcher] also understands the conditional and contextual relationships that occur daily within complex “real world” situations faced by [participants].” (Castro, Obert, Rawson, Lin, & Denne, 2003, p. 543).

It is important to acknowledge that cultural competency is not without critics (Gross, 2000; Pon, 2009; Sakamoto, 2007). Pon (2009) argues that cultural competency resembles new racism by using modernist and absolute views of culture and ‘otherizing’ and discriminating non-whites without using racialist language. The term new racism refers to racial discrimination that involves a shift away from racial exclusionary practices based on biology to those based on culture (Goldberg, 1993). Like new racism, proponents of cultural competency are able to promote racialised and stereotypical views of cultural groups without ever having to use racialist language (Pon, 2009). Postmodern views of culture acknowledge that culture is not simple and that there are “too many differences – too many to master to achieve cultural competency” (Gross, 2000, p. 59). Gross (2000) goes on to caution that “master of minority content may not be possible, and those who believe they have such mastery are in danger of understanding clients too soon, too superficially” (p.47).

This paper takes the view that the process of becoming culturally competent is an ideal state, but one with no end point. It is conceived as a development process that requires life long learning
(Este, 2007). Self-reflexivity is important especially with issues such as racism and colonialism (Pon, 2009).

**My interest in the research area**
Growing up in South Africa shaped my views and understandings of African culture. At university I studied Anthropology alongside Psychology and have always been interested in how culture influences human interaction and human life. My clinical experience has included working alongside a Clinical Psychologist in a child development centre in Northern Malawi and as a voluntary support worker with nurses and doctors in a rural health centre in Malawi. I was able to see how a collectivist culture views, understands and treats physical health, mental health and developmental difficulties. I was able to see the similarities and differences in the experience of mental health difficulties across cultures. Motherhood is considered a source of empowerment in most African cultures and women in African society are the main source of support for family life; they bear children, make and manage homes, earn a living and contribute to the running of society. My personal history along with my respect and admiration for African women has led to a keen interest in this research area.

**Diversity of African culture**
Consideration of the impact of diversity of African culture influenced the research process at every stage; from reviewing the literature to participant characteristics and the research methodology chosen. Culture is described as shared beliefs, learnt values and attitudes which shape our influences on perception and form behaviour (Kleinman & Good, 1985). Anthropologists refer to culture as a complex system of values, beliefs and codes of conduct that are socially acquired. Culture is not stable and is subject to variations, innovations and change (Lewis, 1976). African cultures are diverse and varied, single African countries may comprise hundreds of different ethnic and language groups, diverse religious practices and varied lifestyles ranging from nomadic farmers to urban city dwellers. A decision was therefore made with the literature review to limit studies that were undertaken in Sub-Saharan Africa. Sub-Saharan Africa refers to the area on the continent of Africa that lies south of the Sahara, throughout history the Sahara has culturally separated Northern Africa from the rest of Africa. North Africa along with the Middle East is a major part of the Arab world and the cultures of North Africa are much more closely tied to Southwestern Asia.
and Europe than Sub-Saharan Africa. Thus, it was decided to focus on studies of postnatal depression in Sub-Saharan Africa. However, this led to limitations which will be discussed in the ‘literature review’ section. Although recent reviews of African literature have been undertaken in Sub-Saharan Africa (e.g., Cortina et al., 2012), it is acknowledged that there is a tremendous diversity of culture within this region. There is also a significant lack of research within this area. Therefore, findings of this review should be considered preliminary and exploratory and be interpreted with some caution.

The diversity within African culture was also considered an issue when exploring women’s postnatal experience. In order to obtain as much of a homogenous sample as possible, it was decided to limit recruitment to women who considered themselves from a Black West African background. The United Nations description of Western Africa includes 16 countries within the Westernmost region of the African continent. Despite the wide variety of culture in West Africa there are general similarities in dress, cuisine, music and culture that are not shared within groups outside this geographic region (Hart, 1985). A West African population was chosen because it is the largest African population living in Manchester and the United Kingdom (Census 2001; Department of Health, 2000). A report from the Department of Health in 2000 looking at diversity among Black African communities in the UK found that migration experiences and reasons for living in the UK varied within communities. Communities such as Nigeria, Ghana and Uganda have been settling in the UK for over 50 years, and are considered long term communities. These include mainly voluntary migrants, highly qualified people, students, people who identified with English culture; people who had spent considerable time living in both Africa and the UK, second and third generations of migrant families and occasional waves of involuntary migrants who left their homes in Africa following changes in political or economic situations (DOH, 2000). The sample of participants recruited for the current study were from Nigeria and Ghana and they were all first generation migrants. For this reason, future research could look at PND in second and third generation migrants, involuntary migrants and asylum seekers.

Diversity within regional and tribal subgroups should also be acknowledged within the study sample. Within the Nigerian community in the UK the Yoruba, make up the majority of the UK population, with the Ibo a further significant group (DOH, 2000). Within the Ghanaian community the main ethnic group is considered to be the Akan, of which the Twi and Fante forms were the
most common, other sub-groups include the Ashante, Ga and Ewe (DOH, 2000). These tribes were represented in the sample population by the languages spoken by the participants. Tribal background has an impact on culture, diet, ceremonies, beliefs and languages spoken. Although tribal differences among migrant African communities exist, research indicates that there are mixed views on whether these have a major impact (DOH, 2000). Future studies should investigate the impact of tribal differences in African communities on postnatal experience.

The diversity in African culture also influenced the methodology chosen. Interpretive phenomenological analysis (IPA) was chosen to explore the experiences of West African mothers. Cultures are effectively frameworks for meaning-making (Much, 1995). Thus, while IPA’s primary purpose is with understanding an experience, it is inevitably enmeshed with language and culture, and as such IPA research is in part an inquiry into the cultural position of a person (Smith, Flowers & Larkin, 2009). This means that in order to understand the experiential claims being made by participants, the researcher often needs to understand participants’ terms of reference. It was therefore important that I demonstrated cultural competence throughout the research process. I took into account West African culture and the diversity of participants when developing research ideas, conducting research and exploring applicability of research findings. Attention to culture is necessary to advance scientific understanding of phenomena under study (Hill, Knox, Thompson, Williams, Hess & Ladany, 2005; Lyons & Bike, 2010).

There was a fine balance throughout the research process to acknowledge and identify issues of cultural diversity whilst at the same time exploring and communicating the experiences of West African populations. This balance was achieved by regular discussions in supervision with the research team and written reflections in the reflective journal.

**Motherhood in African culture**

Women in African culture occupy various positions – a mother, a wife, a daughter, a priestess, or even a witch. The way she is perceived depends on the position she occupies, and the different perceptions are reflected through songs, works of art, music, language, and religion (Makinde, 2004). Often the highest value is given to woman as a mother because motherhood is revered, especially within the Yoruba people of Nigeria (Makinde, 2004).
A popular proverb among the Yoruba presents motherhood as very precious:

“Iya ni wura Baba ni dingi” (Yoruba)

Meaning: Mother is gold Father is a mirror

“Orisa bi iya ko si iya la ba ma a bo” (Yoruba)

Meaning: There is no deity like mother. It is the mother that is worthy of being worshipped.

Motherhood is considered to be very important in Nigerian Yoruba culture because the “preservation of humanity depends on the role of mothers in the society” (Lawal, 1996 p34). The importance of motherhood was found in the current study when participants described celebrations and traditions often associated in the postnatal period. This observation could also suggest that those who struggle during this time may be seen as going against cultural expectations and norms because motherhood is something to be celebrated, this dissonance may lead to greater feelings of isolation and low mood. The cultural aspects of motherhood in West African culture were important to consider when undertaking this research as it has an impact on women’s postnatal experience.

Literature review

There is very limited research on PND in African populations. Only one review to date has looked at pre- and postnatal psychological wellbeing in African women (Sawyer, Ayers & Smith, 2010). This review provided an initial overview of maternal mental health disorders in Africa. However, there are major limitations with comparing findings across the whole of the African continent. A decision was therefore made to consider this variation in cultures by looking at the culturally determined risk factors for PND in Sub-Saharan Africa. Due to the low numbers of studies in this area, it was decided that a mixed-method systematic review approach should be used (Harden & Thomas, 2005). The mixed method framework was developed over several years by researchers at the Evidence for Policy and Practice Information and Co-ordinating centre (EPPI-Centre), the Institute of Education, University of London, and combines both qualitative and quantitative methods in one systematic review (Harden, 2010). This type of review is particularly useful when different types of qualitative and quantitative data are available to inform a review topic. Strength of the mixed
methods review is that it preserves the integrity of findings of different types of studies by using the appropriate type of analysis that is specific to each type of finding. A further strength is that the conclusions of reviews include qualitative data, which are more likely to reflect the experiences of participants, this ultimately could lead to the development of more appropriate and effective interventions (Harden, 2010).

Inclusion criteria could be viewed as somewhat problematic, a decision was made to not include dual heritage samples in the review due to the influences of different cultures, their exclusion may have limited results due to the large population of dual heritage (e.g. White African and Asian African) populations within Sub-Saharan Africa. Dual heritage refers to having parents from different ethnic or cultural backgrounds. It was important to observe that during the initial scoping of the literature, no studies to date on Asian African samples were identified, which highlights a need for further research within this area. A further decision was made not to include studies with women with HIV because of the difficulties in differentiating causes of PND. However this may have limited the results of this review given the high prevalence of HIV in Sub-Saharan Africa.

A further challenge encountered when reviewing the literature was difficulty in accessing articles in rare journals. The British Library was unable to access two papers from the Ghana Medical Journal when requested on inter-library loan. Attempts were made to access the articles online; however, the journal had only recently become electronic and not all publications were available. Further attempts were made to access the articles through libraries in Ghana and South Africa but this too was unsuccessful. This highlights difficulties in reviewing topics where there is little research or studies that have taken place in Non-Western countries. It also supports the evidence that using electronic databases to search articles in non Western countries can be challenging (Betran, Say, Gülmezoglu, Allen & Hampson, 2005; Sawyer et al., 2010).

A strength of the literature review was that the quality of all the studies were rated on clearly defined assessment tools and double rated by two researchers. Any discrepancies were discussed and a consensus was reached. There was a good percentage of agreement of scores for quantitative studies (86%) and qualitative studies (71%). On reflection, disagreements could have been in part due to the background of the two raters. The second rater was a researcher in
Education and this may have influenced their understanding and interpretation of findings and therefore the quality ratings they allocated.

**Rationale for IPA**

Qualitative research tends to try to explain associations between events, it focuses on what happens, focuses on meaning, sense making and communicative action, that is, it looks at how people make sense of what happens and the meaning they attach to events. There are numerous qualitative methodologies, such as Grounded Theory and Narrative analysis. The prime reason IPA was chosen over any other qualitative approaches was because it was consistent with the epistemological position of the research question. The aim of the research was to capture the lived experience of West African mothers with PND in the UK, and is particularly suited to a phenomenological approach, as the main objectives are to generate a rich description of lived experience (Giorgi & Giorgi, 2008). IPA aims to allow the researcher to develop an analytic interpretation of participants’ accounts which should be prompted by and clearly grounded in, but which may go beyond, the participants’ own sense-making and conceptualisations (Smith, 2004).

IPA has become well established in qualitative psychology. However, there are a number of limitations to the method that should be acknowledged. Larkin and colleagues (2006) describe how many researchers employing IPA have tended to be over-cautious in their analysis, describing and summarizing participants’ accounts but not developing them further into an interpretative or conceptual level, thus not properly exploring the experiences (Larkin, Watts & Clifton, 2006). It is also important to recognize that the analytic process cannot ever achieve a genuine first person account because accounts are always constructed by both the participant and researcher, which is influenced by the researcher’s own experiences and is reliant on the ability of the participant to be able to verbalize their experience (Willig, 2001). This was apparent in the current study with one participant who struggled at times to express herself as English was not her first language. I remained mindful of these limitations throughout the research process. The use of a reflective journal became paramount when attempting to manage any difficulties. This is discussed further in the following sections.

Although other qualitative methods explore participants’ lived experience the way in which they do so differs. For example, in the context of this study, a Grounded Theory approach would seek to
understand the theoretical processes and would seek confirmation on the developing Theory through participant validation. IPA can contribute to theory development but this is seen as a secondary aim (Lyons, 2007). IPA was chosen as the most appropriate methodology as the aim of the current study was to provide a rich description of participants’ experiences of PND in the UK, rather than a detailed explanation.

**Recruitment – the importance of relationships**

One of the most challenging aspects of this study was recruitment of participants. Ten voluntary African organisations across the UK were contacted regarding recruitment as well as a number of national Psychology and Psychiatric governing bodies whose focus is on cultural aspects of mental health. Unfortunately, no participants were recruited through these avenues. Four strategic Children’s Centres were approached and the advertisement (Appendix 11) for the study displayed, these centres were in inner city locations of Manchester with the highest African populations. The advertisement was also displayed in a local African food shop. The African Caribbean Mental Health Service (ACMHS) invited me to attend open evenings and groups for the African community. A woman from the West African community, who was working with ACMHS, was considered a gatekeeper for the community. “Gatekeepers are individuals who are trusted by the community, are sought out for advice and respected for their opinions, and often are embraced by others both inside and outside the community” (Russell, Maraj, Wilson, Shedd-Steele & Champion, 2008, p. 92). This approach enabled me to access women from the community and through this avenue I was able to recruit for the pilot interview.

Time was spent in community locations, such as churches and community centres, engaging with members of the African community and professionals who worked with them. Unfortunately, all of the above community recruitment strategies were unsuccessful. West African women did not contact me directly and although three women were identified via these strategies, they did not meet criteria for the study, as they had children who were older than 24 months or had not experienced low mood in the postnatal period.

All participants were eventually recruited from the NHS, from mother and baby groups that were run in inner city locations. Clinical psychologists, Family Support Workers and an Assistant Psychologist who had therapeutic relationships with the mothers, recruited all six participants.
These relationships with professionals appeared to be vital in the recruitment process. Although the professionals were not from the West African community, they had developed trusting relationships with these mothers. Research suggests that when recruiting African populations, people who have a demonstrated history as an ally to the community are often helpful when accessing participants and recruitment tends to run more smoothly (Gibson & Abrams, 2003). By having a fellow professional approach potential participants, I was ‘personally vouched for’ by someone participants knew, which ultimately afforded greater connection with African mothers (Diemer, 2002).

With this idea in mind, time was spent developing relationships with professionals who were in contact with the African community. I attended a number of team meetings and referral discussions within the Children and Parents’ service which enabled me access to professionals who were working within the African community. Here I was able to discuss aspects of my research and answer any questions or concerns professionals had about my study. One of the reflections I noted was that professionals were often very protective of the mothers that they helped to recruit, often wanting to ensure that I was able to maintain confidentiality and that I had a risk assessment and management plan in place (which I had).

After potential participants were identified, time was spent organising a location, date and time that was most convenient for participants. This process often took a number of phone calls and was useful in developing and building relationships with mothers before the interview. On one occasion I met with a potential participant in her home to discuss the research and what would be required. Although the study had been explained to her on several occasions by myself over the phone, this mother was keen to meet me in person before she consented. This process may reflect wider issues for this population with distrust of others and concerns around confidentiality, as highlighted in the main findings of the study.

Difficulty in recruitment was also compounded by broader issues such as current changes within the NHS. For example, the mother and baby groups, where participants were recruited from, were unexpectedly decommissioned during the process of recruitment. This NHS change had a major impact on recruitment but also for the African mothers themselves, because these groups provided a life line for those who were most in need.
Sample size is often debated in qualitative research and partly depends on the degree of commitment to the case study level of analysis and reporting, the richness of individual cases and organisational constraints (Smith et al., 2009). Smith and colleagues suggest that between three and six participants can be a reasonable sample size for an IPA project as it should provide sufficient cases for the development of meaningful points of similarity and difference between participants but not so many that the data generated are overwhelming (Smith, Flowers & Larkin, 2009). They suggest that, for professional doctorates, numbers of interviews should be between four and ten (Smith et al., 2009). They explain that “it is important not to view higher numbers as being indicative of ‘better’ work as successful analysis requires time, reflection and dialogue and larger datasets tend to inhibit all of these things” (Smith et al., 2009 p52). Finally, the study was prepared in accordance with requirements to the submission to Qualitative Health Research Journal in which there have been a number of recent published studies that contain sample sizes of five (Hadfield, Brown, Pembroke & Hayward, 2009; Ogden & Austin, 2011) and sample size of six (Sargent & Gross, 2011).

**Difficulties with measures**

Most qualitative studies do not use measures, however within the current study the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987) was used as a screening measure and the Structured Clinical Interview for DSM Disorders (SCID; Spitzer et al., 1992) was used to describe participants’ current emotional states and the degree of depression after childbirth. Although the EPDS (Cox et al., 1987) has been validated across a range of cultural settings, including West Africa (Uwakwe & Okonkwo, 2003), it does not include a somatic subscale which could be disadvantageous in non-Western parts of the world where somatic symptoms are considered manifestations of depression (Halbreich, Alarcon, Calil, Douki, Gaszner & Jadresic, 2006). Clifford and colleagues (1999) further demonstrated that the EPDS does not reflect the understanding and perceptions of women from BME groups and Hewitt and colleagues (2009), report that the use of the EPDS is less specific and sensitive to the needs of African woman.

It was useful to include the SCID (Spitzer et al., 1992) as it provided detail on the degree of depression after childbirth. However the SCID was time intensive and after sharing their emotive personal accounts, participants often appeared reluctant to complete it. There was a balance...
between scientific rigour, as journals often require studies to provide diagnostic measures, and concerns around over-burdening participants. Administration of the SCID was undertaken sensitively and I remained responsive to participants’ feelings.

Overall, the measures were useful in seeing how PND might be identified in West African women living in the UK and potentially missed with the current tools available to health visitors, midwives and other professionals.

**Interviews**

The process for developing the interview schedule was iterative, because ideas developed and changed, both during the process and then again after the pilot interview. The range of topic areas were developed after reviewing the literature and were similar to questions asked within similar studies with other migrant mothers (Lam, Wittkowski & Fox, 2012; Wittkowski, Zumla, Glendenning & Fox, 2011). The order of topics was placed in an appropriate sequence by constructing the interview so as to work gradually towards the more sensitive issues, such as feelings towards self and baby. Consideration was given to appropriate phrasing of questions. For example, it became apparent that mothers were not using the word ‘depression’ and it felt uncomfortable for me to refer to their experiences as such. Therefore the words ‘stress’, ‘low mood’ or ‘difficulties’ were used during the interview. Finally, the list of questions were discussed with the participant after the pilot interview and re-drafted as appropriate. Some of the initial questions were too direct and so were redesigned to allow the participants to describe what it was like to live in their personal worlds.

There were a number of reflections and learning points that were noted throughout the interview process. One of which was the acknowledgement of power differentials inherent in the interview process (Allen & Baber, 1992), and the acknowledgment that I as a researcher, was from a privileged population relative to race and social class. I was mindful of the potential for such power issues to interfere with the interview process. I employed strategies to reduce the uneven power relationship including: (1) maximising participant control of the interview, (2) allowing the participant to control the tape recorder, and (3) using culturally appropriate verbal and non-verbal language during the interview.
Having taken cultural considerations and power differentials into account a further important factor was establishing trust with participants. Research suggests that qualitative researchers who are effective with participants of African descent are “willing to set aside the individualistic approach and adopt the expectation that interpersonal relationships and their impact are more important than personal gain” (Houston, 1990, p.102). As I am not from the same cultural or ethnic background as my participants, I was aware that some participants might have filtered their responses in an effort to protect themselves and their community from negative characterisations (Gibson & Abrams, 2003). However, it could also be that some participants were more willing to explain themselves in detail to someone outside their own cultural identity, because there might be an assumption that I lacked an understanding of their worldview and their experiences, thus needing further explanation. Others could have viewed the interview as an opportunity to confide in a ‘safe stranger’ (Colins, 1986; Gibson & Abrams, 2003). This was the case for one of the participants who explained how she preferred to talk to others who were outside of her community for fear of stigma.

The impact of my professional background and my clinical training were also considered in the context of responses from participants. I was mindful of the asymmetry of power and my skills as a therapist that participants may have found themselves sharing more than they wished to (Haverkamp, 2005; Morrow, 2007). The interviews undertaken for this study were emotive experiences for both myself and participants. I often went away feeling a sense of powerlessness, as participants’ difficulties felt overwhelming because they were a result of major social or societal issues. The use of the reflective diary and discussion in supervision became essential.

I discovered that it was important to be mindful of participants’ needs before, during and after the interview. It became vital to provide a detailed explanation of the interview purpose and process, including how many questions I would ask, how long the interview would take and that I would occasionally take notes to remind myself if there was something that I would like to follow up. During the interviews, a respect for participants’ self-efficacy and safety was considered; for example, I turned off the recorder when one participant became distressed and their family members entered the room. At the end of the interview time was given to allow participants to reflect on their experience, by asking if there was “anything else they would like to share before we finish?” I also gave culturally appropriate resources at the end of our interview; this can be thought of
as reinforcing the African value of human-to-human interaction, while acknowledging the collaborative aspect of researcher-participant dynamic in qualitative research (Haverkamp, 2005; Ponterotto, 2005).

Location of interviews was also considered individually for each participant, five out of the six participants were interviewed in their own homes. Mothers would often request to be interviewed at home, because they did not have the means of transport or money for transportation to community locations. Interviewing mothers in their homes provided a confidential space where they would feel relaxed and more willing to open up. The findings of this study suggest that issues of trust and concerns around confidentiality and stigma are major issues for West African mothers and therefore interviewing them in locations of their choosing was most appropriate. There were, however, a number of challenges to interviewing participants in their homes. Risk to myself had to be considered during each home visit; The lone working policy was followed and a fellow trainee acted as a ‘safe person’ and was contacted as soon as interviews were completed. Another issue was family members being present during interviews; culturally collectivist societies live and work together. For one mother who lived with her parents, brothers and sisters in a small house, having time to talk privately was a challenge. I had to be creative and flexible when interviewing one participant as a number of church and community locations had to be negotiated.

All babies were present for each interview, although this meant that at times mothers were distracted, it was impossible to arrange childcare for every interview. A number of mothers would ‘back’ their babies, this is a tradition throughout Africa where mothers carry their babies wrapped on their backs. This created an interesting dynamic because this meant that the babies were physically present and attached to mothers during the interview, when talking about the postnatal experience. Arguably this close contact facilitates mother and baby bonding and helps to develop relationships, which is interesting considering the findings of this study suggest that a protective factor for West African mothers is their relationship with their baby.

**Reflective journal**

The reflective journal was used to make my experiences, opinions, thoughts, and feelings visible and an acknowledged part of the research process. Reflexivity is thought to be the process by
which the researcher reflects on their journey as a researcher. “Learning to reflect on your behaviour and thoughts, as well as on the phenomenon under study, creates a means for continuously becoming a better researcher” (Watt, 2007 p 82). Reflexivity helped me to explore, learn and understand what I brought to the study and how I influenced it.

The reflective journal was used to record feelings, experiences and ideas after each interview. It also provided a space to explore how I influenced the research process. There were certain questions that I reflected on: (1) how has my personal history led to my interest in this topic? (2) What are my personal values and what areas do I know I am subjective about? (3) How does my gender/ social class/ ethnicity/ culture influence my positioning in relation to the topic and the participants? (4) Where is power held in relation to my research project and where am I in the power hierarchy?

One of the interesting reflections was on my own cultural background. Qualitative researchers are encouraged to document their own histories as a way of making readers aware of their potential biases (White & Dotson, 2010). I was mindful of the fact that I was from a different cultural and ethnic background. However, it is acknowledged that cultural similarity alone is not enough to facilitate understanding, rapport or a useful working relationship (Few, Stephens & Rouse-Arnett, 2003).

The reflective journal helped me to understand, reflect on and process certain dilemmas and challenges that I came across when undertaking this research. One of which was the conflict between being a researcher and being a clinician. When undertaking interviews, I found that I summarised as a way of understanding what participants had said, I started to realise that although I would do this in my clinical work, as a researcher, this could be incredibly leading. Interviewing vulnerable and isolated women would often leave me feeling hopeless, because my role as a researcher was to listen and make sense of their experiences rather than help to alleviate some of their distress, which is what I would naturally want to do as a clinician.

The reflective journal was also useful during the analysis stage, not only for memo writing but also for reflections on the process of analysis. Qualitative research has a certain amount of unpredictability, it can be chaotic and seem overwhelming at times (Smith et al., 2009). The journal
was used as a means to think things through, on both a personal and research level. I have learnt that before undertaking any further qualitative research it would be wise to consider that one is not entirely in control of the process at times and occasionally one may feel out of one’s depth, this is when supervision can prove to be essential.

**Analysis**

The existing literature on analysis in IPA does not detail a single ‘method’ of working with data (Smith et al., 2009), part of the process of analysis was being able to tolerate this uncertainty. The initial analysis process requires researchers to note down anything that is interesting or significant about what participants have said (Smith et al., 2009). As I was so immersed in the data, the amount of information that was generated through this process became overwhelming. Reflecting on the analytical process, as well as the ability to question emerging themes, helped to make sense of the data.

The challenge of IPA is not only to understand participants’ worlds, but also to provide an interpretive commentary on personal ‘sense-making’ of their experiences (Smith & Osborn, 2008). It was initially difficult to identify shared experiences across participants’ descriptions. However, once this was achieved, the challenge was to not neglect individual accounts. Alongside this, a further dilemma was knowing when to stop the analysis process. Elliot and colleagues (1999) suggest that qualitative analysis should attempt to achieve “understanding represented in a way that achieves coherence and integration, while preserving nuances” (p.222). The analytic process ceased once this was achieved.

**Write up**

Smith and colleagues (2009) describe how when undertaking qualitative research, there is no clear-cut distinction between analysis and write up. I discovered that as I began to write, certain themes became more important and began to develop whilst others began to fade. My first draft was very descriptive and contained many quotes, as writing continued each draft contained more of my thoughts and became more interpretive.

During write up it was important to be mindful of the terminology used to describe participants’ experiences so as not to misrepresent participants’ accounts nor label them. Participants did not
describe themselves as having ‘postnatal depression’ or ‘depression’ instead they used the word ‘stress’. The research team felt that the term ‘distress’ encompassed the emotions experienced by mothers during the postnatal period and therefore used this term throughout write up. This is consistent with work undertaken with African women in Ethiopia who used the term ‘distress’ when exploring the postnatal period (Hanlon et al., 2009).

Assessing the quality of the main study
Yardley (2000) describes four broad principles for assessing the quality of qualitative research, I will go through each of them in turn and illustrate how the current study addresses and demonstrates each principle.

(1) Sensitivity to context
Sensitivity to context was demonstrated through consideration of socio-cultural milieu throughout the research process. It was demonstrated through an appreciation of the interactional nature of data collection within the interview situation and consideration of power and dynamic factors. Sensitivity to context was also demonstrated by including a considerable number of verbatim extracts from participants to support the argument being made; thus, giving participants a voice in the study and allowing readers to check interpretations made. Finally, sensitivity to context was demonstrated in the literature review to orient the study and its findings.

(2) Commitment and rigour
Conducting in-depth semi-structured interviews required a considerable amount of personal commitment and investment to ensure that the participants were comfortable, and that I attend closely to what they said. Rigour of the study was seen in the careful selection of a reasonably homogenous sample to match the research question, with consideration of cultural diversity within West African culture (as discussed earlier). Regular meetings with supervisors enabled interviews to be quality assessed and appraised as ‘good quality’. Rigour was demonstrated by conducting good quality interviews. Finally, rigour was also demonstrated during the analysis of findings, through interpretation of meaning and not just a simple description.

(3) Transparency and coherence
Transparency was demonstrated by clearly describing the stages of the research process; there was careful description of how participants were selected, how the interview schedule was constructed and the interview conducted and steps undertaken in analysis. Demonstration of coherence is seen in a coherent argument with themes that hang together logically. Coherence is also demonstrated as the main focus of the study is the experiences of the participants and is therefore coherent with IPA.

(4) Impact and Importance
The clinical implications of this study demonstrate the final principle described by Yardley (2000) and consider implication for service development.

Clinical implications
The clinical implications of the study findings were considered in terms of a community psychology framework. Community psychology is best thought of as a critical, research-based practice that represents a different paradigm or world view of psychology (Nelson & Prilleltensky, 2005). It is the study of people in context. There is a more holistic, ecological analysis of the person within multiple social systems, ranging from micro-systems (for example, the family) to macro-sociopolitical structures. There is a strong belief that people and social processes cannot be understood apart from their context, it is therefore an appropriate model to consider when working with West African mothers. Based on the findings of the study a number of ideas are described within the context of a community psychology framework.

The emphasis on prevention of difficulties for West African mothers is important to consider. It has long been accepted that preventing problems from developing in the first place is far better than trying to resolve them once they have become entrenched (Blair, 1992; Baker et al., 1997). Prevention is superior in terms of both the cost-effectiveness of the service and the experiences of individuals or families (Baker, Gilbody, Glanville & Press, 1997). As part of the preventative ethos, a community psychology approach with West African mothers would view helping people access services, such as child care, immigration, housing, education and employment, as an important role. Psychologists are not experts on these issues but rather there is an acceptance that these issues
impact negatively on African mothers’ psychological health and therefore part of our work should be supporting people to resolve social and community issues.

Accepting community- and self-referrals would be a key part of working with West African mothers, because it enables clinicians to keep in direct contact with issues that impact on people’s lives, rather than this being filtered through a referral system. This would both increase accessibility and reduce stigma for people requesting psychological help.

A further important consideration is to listen to local West African communities; there should be true community participation in the planning and development of services by consulting communities in the development of appropriate services. Local community centres could be used as venues and there should be no exclusion criteria for attending meetings. It is acknowledged that this model of working would require time and energy to connect with and develop trust of the local communities as the aim is to respond to needs that may not fit into mental health service frameworks.

A further consideration is the type of intervention that is offered. If difficulties are social or economic, as described by participants, then therapy is not the only way to relieve psychological distress. This is when advocating for communities becomes important, the underlying values and principles of advocacy include empowerment, confidentiality and independence and should be client-led. For example, part of a clinician’s role could be to meet with community organisations to discuss cultural differences in child rearing. Signposting would be a further important role such as helping people to access or re-access existing or mainstream services, for some people who have had negative experiences with particular services, clinicians could advocate on their behalf by arranging meetings with the client and the service provider.

Group interventions could be considered as most appropriate for West African mothers due to the collectivist values within the community. West African mothers could be co-facilitators of sessions, providing opportunity for their voices to be heard, which often makes organization decision making processes fully respected. Involving the African community at all levels of the organisation of a service would be vital.
Within a community psychology framework, one argument is that long-term therapeutic relationships may be disempowering for families and communities, as they foster the notion that the experts resolve problems. With this in mind, a solution focused approach would be seen as most effective (de Shazer, 2005). This approach moves away from an expert position by maximising the ability of the client to identify and carry out their own solutions to their problems. Other advantages of the solution-focused approach include the fact that it does not assume that there is pathology or dysfunction, and there are no preconceptions about the ways in which change can be brought about (George, Iveson & Ratner, 1999). The solution focused approach is helpful when working with people from different cultures because one can work with families without having to construct pathology-based explanations of their distress, which is effective considering participants did not consider themselves as having an ‘illness’ called PND.

Integral to working with African mothers would be the importance of developing therapeutic relationships in the delivery of successful interventions. Working with clients would require clinicians to adapt traditional psychological models to make mental health more accessible. Through undertaking this research and considering the clinical implications, my thinking has considered participants in the context of their environment and how clinical psychology can be offered at individual, organisational and community intervention levels.

Reflections: What I would do differently
On reflection, a narrative analysis approach would have been useful to investigate West African women’s experience as this would have been a culturally sensitive approach to investigate their lived experiences. West African culture has a strong history in oral story-telling traditions. Narrative analysis focuses on “the ways in which people make and use stories to interpret the world” (Smith et al., 2009, p. 197), it views narratives as social products that are produced by people in the context of specific social, historical and cultural locations (Andrews & Tamboukou, 2008). Narratives are viewed as interpretive devices through which people represent themselves and their worlds to themselves and to others. IPA has strong connections with various forms of narrative analysis (Smith et al., 2009). IPA is centrally concerned with meaning-making and the construction of a narrative is one way of making meaning. Telling the story of one’s life has personal significance and would have been an interesting way to elicit information from West African mothers.
Participants were included during the development of the interview schedule. However, it would have been useful to include participants during the analysis through respondent validity. The results and interpretation of findings would be given to participants in order to check the authenticity of the work, their comments would serve as a check on the viability of the interpretation (Barbour, 2001).

**Conclusions**

I learned a great deal about qualitative inquiry and reflexivity while undertaking this study, the process of writing this critical review has helped to consolidate and extend my learning about qualitative research. Looking back on the dilemmas faced at each stage of the study has led to a deeper understanding of the nature of the qualitative research process, and a fuller appreciation of the vital role of reflexivity both in accomplishing a project, and in my ongoing development as a researcher. I have learnt that there is no such thing as the ‘perfect’ data collection and no version of events which are ‘the truth’. The aim of IPA is to simply understand the participants’ perspectives as best we can. Qualitative research can often be chaotic and unpredictable. Throughout the research process it became apparent that I needed to be open-minded, flexible, patient, empathetic and willing to enter into, and respond to, the participant’s world. It required determination, curiosity and persistence. This approach helped me to develop skills in becoming a more culturally competent researcher and, ultimately an effective Clinical Psychologist.
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Appendix 1:

Submission Guidelines for the Journal of Affective Disorders
Journal of Affective Disorders

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Rapid Communications (1500-2000 words, excluding references and a maximum of 2 tables/figures).

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Books for review should be sent to the appropriate editorial office (see above).

At the discretion of the accepting Editor-in-Chief, and/or based on reviewer feedback, authors may be allowed fewer or more than these guidelines.

Preparation of Manuscripts

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Papers should be divided into sections headed by a caption (e.g., Introduction, Methods, Results, Discussion). A structured abstract of no more than 250 words should appear on a separate page with the following headings and order: Background, Methods, Results, Limitations, Conclusions (which should contain a statement about the clinical relevance of the research). A list of three to six key words should appear under the abstract.

Authors should note that the 'limitations' section both in the discussion of the paper AND IN A STRUCTURED ABSTRACT are essential. Failure to include it may delay in processing the paper, decision making and final publication.

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All references cited in text should be listed at the end of the paper (double spaced) arranged in alphabetical order of first author. More than one paper from the same author in the same year should be identified by the letter (a, b, c, etc.) after the year of publication.

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Appendix 2:
Quality Assessment of Quantitative Studies
Quality Assessment- quantitative studies (Mizra and Jenkins, 2004)

1 Clear study aims
2 Adequate sample size
3 Sample representative of population
4 Clear inclusion and exclusion criteria
5 Valid measurement
6 Good response rate
7 Adequate description of data
8 Appropriate statistical analysis.

Quality Assessment rating of Quantitative studies (86% agreement between raters) (1 = Yes 0 =No)

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Appendix 3:
Quality Assessment of Qualitative Studies
Qualitative studies - Quality Assessment (Rees et al., 2001)

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<td>Explicit account of theoretical framework and/or inclusion of a literature review: does the report provide an explanation of, and justification for, the focus of the study and the methods used? This question is intended to assess whether the research has demonstrated how it was informed by, or linked to, an existing body of knowledge;</td>
</tr>
<tr>
<td>3</td>
<td>Clearly stated aims and objectives: does the report explicitly and clearly state the aims of the study?</td>
</tr>
<tr>
<td>4</td>
<td>A clear description of context: does the report adequately describe the specific circumstances under which the research was developed, carried out and completed?</td>
</tr>
<tr>
<td>5</td>
<td>A clear description of sample: does the report provide adequate details of the sample used in the study including details of sampling and recruitment? This should include presentation of socio-demographic data and data on any other salient factors so that an assessment of who was included and excluded from the research can be made to aid interpretation and judgments about the validity and generalisability of findings.</td>
</tr>
<tr>
<td>6</td>
<td>A clear description of methodology, including data collection and data analysis methods: does the report provide an adequate description of the methods used in the study including its overall research framework, methods used to collect data and methods of data analysis? This question is to assess how the methods shapes the findings of the study, again to aid interpretation and judgments about the validity and generalisability of findings;</td>
</tr>
<tr>
<td>7</td>
<td>Evidence of attempts made to establish the reliability and validity of data analysis: researchers need to show that some attempt had been made to assess the validity and reliability of the data analysis;</td>
</tr>
<tr>
<td>8</td>
<td>The inclusion of sufficient original data to mediate between data and interpretation: does the report present sufficient data in the form of, for example, data tables, direct quotations from interviews or focus groups, or data from observations, to enable the reader to see that the results and conclusions were grounded in the data? Could a clear path be identified between the data and the interpretation and conclusion?</td>
</tr>
</tbody>
</table>

A – No or few flaws
B – Some flaws
C – Significant flaws which may affect the validity of the findings
D – Untrustworthy findings/conclusions
<table>
<thead>
<tr>
<th>Study</th>
<th>QA Criteria</th>
<th>Comments</th>
<th>Rater 1</th>
<th>Rater 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanlon et al., 2009</td>
<td>1. A focus on African mothers’ lives.</td>
<td>This article shows a clear focus on African mothers’ lives and also includes data drawn from those around them such as spouses, extended family, and local and religious leaders. Efforts were also made to conduct interviews and focus groups, thus drawing data from a variety of sources.</td>
<td>A</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>2. Explicit account of theoretical framework and/or inclusion of a literature review</td>
<td>Study clearly set within the context of ongoing research into the topic. References were made to a wide variety of previous studies. However, the introduction and lit review were quite brief and there was a lack of studies taking place nearer to the time of the research. This is a niche area, and studies explicitly connected may be difficult to locate, but the argument could have been strengthened by greater depth of analysis of the context of the research and by locating and discussing a few more recent studies</td>
<td>C</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Clearly stated aims and objectives.</td>
<td>Research questions are clearly stated and referred to throughout the article</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Clear description of context</td>
<td>The article goes into detail on the development and methodology of the study and the analysis of the data. Attention is paid to the unique nature of working in Ethiopia.</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Clear description of sample and recruitment</td>
<td>The report provides adequate details of the sample used in the study. The nature of the study is that, as such, generalisability will be an issue simply because there is only a small body of work on the topic and it would be difficult to draw general conclusions. However, every effort is made to clearly state the sample details and tell the story of recruitment</td>
<td>B</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Clear description of methodology, including data collection analysis methods</td>
<td>The description of the methodology is clear</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Evidence of attempts made to establish the reliability and validity of data analysis</td>
<td>Clear attempts were made to assess the validity of the data gathered. This included mixed-methods (interviews and focus groups) for data gathering and efforts to draw participants from a wide variety of positions and experience. Additionally, themes were allowed to emerge from the data as is encouraged with inductive analysis and codes were independently cross checked by researchers.</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Inclusion of sufficient original data to mediate between data &amp; interpretation</td>
<td>Quotes were used appropriately to support conclusions drawn. The path between interpretation and analysis was clear.</td>
<td>A</td>
<td>A</td>
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<td>-------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Sawyer et al., 2011</td>
<td>1 A focus on African mothers’ lives.</td>
<td>This article shows a clear focus on Gambian mother’s lives. The sample size is adequate for a qualitative study, although there is no indication that non-mother community members were included.</td>
<td>A</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>2. Explicit account of theoretical framework and/or inclusion of a literature review</td>
<td>Study clearly set within the context of ongoing research into the topic. References were made to a wide variety of previous studies. There was a clear effort to place the study in the context of continued research in the area and an awareness of research into methodology and how the methodology might impact a study taking place in an unusual setting</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Clearly stated aims and objectives.</td>
<td>Research questions are clearly stated and referred to throughout the article.</td>
<td>A</td>
<td>A</td>
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<tr>
<td></td>
<td>4. Clear description of context</td>
<td>There is sufficient detail on the context of the research.</td>
<td>A</td>
<td>A</td>
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<td></td>
<td>5. Clear description of sample and recruitment</td>
<td>The report provides adequate details of the sample used in the study. There is a clear sense of the participants and the methods used in recruitment and attention is paid to any discrepancy in the sample versus what might be a typical population for the area.</td>
<td>A</td>
<td>A</td>
<td></td>
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<td></td>
<td>6. Clear description of methodology, including data collection analysis methods</td>
<td>The description of the methodology is clear and care was taken to clearly indicate the reasons behind the study design.</td>
<td>A</td>
<td>A</td>
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<tr>
<td></td>
<td>7. Evidence of attempts made to establish the reliability and validity of data analysis</td>
<td>Limitations in the sample were assessed and discussed. However, it would have been useful to have a sense of any limitations found in the methodology or any struggles with recruitment or analysis.</td>
<td>B</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Inclusion of sufficient original data to mediate between data and interpretation</td>
<td>Quotes were used appropriately to support conclusions drawn. Analysis and discussion were separated into two sections. It is possible that referring to further quotes in the discussion section would have served to make the connection between data and conclusion even stronger.</td>
<td>A</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Oates et al., 2004</td>
<td>1. A focus on African mothers’ lives.</td>
<td>African mothers were only a small part of this study</td>
<td>C</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>2. Explicit account of theoretical framework and/or inclusion of a literature review</td>
<td>Study clearly set within the context of ongoing research into the topic. However, the focus of the study is split between clarifying a technique that could be used to gather data for a second part of the article, making the article feel very crowded. It may have been better to separate out the techniques and</td>
<td>B</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Requirement</td>
<td>Description</td>
<td>Grade</td>
<td>Notes</td>
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<td></td>
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</tr>
<tr>
<td>3. Clearly stated aims and objectives.</td>
<td>Research questions are clearly stated and referred to throughout the article</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Clear description of context</td>
<td>As this research was part of a major project, it is necessary to refer to separate reports for the details of the context, this does make this article less informative than it might be</td>
<td>B</td>
<td>C</td>
<td></td>
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<tr>
<td>5. Clear description of sample and recruitment</td>
<td>The report provides adequate details of the sample used in the study. However, as above, there is a need to refer to separate articles for specific details on the context and salient factors</td>
<td>B</td>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Clear description of methodology, including data collection analysis methods</td>
<td>The description of the methodology is clear and care was taken to clearly indicate the reasons behind the study design.</td>
<td>C</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Evidence of attempts made to establish the reliability and validity of data analysis</td>
<td>Limitations in the sample and methodology were assessed and discussed in detail</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Inclusion of sufficient original data to mediate between data and interpretation</td>
<td>No quotes were used in the discussion on results and there was very little raw data referred to in the article</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Submission Guidelines for the Qualitative Health Research Journal
A Summary of Qualitative Health Research Journal Manuscript Guidelines

Qualitative Health Research (QHR) is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics. We also consider critical reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

General Information Important Considerations

- *Qualitative Health Research* is a peer-reviewed journal. Only complete, finished manuscripts should be submitted for consideration.
- We do not publish stand-alone abstracts, quantitative studies, manuscript outlines, pilot studies, manuscripts-in-progress, letters of inquiry, or literature reviews. Research articles must be pertinent to health.
- Write both the abstract and the text of your manuscript in *first-person, active voice.*
- For best results, review this entire document prior to preparing and submitting your manuscript.
- Proper manuscript preparation will speed the peer-review process for your manuscript, and will facilitate a smoother production process if it should be selected for publication.

Improper manuscript preparation could result in burdensome revisions, lengthy delays in the review and production processes, and the possible rejection of your manuscript.

General Style

Authors considering submission to QHR should first be familiar with the journal, the types of articles we publish, and our readership. Read several recent articles published in the journal prior to submitting your work, and consider whether your manuscript is a good —fit for the journal.

In general, QHR adheres to the requirements of Sage Publications, Inc., and the guidelines contained in the *Publication Manual of the American Psychological Association* *—APA*+, 6th edition (ISBN 10:1-4338-0561-8, soft cover; ISBN 10:1-4338-0559-6, hardcover; 10:1- 4338-0562, spiral bound), with regard to manuscript preparation and formatting. Elsewhere in these Guidelines this book is referred to as the APA *Publication Manual*, or just APA. Additional help may be found online at http://www.apa.org/, or search the Internet for —APA format. Many universities and private organizations have Websites devoted to APA style. However, when guidelines found on those sites, or in the APA *Publication Manual*, conflict with QHR Guidelines, you must follow the QHR Guidelines.

Abstract and Keywords

The abstract should be placed on page 1 of the main manuscript document. It should be a single paragraph, no more than 150 words in length, and briefly describe your article. Place your keywords below the abstract, on the same page. Double space the entire abstract page (including the keywords). Briefly state the purpose of your research, the main findings, and your primary conclusions.

Main Manuscript

*There is no predetermined word or page limit.* Provided they are —tight! and concise, *without unnecessary repetition* and/or irrelevant data, manuscripts should be as long as they need to be.
The editor might require a reduction in length if the manuscript contains material that does not add anything useful to the topic being discussed. Limits might be imposed on the number/size/length of tables, figures, reference lists, and appendices.

The main text of the manuscript begins on page 2 of the document, immediately after the abstract page. Write your article in the first-person, active voice.

The main text of the manuscript should be broken into appropriate sections by the use of section headings. Sections should flow in a logical sequence, and include, at a minimum, Methods, Results, and Discussion; other headings and subheadings may be used at the author’s discretion. The author may choose to use different names for the three main sections, but the basic content should be that which would appropriately fall under the headings of Methods, Results, and Discussion.

There are very specific requirements for the preparation of in-text citations; refer to the APA Publication Manual, 6th edition, for details. Every in-text citation should have a corresponding reference in the reference list—no exceptions.

During the review process, author citations should include only the word Author and the year: (Author, 2008). If and when the manuscript is accepted for publication, the missing information can be restored.

Double space the entire manuscript document, except for text contained in figures. Use only U.S.-English spelling (except in the references, as appropriate, and for direct quotations from published written sources). Use U.S.-English translations of non-English quotations or excerpts.

Attend to copyright regulations and permission requirements (required). Submit, at the time of manuscript submission, written permission for the use of any names, photographs, or copyrighted tables, figures, and/or text; written permission must come from the person(s) depicted in the photographs, or in the case of copyrighted work, from the copyright holder (which is not necessarily the author or the journal in which it is published; see page 6).
Appendix 5:
National Research Ethics Service Approval letter and R & D Approval letter
Dear Miss Gardner

Study title: A qualitative investigation into the experience of postnatal depression in African mothers living in Great Britain

REC reference: 11/NW/0270

Thank you for your response of 16 June 2011 to the Committee's request for further information on the above research and submitting revised documentation. The further information has been considered on behalf of the Committee by the Chair and Nessa Thomas.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study:

Standard condition

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned. Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.
Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Additional conditions

- Please make the changes to the study documentation as shown on the attached.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Please notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of insurance or indemnity</td>
<td></td>
<td>08 April 2011</td>
</tr>
<tr>
<td>GPX/Consultant Information Sheets</td>
<td>1</td>
<td>26 May 2011</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>16 February 2011</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Ms P Gardner</td>
<td>05 April 2011</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Dr A Wittkowski</td>
<td>06 April 2011</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Dr Penny Bunton</td>
<td>22 February 2011</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Dr Dawn Edge</td>
<td>22 February 2011</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>08 April 2011</td>
</tr>
<tr>
<td>Other: Approval from Research Sub-Committee</td>
<td></td>
<td>15 November 2010</td>
</tr>
<tr>
<td>Other: Useful numbers</td>
<td>2</td>
<td>26 May 2011</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>30 November 2010</td>
</tr>
<tr>
<td>Questionnaire: Edinburgh Postnatal Depression Scale (EPDS)</td>
<td></td>
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<tr>
<td>Questionnaire: Structured Clinical Interview for DSM-IV (SCID-1/NP)</td>
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<tr>
<td>REC application</td>
<td>3.1</td>
<td>20 April 2011</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td>1</td>
<td>16 June 2011</td>
</tr>
</tbody>
</table>

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk

| 11/NW/0270 | Please quote this number on all correspondence |

With the Committee’s best wishes for the success of this project

Yours sincerely

Dr Ann Wakefield
Chair

Email: elaine.hutchings@northwest.nhs.uk

Enclosure: “After ethical review – guidance for researchers”

Copy to: Mrs Catherine Barrow, R&D, University of Manchester

Dr Lynne Webster, R&D
Central Manchester University Hospitals NHS Foundation Trust
Miss Philippa Gardner  
Post Trainee Clinical Psychologist  
The University of Manchester  
2nd Floor Zochonis Building  
Brunswick Street  
Manchester  
M13 9PL  

Dear Miss Gardner,  

Ref: R01741-Ltr 2-Gardner  

PIN: R01741 (Please quote this number in all future correspondence)  
Research Study: A qualitative investigation into the experience of postnatal depression in African women living in the UK  

Thank you for submitting the above study for approval.  

We acknowledge that the University of Manchester has accepted the role of Research Governance Sponsor for this study.  

We understand that this study is not adopted by the NIHR Portfolio.  

I am pleased to confirm that the Research Office has now received all necessary documentation, and the Trust Director of Research & Innovation has given approval for the project to be undertaken. This approval is in relation to the documentation supplied to us below.  

Approval is given subject to the attached conditions – please ensure you and all members of the research team are familiar with these before commencing your research.  

Please note: You must tell your Divisional Research Manager – Alison Robinson  
- the date that you intend to start recruiting to this study AND  
- the date on which the first participant is recruited/consented  

The Trust aims for its research projects to recruit their first participant within 30 days of the recruitment start date. If you do not tell us your actual recruitment start date, we will use this approval date. This information is important for monitoring Trust recruitment performance for internal and external assessment.
I would like to take this opportunity to wish you well with your research.

Yours sincerely

[Signature]

Dr Lynne Webster
Head of Research Office

Date: 31/8/2011

Encs  SSI Form – Fully Signed

cc  Alison Robinson, Divisional Research Manager for Children’s Services Division and Clinical and Scientific Services Division – CMFT

<table>
<thead>
<tr>
<th>Documents Acknowledged/Approved</th>
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<th>Date</th>
</tr>
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<td>NRES Approval</td>
<td>11/NW/0270</td>
<td>30 June 2011</td>
</tr>
<tr>
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<tr>
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<td></td>
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<tr>
<td>Other – Approval from Research Sub-Committee</td>
<td>2</td>
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<tr>
<td>REC Application</td>
<td>3.1</td>
<td>08 April 2011</td>
</tr>
</tbody>
</table>
Appendix 6: The Edinburgh Postnatal Depression Scale (EPDS)
As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed:

I have felt happy:
  a. Yes, all the time
  b. Yes, most of the time
  c. No, not very often
  d. No, not at all

This would mean “I have felt happy most of the time during the past week.”

In the past 7 days:
1. I have been able to laugh and see the funny side of things -
   a. As much as I always could
   b. Not quite so much now
   c. Definitely not so much now
   d. Not at all

2. I have looked forward with enjoyment to things -
   a. As much as I ever did
   b. Rather less than I used to
   c. Definitely less than I used to
   d. Hardly at all

3. I have blamed myself unnecessarily when things went wrong -
   a. Yes, most of the time
   b. Yes, some of the time
   c. Not very often
   d. No, never

4. I have been anxious or worried for no good reason -
   a. No, not at all
   b. Hardly ever
   c. Yes, sometimes
   d. Yes, very often

5. I have felt scared or panicky for no good reason -
   a. Yes, quite a lot
   b. Yes, sometimes
   c. No, not much
   d. No, not at all
6. Things have been getting on top of me -
   a. Yes, most of the time I haven’t been able to cope at all
   b. Yes, sometimes I haven’t been coping as well as usual
   c. No, most of the time I have coped quite well
   d. No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping -
   a. Yes, most of the time
   b. Yes, some of the time
   c. Not very often
   d. No, not at all

8. I have felt sad or miserable -
   a. Yes, most of the time
   b. Yes, some of the time
   c. Not very often
   d. No, not at all

9. I have been so unhappy that I have been crying -
   a. Yes, most of the time
   b. Yes, quite often
   c. Only occasionally
   d. No, never

10. The thought of harming myself has occurred to me -
    a. Yes, quite often
    b. Sometimes
    c. Hardly ever
    d. Never
Appendix 7:
Structured Clinical Interview for DSM Disorders (SCID)
Due to copyright law, the Structured Clinical Interview for DSM Disorders (SCID; Spitzer, Williams, Gibbon, & First, 1992) has not been included in the current thesis. For a copy of the SCID recording form please refer to the plastic folder.
Appendix 8:
Participant Information Sheet and Consent form
Participant Information Sheet

1. **Title of the study**
   “The experience of Postnatal Depression in African Women living in the UK”

2. **What is the study about?**
   This study explores the experience of Postnatal Depression in African women who live in the UK. The study is being conducted for the purposes of an educational qualification.

3. **Invitation**
   We are trying to explore African women’s experiences following the birth of their baby and would like to invite you to take part in the study.

4. **Why have I been chosen?**
   I am inviting anyone who feels they are of Black West African origin, who has experienced depression following the birth of their baby within the last 24 months to take part in the research.

5. **Do I have to take part?**
   No, taking part is up to you. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You will also be given a signed copy of the consent form to keep. You will be free to withdraw at any time and without giving a reason. A decision to withdraw or not to take part in the study will not affect your current care in any way. This study requires 15 – 20 participants. If you do not meet the criteria for this study you will be thanked for your interest and will not be interviewed.

6. **What do I have to do?**
   If you choose to meet with me, the meeting will last around 1 ½ hours. I can meet with you at a location convenient to you, such as a local GP clinic or children’s centre, if there is no alternative I could meet with you in your home. I will go through a brief questionnaire and some questions to get some information about yourself. I will then interview you asking about your specific experiences. This interview will be audio recorded to help me remember your answers. There will then be a second questionnaire that we will go through at the end of the interview.

7. **Are there disadvantages and risks of taking part?**
   Usually there are no risks with studies of this kind. The care you receive will not be affected in any way, whether you want to meet me or not.

   Although we hope you find the interview interesting, it is possible that a subject area may be upsetting for you. If you did become upset during the study, you would be offered the following options: to carry on, to have a break, to carry on a different time or to stop the interview. I can give you information on services for advice or to talk to them about your worries which have come up in the study.

   What you say will be private. However I would need to tell someone else if I was worried about any risk of harm to yourself or to someone else but I would always talk to you about this first.

8. **Are there any benefits to taking part?**
   You may benefit from speaking to someone about your experiences. This research may help other women in a similar position in future.

9. **Expenses and payments**
Unfortunately I can only interview a certain amount of people. If you complete the study, you will be offered a £10 voucher as a small token to compensate you for your time.

10. What will happen to the information I give you at our meeting?
I will analyse your answers. The information will be locked in a cupboard. Any forms that you fill in will not have your name on but will have a number. I will be the only person that knows what your number is. All information will be destroyed in 5 years time. At no point will your name be on the research, or any published material. Anonymised quotations might be used in research publications. I will give you a summary of all the findings if you wish, this will be a sheet of paper or in person.

11. What if there is a problem?
If you have any concerns about this study, you can speak to the researchers who can answer your questions. If you wish to make a complaint regarding the study please contact the university Clinical Psychology department on 0161 2757583 or 0161 2758093

12. Who is organizing and funding the study?
The study has been organized and funded by The University of Manchester and has been reviewed by the NRES Committee North West – Greater Manchester South.

If you would like further information you can ring or text me on 07912647840. I can also be contacted at philippa.gardner@postgrad.manchester.ac.uk

Thank you for reading this information sheet.

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Consent form (Version 2 26.05.2011)
Project: The experience of postnatal depression in African Women living in the UK

Please Initial Box

1. I confirm that I have read and understood the participant information sheet dated __/__/____ (version __) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I give my permission for my data to be retained by the researcher and used confidentially in connection with the study if I withdraw.

4. I understand the reasons for disclosing my contact details and agree to this.

5. I understand that I will be asked to take part in an audio-recorded interview.

6. Anonymised quotations may be used in research publications as a result of this study.

7. I give permission for my GP to be informed of my involvement in this study.

8. I understand that data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

9. I would like to receive a summary of the findings from the study.

10. I agree to take part in the above study.

Name of Participant: ___________ Date: ______ Signature: ___________
Name of Person taking consent: ___________ Date: ______ Signature: ___________
Appendix 9:
Final Interview Schedule
Qualitative investigation into the experience of postnatal depression in African mothers living in Great Britain

<table>
<thead>
<tr>
<th>Participant</th>
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<tbody>
<tr>
<td>Date of birth (age)</td>
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<tr>
<td>Country of birth</td>
<td></td>
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<tr>
<td>Duration of time in the UK</td>
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<td>Language(s) spoken</td>
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<td>Immigration status</td>
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<td>Details of others present</td>
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<td>EPDS score</td>
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<td>Date of birth of your baby</td>
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<td>Date of interview</td>
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<td>Place of interview</td>
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Note to the interviewer:

1. Go over the information already supplied about the project, and the nature of the interview.

2. Answer any questions/concerns about the project. Stress confidentiality (i.e. anonymous responses will be used to summarise the project). Also discuss the limits to confidentiality (i.e. risk to self/others).

3. Explain to the interviewee that they can stop the interview at any time, and that this will not affect the normal care that they receive.
Warm up:

How do you feel about coming here today?

Are you comfortable to talk with me about your experience after pregnancy?

_____________________________________________________________________

2) How would you describe how you have been feeling since the birth? (Prompts if needed:

- Do you understand what this means/what is happening?

-Scores on EPDS. Western culture calls this PND, would you agree? What would you call it?)

_____________________________________________________________________

3) Have you had any support (practical/emotional etc) following the birth?

(Prompts if needed:

- Is this what you expected? What expectations did you have?

- Who did you turn to? Was there anybody? Friends/family/services?

- If you have had support what was helpful/ not so helpful?

- Would this be similar or different to your country of origin?

_____________________________________________________________________

4) During this time after the birth, how were/have you been feeling:

a) Towards your baby? (Prompts if needed:

Is this what you expected? What did you expect? )

b) Family members? (Prompts if needed:

Is this what you expected? What did you expect? Has it affected your relationships with them?)

c) Yourself?

_____________________________________________________________________

5) What factors do you think led to how you have been feeling after the birth?

_____________________________________________________________________

6) Is there anything more that you would like to tell me before we end off?

Thank you for spending the time talking to me. It has been very helpful. I realise that we have talked about some difficult issues.

Are you feeling okay to leave now?
Appendix 10:
Anonymised coded transcript
INT: Thank you for talking with me today, are you ok to talk to me about your experiences?

Seems Ok to talk about it. "Why not" = nothing to lose?

P6: Why not..... yeah

INT: Yes? Ok, how would you describe how you have been feeling since the birth of your little one?

Very hard being a single mum with no support

Abortion
Religious beliefs? Get up on myself? = pull herself together – become strong? Find inner strength?

Stress of having a new baby
Never experienced something this challenging?

Had a good experience of childhood
Had a new appreciation for her parents?

'Being in a country that is not yours' = not knowing people? Places? Culture? Not feeling like home?

Not being able to work – financial issues?

Trying to take care of baby

Giving up- wanting to end things?

Stressful – what is the meaning of stress?

P6: well um it’s been too tough, you know, being a single mum. I had the opportunity of um.. aborting her when I was pregnant but I felt it wasn’t um.... human, it was inhuman to deprive a baby of a life. She is supposed to live.. So I had to get up on myself, know the consequence you know of having her...that I have to go through stress and all that. I was ready to face the challenges. Ever since then it has been so tough..... I mean tough, something I have never experienced oh my god. I wouldn't say that um..... I have all the stress growing up. I never lacked anything ok......, so seeing myself you know being a mum, just remembering my parents those days, how they..... you know, get out for me and all that, me now responsible for a child... I was like wow! So this is what they have been going through and all that. You know, being in a country that is not yours, you are meant to work for few hours, even ever since I came to this country I have not worked and um.... You know Trying to take care of myself and the baby and all that....

INT: Would you say you have been trying to find inner strength?

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| **Suicidal thoughts?** | Sometimes I feel like just giving up on everything but... you know the only consolation I do have is..... Oh... you knew it was going to be stressful so why not face it. And um... again she is the reason why I am still living you know..... for me to summon the courage not to abort her then why should I you know, take my life now for instance? You know. I am really behind this is what I have to live by it and um provide the best.... Um...... things she needed to... My own capability. So its' its...... REALLY really tough and I mean.... when I say tough I think I don't really have the right word to qualify it right now... because um... using tough is an understatement yeah? | Giving up  
Ending things?  
Taking life?  
Stressful  
Relationship with baby as protective factor  
Can't find the words to describe experience |
| **Stress is cause of distress?** | |  |
| **Relationship with baby gives her strength like P3 and P5 Live for her?** | |  |
| **Can’t find the words to describe how she is feeling?** | INT: mmmmmm... |  |
| **Not being able to find a word - is there a translation?**  
**Thank god = religious beliefs**  
**Go along with the system- services support and help?**  
**Doesn’t feel like she can take care of herself or baby right now?**  
**Get settled**  
**Looking to a more positive future** | INT: it’s more than tough but I don’t really know the right word right now to use so...... thank god she is 8 months today and by his grace we have more years to spend together so....... just have to, you know, get myself settled.... You know.... Try to go along with the system and before you know it I should be able to take care of herself and myself so... hopefully I look up to a brighter future with this for the both of us...... |  |
| **Finding it hard to quantify and qualify experience – language issue or just that it is a novel experience?**  
**Tougher then tough – hardest experience in** | P6: yeah, tough is not the right word. I am still looking for the word I have not really seen the word, I have not come across the word yet, but if I come across the word why not I think this is tougher than tough... you know, tough... you know when they say | Hard to express feeling  
Hard to understand feeling  
Can’t describe experience |
tough is to power ten up tough is to power infinity. You cannot quantify or qualify the power it attributes it. It’s like REALLY REALLY tough, really tough.

INT: Do you think there is a word for it in the other languages you speak?

No words to describe

P6: No.... no... when you translate it, it is still tough. But I think there should be a word that is more than tough in the dictionary...... so that is the way it is.

Wanting to find a new word for experience

INT: mmm....... During the time you describe, what have people called it? How have they explained it to you?

Supportive parent group
Sharing experiences
Not alone
Encouragement
Finding inner strength
Struggle to overcome
Compliment on being a mother
Looking to the future
Others as a source of support
Sharing problems
Taking as a way of helping
Gaining advice

P6: Well the only people that I came across um.... were the group, sure start group, who you know tried to let me see that there are other people again like me, that I just need to be strong, you know so I like to describe the word as being ...um... they are just encouraging me to keep pushing... that I have done a good job you know, taking care of her at that stage before I joined them was quite an effort... then I had to add more effort to just keep looking up and never backwards, so the word is encouraging and you know and they kind of make life easier kind of you know.... When you talk about your problems cause they say problem shared is half solved... so when you open up and share your problem you know, the advice you get kind of you know... make the situation less easy it makes your situation better so the word has been encouraging. You just have to do the little you can. Yeah....

INT: So during this time when things have been harder than tough, in the UK they call it postnatal depression when you feel low after having a baby, what do they call that in Nigeria?
<table>
<thead>
<tr>
<th>Not experienced it before? Not heard of it in Nigeria?</th>
<th>P6: Well I don't know......</th>
<th>Don't have a name for PND in Nigeria</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT: Do you think it happens in Nigeria?</td>
<td>P6: Well... um.... I don't think so. Yeah why is that um....... you've got relatives, you've got a family you've got everybody, it's your home.... So you can't be depressed in your home. That's not when you have a baby and you don't see people that will help.... Relatives do it because we've got nothing like social worker or the group that I went to, there is nothing like that in Nigeria. We've got cousins, got mother, father, relatives the father's people... you know everyone will come close to you because you need them there so..... the rate should be minimal, very minimal... if there is... I over 10, I would say 1 over 10 if there is ever anything like postnatal depression. Except of course if people have their babies and they have some other issues like.... Um.... I do know women do have some kind of depression when they have their baby when it comes to sex of the baby, because in Nigeria they are crazy about male sex yeah.... So maybe a women who has been giving her husband maybe female, female, female maybe up to 4... and the husband is threatening oh... once you have another female I am going to divorce you and marry somebody else you know... that is the time when you can think about depression so once she has the baby and she has a girl, a baby girl, oh she is depressed. Or the family members are mounting pressure on her husband to go and take another woman that would give him a boy, and she has a baby and it is a girl so depression comes... but if it's about the stress and...</td>
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<tr>
<td>Does not happen in Nigeria (like P1, P2, P5) Can't be depressed in your home as you have family and support network Don't have the same services Relatives as caregivers Extended African family Everyone will come close = gathering around mother. You need them = mothers need support (expectations) Depression caused by gender of baby Not being able to produce a male hair Husband will divorce woman and marry someone else Divorce if no male baby, marry someone else? – Polygamy? Baby girl = unhappy Family members mounting pressure on her to have a boy Stress and the...</td>
<td>PND does not occur in Nigeria Large support network Extended African family Not depressed in home Different services Relatives as care givers Collectivist culture African extended family Family take cares of mother Mothers need support PND rare in Africa? Reason for depression is gender of baby Wanting to have male baby African culture African tradition Divorce if no male child Gender of baby leads to depression in Africa Pressure from family members *Stress and the...</td>
<td></td>
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<tr>
<td>Community = reason behind PND in UK</td>
<td>Community’</td>
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<tr>
<td>Africa no issues with money?</td>
<td>Don’t have financial pressures</td>
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<tr>
<td>Don’t have financial problems, looked after by family not on your own, not isolated</td>
<td>Supported by family</td>
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<tr>
<td>Cook for you, Bath baby for you, (teach how to be a mum?)</td>
<td>Not isolated in Africa</td>
<td></td>
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<tr>
<td>Less pressure in Africa (pressure=stress?)</td>
<td>Bathing baby</td>
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<tr>
<td>In UK don’t have anybody. Novice= no experience, no one to teach?</td>
<td>Family as caregivers</td>
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<td>Family as educators</td>
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<td>Less pressure in Africa</td>
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<td>Lack of support</td>
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<td>No experience</td>
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<td></td>
<td>Not knowing how to be a mother</td>
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the community... nothing like that because ..... the little you have will be enough for you. You don’t have taxes to pay, you don’t have bills to pay, 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 nothing. 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. Like here when you don’t have anybody it is just like ........ Like... a novice. You know that is the way it is... so......
Appendix 11:
Advertisement
Are you an African Mother over 18 years old?

- Would you describe yourself as Black West African?
- Have you had a baby in the last 24 months?
- Are you feeling down, low, tearful, emotional and guilty?

I want to find out more about African women’s experience of postnatal depression. If you would like to take part in the study, you will be asked to talk privately about your experiences for about an hour and a half.

If you would like further information, please contact Philippa Gardner on 07866849130

A £10 gift voucher will be given to you to compensate you for your time.