

Research Article

Predicting Perinatal Low Mood and Depression for BAME Women - The Role of Treatment, Perceived Public, and Internalised Stigma

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Abstract

The study aims to build on existing empirical evidence looking at the extent to which stigma impacts perinatal low mood and depression. This study examined the associations between treatment, perceived public, and internalised stigma and perinatal low mood and symptoms of depression. The study aimed to examine perinatal depression symptoms and three predictor variables.

This study used correlational cross-sectional survey data from a representative sample of BAME (Black, Asian and Minority Ethnic) women (n=123). The BAME women completed four surveys to assess perinatal depression symptoms and treatment, perceived public, and internalised stigma toward perinatal depression symptoms conducted online. The results were subsequently uploaded onto SPSS. Exploratory research was also analysed to investigate preferable approaches to discuss low mood with a healthcare professional.

Results showed internalised stigma was predictive of perinatal

depression symptoms for BAME women. Internalised stigma was found to be a significant predictor variable of perinatal depression for both women who identified as Black and those that identified as all other ethnic minority groups. In addition, for the BAME women with an upper income and from the 25-34 age group internalised stigma was found to be predictive of perinatal depression symptoms. Treatment stigma was also a significant predictor variable of perinatal depression for BAME women aged between 25-34. Perceived public stigma was found to be a significant predictor variable of perinatal depression symptoms for BAME women with a lower income.

Improvements on the present study, and implications for future research, are discussed with regard to the findings. These results suggest that, at least in this population, internalised stigma is an important factor towards perinatal depression.

Keywords: Perinatal; Perinatal mental health; Mental health; Stigma; Ethnic minority; Healthcare

Overview

What is known?

1. Little is known about Black, Asian and Minority Ethnic (BAME) women and perinatal mental health care.
2. Policy makers are increasingly interested in supporting women from ethnic minority backgrounds.
3. Research has found that stigma disproportionately impacts individuals from BAME communities.
4. Evidence suggests that services do not provide BAME women with adequate support to meet their needs.

What this paper adds

1. The analysis suggests stigma plays a role in perinatal mental health for women from ethnic minority backgrounds.
2. Stigma impacts perinatal low mood and depression for women from ethnic minority backgrounds.
3. Internalised, perceived public and treatment stigma were found to have an association with one another.
4. Internalised stigma was found to be a significant predictor variable of perinatal depression for women from ethnic minority groups.

Introduction

In relation to perinatal mental health (PNMH), the term perinatal, refers to the period of pregnancy and the first postpartum (postnatal) year [1]. Perinatal depression, is new or pre-existing depression, which occurs throughout pregnancy (antenatal depression) or up to one year (postnatal depression); perinatal depression has been characterised as the most frequent problem of maternity, more prevalent than diabetes [2], twice as common as hypertension [3] in addition to other physical difficulties which impact maternal mental health during the postpartum period [2]. Women also experience brief periods of common low mood after childbirth; these feelings include 'baby blues'; a short period of low mood after childbirth [4].

Low mood and depression have been identified as frequent mental health difficulties that develop in the perinatal period [5].

Perinatal depression is considered a major public health concern in the UK, which impacts about 15% of women [6]. Masood *et al.* [7] found that the incidence of perinatal depression is greater amongst women from particular BAME communities. 'BAME' (Black, Asian and Minority Ethnic), can be considered as the term typically used in the UK to describe individuals who descend from non-white backgrounds [8]. In the following study, BAME can be considered as an umbrella term used to include a collection

of heterogeneous sub-categories, for instance, White sub-groups including Europeans, in addition to, recent migrants or migrants who have settled from a vast array of ethnicities and countries (Edge, 2011b).

While both BAME women and women from all ethnic backgrounds have been found to fear or experience stigma if their mental illness is discovered, evidence suggests that stigma disproportionately impacts individuals from BAME communities who experience the intersectionality of having experienced discrimination and prejudice or double stigma within health services; this is when ethnic minorities experience internal and public stigma when experiencing mental illness [9]. Stigma can be described when status loss, labelling, discrimination, stereotyping, and separation simultaneously occur in a condition where power is implemented [10]. Conceptions about the social consequences of mental illness suggest that stigma is a prejudice, based on stereotypes, which results in discrimination [11]. Stigma in relation to mental ill health characterises an important public health concern due to it being a significant barrier to seeking care or continuing treatment [10]. In addition, stigma has a range of components including self-stigma and perceived stigma [10]. Self-stigma is also known as internalised stigma [12].

Internalised stigma can be considered as a facilitator in the path from public stigma to avoiding healthcare and treatment stigma can also be a factor in this connection and this can describe their strong association with the decline in seeking help which causes a barrier to healthcare [13]. Clement *et al.* [14] conducted an online survey with a total of 117 individuals who had undertaken treatment from mental health service provision, and found that perceived public, internalised, and treatment stigma were found to positively correlate with each other. These components of stigma can be considered as; treatment stigma which is the stigma related to undertaking or seeking treatment for mental ill health, internalised stigma, having stigmatising beliefs about oneself and perceived stigma, an individual's perception about the degree to which individuals usually have stigmatising behaviour or attitudes towards individuals with mental ill health [13].

Watson *et al.* [9] found women from ethnic minority backgrounds are at a greater risk of developing mental illness. Effective and quick treatment is especially important in the perinatal period as one in five women from all ethnic backgrounds experience a mental health difficulty [15]. Furthermore, chronic, insistent perinatal mental ill health may be associated with the unmet need of care for BAME women [16]. Significant literature is emerging about postpartum depression in BAME women [17]. There has been some work conducted to investigate the particular representations of postnatal depression or depression in BAME groups; the occurrence of postpartum depression does not seem to differ across cultures when evidence has been able to explore this, however there has been inadequate comparable evidence in terms of clarifying this [18]. Gardner *et al.* [19] found research in the UK that demonstrated being a mother from a BAME group considerably increases the likelihood of developing postnatal depression. Evidence suggests being a mother from a BAME group, particularly being an Asian mother nearly doubled the likelihood for developing postnatal depression [20]. Latif [21] argues, at present, literature shows that there is a knowledge gap in terms of the effect of cultural factors on maternal mental

disorders. Many researchers have promoted research into maternal mental health across diverse cultures to better determine the issues of risk for depression [22].

A Closer Look at Stigma

Treatment stigma

Edge [23] reported that the relationship between accessing mental health service provision, cultural attitudes, and the related difficulties that women with perinatal mental illness experience is an emerging theme in many studies. Memon *et al.* [24] suggests BAME communities tend not to consult healthcare professionals concerning mental health problems. Button *et al.* [25] found that women were reluctant to seek help because of perceived consequences of the diagnosis, with what they considered a condition which carried stigma, for example; Black women were concerned about the relationship between diagnosis and ethnicity.

Perceived public stigma

Templeton *et al.* [18] suggests postnatal depression or depression is seen as mental ill health that carries stigma with it, in some cases this stigma covers the whole family or community. Ethnic minority groups because of social stigma are also less likely to seek help for treatment on behalf of another member of their community [24]. Furthermore, a study by Sambrook Smith *et al.* [26], found the term double disadvantage was referred to ethnic minority groups, whereby there was a concern regarding the public stigma of being mentally ill but also the experience of double disadvantage as there was also concern that employers may find out about mental ill health and that such an illness may have a negative impact in their workplace.

Internalised stigma

Evidence suggests BAME communities have a mistrust or fear of mental health service provision which may result in women from minority groups being less likely to either being referred to services by their families or self-referring [16]. Discrimination has been found to affect fair access to health services which includes mental health service provision in the UK and this is confirmed by the analysis of regular collected data and women's reports in research [9]. Individuals from ethnic minorities who present histories and mental health symptoms experience double stigma (minority groups experiencing mental illness while also experiencing discriminatory practices) in comparison to their White Western counterparts and this presents the individual with considerable barriers [27]. Research has shown that women from ethnic minorities have felt that they are especially at risk of stigmatising attitudes from the public and healthcare professionals because of cultural differences in social expectations [26]. Mental illness itself may be misunderstood but this also may affect BAME women's self-concept [28].

Aim of this article

The primary aim of this article is to examine various factors that may influence perinatal low mood and depression for BAME women such as treatment, perceived public, and internalised stigma. The article will look at socio demographic differences within this group. The entire perinatal period will be explored, as this is an interlinking transitional period of life for women

with external factors which affect maternal health, including before conception and having an untreated pre-existing or antenatal mental health difficulty considerably increases the risk of developing a postpartum mental health disorder [29]. The study will include women from across the fertility spectrum from 18 years and above (18-55+), in addition to, primiparous mothers (expecting their first child) and multiparous mothers (expecting their second or subsequent child) [30]. The study will also include mothers who have had a baby in the last year and beyond and will focus on mild and mild to moderate low mood and depression. Most mental health difficulties throughout the perinatal period are mild to moderate [31]. The milder forms go untreated and undetected, and these may settle spontaneously, clinically significant depression considered moderate to severe depressive ill health is detected [32].

Specifically, the main research question asked was:

- What is the relative contribution of the following variables, assessed during the perinatal period for BAME women?
 - i. Perinatal low mood and depression
 - ii. Treatment stigma
 - iii. Perceived public stigma
 - iv. Internalised stigma
 - Ethnic background - Those that identify as being from a Black background and those who identify as being from all other ethnicities
 - i. Age
 - ii. Financial factors

The following hypotheses were made:

- Treatment stigma will positively and significantly predict perinatal depression symptoms.
- Perceived public stigma will positively and significantly predict perinatal depression symptoms.
- Internalised stigma will positively and significantly predict perinatal depression symptoms.

A further aim of the research is to investigate how approaches may enable BAME women to feel more comfortable about talking about their low mood and depression with healthcare providers. As there are no previous research studies in this area this part of the thesis was exploratory in nature with no hypotheses generated and no statistical analyses conducted.

Methods

Participants

Overall, the sample consisted of 123 participants. Table 1 shows the self-identified ethnicities of the sample. The ages ranged from 18-44 years - Just over one-half (59%) were 25-34 years old. 81% had middle to upper income > £20,000 (Table 1).

Measures

Demographic and Clinical Information: BAME women completed fifteen demographic questions such as age, marital status, country of birth, religious identity and others. Clinical

Table 1: Personal Characteristics of BAME women.

Personal Characteristics	BAME Women %
Age	
Valid N	123
18-24	14.6
25-34	58.5
35-44	26.8
Ethnicity	
Asian British/Bangladeshi	3.3
Asian British/Chinese	0.8
Asian British/Indian	3.3
Asian British/Pakistani	2.4
Black British/African	30.1
Black British/Caribbean	32.5
Black Other	2.4
Eastern European e.g. Polish	0.8
European (EU) e.g. Spanish, French	0.8
Mixed Asian and White	0.8
Mixed Black African and White	4.9
Mixed Black Caribbean and White	13
Mixed Other	3.3
Other groups	1.6
Valid N	123
Income	
Lower	19.5
Middle	29.2
Upper	51.3
Valid N*	113
*Missing values varied for different data item; valid N indicates base number of calculations after excluding missing values	

questions were based on pregnancy and mental health history.

Edinburgh Postnatal Depression Scale (EPDS): The Edinburgh Postnatal Depression Scale (EPDS) - BAME Women completed a 10-question self-rating scale used to ascertain patients at risk for perinatal depression. The split-half reliability of the scale was found to be 0.88, and the standardised $\alpha=0.87$ [33].

Barriers to Access to Care Evaluation (BACE): Barriers to Access to Care Evaluation (BACE) - The Treatment stigma subscale, a 12-item scale asks about various barriers to care and focuses on barriers relating to stigma [14]. The treatment stigma subscale is used to assess the stigma associated with receiving care for mental health. The treatment stigma subscale assessed the extent to which the stigma was associated with mental health care has been a barrier for a participant. Using Cronbach's alpha, the internal consistency of the treatment stigma subscale was assessed, with a value above 0.7 but not greater than 0.9, which indicates good internal consistency. The instructions explain the definition of 'professional care' relates to 'low mood/depression during pregnancy and/or the year after childbirth' and although, 'the term 'mental health problem' was used in the following questionnaire please think of this to mean low mood/depression during pregnancy and/or the year after childbirth.'

Adapted Stigma Scale for Receiving Psychological Help (SSRPH): Adapted Stigma Scale for Receiving Psychological Help (SSRPH) - SSRPH is a 5-item scale. This measured the perceived public stigma relating to using mental health service provision and was adapted from the Stigma Scale for Receiving

Psychological Help [34]. The scale was adapted to relate to the stigma associated when receiving treatment for emotional or mental health difficulties, for the purposes of this research project this was defined as mental health difficulties during pregnancy and the year after childbirth. The scale had good internal consistency (Cronbach's alpha of .74). This was created by summing the score (0-3) for each item, yielding a continuous variable ranging from 0 (lowest perceived stigma) to 15 (highest perceived stigma). Instructions explain, please state feelings for, 'perinatal mental health treatment for low mood/depression during pregnancy and/or the year after childbirth?', although, 'the term 'mental problems' was used in the following questionnaire please think of this to mean low mood/depression during pregnancy and/or the year after childbirth.'

Internalized Stigma of Mental Illness Inventory (ISMI): Internalized Stigma of Mental Illness Inventory (ISMI) -The revised 29-item, 4-point Likert scale, from 1 (strongly disagree) to 4 (strongly agree), focuses on the participant's subjective experience as having mental ill health [35]. The ISMI demonstrated good internal consistency reliability. Scale was revised so that items refer to depression specifically instead of mental illness in general. Higher scores reveal more internalised stigma. The original questionnaire had a strong internal consistency ($\alpha=0.90$). Instructions explain for a participant to state feelings for, 'low mood/depression during pregnancy and/or the year after childbirth?' although, 'the term 'mental illness' was used in the following questionnaire please think of this to mean low mood/depression during pregnancy and/or the year after childbirth.'

Adapted Barriers and facilitators of mental health screening in pregnancy questionnaire: Adapted Barriers and facilitators of mental health screening in pregnancy questionnaire - Barriers and facilitators of mental health screening in pregnancy questionnaire (Only PART B- Q14) [36]. A 7 item questionnaire was used from the original survey looking at the approaches to talk about mood. Instructions explain for a participant to state feelings for, 'how comfortable you would feel, being asked about your mood, during pregnancy and/or the year after childbirth-For example, 'upsetting feelings around birth?' by health care providers.'

Procedure

BAME women were invited to participate in this study via an email sent by the department heads of charities in the voluntary sector on the researcher's behalf. This e-mail mainly served to introduce the study, to assure participants of their anonymity, and to provide a link to the online survey, hosted by Qualtrics [37]. BAME women were also recruited by publicising on perinatal mental health websites, baby-related websites/blogs, Facebook groups, Twitter and Instagram. For example, www.netmums.co.uk, <http://www.mumsnet.co.uk>, Maternal Mental Health Alliance, Pandalas foundation and Home-Start UK Facebook group and @PNDandMe Twitter account.

Data Analysis

To address the research question, linear regression models were used to examine significant differences in treatment stigma, internalised stigma and perceived public stigma between those that identified as being from a Black background only and those that identified as being from all other ethnicities. In addition, linear

regression models were used to examine significant differences in treatment stigma, internalised stigma and perceived public stigma between socio demographic groups. This study employed correlation and linear regression techniques, to examine the foretasted hypotheses. A α level of 0.05 was used for all statistical tests.

For hypothesis 1, a series of correlations were conducted, with perinatal depression symptoms and treatment stigma, perceived public stigma and internalised stigma. Differences in ethnic background, age and income were also examined. A series of linear regression was further performed. Prior to investigating hypotheses, participants were assigned to 3 groups based on the classification of ethnic background, age, and income. Separate linear regression was performed to test hypotheses 1, 2 and 3 with all 3 assessing the effects of ethnic background, age, and income as conditions. Before testing the hypotheses, simple correlations between variables were calculated using the Pearson correlation test. The linear regression procedure was used to estimate the potential association between perinatal depression symptoms and treatment stigma (Hypothesis 1), perceived public stigma (Hypothesis 2) and internalised stigma (Hypothesis 3).

Findings

Symptoms of perinatal depression (EPDS)

Figure 1, shows symptoms of perinatal depression for all BAME women in the study using the EPDS scale. The maximum score is 30, possible depression is 10 or greater. The majority (62%) of BAME women, had possible depression at the time of completing the survey (Figure 1).

Descriptive statistics

Table 2, shows good variation for perinatal depression symptoms with a score of 0 min and 26 max (Mean=11.68, SD=5.53). In addition, the results for treatment stigma showed a min score of 0.00 of 3.00 (Mean=1.21, SD=0.79). For perceived public stigma the min score was 0 and max 15 (Mean=6.71, SD=3.74). In addition, internalised stigma resulted in a min score of 30 and max score of 94 (Mean=48.42, SD=12.12) (Table 2).

Statistical analyses

BAME Women: Table 3 indicates, the correlations found are in

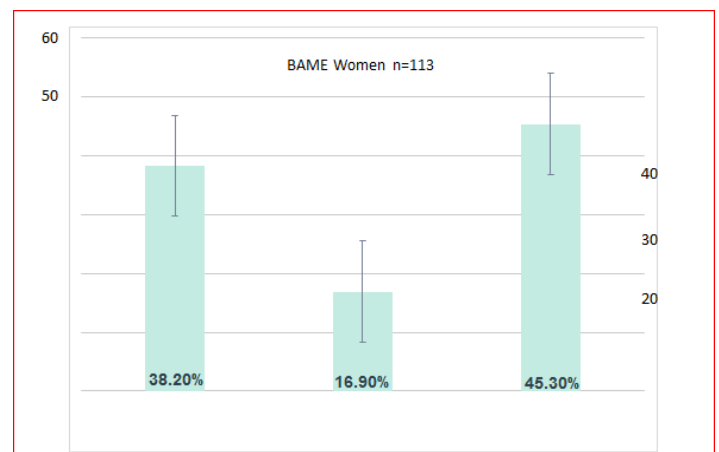


Figure 1: Shows symptoms of perinatal depression for all BAME women in the study using the EPDS scale.

Table 2: Descriptive Statistics scores including; mean, standard deviation, minimum and maximum for Perinatal Depression Symptoms and the 3 predictor variables.

Variable	n	Minimum	Maximum	M	SD
Perinatal Depression Symptoms	113	0	26	11.68	5.53
Treatment Stigma	113	0	3	1.21	0.79
Perceived Public Stigma	113	0	15	6.71	3.74
Internalised Stigma	113	30	94	48.42	12.12

Note. *n* = number of participants, *M* = Mean, *SD* = Standard deviation

Table 3: Correlation of Perinatal Depression Symptoms onto the 3 variables.

Variable	1	2	3
Internalised Stigma			
Perceived Public Stigma	.517**		
Treatment Stigma	.536**	.567**	
Perinatal Depression Symptoms	.424**	.214*	.338**

Note: *indicates < .05. **indicates *p* < .01.

line with the hypothesis for each predictor variable (Table 3). The relationship between perinatal depression symptoms and treatment stigma was found to be positively correlated ($r=0.34$, $p<0.001$). In addition, perceived public stigma was found to positively correlate with perinatal depression symptoms ($r=0.21$, $p<0.001$). Furthermore, results showed that perinatal depression symptoms positively correlates with internalised stigma ($r=0.42$, $p<0.001$). In addition, treatment stigma was found to positively correlate with perceived public stigma ($r=0.57$, $p<0.001$) and with internalised stigma ($r=0.54$, $p<0.001$). In addition to this, perceived public stigma positively correlates with internalised stigma ($r=0.51$, $p<0.001$). Regression can be analysed in Table 4 as one of the assumptions for regression is linearity.

Table 4 illustrates, the association between the criterion and explanatory variables was also found to be moderately strong (Multiple $R=0.45$). Together treatment stigma, perceived public stigma and internalised stigma accounted for 18% of the variation in perinatal low mood (adjusted R^2). The regression coefficient for treatment stigma was 1.33 (95% CI= -0.21-2.87); perceived public stigma was -0.12 (95% CI= -0.44-0.20; and internalised stigma was 0.17 (95% CI=0.70 - 0.26) (Table 4). Internalised stigma positively and significantly related to perinatal depression symptoms $t=3.421$, $p=0.001$. Treatment stigma and perceived public stigma were found to be non-significant (treatment stigma: $t=1.714$, $p=0.089$ /public perceived stigma: $t=-0.753$, $p=0.453$).

A closer look at various variables

Ethnic origin: Table 5 indicates, for those who identified as having a black ethnicity only, perinatal depression symptoms positively and significantly correlate with treatment stigma $r=0.37$, $p<0.001$ and internalised stigma $r=0.41$, $p<0.001$ (Table 5). Perinatal depression symptoms and perceived public stigma were found to be non-significant $r=0.16$, $p=0.174$. Treatment stigma positively and significantly correlated with perceived public stigma and internalised stigma (perceived public stigma: $r=0.47$, $p<0.001$, internalised stigma: $r=0.51$, $p<0.001$). Perceived public stigma positively and significantly correlated with internalised stigma $r=0.41$, $p<0.001$.

Table 6 shows, the association between the criterion and explanatory variables was also found to be moderately strong

Table 4: Regression of Perinatal Depression Symptoms onto the 3 variables.

Predictor	b	SE(b)	beta	t	p
(Intercept/Constant)	2.822	1.981		1.425	0.157
Treatment Stigma	1.332	0.777	0.19	1.714	0.089
Perceived Public Stigma	-.122	0.162	-.082	-.753	0.453
Internalised Stigma	-.166	0.049	0.364	3.421	0.001

Note: $R^2 = 0.201$, $F(3, 109) = 9.14$, $p = 0.001$

Table 5: Correlation of Perinatal Depression Symptoms for Black Ethnic Backgrounds onto the 3.

Variable	1	2	3
1. Internalised Stigma			
2. Perceived Public Stigma	.408**		
3. Treatment Stigma	.537**	.471**	
4. Perinatal Depression Symptoms	.407**	.158	.368**

Note: *indicates < .05. **indicates *p* < .01.

Table 6: Regression of Perinatal Depression Symptoms for Black Ethnic Backgrounds onto the 2.

Predictor	b	SE(b)	beta	t	p
(Intercept/Constant)	1.762	2.782		.633	.529
Treatment Stigma	1.617	.957	.210	1.689	.096
Internalised Stigma	.160	.068	.295	2.370	.020

Note: $R^2 = 0.197$, $F(2, 73) = 8.98$, $p = 0.001$

(Multiple $R=0.44$). Together treatment stigma and internalised stigma accounted for 18% of the variation in perinatal depression symptoms (adjusted R^2). Internalised stigma positively related to perinatal depression symptoms (Table 6). The regression coefficient for treatment stigma was 1.61 (95% CI=-0.29 - 3.52); and for internalised stigma it was 0.16 (95% CI=0.03 - 0.30). Internalised stigma positively and significantly related to perinatal depression symptoms $t=2.370$, $p=0.020$. Treatment stigma was non-significant with perinatal depression symptoms $t=1.689$, $p=0.096$.

Table 7 shows, for those who identified as having all other ethnic backgrounds and not black only, perinatal depression symptoms positively and significantly correlated with internalised stigma $r=0.44$, $p<0.001$ (Table 7). Perinatal depression symptoms were found to be non-significant with treatment stigma and perceived public stigma (treatment stigma $r=0.27$, $p=0.105$, perceived public stigma $r=0.31$, $p=0.065$). Treatment stigma positively and significantly correlated with perceived public stigma and internalised stigma (perceived public stigma: $r=0.75$, $p<0.001$, internalised stigma: $r=0.55$, $p<0.001$). Perceived public stigma positively and significantly correlated with internalised stigma $r=0.66$, $p<0.001$.

Table 8 illustrates, the association between the criterion and explanatory variables was also found to be moderately strong (Multiple R=0.44) (Table 8). Internalised stigma accounted for 17% of the variation in perinatal depression symptoms (adjusted R²). Internalised stigma positively related to perinatal depression symptoms. The regression coefficient for internalised stigma was 0.15 (95% CI=0.43 - 0.25). Internalised stigma positively and significantly related to perinatal depression symptoms $t=2.867$, $p=0.007$.

Age group: Table 9 shows, for the 25-34 age group perinatal depression symptoms positively and significantly correlated with internalised stigma $r=0.54$, $p<0.001$. Perinatal depression symptoms positively with perceived public stigma and treatment stigma (perceived public stigma $r=0.34$, $p<0.001$, treatment stigma $r=0.46$, $p<0.001$). Treatment stigma positively and significantly correlated with internalised stigma and perceived public stigma (internalised stigma: $r=0.54$, $p<0.001$, perceived public stigma: $r=0.60$, $p<0.001$). Perceived public stigma positively and significantly correlated with internalised stigma $r=0.59$, $p<0.001$ (Table 9).

Table 10 indicates, the association between the criterion and explanatory variables was also found to be moderately strong (Multiple R=0.58). Treatment stigma, perceived public stigma and Internalised stigma accounted for 30% of the variation in perinatal depression symptoms (adjusted R²). Internalised stigma positively related to perinatal depression symptoms (Table 10). The regression coefficient for internalised stigma was 0.18 (95% CI=0.07 - 0.30). Internalised stigma positively and significantly related to perinatal depression symptoms $t=3.223$, $p<0.001$.

Financial income: Table 11 illustrates, when looking at BAME women on low income, perinatal depression symptoms positively correlates and significantly correlates with perceived public stigma $r=0.46$, $p<0.001$. Perinatal depression symptoms was found to be non-significant with treatment stigma and internalised

Table 7: Correlation of Perinatal Depression Symptoms for Other Ethnic backgrounds onto the 3

Variable	1	2	3
1. Internalised Stigma			
2. Perceived Public Stigma	.661**		
3. Treatment Stigma	.546**	.744**	
4. Perinatal Depression Symptoms	.436**	0.307	0.271

Note: *indicates < .05. **indicates $p < .01$.

Table 8: Regression of Perinatal Depression Symptoms for Other Ethnic Backgrounds onto Internalised Stigma

Predictor	b	SE(b)	beta	t	p
(Intercept/Constant)	5.114	2.765		1.850	.073
Internalised Stigma	.146	.051	.436	2.867	.007

Note: R² = 0.190, F(1, 35) = 8.22, $p = 0.001$

Table 9: Correlation of Perinatal Depression Symptoms for 25–34 onto the 3 variables

Variable	1	2	3
1. Internalised Stigma			
2. Perceived Public Stigma	.586**		
3. Treatment Stigma	.535*****	.598***	
4. Perinatal Depression Symptoms	.535**	.339**	.459**

Note: *indicates < .05. **indicates $p < .01$.

stigma (internalised stigma: $r=0.41$, $p=0.06$, treatment stigma $r=0.40$, $p=0.062$). Treatment stigma positively and significantly correlates with internalised stigma $r=0.62$, $p<0.001$ and perceived public stigma $r=0.75$, $p<0.001$. Perceived public stigma positively and significantly correlates with internalised stigma $r=0.62$, $p<0.001$ (Table 11).

Table 12 confirms, the association between the criterion and explanatory variables was also found to be moderately strong (Multiple R=0.46). Perceived public stigma accounted for 18% of the variation in perinatal depression symptoms (adjusted R²). Perceived public stigma positively related to perinatal depression symptoms (Table 12). The regression coefficient for Perceived public stigma was 0.68 (95% CI=0.08 - 1.29. Perceived public stigma positively and significantly related to perinatal depression symptoms $t=2.343$, $p=0.030$.

Table 13 illustrates, when looking at BAME women on upper income, perinatal depression symptoms positively and significantly correlates with internalised stigma $r=0.39$, $p<0.001$ and treatment stigma $r=0.26$, $p<0.001$ (Table 13). Perinatal depression symptoms was non-significant with perceived public stigma $r=0.20$, $p=0.138$. Treatment stigma positively and significantly correlates with internalised stigma $r=0.55$, $p<0.001$ and internalised stigma $r=0.62$, $p<0.001$. Perceived public stigma positively and significantly correlates with internalised stigma $r=0.56$, $p<0.001$.

Table 14 confirms, the association between the criterion and explanatory variables was also found to be moderately strong (Multiple R=0.39) (Table 14). Together treatment stigma and internalised stigma accounted for 12% of the variation in perinatal depression symptoms (adjusted R²). Internalised stigma positively related to perinatal depression symptoms. The

Table 10: Regression of Perinatal Depression Symptoms for 25–34 year olds onto the 3 variables

Predictor	b	SE(b)	beta	t	p
(Intercept/Constant)	1.536	2.226		0.690	.493
Treatment Stigma	1.890	.944	.273	2.003	.050
Perceived Public Stigma	-.114	.206	-.078	-.552	.583
Internalised Stigma	-.183	.057	.434	3.223	.002

Note: R² = 0.331, F(3, 61) = 10.05, $p = 0.001$

Table 11: Correlation of Perinatal Depression Symptoms for Lower income onto the 3 variables

Variable	1	2	3
1. Internalised Stigma			
2. Perceived Public Stigma	.624**		
3. Treatment Stigma	.624**	.745**	
4. Perinatal Depression Symptoms	0.407	.464*	0.404

Note: *indicates < .05. **indicates $p < .01$.

Table 12: Regression of Perinatal Depression Symptoms for Lower income onto Perceived Public Stigma

Predictor	b	SE(b)	beta	t	p
(Intercept/Constant)	9.428	2.206		4.274	0
Perceived Public Stigma	0.68	0.29	0.464	2.343	0.03

R² = 0.215, F(1, 20) = 5.49, $p = 0.001$

Table 13: Correlation of Perinatal Depression Symptoms for Upper income onto the 3 variables

Variable	1	2	3
1. Internalised Stigma			
2. Perceived Public Stigma	.556**		
3. Treatment Stigma	.549**	.620**	
4. Perinatal Depression Symptoms	.389**	.197	.263*

Note: *indicates < .05. **indicates p < .01.

Table 14: Regression of Perinatal Depression Symptoms for Upper income women onto the 2 variables

Predictor	b	SE(b)	beta	t	p
(Intercept/Constant)	3.542	2.576		1.375	0.175
Treatment Stigma	0.42	0.877	0.071	0.479	0.634
Internalised Stigma	0.147	0.063	0.35	2.358	0.022

Note: R2 = 0.155, F(2, 55) = 5.03, p = 0.001

regression coefficient for treatment stigma was 0.42 (95% CI=-1.34 - 2.18); and for internalised stigma it was 0.15 (95% CI=0.02 - 0.27). Internalised stigma positively and significantly related to perinatal depression symptoms (t=2.358, p=0.022). Treatment stigma was non-significant with perinatal depression symptoms (t=0.479, p=0.634).

Exploratory Research

Table 15 shows, that BAME women are most comfortable being asked about mood by ‘answering questions at home and then bringing paper’ with them to their next visit with their healthcare provider (50.8%) and ‘answering questions online using a computer in their home’ before their next visit to see their healthcare provider and then electronically sending responses to their healthcare provider so that they can talk about their responses on their next visit (50.8%) (Table 15).

Table 15: Descriptive Statistics scores for BAME Women and HCPs and the seven variables that BAME Women would feel comfortable being asked about mood.

Variable	Condition	n	Percentage
Answering questions on paper while sitting in the waiting room before my appointment and then talking with my health care provider during my visit	very comfortable	43	34.7
	somewhat comfortable	49	39.5
	somewhat uncomfortable	19	15.3
	very uncomfortable	3	2.4
Answering questions at home and then bringing paper with me to my next visit with my health care provider so that we could talk about the results	very comfortable	63	50.8
	somewhat comfortable	35	28.2
	somewhat uncomfortable	11	8.9
	very uncomfortable	5	4.0
Answering questions on a computer or iPad in the waiting room before my appointment and then talking about my responses with my health care provider during my visit	very comfortable	44	35.5
	somewhat comfortable	46	37.1
	somewhat uncomfortable	17	13.7
	very uncomfortable	7	5.6
Answering questions online using a computer in my home before my visit and then electronically sending my responses to my health care provider so that we could talk about them at my next visit	very comfortable	63	50.8
	somewhat comfortable	32	25.8
	somewhat uncomfortable	13	10.5
	very uncomfortable	6	4.8
Being called at home by my health care provider, answering the questions over the telephone and then talking about my responses with my health care provider over the telephone	very comfortable	27	21.8
	somewhat comfortable	36	29.0
	somewhat uncomfortable	26	21.0
	very uncomfortable	25	20.2
Bringing up the topic of my mood on my own with my health care provider	very comfortable	22	17.7
	somewhat comfortable	39	31.5
	somewhat uncomfortable	33	26.6
	very uncomfortable	20	16.1
Having my health care provider bring up the topic of my mood and having a discussion	very comfortable	40	32.3
	somewhat comfortable	57	46.0
	somewhat uncomfortable	13	10.5
	very uncomfortable	4	3.2

Note. n = number of participants.

Discussion

The results showed, as hypothesised, that internalised stigma was positively and significantly predictive of perinatal depression symptoms for BAME women. The majority of BAME women (62%) had possible depression at the time of completing the survey. The results showed higher scores in internalised stigma were associated with higher scores in perinatal depression. The findings in this article add to previous research, as fear of internalised stigma may have an impact upon help-seeking behaviour towards accessing care, which in turn may affect perinatal depression symptoms. Watson *et al.* [9] suggests that despite women from ethnic minority groups being aware of or suffering from PNMH symptoms, they may not consider symptoms to be ill health or assume different explanations for the symptoms which include isolation, absence of support, practical problems, lack of rest or something that would just go away. Furthermore, for some BAME women such as Bangladeshi, privacy is an issue and what they may consider as restraint to reveal emotional and intimate feelings might be misinterpreted by health visitors and any precursor to postpartum depression might be missed [17]. The findings are also in line with studies that suggest many women describe that it was unacceptable in their culture to discuss their feelings or emotional issues or problems, to individuals who are not members of their family and that if these feelings were revealed it would lead to stigma [9].

The results support previous research that suggests internalised stigma may play a vital role in feelings around motherhood and this may have an effect on perinatal depression symptoms. A large proportion of the study sample reported that they had a baby in the last year (44.1%). Chew-Graham *et al.* [32] suggests severe depression even mild to moderate postnatal depression may reduce confidence in being a parent and have damaging effects for the family. Furthermore, despite the notion of motherhood as no longer being considered as the only basis of a woman's identity, nurturing or 'mothering' is considered an essential value in society underlying the lives of women with children, the guilt portrayed in terms of feeling depressed is owing somewhat to cultural pressure on mothers to 'nurture' [38]. Furthermore, stigma has discouraged women from help-seeking behaviour as women view themselves strictly and feel the pressure to fit what they consider as idyllic standards of motherhood, most of which were internalised, where distress was seen as a test to a woman's self-identity [25]. Thus, notions around motherhood may have an impact on internalised stigma which may impact perinatal depression symptoms.

When looking at sociodemographic factors, internalised stigma was positively predictive of perinatal depression symptoms for both women that identified as Black and women that identified as having all other ethnic backgrounds. Our findings add to existing research as internalised stigma plays a role in perinatal depression for both Black women and women from Asian and Minority Ethnic backgrounds. Edge [39] found for women of Black Caribbean and African descent emphasis is placed on self-efficacy, in addition to, strong social requirements around being a 'strong black women' and fear of being stigmatised are strong barriers to seeking help. Furthermore, women from other BAME backgrounds such as Bangladeshi women also view depression as implying weakness [9]. Wittkowski *et al.* [20] found the three main predominant groupings in relation to postnatal depression in South

Asian women were; firstly internalising their misery, secondly individuals will judge them and they feel on their own, and thirdly they talk to health professionals and they don't understand. This is also consistent with the work of Button *et al.* [25] that found, help seeking is impacted by stigma including personal beliefs (self-stigma or internalised) and stigma is considered one of the main barriers to help-seeking behaviour for mental illness, in particular those from ethnic minority backgrounds.

Interestingly, for BAME women that had upper income, internalised stigma was found to be positively and significantly predictive of perinatal depression symptoms. The findings build on existing research which suggests that internalised stigma does play a part in perinatal depression where women with upper income may silence their feelings towards low mood. Mauthner [40] suggests women are involved in a conflict with themselves, and the social world and people in their lives, they see no way of revealing their feelings within a personal and political context which, as they viewed it, firmly suggested what a 'good' mother ought to feel, think and do, and judges mothers who fail to meet these norms, this transfer into silence made sense psychologically, as it protected the mothers from what they experienced as the discrediting and dismissal of their feelings by others and by the culture in which they lived, however, this move was also a highly costly one for it was linked to their depression.

Treatment stigma was found to be non-significant with BAME women as a collective group as against hypothesised. However, when looking at the sociodemographic factors - Treatment stigma along with internalised stigma was found to be positively and significantly predictive of perinatal depression symptoms for 25-34 year old women. This is an important age group to observe, as babies who were born in England and Wales in 2013 were found, to have a mother most likely to be aged 25-34, with 59% (over one-half of mothers) in this age category [41]. Thus, treatment stigma may play a part in perinatal depression for this age group as they may be conscious of how they are seen. Vogel *et al.* [12] found that the concern of being regarded as 'crazy' is a common barrier to seeking formal help and that individuals are more likely to report stigma as a barrier to treatment when they do not seek therapy compared to those who do, stigma in terms of mental ill health has been associated with the early termination of treatment, thus, there is strong support concerning awareness of the stigma in relation to pursuing treatment which impacts negatively individuals' attitudes towards help-seeking behaviour and prevents a lot of individuals from seeking help even when they have considerable issues [12].

In addition, for 25-34 year olds, motherhood may play an important role and women might not want to reveal feelings of perinatal low mood and depression due to internalised stigma. Templeton *et al.* [18] found childbirth is the fundamental goal for most women and women are expected to have an instant bond and unconditional love should happen between mother and baby, if not, the mother may feel guilty, upset and confused, many women will not seek the support or help they need due to feeling that they should be able to manage and that any negative feelings will fade, there may also be confusion between symptoms of depression and those occurring after childbirth for example anxiety and tiredness.

Perceived public stigma was found to be non-significant with perinatal depression symptoms in contrast to what was

hypothesised. However, when looking at socioeconomic factors, perceived public stigma was found to be predictive for BAME women with a lower income. Socioeconomic factors revealed in this study may have an impact on BAME women seeking help. Golberstein *et al.* [34] found greater socioeconomic status may show a different association between mental health care and stigma compared to groups with low socioeconomic status or older groups, financial factors are some of the most significant barriers to pursuing care for mental ill health. Russell *et al.* [5] suggests women from all ethnic backgrounds are using online self-help, other methods of treatment or not receiving treatment, women particularly those who have not been referred, often find this to be the most beneficial source of support as this is an easy way to find others going through similar problems and seek support outside of NHS services including; charities, religious or community groups, activity groups for example yoga, general mother and baby groups or breastfeeding groups and a large proportion were found to report that social media and online groups were a platform and a way to support each other. Therefore, BAME women on a lower income may not have access to these alternative methods. Redshaw and Henderson [42] found the relationship between adverse outcomes and mental health is moderated by education, socioeconomic factors, and adversity, some of these factors may be responsive to psychological and pharmacological treatments and intervention has shown to be effective however not always accepted.

The analysis in this article found that treatment, perceived public, and internalised stigma positively and significantly relate to one another. This supports previous research that these three variables are positively associated with one another [14]. This suggests that internalised stigma plays an important role for BAME women and treatment, perceived, and internalised stigma each have an association with the other.

The exploratory research found that BAME women were most comfortable being asked about mood by answering questions at home and then bringing paper with them with their answers to their next visit with their healthcare provider and answering questions online using a computer in their home before their visit and then electronically sending responses to their healthcare provider so that they can talk about their answers on their next visit. This builds on the statistical analysis as women who may be suffering with internalised stigma may be more likely to admit their feelings in the most comfortable setting such as their home. Being called at home by a healthcare provider and answering the questions over the telephone and talking about responses over the telephone and bringing the topic of mood up themselves with a healthcare provider were found to be situations where BAME women were less comfortable this further suggests that it is not only the comfort of their home that BAME women appreciate but also perhaps BAME women may be seeking a 'safe space' on their own to express their feelings but would also like to have the opportunity to discuss their responses on a next visit to see their healthcare provider and would prefer a set arrangement to do this as opposed to bringing the topic up themselves.

Limitations of this study

This article looked at BAME women by ethnicity-specific subgroups as these groups have differences. This article also looked at BAME women who may identify as having a Black background only or those that identified as having all other ethnic

backgrounds. However, the UK BAME population is highly diverse, thus the analysis may disguise heterogeneity within subcategories. However, the participants in this study represented a subsection of this population.

The majority of BAME women in this study were 25-34, university educated and had middle to upper income. Thus, may not fully represent BAME women in the UK. The sample was also restricted to those with internet access, all participants completed the survey online, and those that do not have internet access were under-represented. Participants also voluntarily took part in completing the survey so they could be particularly interested in perinatal mental health care. Those that know little about perinatal depression may be under-represented. In addition, BAME women could have been particularly keen to partake in the study if they had experienced a negative experience when accessing or using perinatal mental health service provision and would want to share these experiences. However, this study was useful in understanding this particular group of BAME women.

There has been some criticism surrounding the EPDS. The EPDS was used in the present article because it is the tool of choice for healthcare providers in the UK for perinatal depression.

Conclusion

In this article, no claim was made to tell the full picture about the overall effects of stigma for all BAME women with perinatal depression. That said, this study still provided a comprehensive discussion on the BAME population that participated in this study, in addressing important considerations for promoting mental well-being for perinatal depression and exploring treatment stigma, perceived public, and internalised stigma. The findings added to the body of existing research on perinatal depression and BAME women in the UK. Such insights are vital in order to reduce stigma and support BAME women experiencing perinatal depression.

In conclusion, as hypothesised, internalised stigma was found to be a significant predictor variable of perinatal depressive symptoms; socio demographic factors also showed, in the case of both women that identified as Black and women that identified as all other ethnicities, that perinatal depression symptoms was found to be positively and significantly predictive of perinatal depression symptoms. In addition to this, internalised stigma was also found to be predictive of perinatal depression symptoms for the 25-34 age groups of BAME women and BAME women with upper income. Alternatively, treatment and perceived public stigma were found to be non-significant with perinatal depression symptoms for BAME women as a collective group. However, treatment stigma and internalised stigma were significant predictor variables of perinatal depression for BAME women aged between 25-34 and perceived public stigma was found to be a significant predictor variable of perinatal depression for BAME women on a lower income. More work is needed to determine and differentiate between perinatal depression symptoms and measures over time for BAME women.

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Conflicts of Interest

None

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