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Perspectives on Mental Illness Stigma Among African Immigrant Pregnant and Post-Partum Women in an Urban Setting: A Brief Report

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Abstract

Purpose: This study assessed the perspectives of pregnant and postpartum African immigrant women on mental illness.

Methods: We conducted a focus group session ($n = 14$) among pregnant and postpartum African immigrant women in June 2020. We used an inductive driven thematic analysis to identify themes related to mental health stigma.

Results: Five core themes emerged: conceptualization of mental health, community stigmatizing attitudes, bio-psychosocial stressors, management of mental health, and methods to reduce stigma.

Conclusion: Understanding the perspectives of pregnant African immigrant women at the intersection of their race, ethnicity, gender, and migration are necessary to improve engagement with mental health services.

Keywords: stigma; immigrant; African; women; mental health

Introduction

The African immigrant population increased by nearly 90% since 2000, yet they remain underrepresented in health care research.[1,2] The intersection of race, ethnicity, gender, and migrant status compounds discrimination and health inequities for African immigrants, and this may be further pronounced during the vulnerable period of pregnancy.[3–5]

Past systematic reviews and meta-analysis show 1.5 times higher likelihood of postpartum depression among immigrant women compared to nonimmigrant women.[6] However, majority of these studies on postpartum depression in immigrant women to high income countries have been conducted in Canada, Europe, and Asia, for example, in one meta-analysis, of the 22 studies included, only one was conducted in

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the United States.[6] One study focused on general health behaviors suggested that pregnant African immigrant women reported better overall health compared to native-born pregnant Black women.[7]

Generalization on perspectives of mental health across geographical regions and ignoring the unique experience of mental health in the pregnancy and the postpartum period will lead to further public health gaps. Studies of African immigrants in the United States show reliance on religious support systems; acculturation (or stress of integration) and social exclusion have an impact on mental health service utilization.[8,9] Dedicated studies are necessary to expand our understanding of the unique perspectives and needs of African immigrant mothers in the peripartum and postpartum period to improve engagement in mental health services.[10–13] The aim of this study was to assess these unique perspectives that affect mental health service use.

Methods

Ethical consideration

The institutional review board at Northwestern University approved this study. Written and informed consent was completed.

Setting, participants, and study design

Setting. The study was completed in partnership with the United African Organization (UAO). UAO provided social services to African immigrants.

Participants. The focus group and survey participants ($n = 14$) inclusion criteria were as follows: (1) identifying as an African immigrant, (2) pregnant or postpartum within the past 12 months, (3) English speaking, and (4) 18 years of age or older. Participants were recruited using convenience sampling. Participants completed one focus group and a brief survey.

Recruitment. Flyers and brochures were placed in UAO offices. Text messages and word of mouth were used, and community members were self-referred.

Interview procedure and protocol. The semistructured interview guide and survey components were developed by a multidisciplinary team, including academic and community partners, to ensure culturally acceptable language in discussing mental health. We developed the interview guide and survey based on the existing literature on mental illness related to religiosity and the influence of social stigma within the community.[14]

The questionnaire was completed before the focus group, and all study activities lasted ~75 min. Due to the COVID 19 pandemic, videoconferencing was used. Participants received $30 compensation for their time. Probes and member checking were used to verify meaning.[15] All participant information was deidentified.

Data analysis

The focus group questions are presented in Table 1. We used a grounded theory thematic approach to ensure that emerging themes were elicited given the limited data on this population.[16,17] NVivo software, a qualitative analysis tool, was used. The focus group was audio recorded and transcribed. We used five iterative steps[16]: initial review, line coding, organization of meaning units, discussion, and final review of consistency between two experienced coders (a first generation African immigrant female psychiatrist and a white female postdoctoral psychology student). One coder also had lived experience as an African immigrant mother. Intercoder reliability ($K > 0.80$) was reached. Coders applied the codebook to the full transcript.

Assessments

We developed a *sociodemographic questionnaire* to assess age group, education, marital status, citizenship status, income, employment status, and insurance

Table 1. Focus Group Questions

Focus Group Questions
(1) What is emotional wellness?
(2) What is your understanding of changes in emotional wellness including stress or distress that can happen while pregnant or after pregnancy?
(3) What are your perceptions of your community's understanding of stigma of emotional wellness while pregnant or after pregnancy? Do you believe emotional wellness of mothers is looked down upon in our society/community? In what ways?
(4) What is the definition of mental health stigma?
(5) Tell us about personal stigma of emotional wellness while pregnant or after pregnancy: *What are your personal beliefs about emotional wellness during or after pregnancy, beliefs about emotional wellness treatment—including* ***views on taking medication****—while pregnant or breastfeeding or in general?*
(6) Do people experience shame about mental illness at home or at work or in public settings while pregnant or after a pregnancy? What can reduce the negative attitudes or feelings of shame?
(7) What do you think would help reduce stigma around having emotional stress or challenges? Would you participate in these strategies such as meeting peers who have mental health challenges (direct contact), education about mental health using presentations or videos, entertainment or theatre, mental health awareness campaigns? What are some barriers to participating?

status. The *Patient Health Questionnaire (PHQ2)* is a validated two-item depression screening measure.[18] This measure has a high positive predictive value.[18] We also developed a *brief questionnaire* to assess specific beliefs about mental illness such as religiosity and views on medications.[19]

Results

Among the African immigrant women ($n=14$) in the study, 50.0% of respondents reported being pregnant ($n=7$; 5 in the first trimester) and 3 (21.4%) participants had a positive screen on the PHQ-2. Participants' characteristics are shown in Table 2.

Summary of focus group and brief questionnaire results

Five core themes related to mental health and mental health stigma emerged:

Theme 1. *Conceptualization of mental health in the community*. Some respondents described mental health as an emotional experience, possessing resilience and having good functional well-being. The word "mental" was seen as having negative connotations. Some respondents ($n=4$, 28.57%) believe that depression is not a medical illness, and some respondents ($n=3$, 21.4%) reported that people with depression are dangerous, while others ($n=7$, 50%) reported people with depression are unpredictable.

Theme 2. *Community stigmatizing attitudes toward mental health challenges during pregnancy*. Several respondents shared their experience of judgment. People with emotional struggles were seen as "crazy" or "mentally retarded." There was majority consensus that pregnant women should not take medication while pregnant ($n=10$, 71.4%), despite acceptance of the biological models of illness (theme 3). Some respondents reported that feelings of sadness or depression are a moral failure (7 [50%]), a result of sin (6 [42.9%]), or caused by evil spirits (5 [35.6%]).

Theme 3. *Biopsychosocial stressors and hormonal changes during the peripartum and postpartum period*. There was general consensus that pregnancy was connected to changes in the emotional state of a person. Stressors included biological and psychosocial aspects of stress—hormones, lack of sleep, and the overwhelming nature of personal and professional responsibilities.

Theme 4. *Management of mental health during the perinatal and postpartum period*. Respondents offered several ways to manage mental health in the context of pregnancy, including self-motivation, religious resources, and talking to others (both in the community and professionally). While 50.0% of respondents reported that they would call 911 or seek immediate help if someone was having suicidal thoughts, 5 (35.7%) said that they would never or rarely seek immediate help.

Theme 5. *Methods to reduce stigma*. One respondent described mental health as invisible and difficult to "normalize." Respondents suggested public health campaigns and awareness groups in the community, similar to the focus group forum. In particular, one respondent described the need to support pregnant women due to the added psychosocial stressors that come with pregnancy (Table 3).

Table 2. Characteristics of Sample

	Overall ($n=14$)
Age group	
26–35	8 (57.1%)
36–45	3 (21.4%)
46–65	3 (21.4%)
Marital status	
Married/partnered	9 (64.3%)
Separated	3 (21.4%)
Divorced	1 (7.1%)
Never married	1 (7.1%)
Gender	
Female	14 (100%)
Citizenship	
Yes	8 (57.1%)
No	6 (42.9%)
Level of education	
High school/GED or less	1 (7.1%)
Some college	2 (14.3%)
Bachelor's degree or above	8 (57.1%)
Master's degree	3 (21.4%)
Personal income	
$9,999 or less	6 (46.1%)
$10,000 to 29,999	4 (30.8%)
$30,000 to $49,999	3 (23.1%)
Nonresponder	1 (23.1%)
Employment status	
No	6 (42.9%)
Yes	8 (57.1%)
Health insurance	
Public	10 (71.4%)
Private	1 (7.1%)
None	3 (21.4%)

Discussion

Our main finding was that stigma toward mental health was associated with the label of being "crazy" or being judged. In addition, medication was not viewed as acceptable, but there was openness to activities such as support from the community and psychotherapy. There was acceptance of the biopsychosocial

Table 3. Core Themes and Representative Quotes

Core themes	Key participant quotes
Conceptualization of mental health in the community	"Emotional wellness is when an individual is able to handle stressful situations and they're able to adapt to certain changes and when times are difficult, they're able to deal with it." "I think it's really accepting how I'm feeling, that, 'This is real.' This is how I really feel or what I'm really experiencing as part of myself and who I am." "In our culture … when you use the word mental health, you are crazy, you are not normal, whatever normal is, functional person in society, you are literally a mad person who's not. or nobody should really associate with you because you are not normal. And for that reason, it hinders people from seeking the support they need. So it's, it's, it's very difficult for anybody" "Depression is in different stages, you know. If somebody is depressed, do that mean that they can't get a job? It depend on what, uh, the stage of their depression or why they're depressed, you know." "Talking about mental health, and the stigma that is associated to it. For instance, I personally, I went through that and it was something that …I've never had any experience of that, so it was something very strange to me…. I couldn't sleep, I was just going up and down, I couldn't do anything, I felt like my throat is closing up, I felt like my heart rate is beating so fast" "For example, you're pregnant, you don't wanna tell somebody, 'Oh, I have this problem and I have that problem,' because they will just jump into a conclusion of, 'Uh-oh, this person is, you know, having these issues, maybe, you know.' Using that word 'mental health,' or emotionally unstable, all of these things are negative connotation in our, in our community,"
Community stigmatizing attitudes toward mental health challenges during pregnancy	"Some look down on pregnant women, you're just supposed to stay home, rest and such, but it's like they forget the fact that even though you're pregnant, you still need some type of financial support; if you don't have anyone supporting you, you still have to support yourself somehow." "That's the first thing they will just say, 'You crazy.' And that's what frustrated me even more throughout the pregnancy and this postpartum, that word crazy. I'm not crazy because I'm having some emotional issues, because I'm having some mental issues, I'm not crazy." "I just feel like there's no need for me to even open my mouth and tell you my problem because the first thing you just say is I'm crazy" "you know, a lot of people will not open up, they'll prefer to get the help from outsiders, because sometimes you can have mental issue and the only thing you just want is to talk to someone that can understand you, have someone hear you out and give you different perspective, different answers on how you can help yourself. But when you're dealing with your own emotional health and mental health, and the other person is just saying, 'You're crazy.'" "And by this being my first pregnancy, I get really frustrated because when the baby cries, she doesn't stop crying, I'm just holding her in my hand, like, it irritates me, I get frustrated even more and then, like, many people don't understand that. Instead of giving me different ideas and solutions how I can make it better, you're just standing there telling me I'm crazy, I'm freaking out, like, and that word me, the word crazy." "Check that family, maybe they have mental health history, 'this person comes from the mentally retarded people.' And I'm just, you know, sometimes looking at people like… 'you are diagnosing somebody's entire family based on a challenge'" "But when, because they cannot see your emotional pain, they are quick to judge and call it crazy…. Start opening a door for that conversation, we will get a chance to make it a normal way of knowing, 'Oh, mental health is not craziness, it's just another form of physical health that is not seen.'" "Yes, I've called my doctor and he said if I keep having that feeling then I should come for. then they will have to put me on medication." So when I told my friend, as a nurse, I thought she would be a, a pillar of support but it was something that she was even panicking more than me, and she made me. she gave me more anxiety because she was like, "You can't take any medication. You have to talk to somebody." She [said] "You, you're going to end up in the psych home if you start this medication," so it made the anxiety worse than how it was.
Biopsychosocial stressors and hormonal changes during the peripartum and postpartum period	"One minute your hormones can be like, they're like very unstable, out of control, very high, and you're just very frustrated, every little thing frustrates and irritates you…. And then sometimes the other person does not understand that, and you're not even understanding how you reacting to the person." "I was actually enjoying being pregnant. You know, it could be because the people I surrounded myself with, from work to home, and everything, It was like a support system, it was like an understanding. But the hormones have their own time, but I just find a way to balance it." "You know, there were challenges... challenging time in the middle of it but I just paced myself accordingly. So it was about me thinking, 'Okay, there is somebody in me, she's a priority, not even myself, not even my feeling.' But as time goes by, until about eight months when my feet were swelling…. And I have to get away and r- remind myself that nobody understands" "And after having the baby…. How am I gonna sleep when I have all this 20 things to do? And whether I sleep or not, I still have to get those things done. And then your body is telling you, ' Listen, I'm still hurting, I'm still healing, you can't do all this stuff.'" "And after the pregnancy, it was anything can make me cry. Anything happen, I was like just crying, crying. Sometime when you look at back what happened, you, you feel like, 'This one, I shouldn't cry regarding this,' but when I was feeling it, everything I was just crying, crying." "After having the baby, three months after that, I was still tired. The best thing that ever happened, Corona might be negative, but somehow it saved me because I didn't have to get up and drive. Because I just realized that I could not wake up at 3:00 AM and be with her for about two hours and then get up and start driving to get to work at 9:00 AM."

(*continued*)

Table 3. (Continued)

Core themes	Key participant quotes
Management of mental health during the perinatal and postpartum period, views on psychotherapy, medications, and religious management	"For me, the pregnancy was so easy but adjusting to the schedule of the baby and waking up and doing this every day; when I wake up at midnight, when I wake up at 3:00 AM, when I wake up at 4:00 AM just to feed and put her back to bed, there are times where I'm tired but I have to look at the positive feedback to gain my strength and say, 'Oh, she's healthy. She and I are not in the hospital because of any complication,' and that would be something that I pick from to gain strength." "Breastfeeding, to me, is a way of bonding with my child and just having that connection, and also understanding that's a very healthy process for her, not just for now but in the future, for her own health. So, for me, I kind of encourage myself, empower myself to say, 'I can do this.' It's not an easy thing." "And sometime it's because you have a problem that's affecting you, it's not because you are, as a person, that's mentally, but that that problem that you have is pushing you to the point where you are like, 'I can't even deal with it,' but you need the right person to talk to, who understands what mental health really is." "I do not believe in medication. So to me it's about talking to somebody, because you have to look around you and look for that one person who, who understands where you're coming from, what's happening to you and who is going to listen to you, and also give you good feedback." "Medication, I never medicated when I was pregnant. Thank God I didn't have any issues at all to, to be medicated. And after that, I still did not, um, I just continued to look. [people] around me for the right energy to carry on." "For me, I don't think a medication is a solution, you need to talk to someone when it happened and stuff like that, because medication is not some…. Here, everything is recorded, like you, when you have. you go to the hospital, they prescribe something to you, this, information will be on your medical record. And if something happened later and even not related to your condition you had when you were pregnant, it can be, for me, I think it can be against you. Like, you were saying, people think, like, you are crazy, stuff like that." "from our cultures, right, we don't have. always have the systems in place to get someone that you can open up to and talk about your emotions because, most of the time it's ignored, how you feel and stuff like that, are things that are pushed aside, if you hand is cut you can get someone's attention, but you really expressing how you are feeling is something that is also pushed aside and, and not supported…. I mean, you are in a new environment, being in the United States, but back home. and I think we bring our cultures and our experiences with us here as well." "I didn't tell her but I didn't even know who to talk again, because if I can tell someone who is in the medical field and she put more fear in me than I was going through. So I, I just decided to call the doctor, I saw the doctor and I started taking the medication." "'Just go pick up the Quran,' and they say you'll get better. No, I want to talk. Everything is not spiritual to everyone, and that's just my thing. because every individual is different. And to you, oh, once you just get up and pray everything will go away, no. And that's like a lot of conflict during pregnancy and after pregnancy." "You know, when you just go like, 'Oh, something is wrong.' 'Oh, you're crazy. Just pick up the Quran and you start reading, and then you will feel better.' I'm like, 'No. Like, I need someone to actually hear me out. I need to talk to this person. I need to talk to somebody who can, you know, give me different ideas and different perspectives and how I can manage things.'"
Methods to reduce stigma	"First of all we need to normalize mental health just like where you have the physical health. Physical health is because you cannot hide it, mental health is because you cannot see it. But how can normalize and make people comfortable to know that, 'It's okay to be feeling the way I feel. I talk to somebody and no judge.'" "How can we get to that place where mental health is not a stigma, men- mental health is not craziness? Mental health is just like you having a headache, [00:38:00] and maybe you need to rest or need someone to talk to, or need to address that problem that's causing your stress. Or at least help the community understand that mental health is this and that, and not craziness. Mental health is you having a challenge in your life that's not changing for a long period of time and it starts to affect you emotionally" "We need the campaign, we need the awareness, we need the training, we need the group and the community. We need it all to, you know," "Well, if there's any campaign, any awareness, any group, like we're doing now, to be able to educate each other, to be able to speak freely, and understand what those things means … if you need to go for counseling, if you need to chat with your friend, then you can do that. You can even. There's Zoom now, you can have friends on Zoom, like, evening time, with your wine, chat, whatever, hence you are not recording it, you can chat" "And I also feel like the community should be more involved with helping pregnant women have even some type of part-time job because some people are different …. My experience, my stress was financial stress, my stress was emotional stress and someone else's pregnancy may not be financial stress or that kind of emotional stress, it can be just something else"

aspects of pregnancy (including hormonal changes); despite this acknowledgment, most respondents had stigmatizing views of medications. And some respondents endorsed beliefs that sadness or depression is a moral failure, a sin, or caused by evil spirits. Past studies show that stigmatizing beliefs similar to these led to worse mental health outcomes related to higher morbidity and mortality.[9,20]

Previous studies have also shown that pregnant African immigrant women had better self-rated overall health compared to native-born pregnant Black women,[7] likely due to the healthy migrant effect.[8,21] The healthy migrant effect refers to the concept that migrants tend to have better health status than people of similar backgrounds in the host country[22]; however, over time, likely due to the effect of racism, gender, and migration,

this apparent advantage is diminished.[22,23] In our sample, the willingness to seek professional mental health services, especially pharmacotherapy, was particularly low.

There are higher somatization rates among African immigrants, compared to US born Black people; African immigrants tend to focus on physical health symptoms and prefer primary care health professionals.[8,24] In our study, respondents endorsed anxiety and low mood symptoms, such as difficulty sleeping, elevated heart rate, tearfulness, irritability, and generally feeling overwhelmed. Due to somatization, pregnant African immigrant women are at elevated risk of health care professionals not recognizing their symptoms. Therefore, they may experience further delay in initiation and engagement in mental health services in pregnancy, where early intervention is critical.[4,25]

Study limitations

This was a brief report with a small sample size and the use of one focus group. As a result of the limited size, our recruitment was not representative of the population. In addition, while we used both open ended and closed ended questions, some closed ended questions such as whether people "looked down" on emotional wellness may have been leading. Additional larger studies are needed to further highlight themes and perspectives in the study population, and findings should not be generalized to the entire community.

Conclusion

This study suggests that more research needs to be done to understand the experiences of pregnant and postpartum African immigrant women. While we cannot generalize findings from this study, we found that in this focus group, pregnant and postpartum African immigrant women expressed the need for culturally sensitive providers who are not dismissive of religious and cultural approach to mental health.

While stigmatizing beliefs were evident, there was also a juxtaposition of beliefs in the spiritual causation of mental illness along with the biopsychosocial causation (hormonal changes in pregnancy) of mental illness. There is an opportunity here to improve engagement in mental health services by increasing cultural sensitivity training among health care professionals, and future studies with a larger sample size are needed to explore the specific and unique needs of pregnant and postpartum African immigrant women.

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Abbreviations Used

PHQ2 = Patient Health Questionnaire
UAO = United African Organization