An Ethiopian Perinatal Mental Health Support Group: 12-month Evaluation Report

WA Perinatal Mental Health Unit
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Acknowledgments

This report is the culmination of many months of effort by a diverse team of dedicated and generous people, and their organisations. The WA Perinatal Mental Health Unit expresses sincere thanks to all involved, as without their support and help this 12-month Evaluation would not have been possible.

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Executive Summary

Immigrant and refugee status has been identified as a risk factor for mental illness during the perinatal period, with numerous factors postulated that may predispose these women to suffer from mental health problems, including social isolation, separation from family, financial difficulties, experiences of discrimination, and a lack of familiarity with health care practices in the host country. For women migrating from Ethiopia to Australia, exposure to violence or trauma in Ethiopia, prior to migration, may also increase risk of mental health problems during the perinatal period.

Acknowledging these issues, the WA Perinatal Mental Health Unit (WAPMHU) and State Perinatal Mental Health Reference Group (SPMHRG) endorsed the provision of funding to establish and trial a supported playgroup for Ethiopian women in the perinatal period. In July 2008 a Service Agreement was made between the Women and Newborn Health Service, Department of Health and Gosnells Women’s Health Service Inc. (GWHS) to carry out this project. The following report presents the evaluation framework and results of the first three terms of data collection.

Evaluation is based on a pre and post-group design using both quantitative and qualitative data collection methods. Thirteen Ethiopian and one Sudanese mother completed pre-group assessments, including an interview, a demographic questionnaire and an Edinburgh Postnatal Depression Scale (EPDS). Thirteen of these women completed post-group assessments and were thus included in data analyses.

Quantitative data collected via the EPDS was used to assess changes in depressive symptomatology over the course of the 8-week group term. Interview transcripts were thematically content analysed in nine sections - corresponding to the questions posed during the interviews.

Eligibility for participation in the perinatal mental health support group was based upon ethnicity and motherhood status, irrespective of the presence or absence of depressive symptomatology. In light of this, the level of depressive symptomatology found pre and post-group in this sample of mothers is somewhat concerning. Forty-three percent of the women participating in the supported playgroup scored above cut-off (≥10) on the EPDS pre-group, increasing to 58% post-group, suggesting that the
prevalence of perinatal depression (and anxiety) may be significantly higher in this population of childbearing women than general community samples.

Despite initial difficulties gathering sufficient numbers of women for the group, thirteen local Ethiopian women have now attended the supported playgroup and there appears to be an increase in level of perceived psychosocial support by the participants as a result. The participants’ awareness of perinatal mental health issues improved post-group and the importance of accessing services if/when needed was apparent. Women reported feeling comfortable accessing community and obstetric service pre and post-group with no noticeable improvements. However, there was an improvement post-group in reported levels of comfort engaging mental health services if/when required. The evaluation results indicate that four of the eight key performance indicators are being met.

Given the histories of the women participating in the perinatal mental health supported playgroup and the complexity of their current living arrangements it was not expected that an 8-week term would be sufficient for long-term and significant changes in mental health status. Nevertheless, from the qualitative results, it appears as though the social support, information and exposure to community services afforded by this group are having positive effects and can be built upon for future and extended benefits.
Introduction

Pregnancy and the postpartum period (i.e., up to 12 months after delivery) are referred to as the ‘perinatal period’. For women the perinatal period is associated with major biological and psychosocial changes. Subsequently, it comes as no surprise that major depression in women has been found to peak in onset during the childbearing years (Weissman & Olfson, 1995) and there is now increasing evidence that anxiety may be just as prevalent (Austin, 2004).

Postnatal depression (PND) affects approximately 13% of women who give birth (O'Hara & Swain, 1996), and many women may also be depressed during their pregnancy (Brooks, et al., 2009). Research has linked depression during pregnancy and postpartum to chronic depression, marital difficulties and behavioural and cognitive delays in children (Pope, Watts, Evans, McDonald, & Henderson, 2000), yet despite the prevalence and consequences, many women living in Australia still remain unidentified and untreated.

Women from culturally and linguistically diverse (CALD) backgrounds (i.e., non-English speaking background and born overseas or with at least one parent born overseas) make up 12% of the Australian female population, and Australia’s shifting immigration policies are leading to greater inflows of women (Gwatirisa, 2009). The acculturation or resettlement experiences of immigrant and refugee women are often compounded by their pre-migration experiences and for refugees in particular, their harsh pre-migration experiences often makes the transition difficult (Gwatirisa, 2009). Elevated rates of mental distress and mental disorders are observed in refugee populations compared with the general population (e.g., Boehnlein, 1987; Lin, 1986; Westermeyer, 1986), particularly for those who have experienced war/conflict (Roberts, Damundu, Lomoro, & Sondorp, 2009).

The most commonly researched mental disorders in refugee and conflict affected populations appear to be post-traumatic stress disorder (PTSD) and depression (de Jong, Komproe, & Van Ommeren, 2003; de Jong, et al., 2001). Although mental health research with Ethiopian or Sudanese populations is scarce, PTSD rates of 46% have been recorded amongst Sudanese refugees living in Uganda during the conflict (Karunakara, et al., 2004). In post-war Southern Sudan 36.2% prevalence rates of PTSD and
49.9% prevalence rates of depression have been reported (Roberts, et al., 2009).

Immigrant and refugee status has been identified as a risk factor for depression during pregnancy and in the postpartum period (Dankner, Goldberg, Fisch, & Crum, 2000; Glasser, et al., 1998; Onozawa, Kumar, Adams, Dore, & Glover, 2003; Small, Lumley, & Yelland, 2003; Goyal, Murphy, & Cohen, 2006; Robertsson, Wickberg, Gustavsson, & Radestad, 2005; Zelkowitz, et al., 2008). Numerous factors have been postulated that may predispose immigrant and refugee women to suffer from mental health problems, including social isolation, separation from family, financial difficulties, experiences of discrimination, and a lack of familiarity with health care practices in the host country (Mulvihill, Mailloux, & Atkin, 2001).

For women migrating from Ethiopia or Sudan to Australia, exposure to violence or trauma prior to migration, may also increase risk of mental health problems during the perinatal period. Results of recent research conducted in post-war Sudan reported that 44% of female respondents had witnessed the murder of family or friends, 48% had directly experienced a combat situation, 22% had been forcefully separated from family and friends, 15% beaten or tortured, 10% imprisoned, and 8% raped (Roberts, et al., 2009). This same study found a PTSD rate of 42.5% and a depression rate of 58.7% amongst female respondents (Roberts, et al., 2009)

So, although research into the perinatal mental health status of Ethiopian or Sudanese women is unavailable at this time, statistics such as these, together with the extensive knowledge regarding the risks of psychological distress during the perinatal period for the general population, leave no question that these women can be regarded as a high-risk population in need of culturally appropriate support during the transition to Australia and motherhood.

**Background**

In 2004, a state-wide mapping of perinatal mental health services was conducted and consultations with a range of community health workers undertaken. The resulting report (State Perinatal Mental Health Reference Group, 2005) highlighted significant gaps in health professionals' cultural awareness when addressing the perinatal mental health needs of women from culturally and linguistically diverse (CALD) backgrounds. Adding to the
difficulties was a lack of culturally or linguistically appropriate perinatal mental health resources.

Subsequent to this report, a series of focus groups were conducted with women from Iraq, Sudan and Ethiopia, with the objective of gathering information on their experiences and thus mental health requirements during the perinatal period. The selection of these three CALD communities was based on a number of factors, including population size, percentage of child-bearing women, family size, and levels of education and literacy.

The results of the focus groups, as well as a literature review, are presented in “Social and emotional experience of the perinatal period for women from three culturally and linguistically diverse (CALD) communities” (State Perinatal Mental Health Reference Group, 2008). Recommendations from this report highlighted the importance of linking together pregnant women and new mothers within the community. It was proposed that ethnic-specific cultural liaison workers could co-ordinate self-help or support groups from within the community. It was envisaged that these groups could be used as forums for women to share their experiences and develop culturally appropriate coping strategies.

On the basis of these results, the State Perinatal Mental Health Reference Group (SPMHRG) endorsed the provision of funding to establish and trial a support group for Ethiopian women in the perinatal period based on a supported playgroup format. In July 2008 a Service Agreement was made between the Women and Newborn Health Service (WNHS), Department of Health and Gosnells Women’s Health Service Inc. to carry out this project.

This report presents the evaluation framework and results of the first 12-months of data collection and analyses conducted under the auspices of that framework.

**Expected Outcomes**

It is hoped that as a result of attending the support group Ethiopian women living in the Perth metropolitan area will become more comfortable engaging with community and mental health services. Subsequently, the level of psychosocial support perceived by Ethiopian women is expected to increase. A raised awareness of perinatal mental health issues within the Perth Ethiopian community and increased perinatal specific knowledge by local service providers are also objectives of the project. These outcomes are
then expected to assist in facilitating early identification and intervention for
women at high psychological risk and a subsequent increase in engagement
with mental health and community services may occur.

**Key Performance Indicators (KPI)**

1. Participation in support groups by local Ethiopian women (i.e. interest
   and attendance)
2. Increase in level of perceived psychosocial support by Ethiopian
   women in the local area
3. Decrease in depressive symptomatology, as assessed by the
   Edinburgh Postnatal Depression Scale
4. Increased perinatal specific knowledge by participants and local
   service providers
5. Increase in reported levels of ‘comfort’ during engagement with
   obstetric services during pregnancy by local Ethiopian women
6. Increase in reported levels of ‘comfort’ during engagement with
   community services during pregnancy and postpartum by local
   Ethiopian women
7. Increase in reported levels of ‘comfort’ during engagement with mental
   health services in pregnancy and postpartum by local Ethiopian women
8. Increased capacity with local communities for bicultural community
   worker to facilitate support groups (independent of original facilitator)
**Evaluation Framework/Research Design**

Evaluation is based on a pre and post-group design using both quantitative and qualitative data collection methods. However, awareness of cultural sensitivity and literacy issues led to greater emphasis placed upon collection of qualitative data.

There is a vast array of paradigms available to qualitative researchers, each with diverse views of what is real, what can be known, and how these social facts can be faithfully rendered. Guba and Lincoln (Guba & Lincoln, 1989) hold that socially constructed realities are governed by laws, natural or otherwise and that these constructions are devised by individuals as they make sense of their experiences. The task of the qualitative researcher is therefore to simply reflect and interpret these constructions as accurately as possible without any commitment to assuming an underlying and shared reality or indisputable facts (Gibbs, 2002).

Specifically designed semi-structured interviews were employed to collect the qualitative data for this evaluation. The research interview is one form of a conversational approach to qualitative analysis (Kvale, 1996). The interview allows the researcher to gather vast amounts of data and to use that data to understand the experiences of the participants and the meaning they make of their experiences. Interviewing provides a powerful and flexible way to gain insight into people’s experiences and allows unanticipated responses to be expressed and analysed. With an exploratory semi-structured interview technique employed, a framework within which respondents could express their own personal perspectives was provided. The interview questions served as a checklist to ensure all pertinent issues were raised but allowed for unexpected lines of enquiry to emerge and be pursued.

**Rigour**

Five main, somewhat overlapping issues have been addressed in the design, implementation and analysis of the present study to obtain the highest quality conclusions: (1) Objectivity/Confirmability, (2) Reliability/Transferability, (3) Internal Validity/Credibility, (4) External Validity/Credibility, and (5) Utilization/Application.
**Objectivity/Confirmability.**

The question of whether conclusions depend on the subjects and conditions of the enquiry rather than on the inquirer (Guba & Lincoln, 1989) is sometimes labelled as ‘external reliability’ with emphasis on the replicability of the study by others (Le-Compte & Goetz, 1982). Objectivity or confirmability of the current findings was strengthened by numerous strategies, including: methods and procedures are described in detail and presented explicitly, the actual sequence of data collection and analyses that lead to the conclusions can be followed, conclusions are explicitly linked with exhibits of condensed/displayed data, and study data has been retained and is available for reanalysis by others (Miles & Huberman, 1994).

Reflexivity was used to identify areas of potential bias. The researcher’s personal assumptions, values, and biases as a result of her social identity and background are presented as an Appendix and ‘reflexive bracketing’ techniques (Ahern, 1999) were applied. “The ability to put aside personal feelings and preconceptions is more a function of how reflexive one is than how objective one is because it is not possible to set aside things about which they are not aware” (p. 408, Ahern, 1999).

**Reliability/Transferability.**

Reliability or transferability, that is, stability of observations over time and across researchers and methods was sought through: the development of clear key performance indicators (KPIs) and congruence between these KPIs and the evaluation design.

The researcher’s role within the research context was explicitly described, and a ‘meaningful parallelism’ was sought across data sources by maintaining parameters with respect to participants, contexts and times (Miles & Huberman, 1994). That is, one researcher conducted all pre and post-interviews in the participant’s homes and this same researcher was responsible for transcribing all interviews, and then a second researcher was allocated to the collation and analysis of the data.

**Internal validity/Credibility.**

Unlike the classic, measurement-oriented view which differentiates face, content, convergent, discriminant, and predictive validity,
for the purposes of the current study a more qualitative approach was taken, thus the inclusion of the term ‘credibility’. Maxwell (1992) distinguishes among the types of understanding that may emerge from a qualitative study: descriptive (what happened in specific situations); interpretive (what it meant to the people involved); theoretical (concepts, and their relationships, used to explain actions and meanings); and evaluative (judgments of the worth or value of actions and meanings). Warner (1991) also refers to ‘natural’ validity – the idea that the events and settings studied are not modified by the researcher’s presence and behaviours. To this end, interviews were conducted by a person familiar to the participant in the participant’s home.

Triangulation of data sources (i.e., Edinburgh Postnatal Depression Scale, interviews and research literature) were also used in an effort to produce converging conclusions and give support for adequate validity/credibility within the present study.

**External validity/Credibility.**

Maxwell (1992) speaks of ‘theoretical’ validity, the presence of a more abstract explanation of described actions and interpreted meanings. Maxwell suggests that generalisability requires connections to be made, either to unstudied parts of the original case or to other cases. Although such an explanation could be considered as ‘internal’ validity, it gains added power if connected to theoretical networks beyond the immediate study. With this in mind the present evaluation employed ‘multiple case sampling’ (Miles & Huberman, 1994), that is, 13 Ethiopian and 1 Sudanese mother living in the Perth metropolitan area and attending the supported playgroup were interviewed prior to group commencement. A literature review was then used to ‘connect’ the conclusions to existing theory. The characteristics of the current sample of mothers are described in enough detail to permit adequate comparisons with future samples and the boundaries and limitations of this sample are also discussed.

**Utilisation/Application.**

‘Pragmatic validity’ (Kvale, 1996) is an essential addition to more traditional views of ‘goodness’. In addition to informing future funding decisions, the present study ultimately aimed to provide useful information to
people working with and providing support and information to Ethiopian mothers living in Australia. Whether those people were health professionals, policy makers or volunteer mothers working within organisations concerned with providing services to CALD mothers was unimportant. What was important was the identification of positive strategies, techniques and information that could be passed on to expectant or new mothers to ease their transition and enhance their parenting experience.

**Instruments**

The evaluation instruments included the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987), an interview schedule and a demographic questionnaire.

*Interview schedule*

A semi-structured interview schedule was developed by the WAPMHU Project Officer, in consultation with the WAPMHU Research Officer, to guide the face-to-face interviews with participants. Questions included in the interview schedule were guided by the KPIs, that is, questions were included to illicit discussion of perinatal mental health issues, ascertain current levels of support and assess comfort levels whilst engaging with available services.

The establishment of rapport, cultural sensitivity and flexibility were considered in the design of the schedule.

The following nine questions were included in the interview schedule and prompts were suggested for use as required to elicit elaboration and/or clarification:

1. How do you feel about the amount of support you have at the moment?
2. Can you tell me what you know about a woman’s emotional health when she becomes a mother?
3. Can you think of any emotional problems a mother might experience while she is pregnant or after she’s given birth?
4. For a woman who may be pregnant, or has a baby, what kinds of things do you think are helpful to ensure good emotional health?
5. What kinds of services have you visited during your pregnancy or since you’ve had the baby?
6. How do you feel about these services?
7. Where would you go to get help if you felt overwhelmed? Like you’re not coping? Like you’re not emotionally healthy?
8. How would you feel about asking for this kind of help?
9. How would you feel about using/visiting/going to a mental health service?

Two additional questions were asked during the post-group interview:
10. Has this group been good for you? If so, how has it helped you?
11. Would you recommend this group to other women from your country coming to live in Australia? Why?

**Demographic Questionnaire**

The demographic questionnaire was purpose designed for this evaluation to gather information on basic demographic variables. It was a structured questionnaire containing 10 questions to be completed by the interviewer at the time of interviewing the participant. These questions provided information on the participant’s age, parity, number of children, woman’s country of origin, whether the children were born in Australia, marital status, primary spoken language, other language/s, EPDS version used, and whether the EPDS and interview were completed with the assistance of an interpreter. There were also spaces provided to record the total EPDS score before the group began and at the end of the 8-week term.

**Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987)**

The EPDS was used to measure depressive symptomatology. This 10-item screening questionnaire takes about 5 minutes to complete and pertains to the women’s feelings during the past 7 days. The items refer to depressed mood, anhedonia, guilt, anxiety, and thoughts of self harm.

The EPDS has been widely used in cross-cultural work to measure depressive symptoms during the perinatal period and appears to be a reliable measure for both immigrant and non-immigrant respondents (Small, Lumley, Yelland, & Brown, 2007). The EPDS has been translated into many languages and validated in many countries, including Africa.

In the present study, an EPDS score of 10 or more was considered ‘high risk’ or indicative of depressive symptomatology, as recommended for
use when screening migrant women during the antenatal and postnatal period in Western Australia (Department of Health, 2006).

**Procedure**

Eligibility for participation in the perinatal mental health supported playgroup was based upon Ethiopian ethnicity and motherhood status, irrespective of the presence or absence of depressive symptomatology. As such, group participants varied in terms of current mental health status/psychosocial well-being, as well as age, education, whether English was spoken, occupation, marital status, and parity.

Once informed consent was obtained from group participants (i.e., to use de-identified data for evaluation purposes), the Project Coordinator, employed by GWHS, administered an EPDS, completed the demographic questionnaire, and conducted a semi-structured interview with each participant prior to commencement of the group.

Interviews and questionnaire completion took place in the women’s homes. After introductions and cultural formalities the interviews took place in an area in the home where the women felt comfortable (e.g., bedroom, kitchen or lounge room). An explanation was given to the women for the reason for the interviews and a written program outline was given to them. It was made clear to the women that the information was confidential and would not be identifiable when analysed/evaluated.

Depending on the woman’s level of English and feelings of competence either she would be asked the interview questions in English or through an interpreter. Probes and prompts were used when required to assist the women in understanding the questions, especially because of the language barrier. The questions were asked and their answers written as closely as possible to verbatim by the interviewer at the time of interview in the woman’s home. The answers were interpreted back into English if required by the interpreter present at the interview. Each interview took between 60 and 120 minutes to complete.

The typing of the handwritten answers to the interview questions was done by the Project Coordinator, who had also conducted the interviews. This de-identified pre-group data was then submitted to in hard copy and electronic format.
Post-group evaluation data, was collected via the same process and using the same questionnaires, at the completion of the 8-week supported playgroup term by the Project Coordinator. This data was also de-identified and submitted in hard copy and electronic format to WAPMHU.

The WAPMHU was responsible for collating and analysing pre and post-group data and preparing this evaluation report in consultation with GWHS.

Appropriate ethical clearance, and registration, for this Quality Improvement activity was obtained from the King Edward Memorial Hospital for Women Ethics Committee.

**Participants**

Participants were females born in Ethiopia or Sudan and now living in the Perth metropolitan area, had given birth in the last 2 years, and were subsequently attending the supported playgroup being run by GWHS. Five women attended the group in the first term, one new participant joined for term two, and eight new women joined the group in term three. Although 14 women in total were interviewed and completed questionnaires pre-group, 13 women were interviewed again post-group and included in the pre-group post-group analysis.

Mothers’ ages ranged from 26 to 41, with a mean age of 34. Two of the women were primiparous. Average number of children per woman was four, with the number of children per woman ranging from one to eight. Only three of the women had an infant less than 12 months of age at the commencement of the group, with the average infant age being 21 months (range 2 to 48 months). Twelve of the women attending the group were married, one had recently separated and one was single.

Developed as a ‘universal’ service, that is, by recognising that all women born in Ethiopia and currently in the perinatal period could potentially benefit from the support group (Williams & Berry, 1991), mothers who scored above or below the recommended cut-off on the EPDS (i.e., ≥10; Department of Health, 2006) were eligible for group attendance and were thus included in this evaluation sample.
Attrition of participants

Only one woman who was interviewed pre-group did not complete a post-group interview, this woman stopped attending the group mid way through the first term. The reason for this is unknown. Two women did not attend a substantial part of the term in which they joined the group, due to a death in the family (and thus adherence to a traditional mourning period).
Analysis

Interview Data

Thematic content analysis of the de-identified qualitative interview data involved three phases: coding, pattern coding, and reporting of findings and interpretations.

Coding

The initial coding phase involved the development of a question-ordered matrix using Microsoft Excel for the participants’ responses to each of the interview questions. Each participant received a unique code and their transcript was divided into nine sections, according to the participants’ responses to the nine interview questions. The sections were then read and speech units of varying lengths, typically 7 to 10 words, were coded and transferred into the matrix.

Pattern Coding

Pattern coding is a method for grouping initial codes into a smaller number of themes, sets or constructs (Miles and Huberman, 1994). To facilitate pattern coding and enhance transparency of the process, a new matrix was constructed for each of the interview questions: 1) current support, 2) importance of emotional health, 3) knowledge of depression and anxiety, 4) helpful ideas, 5) service usage, 6) service comfort, 7) future service seeking, 8) comfort asking for help, and 9) mental health service comfort. Coded text was transferred from the question ordered matrix to the corresponding new matrix and then searched for key words/phrases, which were entered into two separate columns – one for pre-group and one for post-group responses.

The number of times each of the key words/phrases was repeated across cases/participants was then counted and entered into the matrix, maintaining separate columns for pre and post-group data. This process was repeated within each of the matrices as appropriate, identifying the most common responses to each of the focus group questions. However, for some of the matrices, responses did not warrant a key word search, with identification of a pattern easily facilitated by counting ‘positive’ or ‘negative’ responses.
With the repetition of key words/phrases across cases clearly displayed within each matrix, the most ‘dominant’ or ‘prevalent’ patterns could be identified – and analysis of pre-group and post-group themes was facilitated. Development and revision of themes took necessary precautions (i.e., ensuring all themes were distinct from each other in meaningful ways and keeping themes semantically close to the terms they represent) as recommended by Miles and Huberman (1994).

The use of matrices and their availability to readers of this report (via request) facilitates transparency of the research methodology – from initial coded data to themes, strengthening objectivity or confirmability of the current findings (Miles & Huberman, 1994). The participants own words were used within matrices and refinement (i.e., development of themes) was made explicit, leaving a clear ‘audit trail’ so that ‘lower levels’ of analysis could be referred to easily.

**EPDS Data**

Data was coded and entered into PASW Statistics version 17 for data analyses. One participant was removed from the sample for statistical analysis as they did not complete the term, and thus did not participate in post-group interviews. Due to a death in the family, a second participant did not complete the EPDS post-group, although they were interviewed post-group. This left a total of 12 women in the sample for pre to post-group EPDS analysis.

The researcher was interested in any change in levels of depressive symptomatology for the mothers attending the supported playgroup, that is, from pre to post-group. A paired samples t-test was used to investigate these changes. A score of 10 or higher was used as the cut-off score to indicate the presence of depressive symptoms in this population of migrant women, as recommended by the Department of Health, Government of Western Australia (2006).

Any further statistical analysis was not possible at this time due to the small sample size, but it is expected that greater quantitative analysis will be possible for the final evaluation (i.e., after 2-years of service provision).
Results

The results of analysis are presented in two sections: qualitative and quantitative. The qualitative section is divided into eleven sub-headings, corresponding to the questions posed during the interviews.

Qualitative Results - Interview Data

**Question 1: How do you feel about the amount of support you have at the moment?**

An overall improvement in the level of support was reflected in the theme “enough support” becoming “good” support from pre to post group. This appears to be largely due to the friends made through the playgroup.

- E1.2 post-group: “I now feel like I get more support from the playgroup.”
- E1.3 post-group: “Being part of the playgroup is useful.”
- E3.14 post-group: “Yes, I can now talk to other women when I came to playgroup, I like this.”

However, there were still a number of women who felt they did not have sufficient support. The absence of family was the reason most often cited for feeling this way.

- E3.7 (mother of 4) post-group: “If you have a big family you become depressed because of stress, back home you have lots of support from family but here in Australia it is good to have small family.”

Family and friends, the church, professional/government services and the Ethiopian community were listed as sources of support by many of the women. However, for those who reported no support or very limited support in both their pre and post-group interviews, the playgroup was said to be the only source of support post-group.

- E3.11 post-group: “No, I don’t have any support only sometimes my husband… I feel like I get more support now that I come to the group because I have other ladies around me who know what it’s like, and we can talk and laugh.”
**Question 2: Can you tell me what you know about a woman’s emotional health when she becomes a mother?**

A mother’s emotional health was seen as important by participants’ pre and post-group. However, more emphasis was placed on self-care for the emotional well-being of the woman as an individual (as opposed to just for the sake of her baby) post-group – reflecting a positive shift.  
E2.6 post-group: “You become very tired and you need to relax and look after yourself. You need to eat healthy and exercise.”

The need for support was a strong theme both pre and post-group. The importance of feeling supported, and its contribution to emotional wellbeing was very well articulated by the women.  
E3.9 post-group: “Things change when you become a mum so it’s important to have support. If you don’t have support you can become sick and have many more problems.”  
E3.13 post-group: “If you have support everything is easy, I mean you need attention and someone to talk to. Without this a person can become very sad. As a mother you do the best with what you have. Sometimes you would like more but this is not possible.”

**Question 3: Can you think of any emotional problems a mother might experience while she is pregnant or after she’s given birth?**

Overall, the results indicated an increase in awareness of the types of mental health issues mothers can experience from pre to post-group in ten of the thirteen mothers. This improvement is illustrated by the responses of this primiparous mother of a 2-month old.  
E1.3 pre-group: “Depression maybe. Yes.”  
E1.3 post-group: “After she has had the baby she becomes tired with not enough sleep, she is busy and is expected to be happy. Yes I have heard of mothers with depression, this is when she is unhappy and things are not right in her life. Like baby not well and she becomes very busy doing things for baby, husband and the home can be too much. When you are a new mother you get little sleep and all this can make you sad.”

Although not as eloquent, the improvement in level of understanding/awareness of perinatal mental health issues from pre to post-group was again evident from the responses of this mother of four.
E1.4 pre-group: “I don’t know if they have problems. I have heard of depression but I don’t know what it is.”
E1.4 post-group: “Yes I have heard of depression, this is when things are not well for the mother and she is sad.”

**Question 4: For a woman who may be pregnant, or has a baby, what kinds of things do you think are helpful to ensure good emotional health?**

Women had many useful and practical strategies for pregnant and postpartum emotional health, and due to the surprising level of knowledge pre-group there was not a significant improvement post-group. Socialising, getting out of the house, going for a walk, getting their hair done, going to a movie, having a coffee with friends were mentioned numerous times by the women as helpful coping strategies or ways to improve their mood.

E3.13 pre-group: “If she has time she should go out shopping and do her hair. I would call friends and have a coffee, maybe go out to the shops so I can forget.”

E1.4 post-group: “Things that are good to do is go to playgroup, relax for while with your newborn, eat healthy and be happy, and to ask for help from friends and community. Talking to friends, going out and being with other people, like at the playgroup…”

E1.2 post-group: “If you stay at home for too long this can make you depressed so I think getting out is good. I will go out for a coffee, go shopping for retail therapy and meet with friends.”

Although women were aware of the importance of support to their emotional health pre-group there was an increased acknowledgment post-group of the need to ask for help.

E1.2 post-group: “The doctor and child health nurse can help. Having helpful family and friends is also good.”

E3.7 post-group: “These women should talk to someone about their problem when they are not coping, maybe counsellor or professional. You need to go to doctors for regular check up, get enough exercise and eat healthy.”
**Question 5: What kinds of services have you visited during your pregnancy or since you’ve had the baby?**

There did not appear to be any significant changes from pre to post-group in regards to the type of service the women were utilising. Many varied services were being accessed by the women and they appeared to be quite knowledgeable, both pre and post-group about what is available. The awareness levels observed were not unexpected given that there were only two primiparous women, all of the participants had been living in Australia for over 2 years, and seven of the women had lived in Australia for more than ten years.

E2.6 (mother of five) pre-group: “Family GP and then when close to giving birth, you go to hospital. After I had the baby the child health nurse came to check me and the baby.”

E3.12 (mother of four) post-group: “Child health nurse, King Edward hospital, Princess Margaret hospital and the family doctor. After I had my baby I was at home for 40 days and had continuous support from the community. GP, but I also may use the family place in the city (Family Planning Western Australia) now if I need advice.”

**Question 6: How do you feel about these services (those visited in question 5)?**

Similarly to question five, there does not appear to be any significant change from pre to post-group, with many varied services utilised and women appearing to be knowledgeable and comfortable pre and post-group accessing what is available.

E3.11 pre-group: “I feel ok but I have language problem and their dad comes with me. If my husband is not here then I ask for interpreter. I feel comfortable; if I need it I will go.”

E2.6 post-group: “The hospital was very nice, the CHN was nice as well she visit me couple times. I feel comfortable using these services.”

E3.10 post-group: “I feel comfortable using these services. I go to the doctors and they call interpreter for me, if I need it.”
**Question 7: Where would you go to get help if you felt overwhelmed?**
*Like you’re not coping? Like you’re not emotionally healthy?*

There appeared to be a minor improvement in the awareness of who to go to and then accepting professional help if they were not coping emotionally. That is, a positive shift was observed in the responses of four of the thirteen women from pre to post-group.

E1.3 pre-group: “GP. I don’t know.”

E1.3 post-group: “If I felt I could not cope I would go the doctor and child health nurse. Yes I would. I do not have any problems asking others for help, I only have one. The others (other mums in the playgroup) all have coped with many children. So far I feel like things are good. No, I don’t have one. If I needed one then I would speak with them.”

Participant E3.9, who due to feeling ostracised from the Ethiopian community, reported feeling unsafe to share problems pre-group was able to list a number of alternative sources of support post-group.

E3.9 pre-group: “My friend she is good. My aunt is good too…Not community – Ethiopian- they will laugh and talk about you. It’s best to keep it for yourself.”

E3.9 post-group: “The GP, hospital, if it’s the weekend I would go to the hospital. Maybe call where you work, the women’s place (GWHS)... sometimes when I need to I will ask.”

**Question 8: How would you feel about asking for help?**

Women remained divided on this issue, with approximately half being comfortable asking for help, half not so. This remained the same for each woman pre to post-group.

**Question 9: How would you feel about using/visiting/going to a mental health service?**

There were mixed results in regards to accessing mental health services, with four women ‘improving’ from uncomfortable to comfortable over the course of the term, seven women remaining comfortable pre and post-group, and two remaining uncomfortable from pre to post-group.

Example of improving comfort level:

E1.4 pre-group: “No I’m not comfortable using counselling.”

E1.4 post-group: “If I was told to go, I would go and I would feel comfortable.”
Example of remaining comfortable:

E1.2 pre-group: “I would first go to the doctor, then if I am asked to go to counselling I feel comfortable to go to anywhere where there is help.”
E1.2 post-group: “Not bad, it’s good. I would feel comfortable about using these services.”

Example of remaining uncomfortable:

E2.6 pre-group: “No I would not use this, I wouldn’t want to go there, it’s a bad thing, because if you go there this means you’re not well and that’s a bad thing.”
E2.6 post-group: “I won’t go if I don’t have too”.

**Question 10: Has this group been good for you? If so, how has it helped you?**

All thirteen of the women who participated in a post-group interview spoke warmly of the group, and believed it had been beneficial for them.

“It’s good I enjoy it, I feel free when my kids are here playing. I also learn a lot of things here like sewing, cooking, about my health and children.”

“Yeah good, its nice, friendly good people, they are like my sisters. When we meet in other place we are now more close. More friends now and I would speak to them if I need to. When I don’t know something I will ask Maarenet (co-facilitator) now.”

“Yes, it was very good, you learn new stuff, children play together and I enjoy the social events.”

“I enjoy it, my son enjoys it and I like seeing the ladies laughing together like back home. I know there is more help out there and I feel happy when I’m here.”

**Question 11: Would you recommend this group to other women from your country coming to live in Australia? Why?**

Once again, all thirteen women responded positively to this question, stating that they would recommend the group to others as they had found it beneficial. Many were already doing so.

“Yes, I would recommend it, I already told lots of people about playgroup and some of the ladies have started coming along. So we can learn laugh and share memories.”
“Yes, because they bring their children to play with other kids and they come and learn new things. It has been good to learn ways to deal with different things and find out what different places in our community can help us with. I really liked the first aid and meeting with the other women each week – its good to laugh.”

**Quantitative Results - EPDS Data**

On average, participants in the group did not report a significant reduction in depressive symptomatology from pre-group ($M = 9.25$, $SE = 1.37$) to post-group ($M = 10.33$, $SE = 1.58$, $t(11) = -1.07$, $p > 0.05$). Conversely, scores on the EPDS increased from pre to post-group, although not significantly so. Six women (43%) in the pre-group sample of fourteen scored above cut-off ($\geq 10$) on the EPDS, indicating presence of depressive symptomatology, increasing to seven women (58%) out of twelve scoring 10 or more at the end of the 8-week term.

The increase in symptomatology reported by women post-group may be due to an increase in their level of awareness regarding mental health as a result of information received during the term. This outcome may also be a reflection of an increased level of rapport and trust built up over the course of the term with the interviewer, who was also the co-facilitator of the group.

Interestingly, all women scoring in the clinical range on the EPDS also scored above the recommended cut-off of four or more (Swalm et al., submitted) on the anxiety sub-scale of the EPDS. Moreover, two women who did not score in the clinical range for depressive symptomatology did score highly on the anxiety sub-scale. A total of ten women (71%) scored above four on the anxiety subscale pre-group and nine women (75%) post-group, indicating concerning levels of anxious symptomatology.

This result indicates anxiety may be a significant factor in the mental health and well-being of this sample of women, which is not surprising given the multiple stressors being experienced by many of the women (e.g., financial hardship, housing difficulties, health problems, children’s behavioural issues).

No women, pre or post-group reported any thoughts of self-harm (i.e., a positive response to question 10 on the EPDS).
Discussion

The concept of acculturation is widely used, and refers to the changes that an individual undergoes when they come into contact with another culture, such as when migrating to a new country. This acculturation entails numerous psychological changes, including adjustments in behaviour, values, attitudes and identity (Williams & Berry, 1991). Despite earlier views to the contrary, acculturation does not inevitably lead to psychological distress, with the level of distress dependent upon numerous factors. One of the most influential of these factors is the presence of social and cultural groups that may provide support for the person entering into the experience of acculturation (i.e., a protective cacoon). With a lack of social support identified in ‘mainstream’ research as an important risk factor for postnatal depression (Dennis, 2004; Pope, et al., 2000; Robertson, Grace, Wallington, & Stewart, 2004) this perinatal mental health supported playgroup was intended to provide such a ‘cacoon’ for Ethiopian mothers living in the Perth metropolitan area.

Despite immigrant status being identified as a risk factor for depression during the perinatal period (Dankner, et al., 2000; Glasser, et al., 1998; Onozawa, et al., 2003; Rubertsson, et al., 2005; Small, et al., 2003; Goyal, et al., 2006), there is limited research available on specific risk factors for immigrant women. From the research available the risk factors for postpartum depression appear to include: a lack of social support, stressful life events, physical health problems, and an inability to speak the language of the host country (Small, et al., 2003; Parvin, Jones, & Hull, 2004). For example, a Quebec study that used language spoken at home as an index of acculturation, found that women who spoke neither of the ‘native’ languages (i.e., English or French) at home were at twice the risk for postnatal depression compared with those women who did (Zelkowitz & Milet, 1995). Such research findings are noteworthy given that none of the 14 women initially participating in this support group nominated English as their primary (i.e., spoken at home) language, and 11 women required an interpreter during the evaluation assessments.

Under the Government Settlement Program, any newly arrived immigrant in Australia may be eligible for a range of settlement services, such as assistance in accessing medical services (Gwatirisi, 2009).
Despite this, immigrants and refugees continue to face challenges, such as health providers and other service providers’ inadequate understanding of their needs and challenges. This is particularly the case when it comes to mental health service provision, with high costs, misunderstanding, stigma and shame in addition to the cultural and language differences. An extensive body of literature can be found on the barriers to mental health care utilisation amongst refugees and immigrants (Wong, et al., 2006).

Acknowledging all these issues (e.g., immigrant status as a risk factor for depression, importance of social support to acculturation and mental wellbeing, barriers to accessing mental health services), qualitative techniques were applied to gather information on Ethiopian mothers’ knowledge of perinatal mental health issues, the amount of support Ethiopian mothers’ believe is available for them in the Perth metropolitan area, and their experiences whilst accessing services.

All Ethiopian women living in the Perth metropolitan area who were pregnant or had given birth in the last 3 years were eligible to participate in the support group. Fourteen women completed pre-group assessments, including an interview, a demographic questionnaire and an EPDS. Thirteen of these women completed qualitative post-group assessments and were thus included in this data analyses. Interview transcripts were thematically content analysed in nine (+ two) sections - corresponding to the questions posed during the interviews.

A theme repeated during post-group interviews was that women felt that their support networks had expanded, to include the other mothers attending the groups. Many of the participants spoke positively about the playgroup and the benefits of being able to talk to other mothers “who understood”.

Although comfort levels did not increase regarding community or obstetric services, this was not seen as a failing of the project due to high levels of comfort pre-group. However, women participating in the group appeared to increase their knowledge regarding sources of mental health support, and also became more comfortable with the idea of accessing such supports if/when needed. Women’s responses also indicated that their knowledge of perinatal mental health issues had increased, that is, that mothers can become depressed or anxious and what may cause these
feelings. Moreover, women’s responses post-group indicated that they knew talking to others, looking after themselves (i.e., self-care) and accessing support was an important step to feeling better.

As stated previously, eligibility for participation in the perinatal mental health support group was based upon ethnicity and motherhood status, irrespective of the presence or absence of depressive symptomatology. In light of this, the level of depressive symptomatology and anxiety found pre and post-group in this sample of mothers is concerning.

Quantitative data collected via the EPDS was used to assess changes in depressive symptomatology over the course of the 8-week group term. Forty-three percent of the women participating in the supported playgroup scored above cut-off (≥10) on the EPDS pre-group, increasing to 58% post-group. Anxious symptomatology appears to be a predominant factor in these high scores, as indicated by the anxiety subscale of the EPDS.

Compared to a prevalence rate of 13% established via a meta-analysis of 59 studies with nearly 13,000 participants (O’Hara & Swain, 1996), these results suggest that the prevalence of perinatal depression/anxiety may be significantly higher in this population of childbearing women. Although prevalence estimates have varied from 3% to 30%, depending on the period of time under consideration (i.e., symptoms in the past week or past year), the length of postnatal follow-up assessments, and the type of measurement being utilised (Pope, et al., 2000) the difference with this childbearing population is still significant.

However, this result does appear to be in-line with prevalence rates obtained via research with immigrant populations in other countries. It appears that the majority of perinatal mental health research conducted with immigrant populations has been Canadian. For example, in a community sample of pregnant immigrant women in Canada, 42% indicated high risk of depression on the EPDS (Zelkowitz, Schinazi, Katofsky, Saucier, & Valenzuela, 2004). Furthermore, women who had lived in Canada for less than 5 years were found to be at greatest risk. In another large sample (N = 1250) of pregnant Canadian women assessed for depressive symptomatology using the EPDS, 15% of the immigrant women in the sample scored in the high risk range compared to 7% of women born in Canada (Sword, Watt, & Krueger, 2006).
Postpartum research on the mental health of immigrant women is just as scarce as that available during pregnancy, with Canada once again being the site of the majority of study. Nevertheless, as found with depression during pregnancy, women born outside of Canada or having lived in Canada for less than 5 years have been found to be at greatest risk of postnatal depression (Dennis & Ross, 2006).

A longitudinal study in Canada (Zelkowitz, et al., 2008) investigated stability and change in postnatal depression in 106 childbearing immigrant women. They reported that 37.7% of these immigrant women scored in the high risk category of the EPDS at 2 months postpartum. This result was compared to the prevalence rate of 3.4% found in a sample of over 1500 postpartum women from the same catchment area. The authors concluded that their results “provide further evidence that immigrant women are at risk for postpartum depression” (Zelkowitz, et al., 2008, p. 8).

The current findings (i.e., 58% scoring ≥10 on the EPDS post-group) add support to the Canadian research, and indicate that Ethiopian immigrant women giving birth in Australia may be at high risk of depression. Given the traumatic and complex case histories of the 14 women participating in this supported playgroup, these results are not completely unexpected.

Although only one psychological study has been conducted in post-war Southern Sudan to date (Roberts, et al., 2009), its results put the current findings into context. The objective of this collaborative study conducted by researchers from the Department of Public Health and Policy, London, and the Ministry of Health, Southern Sudan, was to measure PTSD and depression in the town of Juba, Southern Sudan and to investigate the association of demographic, displacement, and past and recent trauma exposure variables on PTSD and depression (Roberts, et al., 2009). The results showed a strong association of gender on mental distress, with women more than twice as likely as men to exhibit symptoms of PTSD (odds ratio 2.01) and depression (odds ratio 2.37). The PTSD rates were 42.5% and the depression rates were 58.7% amongst women (Roberts, et al., 2009).

With 92.4% of respondents experiencing one or more of the 16 trauma events covered in the Harvard Trauma Questionnaire used in the study, and trauma being closely associated with psychological distress, it is not
surprising that prevalence of these disorders in post-war Sudan is so high. Women and refugees were found to be two of four subgroups who were significantly more likely to have experienced eight or more traumatic events. For instance, 63% of women respondents had ever lacked food or water, 48% had been seriously ill without access to medical care, 44% had witnessed the murder of family or friends, 48% had directly experienced a combat situation, 22% had been forcefully separated from family and friends, 15% beaten or tortured, 10% imprisoned, and 8% raped.

Given the severity of these traumas, it was noteworthy that being forcefully separated from family was one of three trauma events with significant associations with PTSD and depression. For the women participating in this supported playgroup, who had recently given birth and are now raising their children in a foreign land, away from family, the impact of this separation on their mental health was tangible, with almost all participants speaking of missing family and feeling lonely at times.

Acknowledging that there are no quick fixes that will address the level of trauma and complex life histories that these women present with, the current evaluation results do indicate that four of the eight key performance indicators are being met. Despite a slow start, local Ethiopian women are now attending the supported playgroup and there appears to be an increase in level of perceived psychosocial support by the participants as a result. The participants’ awareness of perinatal mental health issues had improved post-group and the importance of accessing services if/when needed for the sake of themselves and their children was apparent.

Although there was an increase in depressive symptomatology the difference was not significant. However, one 8-week term was not expected to make a significant improvement to participants’ mental health status, given the complex case histories of the women. With continued group attendance and the associated improvements in mental health knowledge and social support provided by the other mothers it is hoped that further improvements would be made by women.

Finally, an increased capacity within local communities for a bicultural community worker to facilitate support groups (independent of original facilitator) was not yet evident, but this is expected to develop as the group continues.
**Recommendations**

Given the history of the women participating in the perinatal mental health support group and the complexity of their current living arrangements it was not expected that an 8-week group would be sufficient for long-term and significant changes in mental health status. Nevertheless, the social support, information and exposure to mental health services afforded by this group appear to have had a positive effect and can be built upon for future and extended benefits.

Due to the difficulties obtaining sufficient numbers of Ethiopian women reported by GWHS (i.e., to make the project economically viable), it is recommended that the inclusion criteria for the playgroup be extended to all women born in Africa who are pregnant or have had a child in the last three years.

Although data availability limits the conclusions that can be made at this point, the number of women reporting depressive and anxious symptomatology in the current sample is higher than both the general population and that reported in the literature for immigrant mothers, and confirms the need for perinatal mental health strategies for Ethiopian mothers in WA.
References


in Canada. Winnipeg, Manitoba: The Centres of Excellence in Women's Health, Canadian Women's Health Network.


Appendix - Reflexivity Exercise

As a white middle-class Australian woman, I have inherent biases, many of which I may not even be conscious of, those that I am aware of and believe may bias the current research are documented in the following two paragraphs:

I undertook this evaluation as an employee of the WA Perinatal Mental Health Unit (WAPMHU), in collaboration with Gosnells Women’s Health Service. My responsibilities within this role include the evaluation of services, such as this, that are funded by the WAPMHU and provided by community organisations. Funding decisions for the second year of service delivery, as outlined in the Service Agreement, are based upon evaluation results. Subsequently, I attempted to remain impartial and unbiased in my dealings with both parties of the Service Agreement. Nevertheless, as an employee of WNHS, a perinatal mental health specialist, a psychologist and mother, I am aware that I bring to this work a paradigm (enquiry lens) and epistemology.

First and foremost I am aware that I want this service to succeed in its goal to support Ethiopian families living in WA. However, I believe that my use of both qualitative and quantitative data, application of a critical realist paradigm, and professional integrity, ensures that I remain as fair as possible in my analysis of the data which was submitted to me for evaluation by Gosnells Women’s Health Service.

My exposure to Ethiopian women is very limited and although I have attempted to familiarise myself with Ethiopian culture through reading and meeting some of the women attending the groups I admit this unfamiliarity will effect my level of understanding of some of the complex issues faced by these women and the refugee communities of WA. Nevertheless, I believe that every woman and man should be treated as equal in society regardless of age, race, ethnicity, sexual preference or socio-economic status, and fully support the provision of perinatal services to CALD women and their families.