Perinatal mental health of mothers from migrant communities: An evidence review commissioned by the National Childbirth Trust

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Summary

- Migration takes various forms, and it is important to remember that **adopting and addressing "migrant mothers" as a category is problematic**, because of the sheer diversity within such a grouping, along all socio-demographic axes. This is a heterogenous group experiencing elevated, but different, culturally and ethnically specific risks factors for mental health often remarkably different difficulties in the perinatal period (Das & Beszlag, 2021; Das et al., 2019; Lindert et al., 2008; Moore et al., 2019; Munk-Olsen et al., 2010; Watson et al., 2019).
- Perinatal mental ill health has been found to constitute a significant part of one of the largest causes of maternal death - suicide (Boyle et al., 2019; Knight et al., 2016). The consequences of the problem hence are not limited to impacting mothers' wellbeing but also have a **significant impact on the whole family**, specifically the next generations (Gaynes et al., 2014; Kingston et al., 2012; Prady et al., 2016) and consequently both directly and indirectly on the country's socioeconomic structure (Cuijpers et al., 2016; TMHT, 2016).
- On average, migrant individuals show higher prevalence of perinatal ill mental health (Anderson et al., 2017; Bhugra, 2004; Heslehurst et al., 2018; Moore et al., 2019; Munk-Olsen et al., 2010; Neale and Wand, 2013; Prady et al., 2016; Schmied et al., 2017; Watson et al., 2019; Zimmerman et al., 2011), such experiences shaped in part by the multiplicity of stressors bound with sociocultural and economic changes experienced. As the perinatal period is a time of particular vulnerability, **mothers from migrant communities are at a significant risk of suffering from mental ill health** during, and shortly after pregnancy (Collins et al., 2011; Fellmeth et al., 2017; Morrow et al., 2008). In High Income Countries perinatal depression affects between 8.5 – 12.9% of women (Fellmeth et al., 2017), whilst rates amongst migrant women are estimated to be one in three (Fellmeth et al., 2017) or even as high as 42% (Collins et al., 2011), nearly half of those cases presenting symptoms of a major depressive disorder (Fellmeth et al., 2017).
- Within such a context, identification of similarities in experiences and challenges to finding support will contribute to the perinatal mental wellbeing of mothers. This may

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mean challenging and reworking healthcare professionals' **understanding of cultural differences**, and their awareness of difficulties bound with pre-migration stress or potential traumatic experiences which the woman could have had prior to, or after migration (Zelkowitz et al., 2008)

Experiences of perinatal mental ill-health and ways of coping

- **Common symptoms** of perinatal mental health disorders as reported by mothers from migrant communities include anxiety (McLeish, 2005; Wittkowski et al., 2011); low mood (McLeish, 2005; Wittkowski et al, 2011); fatigue (Templeton et al.,2010); uncontrolled/prolonged crying (McLeish, 2005); lack of appetite (Wittkowski et al., 2011); sleep problems/insomnia (Wittkowski et al., 2011); frequent or overwhelming negative thoughts (Wittkowski et al., 2011); and change in regular behaviours (Wittkowski et al., 2011). These experiences might be related in cases to a predisposition to chronic depression; impairment of the ability to work; difficulties in providing care; degradation of the relationship with the partner (Beck and Gable, 2001; Howard et al., 2014).
- **Risk factors and circumstances** related to the experiencing of perinatal mental disorders as above include

    - a familial history of mental disorder (Harlow et al., 2007; Jones and Craddock 2001); previous depression (Bjerke et al., 2008; Howard et al., 2014);
    - dependency on, or proximity of in-laws (particularly in the early postnatal period) (Das et al., 2019);
    - poor social support (Anderson et al., 2017; Chen et al., 2013; Howard et al., 2014; Neale and Wand, 2013);
    - social and cultural isolation (Das et al., 2019; Moore et al., 2019; Neale and Wand, 2013; Onozawa et al., 2003);
    - language barriers (Anderson et al., 2017; Bolton et al., 1998; Fellmeth et al., 2017; Karlsen et al., 2005; Yelland et al., 2010);
    - emotional isolation – especially in cases of being misunderstood by the people close to them or being physically separated from their family (Gardner et al., 2014; Raymond, 2007; Wittkowski et al., 2011);
    - broader association of mental health issues with stigma in the community (Clement et al., 2015; Das et al., 2019; Watson and Soltani, 2019);
    - acculturation difficulties (Fortner et al., 2011);
    - post-migration stress bound with accumulation of other risk factors such as experiencing hostility/discrimination or separation from social networks (Giscombe et al., 2020);
    - socioeconomic struggle (Miszkurka et al., 2010; Tsao et al., 2014);
    - marital problems (Das et al., 2019; Zelkowitz et al., 2008);
    - age – over 30 (Bjerke et al., 2008) or under 19 (Glasser et al., 2000);
    - history of being abused (Stewart et al., 2012);
    - experience of discrimination (Wallace et al., 2016; Zelkowitz et al., 2008);
    - inequality in access to healthcare support (Anderson et al., 2017; Firth and Haith-Cooper, 2017; Heslehurst et al., 2018; Latif, 2014; Moore et al., 2019; Prady et al., 2016)/

- In terms of **coping strategies**, suppression and avoidance seem to be common. Among the most common reactions to experiencing symptoms of perinatal mental health disorders are self-silencing or ignoring the intensity of their feelings (Gardner et al., 2014; Raymond, 2007), accepting the symptoms and putting up with them (Parvin et al., 2004), dealing with the problem independently (Edge and Rodgers, 2005; Parvin et al., 2004); and keeping themselves distracted and busy (Gardner et al., 2014). Some seem able to seek solace and help in religion, prayer and spirituality (Edge, 2011; Gardner et al., 2011; Hanley, 2007; Parvin et al., 2004; Raymond, 2007).

Key socio-cultural challenges

- **First-generation immigrants are at increased risk** of perinatal mental disorders (El-Khoury et al., 2018) irrespective of the region of origin, whilst second-generation (especially in cases of having a foreign born mother) have especially high rates of experiencing mental health difficulties in the first weeks after giving birth (Munk-Olsen et al., 2010).
- **Asylum seekers and refugees are likely to experience trauma** before migration, and adversity in the host country significantly increasing their risk of developing mental health difficulties in the perinatal period (Giscombe et al., 2020; Heslehurst et al., 2018);
- In some cultures **perinatal mental health disorders remain unrecognised as a common problem** which leads to some mothers being unaware of the potential conditions they are at risk of suffering (Cantle, 2010; Currer, 1994; Edge and Rogers, 2005; Gardner et al., 2014; Hanley, 2007; Templeton et al., 2010). This may result in not acknowledging or sometimes rejecting the fact that they are ill despite experiencing the symptoms (Gardner et al., 2014; Hanley, 2007).
- The **notion of depression in many traditions is absent from public debate,** often labelling its sufferers as 'weak' (Edge and Rogers, 2005; Parvin et al., 2004). This further contributes to the problem, as these beliefs can lead mothers to cut communication with others in order to fulfil cultural expectations and avoid being stigmatised (Clement et al., 2015; Das et al., 2019; Gardner et al., 2014; Watson and Soltani, 2019).

Challenges in seeking support from healthcare professionals

- Some mothers are reluctant to ask for mental health support as they are **worried about losing custody of their children** (Das et al., 2019; Templeton et al., 2010). The fear of being diagnosed (and therefore labelled) (McLeish, 2005) and unwillingness to take medication (Das et al., 2019; Edge and Rodgers, 2005; Neale and Wand, 2013; Templeton et al., 2010) for mental health disorders often constitutes a problem for some mothers in contacting a specialist.
- **Language barriers** are also a likely obstacle in seeking help, especially due to the importance of communication in the treatment (Almond and Lathlean, 2011; Edge and Rodgers, 2005; Masood et al., 2015; Munk-Olsen et al., 2010; Neale and Wand, 2013; Templeton, 2010; Wittkowski et al., 2011). This largely contributes to the problem of

relatively low detectability of mothers from migrant communities needing mental health support (Prady et al., 2016).

- Another, frequently reported problem is the **lack of awareness or accessible information** about the available support for mothers with perinatal mental health problems and knowledge of the healthcare system (Cantle, 2010; Edge and Rodgers, 2005; Gardner et al., 2014; Moore et al., 2019; Neale and Wand, 2013; Templeton et al., 2010; Watson and Soltani, 2019, Wittkowski et al., 2011).
- **Previous experience of discrimination** is one of the causes for mothers from migrant communities to avoid healthcare services, as in some cases they expect to be mistreated and misunderstood (Edge, 2011; Edge and Rodgers, 2005).
- Other issues having impact on help-seeking and accessing healthcare support include: long waiting lists or inconvenient times of visit (Das et al., 2019; Edge and Rodgers, 2005; Masood et al., 2015); lack of access to childcare (Masood et al., 2015); travel costs (Masood et al., 2015). In general, some of these findings align with findings that **ethnic minority individuals are significantly underrepresented in use of mental health services** (Cooper et al., 2013; Fitzpatrick et al., 2014).
- Some mothers report **perceiving healthcare providers to be too busy** to share with them their concerns about their wellbeing or mental health specifically during the visits (Das et al., 2019; Edge, 2011; Parvin et al., 2004).
- In some cases, mothers felt that healthcare providers tend to not touch the topic of perinatal mental health or show interest in it (Das et al., 2019; Edge, 2011; Parvin et al, 2004; Raymond, 2007; Redshaw and Henderson, 2016), maintaining focus on the pregnancy whilst not engaging with the mothers' emotional needs (Dennis and Chung-Lee, 2006; Foulkes, 2011; Schmied et al., 2017) often leading to failing to recognise symptoms of mental health struggles (McLeish, 2005; Templeton et al., 2010).
- Some **mothers state that they are being not being listened to fully** (Edge and Rodgers, 2005; Parvin et al., 2004; Wittkowski, 2011) and in some cases perceive healthcare providers to be discriminatory or prejudiced about their ethnicity (Edge and Rogers, 2005; Heslehurst et al., 2018; Wittkowski et al., 2011) which is to an extent congruent with Redshaw's and Henderson's study (2016) finding that white women are much more often asked about their mental health during perinatal period than mothers of minority background.
- **Frequent change of care providers** was found to be a significant obstacle in receiving help, as mothers find it hard to share the information about their mental health with multiple, new supporters. Conversely, continuous contact with one healthcare professional enhances the feeling of comfort facilitating recognition of symptoms and the treatment (Das et al., 2019; Raymond, 2007).
- Many healthcare services were found to **fail to provide culturally appropriate support** (Watson and Soltani, 2019) for mothers, for instance providing solely the support of male healthcare professionals, which can make the visit uncomfortable for the mother or in some cases impossible to attend without a husband (Wittkowski et al., 2011). Moreover, the lack of HCPs of ethnic minority background, or professionals with understanding of the respective culture, often results in feelings of being misunderstood (Noor and Rousham, 2007; Templeton et al., 2010).

Recommendations

- Many mothers from migrant communities find **support from their social circle** very helpful in going through mental health difficulties both in person (Almond and Lathlean, 2011; Cantle, 2010; Gardner et al., 2014; Templeton et al., 2010; Wittkowski et al., 2011) and online (Das & Beszlag, 2021; Das et al., 2019; Raymond, 2007).
- **Support groups** were found in many studies to be effective in combating the perinatal mental health problems of women from migrant communities, as they facilitate communicating feelings and symptoms by providing a much needed judgement-free safe space for women to talk and to be listened to (Das et al., 2019; Masood et al., 2015; Templeton et al., 2010; Watson and Soltani, 2019). This emotional help was reported in multiple studies to be effective in combating symptoms, especially via minimising stigma and providing the perception of being supported and cared for (Barclay and Kent, 1997, Dennis and Chung-Lee, 2006; Hanley, 2007; Neale and Wand, 2013).
- The **presence of women experiencing similar problems** (especially of the same cultural or ethnic background) was reported to be particularly beneficial, partially through making mothers aware that what they feel is not uncommon and helping them establish new social ties (Das et al., 2019; Edge, 2011; Raymond, 2007; Wittkowski et al., 2011)
- Healthcare services need to pay **more attention to mothers' mental health** in the perinatal period, which includes not only symptom recognition, but informing about and discussing the symptoms with the mother and introducing the places they can obtain support and advice from (Edge, 2011; Heslehurts et al., 2018; Watson and Soltani, 2019; Wittkowski et al., 2011).
- **Cultural competency training** (Masood et al., 2015; Watson and Soltani, 2019) could benefit support services by improving communication and understanding between healthcare professional and patients. This is particularly important, as the first positive interaction facilitates further engagement with healthcare professionals and encourages effective help-seeking behaviours (Dennis and Chung-Lee, 2006; Schmied et al., 2017; Smith et al., 2009).
- While more difficult to achieve as a common service, **clinical consultants originating from the same or similar ethnicity or culture** as a patient seem to have very promising results in providing help to mothers (Neale and Wand, 2013; Watson et al., 2019).
- **More research** on the perinatal mental health of mothers from migrant communities is needed (Giscombe et al., 2020), especially regarding in-depth analysis of risk factors bound with specific cultures, ethnicities and migration status (Moore et al., 2019).
- **Educating mothers' partners, families and the extended family** about the nature and risks of the perinatal mental ill health is crucial (Clement et al., 2015; Das et al., 2019; Lecompte et al., 2017; Watson and Soltani, 2019).
- **Virtual networks** providing judgement free communication between mothers experiencing perinatal mental health difficulties (Watson and Soltani, 2019), supported by HCP's presence could constitute an effective tool (Das et al., 2019)

- **Routine screening** of mothers' perinatal mental health is of highest importance to facilitate early detection and in turn more efficient treatment for potential mental ill health (Boyle et al., 2019).

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