Cultural sensitivity in perinatal mental health care for ethnic minority women

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Portfolio Abstract

Background: Prior research has identified disparities in perinatal health outcomes for ethnic minority women, and qualitative studies highlighted how ethnic minority women perceive perinatal services as lacking cultural sensitivity. Findings suggest embedding culture into mental health interventions and services can positively influence outcomes. This thesis portfolio comprises a systematic review and meta-analysis of culturally adapted interventions (CAIs) for ethnic minority women with perinatal mental health difficulties. Followed by a qualitative exploration to understand ethnic minority women's experiences of perinatal services in the East of England.

Methods: A systematic review identified studies evaluating perinatal mental health CAIs for ethnic minority women, and CAI components were synthesised. A meta-analysis compared the efficacy of interventions to controls. For the empirical paper, semi-structured interviews were conducted with ethnic minority women who had accessed NHS perinatal teams and analysed using an Interpretive Phenomenological Analysis Framework.

Results: 17 studies (n= 1,923) were synthesised, encompassing the following CAIs; cognitive behavioural therapy (n=9), interpersonal therapy (n=6), problem-solving (n=1) and psychoeducation (n=1), incorporating various surface-level and deep-level adaptations. The meta-analysis included 13 RCTs (n= 1,456) with depression as the primary outcome. The overall effect size was small to moderate and significant (g = -0.33; 95% CI -0.57 to -0.09; *p*= 0.007). From the qualitative analysis, four themes emerged: 1) Strengthening community networks and peer support; 2) Valuing cultural curiosity; 3) Making sense of how culture, ethnicity, race, and racism impact mental health; and 4) Tailoring interventions to ethnic minority women and their families.

Conclusions: Findings suggest that CAIs for perinatal depression are more efficacious than controls and that professionals should support ethnic minority women in community

resources and peer support, explore cultural dynamics and apply cultural and practical adaptations to interventions. Further research should compare CAIs against active controls and explore how specific ethnic minority groups experience different aspects of perinatal services.

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Acknowledgements

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Thank you to the Lived Experience Advisory Group (LEAG) for giving their time to help me develop a project which is relevant and impactful for ethnic minority women; thank you for helping me build confidence in my interview skills and get to grips with social media, something I have avoided mainly until this thesis but needed a good understanding of for our recruitment strategy! Thank you to all of our participants for the empirical study. It was a big ask for you all to give interviews during such a busy time in your lives. I appreciate you sharing your stories to help me understand your experiences and contribute to the evidence for supporting culturally sensitive care.

And a final thank you to my two-year-old, Oliver. We moved to Norwich when you were a baby so I could become a Clinical Psychologist. Looking back, this was a very brave move as a single mum and took a lot of determination. You have always inspired me to be the best mum I can possibly be, and to strike a balance between working hard and living in the moment. Your sense of fun, adventure and unconditional love keeps me going, and I couldn't have done this journey without you.

Chapter One

Introduction to Thesis Portfolio

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The perinatal period is defined as during pregnancy and one year following childbirth (National Collaborating Centre for Mental Health, 2018). Perinatal mental health difficulties include all mental health problems within this timeframe, including pre-existing mental health problems before pregnancy and the onset of mental health problems within the perinatal period (Maternal Mental Health Alliance; MMHA, 2023). The MMHA (2023) reports that approximately one in five women will experience perinatal mental health difficulties, encompassing conditions such as perinatal depression, anxiety and postpartum psychosis. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK (MBRRACE-UK) reported that suicide is the leading cause of maternal death in the first year after childbirth (Knight et al., 2022).

Defining Culture, Ethnicity and Race

Culture, ethnicity and race can interact and influence health access and help-seeking, experiences of services and health outcomes (Bignall et al., 2019; Nwokoroku et al., 2022; Tikka, Thippeswamy, & Chandra, 2022). Culture refers to a set of shared beliefs, customs, traditions, behaviours and practices within a group of people (Kroeber & Kluckhohn, 1952). Ethnicity is defined by the identification with one or more cultural, social or national groups and is embedded in history and culture (Barth, 1969). The concept of race categorises people into groups according to their physical characteristics and has been used to differentiate between people (Omi & Winant, 2015).

Culture, ethnicity and race are heavily influenced by social constructionism, which views reality and truth as constructed through language, one's environment and other social processes; it rejects the idea of an inherent singular reality, and instead, meaning is developed through social interaction and the world is understood by historical, political and cultural contexts (Gergen, 2015). For instance, the concept of race is inherently a social construct because it is based on physical appearance and was first introduced as a pseudobiological

notion that there are biological and intellectual differences between races, which were wrongfully used to justify race-based inequalities (Machery & Faucher, 2005). Race is a poor means of classification as research has identified more genetic variability within racial groups than between them (Brown & Armelagos 2001; Lewontin 1972). Despite these findings and political shifts over time, persisting racial hierarchies maintain racial inequalities and privilege people categorised as White (Oliver & Shapiro, 1997). Although the social construction of race and the harmful consequences of racial discrimination have been increasingly recognised, racial, ethnic and cultural inequalities in healthcare persist (Omi & Winant, 2015).

Health Inequalities: The Intersection of Ethnicity, Gender and the Perinatal Period

Research evidence has identified that people from ethnic minority groups experience disparities in physical and mental health outcomes (Bignall et al., 2019; Nwokoroku et al., 2022; Omi & Winant, 2015; Tikka, Thippeswamy, & Chandra, 2022). The Advancing Mental Health Equalities Strategy (NHS, 2020) identified structural inequalities within NHS services, whereby service users from minority ethnic groups had poorer outcomes, reported lower satisfaction levels than White British service users, and received less culturally appropriate treatments. Concurrently, Jankovic et al. (2020) found that minority ethnic women had significantly lower access to community mental health services, and higher percentages of involuntary hospital admissions were recorded for Black African, Asian and women from non-British White backgrounds. This suggests that minority ethnic women experience delayed intervention when at a crisis point instead of earlier in the illness course.

Women from ethnic minority groups also experience poorer mental health and adverse outcomes in the perinatal period. They are significantly more likely to experience perinatal mental health difficulties than White British women, with Indian and Pakistani women at the most significant risk (Prady et al., 2016; Moore et al., 2019). A UK national

survey, which included 4571 participants, found that non-white women were less likely to be asked about their mental health in the perinatal period and, therefore, were less likely to be referred to mental health services (Redshaw & Henderson, 2016). MBRRACE UK have analysed data from UK and Ireland confidential enquiries into maternal deaths and morbidity from 2017 to 2021 and have consistently reported that Asian women are twice as likely to die in pregnancy than White women, and perinatal mortality rates in Black women are four times higher than in White women (Knight et al., 2021; Knight et al., 2022; Knight et al., 2023).

Furthermore, women who have accessed services perceived a lack of cultural sensitivity. Drake et al. (2022), in a systematic review of ethnic minority women's experiences of maternity and perinatal services, identified that ethnic minority women generally perceive their maternity care more negatively than White women, highlighting poor communication and cultural insensitivity relating to their experiences with healthcare professionals. Watson et al. (2019) highlighted individual challenges for minority ethnic women receiving perinatal mental health care, such as cultural stigma, unavailability of interpreters, a lack of diversity within perinatal team staff, a lack of culturally competent care, and not being asked about treatment preferences.

Timely access to good quality perinatal mental health care provides positive long-term outcomes for all women, including improving mental health outcomes for both the mother and child, improving the parent-infant relationship, and reducing the risk of birth complications, and the wider socioeconomic costs (NHS England, 2018). Recognising and addressing the impact of the intersectionality between gender, ethnicity, and the perinatal period on mental health outcomes for ethnic minority women experiencing perinatal mental health difficulties is an important factor for improving outcomes during this critical time for both the mother and baby.

Perinatal Mental Health Services

Perinatal mental health services provide mental health treatment for women throughout the perinatal period and for those who are planning their pregnancy and at risk of mental health difficulties (Royal College of Psychiatrists, 2021). The National Institute for Health and Care Excellence (NICE) (2020) recommends that specialist perinatal teams provide evidence-based psychological therapies within one month of initial assessment. First-line treatments include Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT) and Behavioural Couples Therapy (NICE, 2020), and the NHS Long Term Plan (2019) sets out to expand access to offer parent–infant, couple, co-parenting and family interventions. Clinical Psychologists are the primary providers of psychological interventions within perinatal teams; however, Systemic Family Therapists, Occupational Therapists, Mental Health Nurses, Social Workers, Support Workers, and other professionals also offer psychological support (Royal College of Psychiatrists, 2021).

The Challenges for Overcoming Health Inequalities for Ethnic Minorities

Despite the known inequalities within healthcare services for ethnic minority service users, there are challenges to providing culturally appropriate care in the context of healthcare services. The Division of Clinical Psychology (DCP, 2020) advises Clinical Psychologists and the psychological workforce to embed equality and inclusion within their services, challenge unconscious bias, and develop culturally sensitive services with evidence-based, culturally diverse interventions. Achieving this can be challenging because the current knowledge base is centred on the individual, White European experience and requires 'decolonising' (DCP, 2020). The Western, Educated, Industrialised and Democratic (WEIRD) subset of individuals has been overrepresented in research, leading to the poor generalisation of findings to other ethnic, racial and cultural groups (Henrich et al., 2010). Furthermore, perinatal mental health professionals reported a lack of culturally appropriate resources and culturally adapted treatments (Edge, 2011).

Defining Culturally Adapted Interventions (CAIs)

Emerging evidence suggests culturally adapted mental health interventions are effective (Rathod et al., 2018). There is no single definition for CAIs. However the literature suggests that CAIs require meaningful cultural input and a series of adaptation stages throughout their development (Barrera et al., 2013). Culturally adapted mental health interventions involve modifying evidence-based treatments to reflect the client's language, culture and context (Bernal et al., 2009). Some culturally adapted interventions (CAIs) assume group homogeneity in their expression of culture, whereas others allow for more individual expressions of culture and tailor intervention components to individual needs (Barrera et al., 2013).

Defining Cultural Sensitivity and Cultural Competence

Cultural sensitivity and cultural competence are fundamental concepts for engaging with diverse communities and providing equitable care. Cultural competence and cultural sensitivity are terms which are often used interchangeably (Claeys et al., 2021). Cultural sensitivity is the conscious recognition, understanding and appreciation of values, norms and beliefs inherent in a cultural, ethnic or racial group; it entails an openness and willingness to adapt one’s behaviour and perspectives (American Psychological Association, 2018). In particular to ethnicity, Zayas et al. (1996) conducted a survey of 150 Psychologist and Social Workers to define ethnically sensitive therapy; professionals reported that ethnically sensitive therapy incorporates the following elements: a sensitivity to cultural nuances, a comprehensive grasp of distinct cultures encompassing their norms, traditions, and languages, and a clear differentiation between cultural factors and pathological conditions.

Cultural competence is often used to define the skills required to embody cultural sensitivity, often amongst professionals in the workplace (Swihart et al., 2023). Cross et al. (1989) described cultural competence as a commitment to continuous learning, reflection,

and development of the knowledge, awareness, behaviours and skills to work adeptly with cultural differences. Furthermore, Campinha-Bacote (2002) defined cultural competence as:

> The ongoing process in which the healthcare professional continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). This process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. (p.181)

Cultural sensitivity is the most commonly used term across contexts and within the literature (Claeys et al., 2021). This thesis will be using the term cultural sensitivity throughout. The working definition will be: cultural sensitivity is the commitment to understanding and respecting the values, beliefs and norms of different cultural, ethnic and racial groups and a willingness to adapt perspectives, approaches, and care to support engagement, build relationships, and improve outcomes for these groups. Some of the literature discussed in this portfolio refers to cultural competency; however, our working definition of cultural sensitivity will encompass cultural competency.

A Model for Understanding Culturally Sensitive Care: Campinha-Bacote's Model of Cultural Competence (1998)

Campinha-Bacote's Model of Cultural Competence was used as a reflecting tool to determine the focus for this thesis and develop impactful aims and objectives which align with the values of culturally competent care.

Campinha-Bacote's Model of Cultural Competence (1998) consists of five stages to guide healthcare services in providing culturally competent care: 1) cultural awareness involves recognising personal cultural biases and how their own culture interacts with service-users; 2) cultural knowledge refers to developing an understanding of various cultures and cultural contexts; 3) cultural skill is the application of cultural knowledge to clinical

practice in terms of communication techniques and adapting assessment and interventions to a range of cultural backgrounds; 4) encounters involves actively engaging with individuals from diverse backgrounds in the services and within the community to understand their perspectives; 5) culture desire represents a genuine motivation to lifelong learning about culture and providing culturally competent care to reduce healthcare inequalities

The Research Aims and Questions

This thesis aims to closely align with Campinha-Bacote's Model of Cultural Competence (1998). Whilst cultivating cultural awareness by identifying biases (stage 1) and motivation for learning about culture (stage 5) are primarily individual processes, stages 2, 3, and 4 were identified as appropriate and feasible areas for this research to focus on to further our understanding. The systematic review and meta-analysis aim to develop our understanding of culturally adapted perinatal interventions and their effectiveness to support clinical decision-making regarding whether treatments require specific cultural adaptations (stages 2 and 3).

The systematic review and meta-analysis seek to answer the following research questions: How are perinatal mental health interventions culturally adapted? Are CAIs more efficacious for women from ethnic minority groups than controls? The empirical paper aims to further our knowledge of ethnic minority women's experiences of perinatal teams and views on culturally sensitive care (stages 2 and 4). The following research questions for the empirical paper were examined: What are the experiences of perinatal mental health care of women from ethnic minority backgrounds in the East of England? And secondly, how do ethnic minority women conceptualise culturally sensitive care in perinatal services?

Overall, this thesis portfolio will contribute to our understanding of culturally sensitive care within the perinatal period and provide an overview of the evidence base for culturally adapted perinatal mental health interventions.

Chapter Two

Systematic Review and Meta-Analysis

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A systematic review and meta-analysis paper prepared for submission to Psychological Medicine

Author guidelines can be found in Appendix A

Culturally adapted perinatal mental health interventions: A systematic review and meta-analysis

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Abstract

Background: Ethnic minority women experience significant perinatal mental health inequalities. Embedding cultural sensitivity in perinatal mental health interventions is important due to the influence of culture on health outcomes. We provide a comprehensive review and meta-analysis of culturally adapted interventions (CAIs) for ethnic minority women with perinatal mental health difficulties.

Methods: Systematic searches of MEDLINE, PsycINFO and CINAHL identified studies evaluating perinatal mental health CAIs for ethnic minority women. CAI components were synthesised, and a meta-analysis compared the efficacy of interventions to controls using a random effects model.

Results: 17 studies (n= 1,923) were synthesised, encompassing the following CAIs: cognitive behavioural therapy (n=9), interpersonal therapy (n=6), problem-solving (n=1) and psychoeducation (n=1), incorporating various surface-level and deep-level cultural adaptations. The meta-analysis included 13 RCTs (n= 1,456) with perinatal depression as the primary outcome. The overall effect size was small to moderate and significant (g = -0.33; 95% CI -0.57 to -0.09; *p*= 0.007). The subgroup analyses found no significant differences between groups. However, extensively adapted CAIs had a moderate to large and near significant effect (g= -0.64; 95% CI -1.29 to 0.01; p = 0.053), whereas interventions with less cultural adaptations had a smaller and significant effect (g= -0.24; 95% CI -0.39 to -0.10; *p* = 0.001).

Conclusions: CAIs for perinatal depression are more efficacious than controls. Further research should compare CAIs targeting a broader range of perinatal mental health difficulties against active controls and determine which cultural adaptations have the greatest effect.

Keywords: culturally adapted interventions; ethnic minority; perinatal mental health; cognitive behavioural therapy; interpersonal therapy; perinatal depression; meta-analysis

Introduction

Perinatal mental health difficulties include all mental health problems during pregnancy and up to 12 months postpartum, including pre-existing mental health conditions (Maternal Mental Health Alliance; MMHA, 2023). Women from ethnic minority groups are significantly more likely to experience mental health difficulties than White British women, with Indian and Pakistani women at the most significant risk (Prady et al., 2016; Moore et al., 2019). Current research has identified treatment inequalities and access barriers for these groups (Pilav et al., 2022; Watson et al., 2019).

Culture encompasses shared beliefs, values, and customs that interact with how communities experience healthcare (Kirmayer, 2012). Culture and ethnicity are interconnected, with culture often reflecting the shared identity of ethnic groups (Barth, 1969). Ethnicity and culture impact how women access and experience perinatal mental health services, and culturally sensitive services and interventions are key factors for improving mental health outcomes (Watson et al., 2019). Cultural adaptation is the modification of evidence-based interventions to reflect the client's language, culture, and context and to be compatible with an individual's beliefs (Bernal et al., 2009).

The content and process of psychotherapy are impacted by culture. Neglecting culture in therapy can lead to disengagement and inequitable outcomes (Koç & Kafa, 2019). For instance, an RCT on Cognitive Behavioural Therapy (CBT) for schizophrenia observed higher attrition and poorer outcomes for Black African than White American populations (Rathod et al., 2005). The authors suggested greater cultural sensitivity to understand barriers to engagement and health beliefs, and further research adapting CBT to different ethnic

groups is needed (Rathod et al., 2005). Therefore, CAIs may address challenges related to engagement and poorer outcomes experienced by ethnic minority groups.

Cultural adaptation is imperative for perinatal mental health populations, particularly for women from diverse ethnic backgrounds. Pilav et al. (2022) interviewed ethnic minority women accessing perinatal teams, who emphasised the significance of care that recognises cultural differences between the patient, NHS system, and professional, racial, and ethnic disparities. Watson et al. (2019) explored the experiences of ethnic minority women in perinatal services in Europe. Their participants expressed the need for culturally competent staff to offer regular and flexible interventions whilst considering cultural preferences (Watson et al., 2019).

Several meta-analyses have found that face-to-face (Griner & Smith, 2006; Harper Shehadeh et al., 2016) and digital CAIs across mental health conditions (Ellis et al., 2022), as well as those specifically targeting depression (Anik et al., 2021), are more efficacious than usual care, demonstrating moderate to large effect sizes. Rathod et al. (2018) reviewed meta-analyses on CAIs across adult mental health populations and found the effect sizes are promising. However, they found few studies compared CAIs with non-adapted active controls and often lacked comprehensive information on cultural adaptation. Only one meta-analysis in Rathod et al. (2018) review investigated the impact of CAIs on perinatal health (Rojas-García et al., 2014); however, participants were recruited based on socioeconomic rather than ethnic minority status, and only nine out of 15 studies included ethnic minorities, while many of the included studies did not define themselves as culturally adapted or had limited cultural adaptations. Therefore, investigating the content and efficacy of CAIs for perinatal mental health among ethnic minority women is imperative due to the existing knowledge gap.

We conducted a systematic review and meta-analysis to (a) synthesise the research on culturally adapted perinatal mental health interventions for minority ethnic women, following Rathod et al. (2018) recommendations for a comprehensive overview of their cultural adaptations, and (b) examine the efficacy of culturally adapted perinatal mental health interventions, using a common mental health outcome across studies to compare CAIs to control conditions. Our review was guided by the following research questions: How are perinatal mental health interventions culturally adapted? Are CAIs more efficacious for women from ethnic minority groups than controls? Answering the research questions will provide valuable insights, aiding cultural sensitivity and clinical decision-making.

Methods

The study protocol is registered on the International Prospective Register of Systematic Reviews (PROSPERO) (CRD42022359674, Gardner et al., 2022).

Electronic Search

A systematic search was conducted using MEDLINE Ultimate, PsycINFO and CINAHL Ultimate databases to identify studies investigating the effectiveness of perinatal CAIs. Only studies published in English were accepted for inclusion, and no date restrictions were applied. The search terms focused on keywords in titles and abstracts to identify relevant studies and were inclusive of the following concepts: 1) the perinatal period, 2) mental health conditions, 3) studies measuring efficacy and effectiveness, 4) cultural adaptation, and 5) ethnic minority groups (Appendix A). Each step in the identification, screening and inclusion of papers is reflected in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram in Figure 1 (Moher et al., 2009). The primary author conducted the search, and all the authors discussed the identified papers and made joint decisions on which met the inclusion criteria.

Study Selection Criteria

The inclusion criteria were as follows: female participants from ethnic minority groups within the perinatal period with mental health difficulties or diagnoses, culturally adapted psychosocial interventions to prevent or treat perinatal mental health problems, and studies which evaluate CAIs' impact on mental health outcomes. The exclusion criteria for the population included participant samples and controls not inclusive of the perinatal period (pregnancy up to 12 months postpartum), not inclusive of minority groups, and participants without mental health symptoms or clinical diagnoses. If there was no evidence of cultural adaptation from the main papers, the primary researcher searched for intervention manuals, and contacted the study authors if the manuals were not available online. If the study author did not respond and no evidence of cultural adaptation was identified by our research team then these studies met exclusion criteria.

Data Extraction and Narrative Synthesis

Table 1 presents the study characteristics. The following study characteristics were extracted: author, year, aims, country of origin, setting, sample size, ethnicity, inclusion criteria, design, follow-up, measures and quality appraisal. Data on the intervention vs comparison group, intervention delivery (individual or group), duration, intervention facilitator, and categories of cultural adaptation recreated by Taylor et al. (2023) from Barrera et al. (2013), and outcomes were also extracted. The categories of cultural adaptation include surface-level and deep-level components for cultural adaptation. Surface-level adaptations include 1) linguistic, ensuring the intervention and associated materials are delivered and translated into a person's preferred language and reading ability, and use of culturally specific language; 2) evidential, integrating narratives and statistics relevant to the cultural group and acknowledging difficult experiences and realities within the group; 3) peripheral, using activities, images, and cultural norms appropriate for a particular group. Deep-level adaptations include 1) socio-cultural, which uses the person's cultural context to formulate

and make sense of difficulties in a way which is familiar and understood; 2) constituent-involving, training and using members of the participant population to enhance engagement (Barrera et al., 2013; Taylor et al., 2023).

Qualitative data synthesis was conducted for all the included studies following two approaches: a) Popay et al. (2006) guidance on narrative synthesis of effectiveness of intervention studies and b) by using the categories of cultural adaptation, recreated by Taylor et al. (2023) from Barrera et al. (2013), with examples of specific adaptations across the studies to help answer how perinatal mental health interventions are culturally adapted. Following guidance from Popay et al. (2006), we used tabulation and textual descriptions in Microsoft Excel to develop the preliminary synthesis. We then explored the similarities and differences within and between studies by using conceptual mapping on Microsoft Word. We reflected critically on the synthesis as a research team to resolve issues and finalise the synthesis.

Meta-Analysis

For the meta-analysis, 13 out of 14 RCTs investigated the impact of CAIs on perinatal depression, and therefore, we chose depression as our outcome of interest. To calculate effect sizes, we used the most common and validated depression outcome measure from each study when more than one depression outcome measure was reported, giving priority to The Edinburgh Postnatal Depression Scale (EPDS; Cox and Holden 2003) and The Beck Depression Inventory, Second Edition (BDI-II; Beck et al., 1996). Means, standard deviations and sample sizes for interventions and control groups were extracted into a spreadsheet.

The data for the included studies were analysed using SPSS version 28 (IBM Corp, 2021). The difference between the intervention and control post-intervention was calculated (Hedges' g). For effect size estimates, we reported the Hedges' g effect size, 95% CI, the *p*-

value, and the prediction interval, indicating where the true effect size of 95% of all populations will fall in future settings (IntHout et al., 2016). Hedges' g scores were interpreted as 0.8 and higher as a large effect, 0.5 as medium and 0.2 as a small effect. The Q test and the I^2 statistic were reported to estimate heterogeneity. For the I^2 statistic, 25% indicates low heterogeneity, 50% is moderate, and 75% is high. Random effects models were used because considerable heterogeneity was expected.

Publication bias was assessed using a series of tests: the funnel plot was inspected, Egger's test of the intercept value was estimated to quantify whether any bias captured in the funnel plot was significant, and the "trim and fill" procedure (Duval & Tweedie, 2000) estimated the effect size taking into account any publication bias. Fail-Safe N was also calculated (Begg, 1994) to identify the number of missing studies averaging an effect size of d= .00 that would be required to make the effect size non-significant. Outliers were identified when the 95% confidence interval did not overlap with the pooled effect size of all studies.

Subgroup analyses were conducted for control type, intervention and extent of cultural adaptation using a random effects model. The level of adaptation was separated into two groups: high when four to five culturally adapted components were identified and low to moderate when three or fewer components were identified. Sensitivity analyses were conducted for studies using the EPDS, and to exclude studies at high risk of bias and the outlier.

Quality Assessment

RCTs' quality and risk of bias were assessed using the Revised Tool for Assessing Risk of Bias in RCTs [RoB 2] (Sterne et al., 2019). The RoB 2 assesses bias using five domains: randomisation process, deviations from intended interventions, missing outcome data, measurement of the outcome, and selection of the reported result. We reviewed each study individually and answered questions for each domain, which led to judgements of "low

risk of bias", "some concerns" and "high risk of bias". The judgements for each domain resulted in an overall risk of bias score (Appendix B). Quasi-experimental studies were quality assessed using the Joanna Briggs Institute Checklist for Quasi-Experimental Studies (Aromataris & Munn, 2020) (Appendix C). The checklist assesses nine items covering the reliability, validity and precision of the results. Responses to items are either yes, no, unclear or not applicable. To generate an overall quality score, we summed the number of yes responses, excluding question three which was reverse scored. The highest score possible is eight, the higher scores correspond with higher-quality studies.

Results

We searched the APA PsycInfo, Medline Ultimate and CINAHL Ultimate databases on 6th May 2023. We updated the search on 23rd January 2024, and one additional paper that met our inclusion criteria was identified.

Study Selection and Characteristics

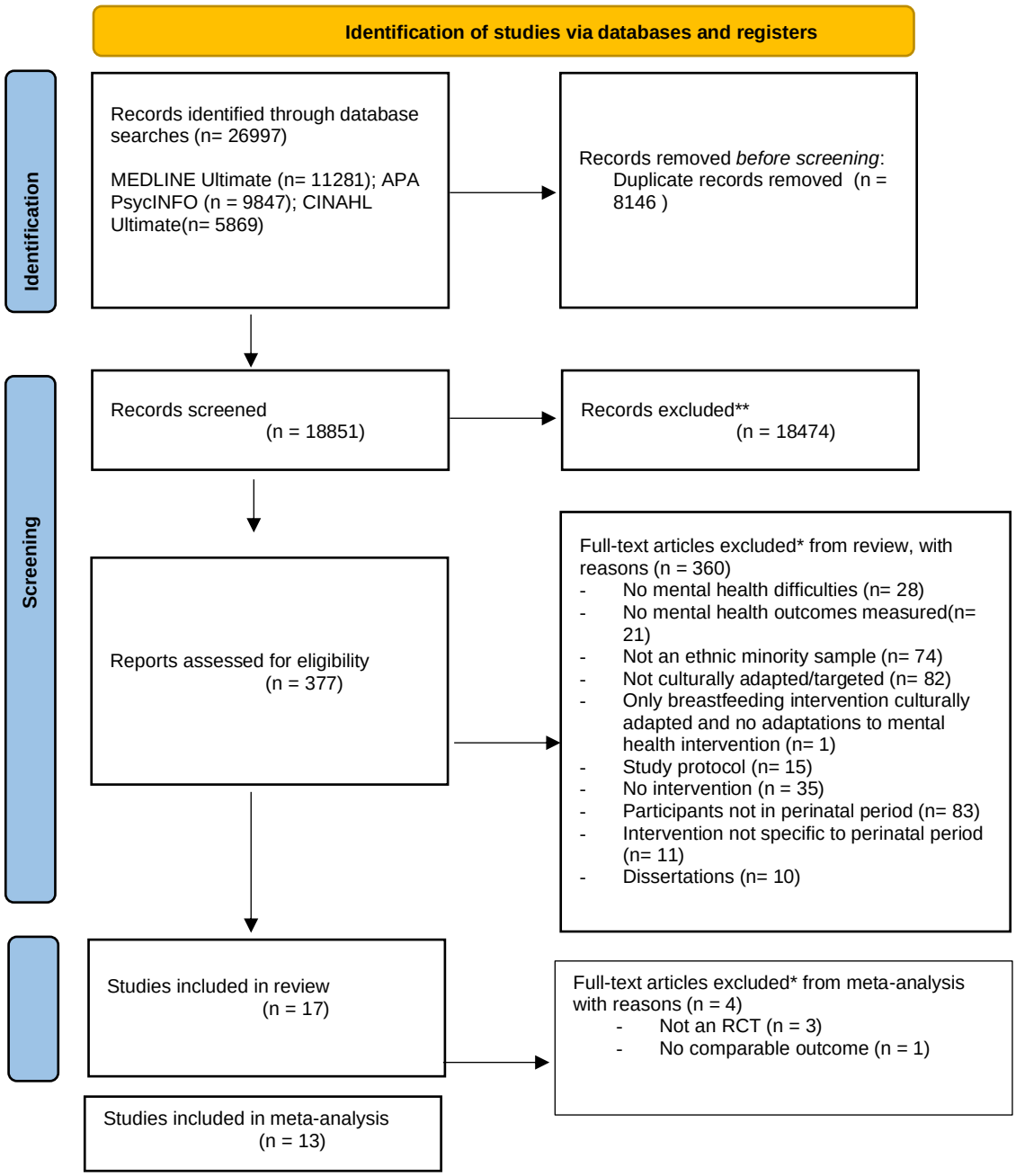
The online search retrieved 26,997 references, and 18,851 studies were reviewed by title and abstract following the removal of duplicates. 377 full-text articles were reviewed, and 360 studies were excluded for not meeting inclusion criteria (PRISMA Flow Diagram in Figure 1). 17 studies with 1,923 participants are included in this review. 14 studies were RCTs, and there was one non-randomised controlled trial and two pre-post studies. 15 studies were published in the USA, and one study in Israel and the UK over the past 19 years (Table 1).

Participants

Most studies included multiple ethnic groups (n=12, 75%). The most frequently represented minority groups were Black or African American (n= 12) and Hispanic (n= 9). Ten studies included White Americans alongside minority groups. Most participants were

recruited antenatally (n=15), and the majority of studies required participants to meet the criteria for depression or be at high risk of developing perinatal depression (n=16).

Figure 1. PRISMA Flow Diagram



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Quality Appraisal

14 RCTs were quality assessed using the RoB 2 (Sterne et al., 2019). Overall, 29% of studies had a low risk of bias (n= 4), 43% had some concerns for bias (n =6), and 29% were high risk (n= 4). Risk of bias for the RoB 2's five domains is as follows: randomisation process (low risk= 71%; some concerns= 29%), deviations from intended interventions (low risk = 100%), missing outcome data (low risk= 43%; high risk= 57%), outcome measurement (low risk= 93%; high risk= 7%), and selection of the reported result (low risk= 50%, some concerns= 43%, and high risk= 7%) (Appendix B). The non-randomised control study (Alfayumi-Zeadna et al., 2022) and pre-post studies (Grote et al., 2004; Jesse et al., 2010) were quality assessed using the Quasi-Experimental Appraisal Tool (Aromataris & Munn**,** 2020) (Appendix C). All the non-randomised control and pre-post studies scored six out of eight. Their strengths included outcome strategies and follow-up procedures. Although pre-post studies were underpowered to detect significant findings, the measurement of outcomes appears acceptable. The non-randomised control study required further transparency and analysis into which interventions were being investigated. Furthermore, reporting outcomes for continuous rather than dichotomous data may have led to more credible results.

Table 1: Study Characteristics

Author, year	Aims	Origin	Setting	Participants			Design	Follow-up	Primary Measures	Quality Appraisal*
				n	Ethnicity	Inclusion criteria				
Alfayumi-Zeadna et al. (2022)	To evaluate staff training, psychoeducation and social support on perinatal depression	Israel	Obstetrics and gynaecology clinic	332	Bedouin Israeli (n= 332)	Bedouin women 26–38 weeks pregnant	Controlled trial	2-4 months postpartum	EPDS	6/8
Ginsburg et al. (2012)	To evaluate the efficacy of Living in Harmony, a CBT based depression prevention programme	US	Participant home or research office	47	Apache American Indian (n=47)	American Indian participants aged 15-19 prior to 29 weeks' gestation with a CES-D score of 16 or higher.	Pilot RCT	4, 12, and 24 weeks postpartum	CES-D, EPDS	High risk
Grote et al (2004)	To evaluate brief interpersonal therapy (IPT-B) for perinatal depression	US	Obstetrics and gynaecology clinic	9	African American (n= 7), White American (n= 1), Hispanic (n= 1)	Between 12–28 weeks' gestation receiving prenatal services, EPDS score >10	Pre-post	Monthly up to 6 months postpartum	EPDS, BDI, HRDS, BAI	6/8
Grote et al. (2009)	To investigate enhanced IPT-B compared to ETAU for reducing depression in low-income pregnant women	US	Obstetrics and gynaecology clinic	53	African American (n= 33), White American (n= 15), Hispanic (n= 2), Mixed-race (n= 3)	African-American and white patients (10-32 weeks' gestation) receiving perinatal care, meeting criteria for depression (EPDS score >12)	RCT	3 months postbaseline and 6 months postpartum	BAI, BDI, DIS, EPDS, SCID	Some concerns
Grote et al. (2015)	To determine whether MOMCare (IPT-B) is associated with improved quality of care and depressive symptoms	US	Obstetrics and gynaecology clinic	168	White (n= 70), African American (n= 39), Hispanic (n=38), Asian/Pacific Islander (n= 12), American Indian/Alaska Native (n= 9)	12-32 weeks' gestation, scores meeting clinical threshold for depression (PHQ-9 or M.I.N.I. 6.0)	RCT	3, 6,12, and 18 months postbaseline	PCL-C, SCL-20	Some concerns

Hankin et al. (2023)	To evaluate IPT-B for pregnant women from diverse backgrounds	US	Obstetrics and gynaecology clinic	234	Asian (n= 10) Black (n= 21) Hispanic (n= 43) Native Hawaiian/ Pacific Islander (n= 1) White (n = 101) Mixed-race (n= 58)	Participants were pregnant and required to meet criteria for Major Depressive Disorder on SCID	RCT	22 weeks, 26 weeks, and 30 weeks' gestation, post-intervention and 36 weeks (end of gestation)	EPDS, SCID & SCL-20	Low risk
Husain et al. (2023)	To evaluate the Positive Health Programme for postnatal depression in British mothers of South Asian origin	UK	Children's centres	83	British South Asian (n= 83)	Participants had a baby up to 12 months old, were aged 16 and above and met criteria for depression on ICD-10	RCT	3 months and 6 months post-intervention	EPDS, PHQ-9 & HRDS	Some concerns
Jesse et al. (2010)	To assess the feasibility and efficacy of Insight-Plus, a culturally adapted CBT intervention for rural, low-income, minority women at risk of perinatal depression	US	Prenatal clinic	26	African American (n=21) and Caucasian (n=5)	Between 6 –30 weeks' gestation; age 18 or older; ability to read at a fourth grade level and to respond to study questions in English; and EPDS score of ≥10	Pre-post	1 month	BDI-II & EPDS Feasibility assessed by numbers refused, dropped out, lost to follow-up.	6/8
Jesse et al. (2015)	To assess efficacy of, Insight-Plus, a culturally adapted CBT intervention for rural, low-income, minority women at risk of perinatal depression	US	Prenatal clinic	146	African American (n= 99), White American (n= 47)	Pregnant women stratified by high-risk for antepartum depression, EPDS score of 10 or higher) or low-moderate risk score of 4-9).	RCT	1 month	BDI-II, EPDS, M.I.N.I. 6.0	Some concerns
Le, Perry, & Stuart (2011)	To evaluate the efficacy of Mothers and Babies, a preventative CBT intervention for perinatal depression for female Central American immigrants	US	Prenatal clinic	217	Hispanic (n= 217)	Low-income Central and South American immigrants up to 24 weeks gestation at high risk for depression, scoring 16+ on the CES –D and/or with a self-	RCT	6 weeks, 4 months, and 12 months postpartum.	BDI –II, CES –D & MMS	Some concerns

						reported personal or family history of depression.				
Lenze et al. (2020)	To assess the feasibility and acceptability of IPT-Dyad	US	Obstetrics and gynaecology clinic, other community location or home	42	African American (n=33), White American (n= 7), other (n = 2)	Between 12-30 weeks' gestation, with EPDS scores ≥ 10 and current depression (SCID)	Pilot RCT	Bi-weekly for the first 3 months postpartum and then monthly up to 9 months postpartum	EPDS, Brief-STAI. Feasibility and acceptability measured by attrition	High risk
Lenze & Potts (2017)	To replicate Grote and colleagues (2009) brief-IPT model for low-income women, and compare to ETAU	US	Research clinic, participants homes or community	42	Black American (n=33), White American (n= 7), other (n = 2)	Between 12-30 weeks' gestation, with EPDS scores ≥ 10 and and SCID	RCT	None	Brief-STAI, EPDS. Acceptability, and feasibility measured by CSQ and attendance	Low risk
Muñoz et al. (2007)	To assess acceptability, feasibility and effectiveness of the Mother and Babies Course (CBT) for perinatal depression	US	Clinic and home	41	Hispanic (n= 41)	Low-income Hispanic women between 12–32 weeks' gestation with a history of major depressive episodes (MDE) and/or ≥16 on the CES –D	RCT	1, 3, 6, and 12 months postpartum	CES –D, EPDS & MMS. Acceptability measured by session rating scales investigating mood, clarity and usefulness, and feasibility measured by follow-up rates.	Low risk
Ponting et al. (2022)	To assess the efficacy of a manualised cognitive behavioural stress management (CBSM) group in reducing anxiety in low-income pregnant women	US	Prenatal health clinic	100	Hispanic (70.3%) and African American (17.8%)	Pregnant women 18 years of age or older, less than 17 weeks pregnant, and fluent in English or Spanish.	RCT	30-32-week gestation, and 3 months postpartum	STPI-S & PRAS	Low risk
Tandon et al. (2014)	To test the efficacy of a Mothers and Babies CBT course in reducing depression symptoms for low-income women	US	Obstetrics and gynaecology clinic	78	African American (n =64), Caucasian (n =9) and other (n =5)	Pregnant women or those less than 6 months postpartum with depressive symptoms (CES-D ≥ 16) and/or a lifetime depressive episode but not current	RCT	1-week, 3–and 6-months post-intervention	BDI-II & SCID	Low risk

Van Horne et al. (2021)	To measure the efficacy of a home visitation program using Problem-Solving Tools for PPD to treat postnatal depression	US	Home visits	118	Black non-Hispanic (n= 36), White non-Hispanic (n =20), Hispanic (n= 39), other (n=7), unknown (n=16)	Mild to moderate depression (EPDS score = 10 –20) and infant aged 4 months or younger	RCT	6 months	EPDS	High risk
Zayas at al. (2004)	To test a CBT-informed intervention for perinatal depression in African American and Hispanic Women	US	Community health centre and/ or participant home	187	African American (n= not reported) and Hispanic (n= not reported)	In third trimester and screened for depression using the BDI-II.	RCT	2 weeks and 3 months postpartum	BDI-II	High risk

*Note. *Quality appraisal:* Includes a Quasi-Experimental Appraisal Checklist Score out of 9 and a RoB 2 overall score from low risk, some concerns to high risk. *Measures:* BAI= 21-item Beck Anxiety Inventory (Beck et al., 1988); BDI= 21-item Beck Depression Inventory (Beck and Steer, 1993); BDI-II= the Beck Depression Inventory, Second Edition (Beck et al., 1996); Brief-STAI= Brief State Trait Anxiety Inventory (Berg et al., 1998); CES-D= Center for Epidemiological Studies-Depression Scale (Radloff, 1977); CSQ= **Client Satisfaction Questionnaire (Attkisson & Greenfield, 1999),** DIS= other lifetime and current psychiatric disorders were assessed by the Diagnostic Interview Schedule (Robbins et al., 1995), EPDS= The Edinburgh Postnatal Depression Scale (Cox and Holden 2003); GAD-7= Generalized Anxiety Disorder Questionnaire (Kroenke et al., 2007); HRDS= Hamilton Rating Scale for Depression (Hamilton, 1960); M.I.N.I. 6.0= The M.I.N.I.-International Neuropsychiatric Interview version 6.0 (Lecrubier et al., 1987); MMS= The Maternal Mood Screener (Le & Muñoz, 1998); ; PCL-C= PTSD severity on the Post-Traumatic Stress Disorder Checklist-Civilian Version (Blanchard et al., 1996); PHQ-9= 9-item patient health questionnaire (Kroenke et al., 2001); PRAS= Pregnancy Related Anxiety Scale (Rini et al., 1999); SCID= lifetime and current major depressive disorder was assigned with the Structured Clinical Interview for DSM-IV, Clinician Version (First et al., 1995); SCL-20= The Hopkins Symptom Checklist-20 (Derogatis, 1983)

Culturally Adapted Approaches

Among the 17 studies in this review, the identified CAIs included CBT-informed interventions (n=9), interpersonal therapy (IPT) (n=6), problem-solving therapy (n=1), and psychoeducation (n=1). Given their prevalence in this review, we have provided an overview of the CBT and IPT interventions below.

CBT Approaches

All CBT approaches were manualised. Most interventions were for English and Spanish-speaking women and focused on psychoeducation, parent-infant attachment and social support (Le et al., 2011; Munoz et al., 2007; Ponting et al., 2022; Tandon et al., 2014; Zayas et al., 2004). Munoz et al. (2007) developed the Mothers and Babies (MB) course, which aimed to address challenges in the perinatal period, promote parenting to develop secure attachments and enhance social networks by using thought monitoring, behavioural activation, psychoeducation, and relaxation techniques such as mindfulness, progressive muscle relaxation, and cognitive imagery. Le et al. (2011) and Tandon et al. (2014) conducted subsequent MB trials, and Ponting et al. (2022) combined the MB course with cognitive behavioural stress management (Antoni, 2003) for perinatal anxiety in Hispanic and African American women.

The remaining manualised interventions prioritised skills to treat depression without an explicit focus on attachment and were developed for Apache Indian women (Ginsburg et al., 2012), British South Asian women (Husain et al., 2023) and for both African-American and Caucasian women (Jesse et al., 2010; Jesse et al., 2015). Whilst these interventions focused on cognitive skills, such as thought monitoring and cognitive restructuring, they utilised different behavioural techniques. Living in Harmony incorporated behavioural activation and enhancing social support (Ginsburg et al., 2012), whereas Insight-Plus emphasised relaxation techniques through guided visualisation and positive affirmations

(Jesse et al., 2010; Jesse et al., 2015). The Positive Health Programme (Husain et al., 2023) utilised social support and relaxation techniques but also focused on religion and building assertiveness as tools to increase wellbeing.

IPT Approaches

All IPT studies used brief IPT (IPT-B) for perinatal depression by Grote et al. (2004) and targeted a range of ethnic groups (Grote et al., 2004; Grote et al., 2009; Grote et al., 2015; Hankin et al., 2023; Lenze at al., 2020; Lenze & Potts, 2017). IPT-B includes an ethnographic interview, perinatal depression psychoeducation, eight IPT sessions and further maintenance sessions. The intervention sessions address coping strategies for interpersonal challenges, strengthening social networks, and reducing social isolation in the context of new motherhood.

Culturally Adapted Intervention Components

Two studies reported using a framework to guide adaptation. Ginsburg et al. (2012) included a Community-Based Participatory Research Framework (CBPR), and Grote et al. (2009) utilised the Ecological Validity Model (Bernal et al., 1995). Table 2 presents the adapted intervention components based on five cultural adaptation domains (Barrera et al., 2013; Taylor et al., 2023). Four studies (24%) demonstrated all five CAI components (Husain et al., 2023; Jesse et al., 2015; Jesse et al., 2010; Ponting et al., 2022). The remaining studies either lacked a comprehensive outline of their adaptation process or did not adapt each component. Details of how the studies adapted their intervention to each domain are described below.

Surface-Level

Linguistic. Linguistic adaptation components include using culturally specific language and information delivered and translated into the participant's preferred language and reading ability. Interventions commonly used translated manuals and interpreters

(Alfayumi-Zeadna et al., 2022, Husain et al., 2023; Jesse et al., 2010; Jesse et al., 2015; Ponting et al., 2022), as well as bilingual facilitators (Husain et al., 2023; Jesse et al., 2010; Jesse et al., 2015; Le, Perry, & Stuart, 2011; Ponting et al., 2022, Munoz et al., 2007; Van Horne et al., 2021), and one study was developed in Spanish (Munoz et al., 2007). Culturally congruent language was used in contexts where depression was not commonly understood. For instance, Ginsburg et al. (2012) used "how'shi", an Apache Indian American term, to describe a change in emotional affect and Grote et al. (2009) described using "stressed" to refer to low mood and minimise feelings of stigma.

Evidential. Evidential components use narratives and statistics relevant to the cultural group and acknowledge adversities within the group. Ginsburg et al. (2012) acknowledged the high risk of depression in Apache Indian adolescents attributed to unemployment, poverty, and education inequality. They also highlighted the historical and colonial traumas experienced by this group, including community relocations and loss of tribal territories due to federal policies. Ponting et al. (2022) emphasised the ongoing contextual and structural problems facing Hispanic and Black participants, such as traumatic migration experiences, systemic racism and poverty, and encountering culturally insensitive perinatal care, increasing the prevalence of perinatal anxiety. Grote et al. (2004) identified IPT as a suitable approach due to IPT's role in strengthening social networks and a lack of perceived social support in low-income minority ethnic women being a vulnerability factor for perinatal depression (O'Hara & Swain, 1996).

Peripheral. Peripheral components use culturally relevant activities, images, and cultural norms. For example, Ponting et al. (2022) used surface-level peripheral adaptations, including using images of Latinas and Black women in their CBT workbook. Jesse et al. (2010) incorporated positive affirmations from Iyania Vanzant, a Black American motivational speaker with experience of depression (Vanzant, 2003). Grote et al. (2009)

displayed culturally relevant pictures of ethnically diverse parents and infants in therapy rooms, using narratives from participants' backgrounds to align with treatment goals.

Deep-Level

Socio-Cultural Expressions of Mental Health. Socio-cultural components use the cultural context to understand and make sense of difficulties. This was important during the engagement sessions in all IPT studies (Grote et al., 2004; Grote et al., 2009; Grote et al., 2015; Hankin et al., 2023; Lenze et al., 2020; Lenze & Potts, 2017), which utilised an ethnographic interview. The ethnographic interview asks open-ended questions to explore socio-cultural factors, perceptions of depression, health-related beliefs, practical and psychological barriers to care, attitudes towards mental health services and hopes for treatment. Grote et al. (2004) described using individualised psychoeducation based on the experiences and needs explored within the ethnographic interview.

Constituent-Involving. Constituent involvement encompasses training and using members of the participant population to develop and deliver the intervention. Some studies emphasised the value of a shared cultural background between participants and facilitators to enhance the therapeutic relationship; for example, Ginsburg et al. (2012) employed family health educators from a congruent cultural background to lead the group. Jesse et al. (2010) piloted their workbook with ethnically diverse pregnant women at risk of depression to ensure cultural appropriateness. Studies also employed women from ethnic minority groups to facilitate interventions (Husain et al., 2023; Jesse et al., 2015; Zayas et al., 2004).

Table 2. Cultural Adaptations and Study Outcomes

Author, year	Intervention vs comparison group	Intervention delivery	Duration	Intervention facilitator	Categories for cultural adaptation (Barrera et al., 2013; Taylor et al., 2023)*					Main Outcomes
					Surface			Deep		
					Linguistic	Evidential	Peripheral	Socio-cultural	Constituent involving	
Alfayumi-Zeadna et al. (2022)	Intervention clinic (n= 169) vs control clinic (n= 163)	Individual + group	Individual sessions NR + 3 lectures	Nurses, gynaecologists, and a psychologist	Y	Y	NR	NR	NR	Significantly greater decrease in EPDS for intervention groups
Ginsburg et al. (2012)	Living in Harmony Intervention (n= 22) vs educational support programme (n= 25)	Individual	8 x 30-60min sessions and 3 monthly booster sessions	Family health educator	Y	Y	NR	Y	Y	Non-significant findings, both groups showed symptom reduction
Grote et al. (2004)	None	Individual	1 pre-treatment engagement session, 8 sessions of IPT-B antenatally and maintenance sessions up to 6 months postnatally	IPT-B trained social workers	NR	Y	NR	Y	NR	Significant reduction for EPDS, BDI and BAI
Grote et al. (2009)	IPT-B (n= 25) vs ETAU (n=28) with psychoeducational resources, signposting and mood monitoring	Individual	1 pre-treatment engagement session, 8 sessions of IPT-B antenatally and maintenance sessions up to 6 months postnatally	IPT-B trained social workers	Y	Y	Y	Y	NR	IPT-B group had significant reduction in depression diagnoses and symptoms antenatally and at 6 months postpartum

Grote et al., (2015)	MomCare & MSS-Plus (n= 83) vs MSS-Plus (TAU from MDT) (N=85)	Individual	2 pre-treatment engagement sessions, 8 sessions of IPT-B or pharmacotherapy treatment, and maintenance sessions up to 1 year postpartum.	IPT-B trained social workers	NR	Y	NR	Y	NR	MOMCare significantly more effective than MSS-Plus in reducing depression severity 3, 6, 12 and 18 month follow–ups
Hankin et al (2023)	MomCare (n=115) vs ETAU (n= 119) (which included option to have counselling and psychiatric consultuation with psychoeducation)	Individual	An ethnographic session + 8 sessions of IPT-B + maintenance sessions until full gestation	Doctoral level therapists trained in IPT-B	NR	NR	NR	Y	NR	SCL-20 scores improved from baseline over gestation for IPT but not ETAU. IPT participants improved faster on EPDS compared with ETAU
Husain et al. (2023)	Positive Health Programme (PHP) (n= 42) vs TAU (n= 41)	Group	12 manualised CBT sessions	Mental health researchers with psychology degrees, trained in PHP delivery	Y	Y	Y	Y	Y	No significant findings for depression.
Jesse et al. (2010)	No comparison group	Choice of group or individual	6 weekly 2hr sessions	Family therapists, social worker, and rehabilitation studies master's student	Y	Y	Y	Y	Y	At 4 weeks postpartum 91% had EPDS scores indicating "recovery" (EPDS < 12). High retention rate- 94% retention at one month follow-up.
Jesse et al. (2015) (adapted from Gordon, 2002, and full	Insight-Plus cognitive behavioural intervention (n=	Group	6 weekly 2hr sessions	A clinical social worker, a marriage and family therapist and a	Y	Y	Y	Y	Y	Both Insight-Plus and TAU had significant reductions in EPDS. The intervention significantly reduced

details in Jesse et al., 2010)	72) vs TAU (n= 74)			professional counsellor associate						EPDS scores for African–American women at high-risk.
Le, Perry, & Stuart (2011)	Mothers & Babies CBT group (n= 112) vs TAU (n=105)	Group with individual booster sessions	8 weekly 2hr sessions and 3 booster sessions at 6 weeks, 4 and 12 months postpartum	Bilingual and/or bicultural research staff	Y	Y	NR	Y	Y	CBT group had a significant difference in depressive symptoms
(Lenze et al., 2020, Lenze et al., 2015 for IPT-B component)	IPT-Dyad (n=21) vs ETAU (n=21)	Individual	1 pre-treatment engagement session, 8 sessions of IPT-B antenatally and 10 postpartum sessions	A clinical psychologist and two master's level clinicians	Y	Y	NR	Y	NR	IPT-Dyad and ETAU had significant improvements in anxiety and depression. No significant differences between groups. Attrition was high (IPT-Dyad 30%; ETAU 40%)
Lenze & Potts (2017) (Lenze et al., 2015)	IPT-B (n= 21) vs ETAU (n= 21)	Individual	1 pre-treatment engagement session, 8 sessions of IPT-B antenatally and maintenance sessions	A clinical psychologist and two master's level clinicians	Y	Y	NR	Y	NR	No significant difference in depression between the IPT-B and TAU groups. Depression symptoms significantly decreased in both IPT-B and ETAU groups. CSQ scores indicated acceptability. 71% of participants assigned to brief-IPT competed minimum dose of sessions.
Muñoz et al. (2007)	Mothers and Babies Course (n = 21) vs TAU (n = 20)	Group with individual booster sessions	12 treatment sessions and 4 booster sessions	Advanced doctoral graduate students in clinical psychology	Y	Y	NR	Y	Y	No significant differences. Session rating scales indicated acceptability and feasibility was indicated by a 91% follow-up rate at 12 months.

Ponting et al. (2022) (adapted from Antoni, 2003, Muñoz et al., 2007 & Tandon et al., 2014). (For full details see Uriza et al. 2019)	CBSM (CBT-based) groups (n= 55) vs self-help control (n= 45)	Group	8 weekly 2hr group sessions	Clinically trained bilingual facilitators	Y	Y	Y	Y	Y	No significant findings.
Tandon et al. (2014) (adapted from Munoz et al. 2007 for black women)	Mothers & Babies (CBT group) (n=41) vs TAU (n= 37)	Group	6 x 2hr weekly sessions + 2 booster sessions	Social worker and clinical psychologist	NR	NR	NR	Y	NR	At follow-up, depression symptoms declined at a significantly greater rate for the intervention in comparison the control group.
Van Horne et al. (2021) (adapted from Sampson et al., 2016)	PST4PPD (n=72) vs psychiatry (n=46)	Individual	5 x 30min-1hr sessions	Social workers	Y	NR	NR	NR	NR	No significant differences.
Zayas et al. (2004)	CBT group (n= 57) vs TAU (n= 44)	Individual	8 CBT sessions, 4 psychoeducation sessions and up to 14 social support sessions held at least 2 sessions per month	Graduate students in social work	NR	Y	NR	Y	Y	No significant differences.

* Categories for cultural adaptation (Barrera et al., 2013; Taylor et al., 2023): surface-level 1) linguistic: culturally specific language, delivered and translated into participant's preferred language and reading ability, 2) evidential: using narratives and statistics relevant to the cultural group and acknowledging adversities within group, 3) peripheral: using relevant activities, images, and cultural norms. Deep-level 1) socio-cultural: use of the cultural context to understand difficulties, 2) constituent-involving: training and using members of the participant population for developing and/ or delivering the intervention.

Efficacy and Effectiveness Across the Studies

All studies exploring acceptability and feasibility reported positive results (Jesse et al., 2010; Lenze et al., 2020; Lenze & Potts, 2017; Muñoz et al., 2007). Six RCT studies found significantly greater improvements in the intervention group than the control condition; all of these studies investigated the impact of either CBT or IPT on depression (Grote et al., 2009; Grote et al., 2015; Hankin et al., 2023; Jesse et al., 2015; Le, Perry, & Stuart, 2011; Tandon et al., 2014). Three RCTs reported significant improvements in anxiety and depression for both intervention and control groups (Ginsburg et al., 2012; Lenze et al.,2020; Lenze & Potts, 2017). The two studies with pre-post designs found significant improvements (Grote et al., 2004; Jesse et al., 2010). Six studies did not report significant findings on mental health outcome measures (Alfayumi-Zeadna et al., 2022; Husain et al., 2023; Muñoz et al., 2007; Ponting et al., 2022; Van Horne et al., 2021; Zayas et al., 2004).

Meta-Analysis

Overall Effects of Culturally Adapted Mental Health Interventions on Perinatal Depression

13 RCTs with 1,456 participants with depression severity as the clinical outcome were included in this meta-analysis. One RCT was excluded due to clinical heterogeneity because it was the only study which did not share a comparable outcome (Ponting et al., 2022). Random effects models were used for all analyses due to the significant heterogeneity of the studies. The overall effect size was small to moderate g=-0.33 (95% CI -0.56 to -0.09; p= 0.007), reflecting that CAIs were more efficacious in treating depression than controls (Table 3). Heterogeneity was found to be statistically significant (Q = 32.36, df = 12, p < 0.001) and high (I^2 = 72%). One outlier was identified on the forest plot in Figure 2 (Grote et al., 2009), and once this was removed, heterogeneity was non-significant (Q = 7.17, df = 11, p = 0.785) and decreased to I^2= 0%. When studies rated as high risk of bias were

removed, there was a greater moderate effect g=-0.43 (95% CI -0.78 to -0.09; *p*= 0.013) with statistically significant heterogeneity (Q = 28.34, df = 8, *p*= <0.001).

A series of tests examined publication bias; the funnel plot in Appendix D suggested some asymmetry; the Egger's Test was performed, the intercept value was estimated as -0.262 and bias captured in the funnel plot was non-significant (*p* = 0.798). The "trim and fill" procedure suggested that no imputation was needed, and the effect size remained moderate g = -0.33 (95% CI -0.56 to -0.09) and statistically significant (*p*= 0.007). Calculation of the Fail-Safe N (Begg, 1994) showed that at least 109 studies with null results would need to be identified to render the effect size non-significant. Therefore, tests of publication bias found no concerns.

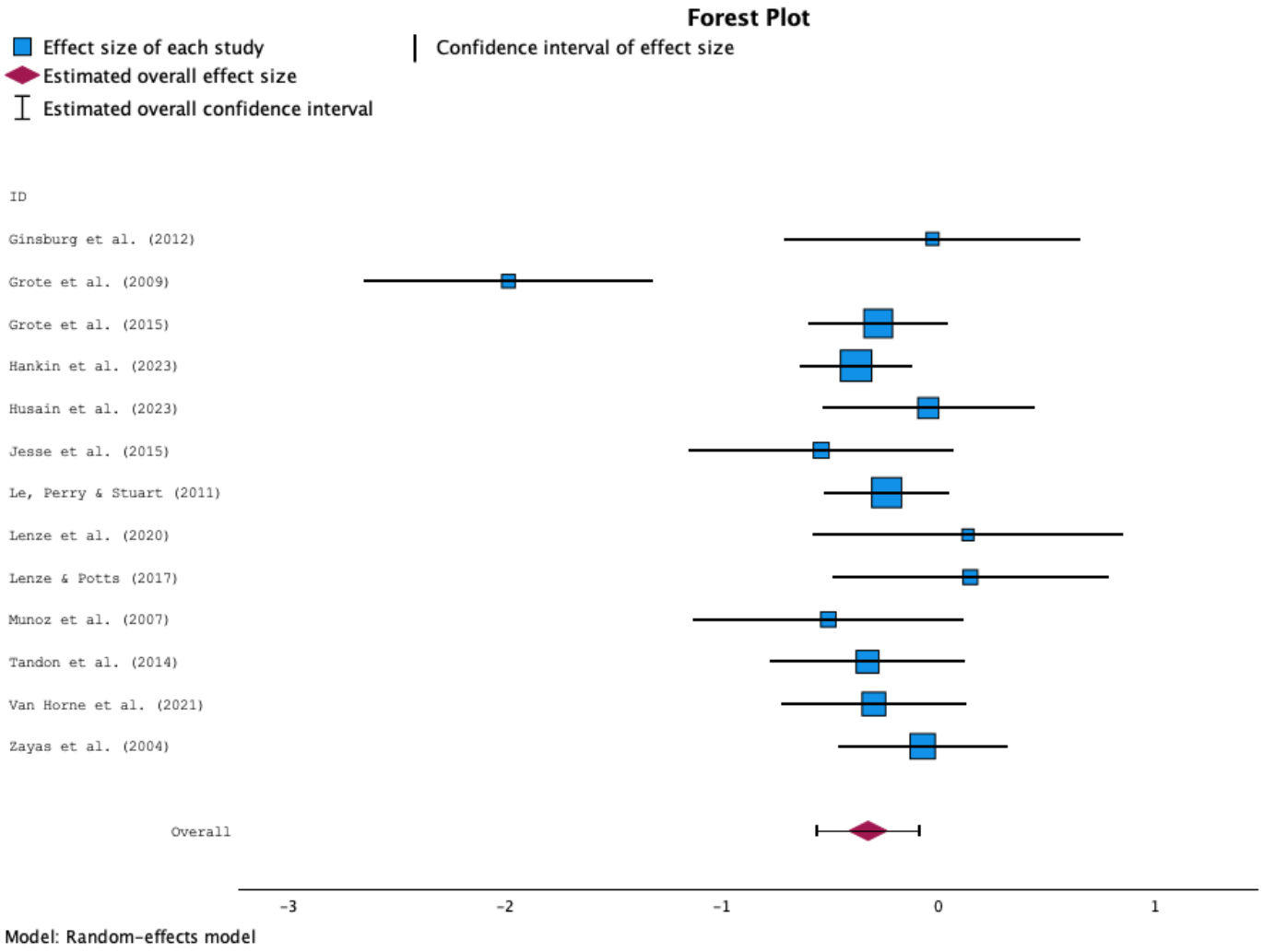
For subgroup analyses, there were no significant differences between the mean effect sizes for the type of control (active, ETAU, TAU), intervention model (CBT, IPT) or level of adaptation (high, low to moderate) (Table 3). However, the high level of cultural adaptation group had a moderate to large and near significant effect on depression g= -0.64 (95% CI -1.29 to 0.01; *p* = 0.053) with significant heterogeneity (Q = 25.11, df = 4, *p* < 0.001), and the low to moderate cultural adaptation group had a small and significant effect on depression g= -0.24 (95% CI -0.39 to -0.10; *p* = 0.001) with non-significant heterogeneity (Q = 4.94, df = 7, *p*= 0.667). The small sample size within each subgroup must be considered when interpreting these results.

*Table 3. Effects of Culturally Adapted Interventions for Perinatal Depression: Hedges' g**

		Effect size estimates					Test of homogeneity				Test of subgroup homogeneity		
		N	***g***	**95% CI**	***p* value**	**Prediction interval**	**I^2**	**Q test**	**df**	***p value***	**Q test***	**df**	***p value***
All comparisons		13	-0.33	-0.56 to -0.09	0.007	-1.15 to 0.50	72	32.36	12	0.001			
Outlier excluded**		12	-0.25	-0.37 to -0.13	<0.001	-0.39 to -0.12	0	7.17	11	0.785			
Excluding high risk of bias		9	-0.43	-0.78 to -0.09	0.013	-1.60 – 0.73	83	28.34	8	<0.001			
Only EPDS		9	-0.39	-0.78 – 0.01	0.056	-1.73 – 0.96	81	30.21	8	<0.001			
Subgroup analyses													
Control group	Active	2	-0.22	-0.59 – 0.14	0.229		0	0.43	1	0.512	0.32	2	0.852
	ETAU	4	-0.52	-1.48 – 0.44	0.290	-5.07 – 4.03	92	26.57	3	<0.001			
	TAU	7	-0.25	-0.41 to -0.10	0.001	-0.45 to -0.05	0	3.13	6	0.793			
Intervention model	CBT	7	-0.23	-0.40 to -0.06	0.008	-0.45 to -0.08	0	3.44	6	0.752	0.385	1	0.535
	IPT	5	-0.47	-1.20 – 0.27	0.210	-3.24 – 2.30	93	27.25	4	<0.001			
Level of cultural adaptation	High	5	-0.64	-1.29 – 0.01	0.053	-3.05 – 1.78	88	25.11	4	<0.001	1.371	1	0.242
	Low to moderate	8	-0.24	-0.39 to -0.10	0.001	-0.42 to -0.06	0	4.94	7	0.667			

* Random effects models. **Outlier= Grote et al. (2009). N.B. Prediction interval was not calculated in SPSS when n= 2

Figure 2. Forest plot using random effects model in SPSS



Discussion

The systematic review identified CBT and IPT as the main CAIs in the included studies, and most studies aimed to reduce perinatal depression. Linguistic, evidential and socio-cultural cultural adaptations were the most common, whereas peripheral and constituent-involving adaptations were less common. The meta-analysis found that CAIs are more efficacious than controls for treating perinatal depression in ethnic minority women. This finding is consistent with previous research, which found that CAIs have higher efficacy than controls (Anik et al., 2021; Ellis et al., 2022; Griner & Smith, 2006; Harper Shehadeh et al., 2016; Rathod et al., 2018). Studies with a high level of cultural adaptation had a moderate to large and significant effect on perinatal depression symptoms, and those with low to moderate adaptations had a small and significant effect, although this difference between group means was non-significant.

Strengths and Limitations

There are key strengths in this study, including the provision of the protocol on PROSPERO with pre-established research questions and inclusion criteria, a comprehensive literature search and extraction process, transparent reporting of characteristics of studies, a comprehensive quality assessment which guided methods, appropriate data analysis methods and tests of publication bias, such as use of the Funnel Plot (Appendix D) and Egger's test.

The findings in the review need to be interpreted with some limitations in mind. Firstly, employing a second rater to extract the studies may have helped to identify discrepancies in the studies selected for extraction and facilitate reflective discussions to negotiate which studies met inclusion criteria. Several studies did not report detailed descriptions of cultural adaptations, as seen in Table 2, and most studies did not specify cultural adaptation frameworks. Greater transparency of the cultural adaptation process would benefit the replication of studies and our knowledge of adapting interventions for best

practice. Furthermore, high heterogeneity was identified; however, all heterogeneity became non-significant following the removal of the outlier (Grote et al., 2009). This outlier's outcomes may differ due to a smaller sample size, missing data, and multiple depression outcome measures used, categorised as 'some concerns' by the RoB 2 (Sterne et al., 2019).

Beet et al. (2023) conducted a meta-epidemiological study investigating the impact of the inclusion of pilot, feasibility and small studies ($N \leq 100$) in meta-analyses, and found these are associated with inflated effect sizes. The current study included seven pilot, feasibility and small studies, therefore as recommended by Beet et al. (2023) our findings should be interpreted with caution. Furthermore, Cuijpers et al. (2023) meta-analysis identified an effect size of $g = 0.67$ for psychological treatments for perinatal depression which was much larger than our effect size ($g = -0.33$). However, Cuijpers et al. (2023) meta-analysis included more pilot RCTs and small studies than the current study, indicating a higher chance of inflated effect sizes (Beet et al., 2023).

Clinical Implications

This study confirms that culturally adapted therapies should be the first-line treatment for perinatal depression in ethnic minority women. Most studies included in this review investigated culturally adapted CBT and IPT, in keeping with the recommended treatments for perinatal depression (Bledsoe & Grote, 2006; Cuijpers et al., 2023; National Institute for Health and Care Excellence, 2014). 75% of the studies provided interventions to multiple ethnic minority groups, demonstrating how psychological therapies can be individualised to diverse populations. For instance, in IPT-B, the ethnographic interview identifies unique socio-cultural contexts and mental health perceptions to tailor treatment. Therefore, clinicians can provide culturally sensitive care across cultures without requiring expertise in numerous models. Clinicians may use the categories of cultural adaptation, recreated by Taylor et al.

(2023) from Barrera et al. (2013), to determine areas for intervention adaptation where treatment does not inherently incorporate cross-cultural modifications.

Implications for Future Research

All of the studies in the meta-analysis and most studies included in the systematic review investigated perinatal depression. Future research should compare CAIs targeting a broader range of perinatal mental health difficulties. Additionally, further research employing unadapted therapeutic interventions as active controls is needed to clarify whether CAIs are superior for ethnic minority women. Rathod et al. (2018) advise using three-armed trials comparing the adapted intervention to both TAU and the unadapted intervention. Observational findings within the subgroup analysis suggested that culturally adapted CBT has a small and significant effect on perinatal depression, and IPT approaches have a moderate and non-significant effect; further studies could randomise participants to culturally adapted CBT or IPT to detect differences between the intervention groups in treating perinatal depression. Future studies should use cultural adaptation frameworks to provide a transparent overview of the cultural adaptation process and identify whether more extensively adapted interventions are superior.

Conclusions

There is a growing evidence base to support the use of CAIs for ethnic minority women in the perinatal period. Accordingly, there is a need for perinatal mental health services to deliver evidence-based CAIs for perinatal depression.

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Conflict of interests

The authors report no conflict of interest.

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Chapter Three

Bridging Chapter

Word count (excluding references): 698

The findings of the meta-analysis suggest that culturally adapting interventions leads to small to moderately better outcomes for perinatal depression in ethnic minority groups in comparison to controls. However, it is important to note that comparison groups mainly consisted of wait list controls and future studies should use active controls. The findings of the systematic review provide an overview of perinatal mental health CAIs for ethnic minority women, illustrate a structure for culturally adapting perinatal mental health interventions (Taylor et al., 2023; Barrera et al., 2013) and can support professionals to consider how IPT and CBT might be used in the perinatal period with women from ethnic minority groups. While using CAIs is important, it is equally valuable to contemplate the other components of a culturally sensitive service and to shed light on the lived experiences and needs of ethnic minority women accessing perinatal teams in the East of England.

This thesis is underpinned by the Model of Cultural Competence (Campinha-Bacote, 1998) and its application to culturally sensitive perinatal mental health care (Chapter One, p.14). The systematic review, meta-analysis and empirical paper aim to enhance our knowledge of working across cultures. Whilst the systematic review and meta-analysis support professionals in understanding the process of cultural adaptation and identify efficacious interventions, the empirical paper involves direct engagement with ethnic minority women receiving specialist perinatal care to explore their perspectives. This involved using a Lived Experience Advisory Group to shape the initial research questions and topic guide for interviews and then conducting interviews with participants receiving care to understand their perspectives. When considered holistically, both papers encompass pivotal components integral to the development of culturally sensitive care and effectively integrate the model's key features.

In the systematic review, we have investigated the adaptations and efficacy of culturally adapted interventions from predominantly US studies with ethnic minority

participants within the US. Therefore, as we move to UK-based participants in the empirical paper, it is of interest to discuss the transferability of the findings across these cultural contexts. In terms of transferability of the findings to UK populations, white people are the ethnic majority in both US and UK contexts, the categories for cultural adaptation used in the systematic review were piloted in the UK (Taylor et al., 2023; Barrera et al., 2013) and the main CAIs in the meta-analysis, CBT and IPT, are first-line treatments for perinatal depression recommended by The National Institute for Health and Care Excellence (2014), a public body in England which publishes clinical practice guidance. Therefore, it is plausible to suggest that culturally adapting CBT and IPT to UK ethnic minority groups may yield similar results. For participants within the empirical paper who discuss interventions, it would be of interest to determine whether these perspectives are consistent with the findings from the meta-analysis and systematic review.

Regarding contextual differences, the UK has a primarily publicly funded healthcare system, The NHS, whereas US healthcare is primarily funded through private health insurance and federal insurance programmes such as Medicare. The UK system improves access to care for ethnic minorities and people with lower socioeconomic status, in comparison to an inequality of access in the US for ethnic minority groups without health insurance (Jackson & Gracia, 2014). Despite this, there are higher rates of maternal mortality for ethnic minority groups in both the UK (Knight et al., 2023) and the US (Centers for Disease Control and Prevention, 2020). Therefore, it is equally necessary to conduct research which aims to enhance cultural sensitivity within UK perinatal teams. Furthermore, the NHS Long-Term Plan (NHS, 2019) aims to reduce these perinatal mental health inequalities.

Currently, the research surrounding culturally sensitive practice within UK perinatal teams and our understanding of minority ethnic women's experiences of these teams is in its infancy. As a starting point for encouraging cultural sensitivity in specialist perinatal teams

within the East of England, it is fundamental to explore the shared experience of being a minoritised group in this area and identify what women find effective and want to be different within perinatal services.

At present, there is no research which identifies how women from ethnic minority groups conceptualise culturally sensitive perinatal services. The following empirical paper is a starting point to consider women's experiences of specialist perinatal teams in the East of England and how perinatal teams in the region could change to become more culturally sensitive.

Chapter Four

Empirical Paper

Word count (excluding abstract and references): 6278

Word count (excluding abstract, tables and references): 5991

Empirical paper prepared for submission to Health Expectations

Author guidelines can be found in Appendix F

Culturally sensitive perinatal mental health care: Experiences of women from minority ethnic groups

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Abstract

Background: Current research has identified how ethnic minority women experience poorer health outcomes during the perinatal period. In the UK, specialist perinatal mental health services provide mental health treatment for women throughout the perinatal period. Service users have previously highlighted that perinatal services are hard to access and lack cultural sensitivity, and healthcare professionals have described limited opportunities and resources for cultural competency development.

Objectives: We explored ethnic minority women's experiences of National Health Service (NHS) specialist perinatal teams and identified what culturally sensitive perinatal mental health care means to this group.

Design: Individual semi-structured interviews were conducted, and an Interpretive Phenomenological Analysis Framework was used to analyse the interview transcripts.

Setting and participants: Participants were recruited from NHS specialist perinatal teams and online via social media.

Results: Six women were interviewed. Four group experiential themes central to the experiences of participants emerged: 1) Strengthening community networks and peer support; 2) Valuing cultural curiosity; 3) Making sense of how culture, ethnicity, race, and racism impact mental health; and 4) Tailoring interventions to ethnic minority women and their families.

Discussion and conclusions: The findings capture how ethnic minority women experience specialist perinatal teams and offer insights into practicing culturally sensitive care. Perinatal mental health professionals can support ethnic minority women by strengthening their access to community resources and peer support, being curious about their culture, helping them to

make sense of how culture, ethnicity, race and mental health interact, and applying cultural and practical adaptations to interventions.

Key words: perinatal mental health, minority, mental health services, experiences, culture, cultural sensitivity, qualitative study

Patient or Public Contribution: A Lived Experience Advisory Group (LEAG) of women from ethnic minority groups contributed to the design and conduct of this study. The LEAG had lived experience of perinatal mental health conditions and accessing specialist perinatal teams. The LEAG chose to co-produce specific aspects of the research they felt fit with their skills and available time throughout five group sessions. These aspects included developing the interview topic guide, a structure for debriefing participants, and advising on the social media recruitment and advertising strategy.

Introduction

Perinatal mental health services provide mental health treatment for women who are planning their pregnancy, are currently pregnant or have a child up to 12 months old (Royal College of Psychiatrists, 2021). An ethnic minority is a group with a different national or cultural origin from the population majority (United Nations, 2018). Culture encompasses the collective customs, languages, traditions, and beliefs within a group of people (Kroeber & Kluckhohn, 1952). Culturally sensitive care is the conscious understanding and appreciation of values, norms and beliefs inherent in cultural, ethnic or racial groups; it entails an openness and willingness to adapt one's behaviour and perspectives (American Psychological Association, 2018). Culturally sensitive care is crucial because culture influences the presentation of perinatal mental health difficulties, how individuals make sense of their difficulties, and their relationship with help-seeking (Tikka et al., 2022).

Current evidence highlights disparities in perinatal physical and mental health outcomes based on race and ethnicity. The MBBRACE UK report found that Asian and women from a mixed ethnicity background are twice as likely to die in pregnancy than White women, and mortality rates in Black women are four times higher than in White women (Knight et al., 2021). In 2015, a report from the National Childbirth Trust (NCT) highlighted that women from ethnic minority groups are more likely to experience postnatal depression. A systematic review by Alhusen et al. (2016) found that experiences of racial and ethnic discrimination can lead to chronic stress, perinatal anxiety and depression, and adverse birth outcomes, such as lower birth rate and preterm birth. Evidence suggests that midwives and general practitioners are less likely to ask ethnic and racial minority women about their mental health when compared to women of White ethnic backgrounds, and ethnic minority

women have lower access rates to mental health care as a result (Redshaw & Henderson, 2016). The National Health Service (NHS) Long-Term Plan (NHS, 2019) has explicitly emphasised the need to reduce these health inequalities and increase continuity of care in the perinatal period.

From the perspectives of healthcare professionals working in perinatal services, a lack of cultural sensitivity and culturally adapted interventions increases care inequalities between groups (Kirmayer, 2012). Claeys et al. (2021) interviewed nurses, midwives, and healthcare students about their perceptions of culturally sensitive care. They reported that professionals shared difficulties in adopting culturally informed practice, a tendency to compare patients from differing cultural backgrounds against their own cultural frame of reference, and a lack of readily available knowledge on cultural competency (Claeys et al., 2021). Edge (2011) explored NHS perinatal mental health professionals' views of service provision for women from ethnic minority groups and the extent to which they observed services to be meeting the needs of this group. Similar to Claeys et al. (2021), professionals reported a lack of culturally appropriate resources and treatments. Some professionals shared a reliance on signposting women to external culturally specific services to meet their needs.

Furthermore, a systematic review by Watson et al. (2019) investigated the experiences of European perinatal mental health services among minority ethnic women. Barriers to accessing services included a lack of awareness of services, language barriers and fear of judgement regarding mental health status. After accessing services, women encountered cultural insensitivity and interpreter unavailability and described staff as ethnically homogenous (Watson et al., 2019). Two recent qualitative studies explored ethnic minority women's experiences with specialist perinatal teams (Conneely et al., 2023; Pilav et al., 2022). Pilav et al.'s (2022) findings highlighted support barriers across individual, familial, social, and societal levels. The clash between cultural norms and societal expectations

regarding women and motherhood, coupled with daily mental health challenges, intensified the participants' perception of their pre-existing psychological distress and undermined their self-worth as mothers. Conneely et al. (2023) identified several factors which impacted accessing help, including self-identity, social expectations, attributions of distress, perceiving services as hidden, and noticed that professional curiosity, kindness, and flexibility were beneficial. Their findings also suggested that a shared cultural background can either help or hinder trust and rapport. Collectively, Watson et al. (2019), Conneely et al. (2023), and Pilav et al. (2022) proposed the following changes to improve experiences of perinatal services: more transparent service information, prompt assessment, flexible treatments, peer support, enhanced multiagency collaboration, staff cultural competency training and culturally tailored support.

Despite the known inequalities in perinatal services, there has been no research which asks minority ethnic women their perspectives on how they would define culturally sensitive care in the context of perinatal mental health services. The following research questions were addressed: What are ethnic minority women's experiences of perinatal mental health services in the East of England? And, how do ethnic minority women conceptualise culturally sensitive care?

Methods

Design

The study implemented a qualitative semi-structured interview design and Interpretative Phenomenological Analysis was chosen for data analysis (IPA: Smith et al., 1999; Smith & Osborn, 2003). IPA focuses on a detailed exploration of participants' lived experiences and meaning-making processes within their own personal, social and cultural contexts (Smith et al., 2009). IPA is interested in first understanding the nuances and complexities of individual participants before identifying patterns of convergence and

divergence across cases (Smith & Eatough, 2007). IPA's strengths of collecting first-hand accounts of personal experiences and meaning-making (Smith et al., 2009; Spiers & Riley, 2019) were most suited to our research aims of understanding experiences of perinatal services and conceptualisations of culturally sensitive care.

The participant group is heterogeneous in terms of the participants' varied ethnic backgrounds and diagnoses however, this group are homogenous in the shared experience of being an unheard minority group. For instance, limited research has focused on ethnic minority women's experiences of mental health services and several East of England perinatal services reported the number of ethnic minority women accessing services was not proportionate to the local ethnic minority population. Therefore, IPA's approach of analysing accounts individually was necessary to understand the unique cultural identities and perspectives of participants before conducting the cross-case analysis, which illuminated the shared identity of participants as a marginalised group.

Setting

All participants in the current study have accessed NHS perinatal mental health teams in the East of England. In this region, ethnic minority groups constitute only 21.5% of the population, and non-white ethnic minorities account for only 13.5%, in contrast to London, where ethnic minorities account for 63.2% of the population (Office for National Statistics, 2021).

Participants

The following inclusion criteria were applied: women accepted onto the caseload of community perinatal teams and/ or mother and baby units in the East England over the past two years, all women who identify as being from minority ethnic groups and/ or mixed ethnicity groups, over the age of 18 and English speaking to a level they can follow and engage in research activities.

A convenience sampling strategy was used to select participants within NHS teams and via social media, whereby cases met the pre-determined inclusion criteria and were selected based on the assumption they had knowledge and experience of the phenomenon of interest (Palinkas et al., 2015). The study recruited six participants and aliases have been used throughout this paper to preserve anonymity (Table 1). Similar sample sizes have been employed in recent studies using an IPA approach to explore the lived experiences of ethnic minorities (Bradbury & Van Nieuwerburgh, 2023; Daloye, 2022; Untanu & Dempsey, 2018). Smaller sample sizes allow for a more in-depth analysis to accommodate the rigorous methods involved in IPA (Smith et al., 2009).

Table 1. Participant Characteristics

Participant alias	Ethnicity	Cultural background	Age	Mental health difficulty	Time under perinatal service	English as first language
Farah	Mixed ethnicity background : Moroccan, Irish and English	British and Islamic family background	34	Depression and anxiety	12 months	Yes
Inaya	British Pakistani	Muslim and Punjabi	31	Depression	12 months	Yes
Ishani	Indian	Malayan and catholic	37	Birth trauma	Five months	No- Malayalam
Alesha	Mixed ethnicity background: Jamaican, Irish and English	Agnostic, and spiritual, raised Catholic	30	Antenatal depression and anxiety, birth trauma	Six months	Yes
Nasrin	Bangladeshi	Hindu	30	Depression	Six months	No- Bangla
Zoya	British Pakistani	Islam	36	Anxiety and depression	11 months	No- Punjabi

Data Collection

Depending on their preference, participants were interviewed online or in person using the topic guide in Table 2. Interviews were audio recorded, transcribed verbatim and anonymised. The interviews and debriefing duration ranged from 60 to 90 minutes. The topic guide was co-produced with a Lived Experience Advisory Group (LEAG) of minority ethnic women with experience of perinatal mental health difficulties and accessing specialist perinatal teams. Semi-structured interviews were appropriate for this research question, as there is a complex relationship between perceptions of ethnicity, treatment pathways, and diverse experiences across minority ethnic groups (Jankovic et al., 2020). The interview topic guide focused on pathways to care, experiences of care, cultural and ethnic identity, and strategies for improvement.

Table 2. Interview topic guide

Topics	Example Interview questions
Pathways to care	• Please tell me about your journey into the community perinatal team/ mother and baby unit?
Experiences of care	• Overall, how was your experience of X team/ teams? • To what extent do you feel you were involved in decisions about your care?
Cultural and ethnic identity	• How important do you feel your ethnic background is to your health? • To what extent do you feel your ethnicity or culture might have influenced the care you received? And why? • What does culturally sensitive care mean to you?
Strategies for improvement	• What were your needs from the service, and were they met?

Analysis

Transcripts were analysed using IPA, which focused on a detailed exploration of participants' lived experiences and meaning-making processes within their own personal,

social and cultural contexts (Smith et al., 2009). IPA is interested in first understanding the nuances and complexities of individual participants before identifying patterns of convergence and divergence across cases (Smith & Eatough, 2007).

The primary researcher analysed each transcript individually before conducting a cross-case analysis. Each audio recording was listened to, and transcripts were read several times; following this, descriptive, linguistic and conceptual exploratory notes were made (Smith et al., 2009). Exploratory notes were formulated into experiential statements. Experiential statements were grouped to make personal experiential themes. These were compiled into a table alongside relevant quotes to ensure the narrative was grounded in the data. Once each case was completed, cross-case analysis began to create group experiential themes from the personal experiential themes and statements. Initial patterns of group experiential themes were formulated as a research team, and the primary researcher finalised the table of group experiential themes. A reflective diary was used throughout the research process, and any questions about the data, preconceptions and key insights were reflected on as a research team.

Results

From the analysis of the six interview transcripts, four group experiential themes central to the experiences of participants emerged: 1) Strengthening community networks and peer support; 2) Valuing cultural curiosity; 3) Making sense of how culture, ethnicity, race, and racism impact mental health; and 4) Tailoring interventions to ethnic minority women and their families. The presence of these themes within each individual's account is highlighted in Table 3. A detailed description of each theme accompanied by participants' quotes follows.

Table 3. Table of group experiential themes and their relationship to participants

Theme	Farah	Inaya	Ishani	Alesha	Nasrin	Zoya
Strengthening community networks and peer support	✓	✓	✓		✓	✓
Valuing cultural curiosity	✓			✓	✓	✓
Making sense of how culture, ethnicity, race, and racism impact mental health	✓	✓	✓	✓		
Tailoring interventions to ethnic minority women and their families	✓	✓	✓	✓	✓	✓

Group Experiential Theme One: Strengthening Community Networks and Peer Support

Women described the beneficial role of perinatal teams in helping them strengthen their community networks and providing them with support from peers with lived experience. This was seen as crucial for those experiencing acculturative stress and isolation.

Farah shared the importance of perinatal teams helping service users to strengthen their social networks. She reflected on this being consequential considering the context of social isolation, as parenting in England is perceived as increasingly self-reliant, as opposed to the interdependent and collectivist approach observed more commonly in non-Western cultures. Similarly, Ishani shared the challenges of living with reduced support in England in comparison to the collectivist approach in her country of origin:

> *It is very typical in our Western culture, the women are quite isolated and this nuclear family is really praised and like doing it on your own and people don't live near their family. So I think a service that can recognise that is the culture we have today, whether we like it or not and try and help tap people as quickly as possible into a community […] You know, if I just meet women once a week… those negative, lonely, isolating thoughts go away...* (Farah)

> *… back home, we have a lot of support and here we don't. I think a lot of women do suffer here, you know, in silence, they don't talk about their feelings. They're meant to get on with it basically.* (Ishani)

Farah and Ishani articulated a cognisance of the challenges inherent in parenting without the help of extended family and established social networks. Interestingly, neither Inaya, Alesha nor Nasrin mentioned receiving support from their partners or wider family. It appears that strengthening social networks is imperative due to the lack of family support experienced by this group. Farah and Ishani suggested that managing parenting without practical, emotional or social support from others is unsustainable. Their accounts implied they had both experienced isolation during the perinatal period, and distancing themselves by sharing their perceptions of other women experiencing this isolation alludes to their feelings of vulnerability.

In contrast, participants who illustrated their perinatal team's involvement in strengthening community networks and peer support conveyed a heightened sense of connectedness, reduced isolation and confidence. Nasrin was given a Peer Support Worker to help her develop confidence in going outside. Inaya and Zoya shared how their perinatal teams engaged in multiagency working to help them expand their professional and peer support networks within their communities:

> *Yeah I have a Peer Support Worker who helped me get out and afterwards I feel more confident.* (Nasrin)

> *There were quite a few projects with Muslim mums* […] *that kind of stuff for like Mum's spirituality*. (Inaya)

> *And then* [care coordinator's name] *told me about Mind* [mental health charity] […] *She* [Mind practitioner] *was amazing. She was seeing me every Monday…Talked to me, asked how I'm feeling. Whoever I met in this journey, they were amazing. So she*

> *was amazing. But actually she said she went through the same. She knows all the experience. She went through all this as well. So in our culture, we don't really think about this thing, you know about mental health, that in our culture it doesn't exist...*
>
> (Zoya)

It was apparent that having regular sessions through a charitable organisation providing mental health support helped Zoya feel cared for. Her account suggests that being seen by a professional with lived experience normalised mental health difficulties in the context of her experiences of cultural stigma towards mental health and helped build her sense of connection with others. Furthermore, Zoya's perinatal team helped her identify existing members of her support network. Zoya shared the value of relying on a close support network to bring her comfort and to help manage family life and routine at a time when her depression was at its most severe. Learning to accept help from others was a valuable learning experience for Zoya:

> *My neighbours and my friends was amazing. Picking up the kids and dropping off the kids. Honestly, just take it, whoever wants to offer you anything. Just take it because I was like no, no, no, I'm fine. I don't need any help. I'm okay. But now I just take anybody's help.* (Zoya)

Participants' responses revealed that viewing the mother and the baby as embedded in their broader social and community contexts helps identify ways to improve mental health as a collective and increase support. Participants whose perinatal teams were actively helping them strengthen their existing social and peer support networks and create new ones appeared to have a more beneficial impact than those who were less connected. Their responses suggest that a neighbourhood approach to care is needed.

Group Experiential Theme Two: Valuing Cultural Curiosity

Women expressed the value of professionals being culturally curious and asking them questions about their cultural background. There were apparent differences in the extent to which participants experienced this curiosity.

Nasrin and Zoya described how culture was discussed in detail throughout their therapy sessions and home visits from staff. Zoya described how staff were culturally attuned and asked them questions about key religious events:

> *I enjoy someone who wants to know about my culture… Curiosity makes me happy. Yeah, because I'm working with someone who has an interest in me.* (Nasrin)
>
> *They asked me what I'm doing for Eid and "did you make clothes for the kids*?" (Zoya)

It was clear that for Nasrin and Zoya, asking about culture and cultural festivities was important for building relationships with professionals. Conversely, Farah and Alesha experienced professionals as neither open nor competent to talk about culture. Farah described providing data on her ethnic background when entering the perinatal service but was later disappointed when her ethnicity was not explored further:

> *…first time you're accessing services, not just asking about your ethnicity for a tick box exercise. […] But actually, yeah, exploring that, spending a few minutes trying to understand, you know, I present as mixed-race, somebody else might present as mixed-race, but our upbringing could be quite different.* (Farah)

Alesha shared how she experienced perinatal team staff as visibly uncomfortable when culture and race became present and expressed that she had wanted this to be explored:

> *I would just like someone to actually acknowledge it before I do sometimes. Because then I can see people getting awkward because they don't know how to talk. And it's like the elephant in the room sort of thing. So, it would just be nice to have people say, you know, oh, "how have you found the service as a mixed-race woman or like, you*

know, has anything ever come up for you?" It'd just be nice for people to check in because it's an important part of your identity. (Alesha)

It is clear from participants' accounts that their culture, ethnicity, and race are integral parts of their identity. Farah and Alesha's experiences suggest that professionals avoiding or failing to ask and explore culture, ethnicity and race may be perceived as rejecting their identities and exacerbating a feeling of discomfort, prohibiting good relationships from forming with staff. Farah and Alesha suggest that asking about ethnicity beyond data collection and professionals conveying an interest in how diverse women perceive services can help improve experiences for ethnic minority women. Despite the differences in the extent to which women felt they received cultural curiosity from professionals, they all felt this was important for their care. Therefore, demonstrating an interest in cultural, ethnic and racial identities is valuable for service user engagement and forming service user and staff relationships.

Group Experiential Theme Three: Making Sense of How Culture, Ethnicity, Race and Racism Impact Mental Health

Participants similarly expressed the value of being able to explore how their culture and mental health difficulties influence one another. However, similar to the prior theme, there were differences in the extent to which participants had been supported by specialist perinatal staff to explore and formulate the impact of culture, ethnicity, race and racism on their mental health.

Inaya, Ishani and Farah each described the influence of their culture and upbringing on their mental health. Inaya reflected on cultural stigma towards mental health difficulties within her culture and how these judgements negatively affected her mental health in the past:

> *…get labelled as crazy. Not, not on purpose, but let's say if someone got depression, so they must be crazy. But they're all words that don't help* (Inaya)

Ishani also described when cultural norms impacted her mental health, but with a focus on childhood trauma:

> *If you are not listened to as a child, for example, quite normal there* (home country). *And you come here, and you look at it and say, "you know, that's just a child and you didn't have to go through all that".* (Ishani)

Ishani shared that she was supported in discussing her cultural upbringing during formulation sessions with a Psychologist from the perinatal team. She noticed the benefit of her Psychologist being from outside of her culture. Ishani believed this difference in cultural outlook on childrearing practices meant that the Psychologist was able to identify that Ishani suffered child abuse, and it was evident that Ishani felt validated by this. Ishani suggested that someone within her own culture may not have recognised this as abuse as she inferred that child maltreatment is normalised in her culture. Being supported to discuss her cultural upbringing and acknowledge the childhood abuse she experienced was interpreted as having supported Ishani to develop compassion towards her difficulties. Similarly, Farah also discussed the impact of her cultural upbringing but reflected on how this influenced her belief system:

> *…my brains been wired from when I was younger and maybe you know, again bringing up my upbringing and certain kinds of beliefs and, or, certain limiting beliefs. For me, all of that is so part of culture. So, part of like why, you know… Why I think certain things, why you're so kind of harsh on yourself, why you're so negative…* (Farah)

By noticing the influences of their cultural upbringing on their well-being, it was interpreted that Farah and Ishani perceived themselves as having an opportunity to make sense of their difficulties and identify their need for self-compassion.

Making sense of the influence of race and racism was identified as particularly pertinent for Alesha. Alesha expressed the importance of professionals acknowledging critical events in the media about perinatal outcomes and race. For instance, Alesha referred to the MBRRACE Report's finding that Asian women and women from mixed-ethnicity backgrounds are twice as likely to die in pregnancy than White women and mortality rates in Black women are four times higher than in White women (Knight et al., 2021). She reflected on the value of professionals asking her about how these events have impacted her:

> *We know that women from minorities have a lower level of care […] There's research into it, like we know it's a thing. And we know that a lot of times people are ignored in times of pain. And so it's even just like oh, "how do you feel about this stuff that's come out* [MBRRACE-UK findings; Knight et al., 2021]*?" Because I was terrified when I was giving birth to* [baby's name], *I was straightening my hair all the time, thinking I want to be more racially ambiguous, which is horrible to me…I think it's important for women to talk about our birth experience and experiences of racism.*
>
> (Alesha)

Alesha highlighted how she felt the MBRRACE-UK statistics were close to reflecting her childbirth experience. Alesha's account suggests that perinatal teams being aware of current affairs and systemic racism is meaningful. Alesha and Farah shared that perinatal staff had not asked about their race, ethnicity and culture. During the interviews, Alesha and Farah were seen to be overtly engaging in active meaning-making. At the end of the interview, they shared that professionals had not discussed these topics with them and reflected on how the research interview acted as a sense-making intervention.

Exploring individual and collective experiences of culture, ethnicity, race and racism were valued by the women included in this study. Women whose healthcare professionals had facilitated these conversations expressed the following: being supported to make sense of how their upbringing impacts them today, having help to identify childhood abuse, and being able to acknowledge cultural stigma and distance themselves from it.

Group Experiential Theme Four*:* Tailoring Interventions to Ethnic Minority Women and Their Families

Critically reflective practice was seen as necessary when working with ethnic minority women. All the women suggested a variety of cultural and practical considerations for working with women from ethnic minority groups. However, there were differences in what women appraised as most important for their care.

Farah shared her experiences of Cognitive Behavioural Therapy and reflected on how integrating her cultural context into therapy would have been beneficial. She conveyed her perspective that evidence-based perinatal mental health treatments often do not fit women from ethnic minority backgrounds. Farah recommended clinicians apply problem-solving and critical reflection to adapt treatment for ethnic minority women:

> *I think a lot of these kind of structures and frameworks are probably created traditionally by like white British males. So, when you look at that kind of systemically, and then somebody isn't responding to a treatment, you've gotta kind of look outside the box a bit.* (Farah)

Inaya, Zoya, Ishani and Nasrin all placed value on speaking with clinicians of the same cultural and linguistic background. Zoya described the ease of communicating in the same language with her Psychiatrists:

Yeah, you know, this language barrier does come up, I try to speak very well, but sometimes you know, it helped to tell them in my own language. (Zoya)

Ishani shared that coming from the same linguistic and cultural background as her therapist would enable her to converse intuitively and express her thoughts and feelings with ease:

When you're trying to find words in English, which is a common language for you, it's kind of ermm difficult to express what you really feel […] You're finding words, it's not from the heart, it's from the brain. (Ishani)

When no clinicians spoke the same language, Inaya described her husband benefitting from an interpreter when attending a group for dads:

He needed a translator for meetings and a few sessions with other dads. (Inaya)

Although Nasrin also felt she may have benefitted from a therapist who matched her cultural and linguistic background, she described a strong therapeutic relationship with her therapist. She thought an English-speaking therapist was acceptable, provided they made adaptations. Nasrin shared that she spent many assessment sessions talking and explaining her culture to her therapist. She thought that the number of intervention sessions was limited due to this extended cultural assessment. She acknowledged that therapy within the NHS is often time-limited but suggested an increased number of sessions in these instances for equitable care:

…I think extended sessions for ethnic minority is also helpful. Yeah. Because our culture is different, so they needed more time to understand me. (Nasrin)

Alesha was the only participant to recommend a new intervention for ethnic minority mothers under the care of the perinatal team to discuss complex cultural narratives and the influence of race on their experiences:

> *It would be good to have a group specifically for minority women, it might involve talking about different experiences of motherhood, family and how our race has impacted us.* (Alesha)

The data suggests that there is no "one size fits" approach to tailoring care for ethnic minority women from different cultural backgrounds; however, participants' responses suggest that practical and flexible adaptations are needed to suit the needs of minority groups.

Discussion

The study investigated ethnic minority women's experiences of specialist perinatal teams and how they conceptualise culturally sensitive care. To our knowledge, this is the first study which asks ethnic minority women what culturally sensitive care means to them. Participants had accessed perinatal teams in the East of England, UK. In this region, non-white ethnic minorities account for 13.5% of the population, a lower percentage than the UK as a whole (Office for National Statistics, 2021). Therefore, this study is unique in exploring the perspectives of a minority group that experiences heightened marginalisation and reduced visibility compared to other regions in the UK and has direct relevance for improving the experiences of ethnic minority women accessing perinatal teams. Four group experiential themes were developed from the six participants' accounts: 1) Strengthening community networks and peer support; 2) Valuing cultural curiosity; 3) Making sense of how culture, ethnicity, race, and racism impact mental health; and 4) Tailoring interventions to ethnic minority women and their families.

Strengthening community networks and peer support was conceptualised as integral for participants' recovery. Outside of Western cultures and within the cultures the majority of study participants originate from, caring for both mother and baby is often a collective responsibility. Previous research states that isolation is a shared experience for many ethnic minority women seen by perinatal services (Gardner et al., 2014; Raymond, 2007;

Wittkowski et al., 2011) and mirrors the current findings. Participants emphasised the need to help mothers overcome isolation, and their responses revealed that seeing the mother and baby in the context of their communities helps improve well-being. Moreover, current research on perinatal mental health interventions for ethnic minority women shows that strengthening the ethnic minority mothers' support networks has a beneficial effect (Grote et al., 2009; Grote et al., 2015; Hankin et al., 2023; Le et al., 2011; Tandon et al., 2014). Previous findings suggested that perinatal teams need to prioritise multiagency working and community peer support (Cantle, 2010; Edge, 2011; Raymond et al., 2007). Several participants in this study shared positive experiences of perinatal teams that offer such support.

Cultural curiosity has emerged as the foundation for the development of cultural knowledge and cultural competency (Mikhaylov, 2016). The extent to which participants experienced professionals as culturally curious varied in this study; however, most participants identified this as meaningful for building relationships with staff and sharing their identity. This supports Conneely et al. (2023) qualitative exploration of Black and Asian women's experiences of perinatal services, which found that the role of professional cultural curiosity, kindness and flexibility makes women feel heard, accepted and supported.

Furthermore, cultural curiosity is essential for professionals to support service users in "making sense of how culture, ethnicity, race, and racism impact mental health". This theme was unique in comparison to other qualitative explorations of ethnic minority women's experiences of perinatal services in that it explicitly identifies the value of professionals and service users making sense of the intersection between mental health difficulties and culture, ethnicity and race. This sense-making helped women to form a cohesive narrative, experience validation in response to suffering, and understand factors contributing towards mental health difficulties.

The final theme, "tailoring interventions to ethnic minority women and their families", is supported by the evidence base for the practical recommendations made by participants, such as linguistic adaptations and flexibility in the length of sessions (Masood et al., 2015). A support group for ethnic minority mothers was also recommended, similar to previous studies whereby ethnic minority participants expressed a need to meet other mothers from similar backgrounds in group settings (Raymond, 2007; Wittkowski et al., 2011).

Strengths and Limitations

This study contributed to the evidence base of an underrepresented group within perinatal mental health. The themes provide user-friendly recommendations for providing culturally sensitive care. When developing a recruitment plan, the research team and the LEAG were aware that recruiting participants via NHS perinatal teams may result in recruitment bias, as organisations may invite service users with positive experiences of their services (Ellard-Gray et al., 2015). To reduce recruitment bias, additional online recruitment was used to identify participants the selected NHS perinatal teams had not approached, and the sample of participants was split equally between those recruited online and via NHS teams.

This study followed Smith's (2011) guide for evaluating IPA research, which outlines the core features of high-quality IPA studies, including a clear focus, strong data, evidence rigour, thematic elaboration, interpretive analysis, incorporation of convergence and divergence, and careful writing. There was a clear focus on exploring ethnic minority women's experiences of perinatal teams and how cultural sensitivity is conceptualised within this context. The interviews elicited rich data by using the topic guide flexibly (Table 1). The study detailed rigour, displaying the prevalence for each theme. For example, Smith (2011) advises providing extracts for half the sample in studies with four to eight participants, and Table 3 demonstrates that each theme had extracts from four to six participants. The extracts

for themes were distributed evenly amongst participants, and themes were elaborated on in sufficient detail rather than superficially. The analysis was interpretative, and conceptual exploratory notes aided this process. The selected extracts represented convergence and divergence among participants' views. The paper was written to capture the key narratives within the data by exploring what has been learned by the phenomena and clinical implications.

Regarding limitations, the sample size aligns with recommendations for an IPA paper (Smith et al., 2009); however, recruitment from perinatal teams was low, and many ethnic minority groups were missing from the sample. An intensive NHS recruitment strategy was implemented, whereby the primary researcher attended perinatal team meetings and communicated regularly with staff; the sample of three participants recruited via the NHS may reflect the challenges teams face due to increased demands, including workload pressures and resource constraints. Black and White Other ethnic minority groups were underrepresented in this study despite efforts to approach a variety of charities and social media sites which support and have an audience of a broad range of ethnic minorities. We would have anticipated women who have accessed the MBU represented within our recruitment sample as ethnic minority women are more commonly seen in acute mental health settings (Jankovic et al., 2020). However, our sample only represents women seen by community perinatal teams. A key limitation of this study is that we cannot comment on the experiences of ethnic minority women who accessed MBUs, particularly in the context of experiencing higher rates of involuntary admission than the White British group (Jankovic et al., 2020), and their understanding of culturally sensitive care in this setting. Lastly, the interview was only conducted in English, which excluded several women from accessing the study. In addition, half of the participants did not speak English as their first language, and the results may have been different if the interview had been conducted in their first language

(Cortazzi, Pilcher & Jin, 2011). However, language differences within datasets and the accuracy of translation have been suggested to affect the understanding and interpretation of data, impacting a study's validity (van Nes et al., 2010).

Clinical Implications

As described in the NHS Long Term Plan (NHS, 2019), the Neighbourhood Model, or place-based systems of care, focuses on multiagency working and embedding health and social care around local communities. This study's findings suggest ethnic minority women value a neighbourhood model of care. Perinatal services should continue to collaborate with multiagency services, help women enhance their existing social networks and build on these by engaging in local community activities and peer support.

The current research emphasises the value of curiosity and how clinicians can work to develop their abilities to explore culture, ethnicity and race. The participants expressed how valuable they found talking about their ethnicity and cultural identity with professionals. Naz et al. (2019) normalise that it is common for White clinicians to lack confidence when talking about culture, ethnicity and race but offer guidance for developing cultural curiosity by discussing culture, ethnicity and race early on in relationships with service users. Naz et al. (2019) describe that when White clinicians tolerate uncertainty and express curiosity when facilitating these conversations, this increases their perceived cultural competence.

Furthermore, clinicians should develop their competencies in supporting service users to make sense of how their culture and mental health influence one another in varying ways. This sense-making can be done through supportive conversations or psychological formulation. Clinicians may wish to refer to the Cultural Formulation Model (Lewis-Fernández & Díaz, 2002) and the Cultural Formulation Interview (Lewis-Fernández et al., 2016), which both encompass key questions including cultural identity, coping, help-seeking,

cultural explanations of illness, social factors, and the cultural elements of the relationship between the individual and clinician.

Professionals seeing women from different ethnic minority groups should review appropriate practical, linguistic considerations and cultural adaptations with them, take a critically reflective position when using Western models of care, and adapt these appropriately to ethnic minority women. Furthermore, a systematic review found that cultural competence training significantly improved professionals' cultural competency and was associated with increased satisfaction in ethnic minority patients (Govere & Govere, 2016). Perinatal teams should provide training and resources for staff to develop their culturally sensitive practice (Masood et al., 2015).

Recommendations for Future Research

Given the differences in perceptions expressed in this research with culturally diverse ethnic minority mothers, further research should focus on participants from specific ethnic minority groups to further explore their shared experiences within specific cultural contexts. Future research studies could recruit participants from a specific cultural and linguistic group whereby interviews are interpreted, or an interviewer speaks the same language as the participants to maintain validity. Research could have a more explicit focus on one stage of an ethnic minority woman's journey within perinatal mental health services, such as specific interventions or relapse prevention, for a more in-depth analysis. It is also essential to consider that these recommendations suggest a more homogenous sample, which may present recruitment challenges depending on the desired sample size.

Conclusions

The findings capture how ethnic minority women experience specialist perinatal teams within the East of England as well as areas services can focus on to improve the experience of ethnic minority women and offer culturally sensitive care. Perinatal services

can support underrepresented ethnic minority women by applying a systemic lens to their recovery, being curious about their culture, supporting them to make sense of how culture, ethnicity, race and mental health interact, and applying cultural and practical adaptations to make care more equitable for this population.

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Conflicts of Interest

No conflicts of interest

Ethics Approval Statement

The NHS Health Research Authority (HRA) granted approval for this research, including ethical approval from Health and Care Research Wales (HCRW) and each participating NHS Trust granted capacity and capability authorisations. REC reference: 22/SW/0173. IRAS project ID: 319722.

Participant Consent Statement

All participants were provided with participant information sheets and were supported in making an informed choice about entering the study. All participants signed consent forms. Participants were informed that they had the right to withdraw and ask for the data's destruction during the data-gathering phase.

Data availability statement

Shared data are not available for this study.

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Chapter Five

Extended Methods

Word count (excluding references): 4734

This extended methods section provides a detailed account of the development of the empirical study and the process and experience of using Interpretative Phenomenological Analysis (IPA) in addition to a reflexive account. The research process was anchored within IPA's theoretical underpinnings in phenomenology, hermeneutics, and idiography, detailed throughout this chapter.

Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative approach that focuses on an in-depth exploration of people's lived experiences and how they make sense of their personal and social worlds (Smith et al., 2009). IPA is an experiential method which incorporates three primary theoretical underpinnings: a) phenomenology, a philosophical approach examining lived experience from a first-person perspective and emphasising the subjective examination of experiences without imposing preconceived assumptions; b) hermeneutics is the theory of interpretation and focuses on making meaning of the said and unsaid; and c) idiographic, the individual focus on each case on their terms and in their specific contexts within the early analysis before cross-case analysis (Smith & Nizza, 2022). IPA looks to explore shared experiences between relatively homogenous participants groups, and is interested in first understanding the narratives of individual participants before identifying patterns of convergence and divergence during the cross-case analysis (Smith & Eatough, 2007).

When developing the study, reflecting on which qualitative approach best fit our research questions and population was essential. The research questions focused on personal experiences and conceptualisations within the context of specialist perinatal teams and participants' broader personal, social and cultural contexts: What are the experiences of perinatal mental healthcare of women from ethnic minority backgrounds in the East of England? And, how do ethnic minority women conceptualise culturally sensitive care in perinatal services? Therefore, the focus of IPA on collecting first-hand accounts of personal

experience and making meaning from these experiences (Smith et al., 2009; Spiers & Riley, 2019) was best suited to answering these research questions. Furthermore, IPA was chosen over Thematic Analysis (TA) because the analytic focus was on understanding participants' lived experiences and sense-making before identifying overall common themes (Braun & Clarke, 2021).

IPA is appropriate due to its unique ability to identify and understand the complex differences in individuals before making comparisons (Smith et al. 2009). It could be argued that the participant group is more heterogeneous than most IPA studies because of the participants' diverse cultural, ethnic and racial identities. However, when requesting data on the number of patients from ethnic minority groups under East of England perinatal services, it was reported by services that approximately 5% of patients were from ethnic minority backgrounds. In combination with the limited research focused on ethnic minority women's experiences of mental health services, it became evident that this group were homogenous in their shared experiences of being from an unheard minority group accessing NHS perinatal teams. Individually analysing each account was necessary to understand the unique cultural identities and perspectives of participants before conducting the cross-case analysis which illuminated the shared identity of participants as a marginalised group. Whereas TA would have limited the idiographic understanding of each account.

Furthermore, the limited number of ethnic minority women accessing perinatal mental health teams may have been reflected in the smaller sample size of six participants. IPA is an appropriate approach to understanding under-researched phenomena and marginalised voices (O'Mullan et al., 2017). IPA warrants a smaller sample size due to its detailed exploration of cases, seeking to uncover nuances and complexities within and between cases (Smith et al., 2009). Moreover, Turpin et al. (1997) recommend six to eight participants for clinical

psychology doctoral theses and this allowed depth to be prioritised over breadth, a core feature of IPA (Pietkiewicz & Smith, 2012).

Method

Ethical Considerations

The NHS Health Research Authority (HRA) granted approval for this research and ethical approval was granted by Health and Care Research Wales (HCRW) with reference 22/SW/0173 (Appendix G), and each participating NHS Trust granted capacity and capability authorisations. All participants were provided with participant information sheets (Appendix H) and were supported in making an informed choice about entering the study. Participants had at least two days to read the participant information sheet before completing the consent form (Appendix I). Participants were informed that they had the right to withdraw and ask for the data's destruction during the data-gathering phase. No information about the study was withheld from participants, and there was no risk of deception.

A detailed plan for information governance and anonymising data was made. The UEA is the Data Controller of the research and is responsible for Data Protection. All personal information collected from participants was on a need-to-know basis. The plan for protecting participants' data is outlined in the "Will my information be confidential and what will happen to my information?" section of the participant information sheet (Appendix H). Participant IDs were linked to contact details, which were used to share each participant's personal experiential table and will be used to provide participants with the summary of findings with participants, for those who opted into receiving study updates.

The project was designed flexibly to reduce access barriers. For instance, offering £20 vouchers for interviews supports people to be able to take part as they otherwise may need to work and prioritise other responsibilities. Coercion concerning offering participants vouchers was considered. Whilst incentivising participation can be ethically problematic, the BPS

Code of Human Research Ethics (Oates et al., 2021) states that paying participants for their time is appropriate due to the practical costs incurred and a payment equivalent to minimum wage level was understood to be a fair reimbursement. No participants expressed dissatisfaction with the reimbursement level.

Patient and Public Involvement and Co-production

Patient and public involvement (PPI) is defined as the involvement of patients and members of the public throughout the research process (INVOLVE, 2012). Co-production is a collaborative and egalitarian approach to PPI (National Institute for Health and Care Research; NIHR, 2021). Beresford et al. (2021) define co-production as acknowledging power inequalities to facilitate equitable, collaborative working between the public, service users and researchers. They describe how this approach ensures that everyone involved makes meaningful decisions and that each member's skillset is applied to the research process.

The NIHR (2021) sets out five fundamental principles for co-producing research projects: 1) the sharing of power; 2) including all perspectives and skills; 3) respecting and valuing the knowledge of all those working together on the research; 4) reciprocity; and 5) building and maintaining relationships. Increasing diversity and inclusivity in PPI is essential as most PPI participants are from a narrower section of society (INVOLVE, 2012). For instance, older people from white ethnic groups of higher socioeconomic status are more likely to be involved in PPI (Pathways Through Participation, 2009). This thesis values and prioritises the exploration of marginalised voices; therefore, working collaboratively with a PPI group, which was representative of the participant population, was central to this project.

The Lived Experience Advisory Group (LEAG). In the early stages of this thesis project, I recruited a Lived Experience Advisory Group (LEAG) via social media. This group included women from ethnic minority groups with lived experience of perinatal mental health

conditions who have accessed specialist perinatal teams. First, I met each group member individually to discuss their strengths relevant to the project, aims and research interests. I also sought to demystify the role of the research team and identify ways to address the issue of power, such as setting a shared agenda for LEAG meetings and reflecting on how each member wishes to contribute to the research process as an action point to end each meeting. Group members could not be involved at every research stage due to members starting employment and going on maternity leave. Therefore, this thesis did not embed co-production in its truest sense because collaborative working, as described by Beresford et al. (2021), was not possible throughout all stages of the project. However, members chose to co-produce specific aspects of the research they felt fit with their skills and available time throughout five group sessions, including the interview topic guide, a structure for debriefing participants, and the social media recruitment and advertising strategy.

Reciprocity was an essential aspect of co-production within this project. Although the LEAG did not wish for training on data analysis, the group learnt skills in developing semi-structured interviews. We thought about how their research involvement would be relevant to job interviews, and members were paid £10 per hour for their time. Similarly, the rationale for paying participants was particularly important in valuing each individual's time and respecting their contributions. The LEAG has been in regular communication throughout the project. Although members have not been able to be involved at every stage of the process, they have appreciated hearing about the project's progress and have expressed their wish to help disseminate the research findings via social media.

Developing the Topic Guide

The research team and the LEAG collaboratively developed the topic guide and associated interview questions and prompts. Guidance for conducting semi-structured interviews suggests using no more than five to 10 interview questions (Creswell & Creswell,

2018) to allow participants to discuss their experiences in detail and for targeted follow-up questions to elicit rich interview data. The interview follows a temporal structure to support participants in telling their story, whereby questions are asked about the beginning when women first needed perinatal mental support, the support they received whilst under the care of a perinatal team, and the ending by being asked to look forward and identify how care might be different. The interview topic guide includes the following four areas: pathways to care, experiences of care, cultural and ethnic identity, and strategies for improvement (Chapter Four, p. 68).

'Pathways to care' was thought to elicit helpful information on barriers to accessing services specific to the East of England, which may need to be addressed by perinatal teams and provide examples of effective service pathways. The topics were chosen to ensure the likelihood that the research questions were answered. For instance, the 'experiences of care' and the 'cultural and ethnic identity' topics were developed to ensure participants could share their specific experiences and what culturally sensitive care means. The 'cultural and ethnic identity' topic aimed to provide a deeper understanding of the individual cultural processes that arise when engaging with mental health services and how healthcare professionals can support people from different cultural backgrounds to engage with healthcare systems meaningfully. The topic, 'strategies for improvement, ' aimed to allow participants to give feedback about their experiences and provide data to support perinatal mental health teams in applying the interview findings to practice (Sandelowski & Leeman, 2012).

Recruitment

Professionals within perinatal teams were asked to contact service users currently on their caseloads or those who had been discharged within the past two years to ask if they would like to participate in this study. Charities or community organisations working with minority ethnic women were also asked to share information about the study with their

members. Derived rapport with NHS teams and charities was thought to ease mistrust of the research process. However, recruitment bias can be associated with this strategy as organisations may be more likely to invite service users with positive experiences (Ellard-Gray et al., 2015). To resolve bias associated with derived rapport, online recruitment was used to identify participants who did not access the selected charities and NHS perinatal teams did not identify. The recruitment advert with details of the study and participant inclusion criteria was dispersed online via social media (Appendix J). Three participants were recruited via NHS teams and three via social media.

The Interviews

Before the interviews, I spoke to all participants on the phone to introduce myself, clarify any questions about the participant information sheet, discuss any concerns or practicalities and explain what the interview involves. Interviews were conducted online via Microsoft Teams and in person. All interviews were held with the baby present or sleeping near the mother. At times when the babies' needs were being met, the temporal nature of the topic guide helped participants return to where they left off with ease. Additionally, the flexible nature of the guide allowed the interview process to be a cooperative endeavour. Employing a semi-structured interview guide with only seven key questions afforded space for participants to share their experiences without interruption. The flexibility of the interview aimed to help participants feel at ease and discuss the areas that feel most pertinent to them, therefore disclosing further and providing more in-depth interviews (Smith et al., 2009). For instance, stepping back to give Alesha space to talk about her experiences of racism and birth trauma, rather than rigidly focusing on a set interview agenda, resulted in a richer discussion.

Defining keywords in the study was important for participant's understanding of the interview questions. "Cultural sensitivity" was referred to on the social media recruitment

posters and participant information sheets. Therefore, I believed participants would be familiar with the definition of cultural sensitivity. However, I soon became aware that cultural sensitivity is not a widely used term, particularly for participants whose first language is not English. Therefore, I started to share a definition of cultural sensitivity within the pre-interview phone call and sought to clarify whether the participant had a similar understanding of the broader definition whilst sharing that the interview intended to illicit what culturally sensitive care means to them personally.

Debriefing

The debriefing allowed the participants to discuss how they found the interview and whether they experienced any distress. None of the participants reported any distress, and two shared that they experienced the interview as therapeutic. The interviewer provided a signposting document at the end of the debriefing (Maternal Mental Health Alliance, 2022) with details of the mental health charities which offer crisis support and counselling, including The Samaritans and Tommy's. Participants were asked about what they would like from the study going forward. All Participants expressed an interest in hearing about the study findings and being updated with action points from perinatal teams following dissemination.

Analysis

I self-transcribed the interviews to become more familiar with the data, as Seidman (2006) suggested that researchers have the opportunity to understand and explore the meanings within their data better when self-transcribing. I then completed steps one to five on each transcript before conducting cross-case analysis (step six) with support from the research team before continuing a process of further interpretative thinking and restructuring during the write-up (step seven).

Step 1: Reading and Exploratory Notes. At the start of the analysis process, I printed each transcript and listened to the audio recording whilst re-reading the interview. Following this, I made exploratory notes by hand in the right-hand column of each page (Appendix K). These exploratory notes encompassed the following categories: 1) descriptive, to summarise and describe the participant's explicit meanings at face value; 2) linguistic, to identify aspects of speech such as pronouns, pauses, laughter, and tone to inform the interpretation; and 3) conceptual, to further develop potential meanings and deeper interpretations, whilst considering the participant's standpoint as well as the researcher's understanding of their experience and own personal experiences and professional background (Smith et al., 2009).

Step 2: Formulating Experiential Statements. I used the series of experiential notes on the right margin of my transcript to formulate experiential statements on the left margin (Appendix K). I identified one or more experiential statements for each participant's speaking turns in the transcript. I aimed to develop the experiential statements as a concise summary of the exploratory notes for each portion of the text. The experiential statements took the form of statements and open phrases that captured the overall ideas, psychological processes, and context at different points of the text. There were approximately 60 to 100 experiential statements per interview.

Step 3: Finding Connections and Clustering Experiential Statements. Once I developed experiential statements for the whole interview, I began to review and refine the experiential statements. I printed a list of the statements, cut each statement out and started sorting them into similar groups, synthesising them and identifying patterns by moving them around my desk, as advised by Smith and Nizza (2022). Doing so physically allowed me to have a spatial representation of the experiential statements and easily group them. I stacked any repeated experiential statements on top of each other. I started by grouping the statements

into 10 clusters with approximately 10 statements each, then further grouped these, resulting in three to five larger clusters. Several similar experiential statements were combined or re-expressed to capture the overall meaning. Statements unrelated to others or which made no significant analytical contribution were removed.

Step 4: Compiling the Table of Personal Experiential Themes. Following the development of satisfactory clusters of experiential statements, I used Post-it notes to name each cluster as a personal experiential theme, aiming to encompass the overall meaning and expression of the convergence of experiential statements. I then developed the tables of personal experiential themes on Microsoft Word (Appendix L). Although not prescriptive, I identified three to five personal experiential themes for each transcript, with approximately three to five experiential statements as recommended by Smith and Nizza (2022). The tables had an evidence trail of quotes with accompanying line numbers from the transcript. Returning to the quotes helped me stay grounded in the data and find the evidence behind my interpretations. The order of each personal experiential theme and the experiential statements within them was chronological, primarily to convey each participant's account as they were experienced in the interviews.

Step 5: Repeating the Process for Each Case. I repeated the above steps for each transcript, and as a result, I had a set of individual tables of personal experiential themes for each participant in the study. It felt it was essential to create space between analysing each case to maintain the idiographic component of the analysis. Therefore, I only analysed one participant per week. Approaching each participant's transcript separately and planning time to pause between each supported me to develop distance between transcripts. This effort was made to minimise the influence of the last transcript on the next when developing themes.

Step 6: Cross-Case Analysis and Compiling the Table of Group Experiential Themes

Next, a cross-case analysis was conducted to identify common patterns and idiosyncratic differences within those patterns. The research team used an interactive online approach to grouping personal experiential themes. I shared the personal experiential themes on a sticky note application (Lucid, 2023), whereby the research team could each start to group the 26 personal experiential themes into patterns (Appendix M) whilst referring back to the tables of personal experiential themes (Appendix L). In this session, we identified connections and idiosyncratic differences between the personal experiential themes.

Following the online meeting, I reviewed whether there were further connections and differences at a lower experiential statement level. When finalising group experiential themes, it was important to define what constitutes as a theme. Smith et al. (2011) IPA quality evaluation guide recommends that studies with a sample of four to eight participants have extracts from at least three participants for each theme. I ensured that each theme related to extracts from at least three participants as a minimum. I then developed the table of group experiential themes (Appendix N) and reviewed this with the research team. Each group theme was accompanied by participant aliases, quotes and line numbers for each participant's transcript.

Step 7: Writing Up the Study. IPA is an iterative process by nature. Therefore, I continued to identify more suitable quotes for themes and changed the wording of themes during the study write-up. Mapping out the themes visually and sharing drafts with my supervisors helped me to see the findings from an outsider's perspective.

Reflexivity

Researcher Position

It is vital to acknowledge positionality because the researcher's perspective in qualitative research plays a fundamental role in data analysis (McCracken, 1988). I am a White British and South Asian woman. I had a baby in 2021 and have worked in a

community perinatal team as an Assistant Psychologist. In the early stages of the study development, I reflected on my position and wrote down my preconceptions before starting the interviews.

Concerning how my own race and ethnicity interact with participants', I was aware that two of the participants are mixed-race, and the intersection of their different identities was discussed during the interviews. I noted that my mixed-race identity drew me towards how different cultures, races, and ethnicities intersect. I was mindful not to privilege specific accounts over others due to my own interests and personal background. I made a note of which extracts I was personally drawn to in my reflective journal following the interviews and revisited this during the data analysis to ensure that the themes were grounded in the extracts rather than influenced by my personal biases. In reference to my own experience of motherhood, I was aware of how evocative these early stages of motherhood can be and was cautious as I did not want my own experiences of motherhood and healthcare services to impact how I interacted with participants. However, I soon noticed this as a strength, as I could engage both the mother and baby in the interview process.

As a clinician who has worked in a perinatal team, I noticed in my team that the workforce and patients weren't representative of the proportion of ethnic minority groups you would expect within the specific population and that culture was not commonly discussed or accounted for within the team. This identification of a potential inequality may have given me the preconception that perinatal teams are more challenging to access for ethnic minority women or that perinatal teams are not culturally sensitive. Focusing on patterns of convergence and divergence in IPA helped me to capture a mixture of views under each theme whilst being mindful of my own experiences. I learned not to group experiences into either negative or positive accounts but to reflect the nuances of experiences in the results. As professional identity influences this project, I imagined that being part of the perinatal

workforce and building relationships with staff might influence my perspective through derived rapport and make it more difficult for participants to confide in me. Therefore, knowing I was due to start work in a perinatal team in the East of England as a specialist placement, I asked for this to follow the submission of this thesis.

Lastly, I was aware of the power imbalance between the researcher and participants in interviews as the researcher asks the questions and often reveals little of themselves (Råheim et al., 2016). Participants may feel uncomfortable giving feedback on perinatal teams or discussing the relationship between their culture and mental health. Putting participants at ease is particularly important when interviews are focused on sensitive topics that may encourage participants towards social desirability in their answers (Liamputtong, 2007; Karnieli-Miller et al., 2009; Bergen & Labonté, 2020). I wanted to address the power imbalance and encourage participants to feel comfortable during the interviews by introducing myself, sharing my background in the initial phone call before the interviews, and allowing the opportunity for participants to ask me any questions. Sharing my 'Insider' positionality in terms of recent experiences of the perinatal period and my mixed-race identity enabled me to put participants at ease and perhaps be more accepted by them (Irvine et al., 2008; Dwyer & Buckle, 2009). For instance, Farah commented on how she felt I understood her better due to the shared experience of being a new mother, perhaps leading to a more open interview style.

Maintaining Reflexivity

Throughout the study, I used a reflective journal and made several accounts of the analytic process. I noticed how the IPA framework helped me balance the interpretative and phenomenological underpinnings by using participants' quotes alongside themes. By pairing quotes and themes, I was able to stay grounded in the participants' lived experiences, and at

times when theme names didn't seem to convey the message of quotes accurately, I was curious as to whether my own biases were emerging.

After the topic guide was developed, a member of the LEAG interviewed me as part of a reflexive exercise. This experience allowed me to mentalise the interview process from a participant's perspective and identify any questions requiring altering. This perspective-taking exercise generated further conversations about the importance of thoroughly debriefing participants and addressing power asymmetry by putting clients at ease.

I attended regular research supervision to share the analytic process and the tables of themes and to review my interpretations. The online group exercise for identifying emerging group experiential themes helped me determine whether any of my preconceived ideas of group experiential themes were different from those identified as a research team and reflect on why they differed and which themes may have been the better fit before moving on to generate the table of group experiential themes.

Key Learning from Applying the Interpretative Phenomenological Analysis Framework

My research skills have evolved throughout the study development, interviewing, analysis and writing phase. I have valued building relationships with the LEAG over time and incorporating lived experience and knowledge into the development of this study. I learnt about what co-production means in practice. I applied this approach to the aspects of the study that the LEAG expressed an interest in being involved in, including the design of the topic guide, the debriefing plan and the social media recruitment strategy.

Co-production by being equal partners and co-creators afforded us the ability to increase the study's relevance, as evidence suggested co-production ensures research addresses real-world issues (Reed & Meacham, 2018) because the LEAG matched the participant population and helped us to overcome practical implications which may have otherwise been unidentified. For instance, the LEAG identified any jargon in the social media

recruitment posters and sought to make them more accessible to participants, as well as identifying a wide range of social media sites used by ethnic minority women in the perinatal period to target for recruitment. Effective co-production is suggested to facilitate a two-way learning experience between researchers and stakeholders (Reed, 2008). This co-production experience fostered a mutual exchange of knowledge whereby I benefitted from practical insights and contextual knowledge, and the LEAG reflected on how they benefitted from a greater understanding of the research process.

I developed confidence in my interviewing skills as the sessions progressed. I became better able to direct participants to their own experiences of the phenomenon when given abstract answers in the interview. For example, when participants provided broad suggestions for improving cultural sensitivity for others, rather than grounding their answers in their perspective, I could emphasise the value of learning from their expert experience. As interviews progressed, they became increasingly centred around sense-making, and I noticed the double hermeneutic (Smith & Osborne, 2003) process more overtly throughout.

Another key learning was listening to the audio recordings and noticing my pacing. For instance, I tended to fill silences with online interviews more than when in person. This was out of concern that I could not use body language to convey empathy towards participants and put them at ease. I also had concerns about accurately identifying their non-verbal cues in case participants experienced silences as uncomfortable. Over time, I grew more aware of these metacognitions and experimented with leaving longer pauses to allow the participants time to reflect and make additional remarks. I noticed interviews becoming more fluid and dynamic, as leaving longer pauses provided more time for reflection and empowered participants by allowing them to steer the interview.

Early in the analysis, during the exploratory note-making stage, I learned to balance linguistic, descriptive and conceptual notes. Initially, my notes appeared more descriptive, and the conceptual notes were formed as hypotheses with question marks. As I progressed through each transcript and gathered more data, these hypotheses were refined, and I formulated a more conceptual understanding of the participants. Listening to audio recordings at the beginning helped me identify interesting linguistic information, such as hesitations and tone, which I would have missed if I only read the transcripts.

Reflecting on my first experience using IPA, the process was time-intensive but rewarding. IPAs' greater idiographic focus over other approaches felt appropriate for exploring individual experiences of care within specific cultural contexts. Each participant allowed themselves to be vulnerable by sharing personal insights and exploring each transcript case by case, and developing personal experiential themes paid justice to this and helped me understand each person to an extent I do not feel would be possible with other approaches.

Chapter Six

Discussion and Critical Evaluation

Word count (excluding references): 5220

Chapter Overview

This chapter presents an overview of the systematic review, meta-analysis, and empirical study findings. The findings are contextualised regarding the current evidence base and their theoretical and clinical implications, and a critical appraisal of the studies, my personal reflections and an overall conclusion follows.

Firstly, revisiting the overarching objectives and research questions pertinent to both studies is essential to frame our understanding of the findings. This thesis portfolio used a mixed-methods design to summarise existing culturally adapted perinatal mental health interventions, investigate their efficacy, and conduct a qualitative exploration of ethnic minority women's experiences of perinatal teams. The systematic review and meta-analysis sought to answer the following research questions: How are perinatal mental health interventions culturally adapted? Are CAIs more efficacious for women from ethnic minority groups than controls? The qualitative empirical study aimed to answer the following using an IPA framework: What are ethnic minority women's experiences of perinatal mental health services in the East of England? Furthermore, how do ethnic minority women conceptualise culturally sensitive care?

Overview of Findings

Systematic Review and Meta-Analysis Findings

The systematic found that culturally adapted CBT and IPT were the most commonly adapted perinatal mental health interventions for ethnic minorities. Apart from one study which recruited participants with anxiety, studies aimed to explore the impact of CAIs on perinatal depression. Regarding the type of cultural adaptation (Barrera et al., 2013; Taylor et al., 2023), the most common adaptations were 1) linguistic adaptations which ensure interventions are in a person's preferred language, consider reading ability and use culturally specific language; 2) evidential adaptations, such as integrating narratives and statistics

relevant to the cultural group and acknowledging realities within the group; and 3) socio-cultural adaptations, which use the person's cultural context to formulate and make sense of difficulties in a way which is familiar and understood. The least common adaptations were 4) peripheral adaptations, including using activities, images, and cultural norms appropriate for a particular group and 5) constituent-involving adaptations for training and using members of the participant population to enhance engagement.

For the meta-analysis, findings suggested that CAIs are more efficacious than controls for treating perinatal depression in ethnic minority women. The overall effect size was small to moderate and significant (g = -0.33; 95% CI -0.57 to -0.09; *p*= 0.007). There were no significant differences between the subgroup analyses; however, studies which utilised more cultural adaptations, according to the categories of cultural adaptation (Barrera et al., 2013; Taylor et al., 2023), had a large and near significant effect on reducing perinatal depression symptoms (g= -0.64; 95% CI -1.29 to 0.01; p = 0.053), and those with low to moderate adaptations had a small and significant effect (g= -0.24; 95% CI -0.39 to -0.10; *p* = 0.001). However, the sample size within each of these subgroups was small.

Empirical Study Findings

The qualitative IPA study explored ethnic minority women's experiences of specialist NHS perinatal mental health teams and their conceptualisations of culturally sensitive care. Four group experiential themes emerged from the six participants' accounts: 1) Strengthening community networks and peer support; 2) Valuing cultural curiosity; 3) Making sense of how culture, ethnicity, race, and racism impact mental health; and 4) Tailoring interventions to ethnic minority women and their families.

Women described the positive impact of perinatal teams in helping them strengthen their community networks and access peer support, and those who had been supported to develop their networks recognised this as a central part of their recovery. Cultural curiosity

from professionals was valued, with participants experiencing this to varying degrees. Cultural curiosity was seen as foundational for professionals to facilitate conversations exploring the complex interplay between women's culture, ethnicity, race and mental health difficulties, yet levels of support to make sense of their intersectionality varied. Lastly, critically reflective practice was viewed to be necessary when working with ethnic minority women, and women suggested a variety of cultural and practical considerations for their mental health interventions.

The Findings in Context with the Research Literature

For culturally adapted interventions (CAIs) in perinatal mental health services, the empirical paper identifies critically applying and adapting interventions to the cultural contexts of ethnic minority women as a priority for achieving equitable care. These qualitative findings strengthen the argument for the provision of perinatal CAIs for ethnic minority women. The meta-analysis provides empirical support for perinatal CAIs demonstrating higher efficacy for treating perinatal depression than controls. Furthermore, this is consistent with the current evidence base, which also found that CAIs have higher efficacy than controls (Anik et al., 2021; Arundell et al., 2021; Ellis et al., 2022; Griner & Smith, 2006; Harper Shehadeh et al., 2016; Rathod et al., 2018; Smith et al., 2011).

Regarding the type of control, Arundell et al. (2021) investigated CAIs for a range of mental health difficulties, and subgroup analysis found that CAIs had greater effects on mental health in comparison to waitlist or non-intervention controls. However, Arundell et al. (2021) also found moderate and significant effects when CAIs were compared to active controls. The effect size for comparing CAIs to active controls for our study was small and non-significant (g= -0.22; 95% CI -0.59 to 0.14; p = 0.229). However, this may be because only two studies were included in the meta-analysis which used active controls.

Studies with a high level of cultural adaptation had a large and significant effect on perinatal depression symptoms, and those with low to moderate adaptations had a small and significant effect. However, the difference between the high and the low to moderate adaptation groups was non-significant. Smith et al. (2011) conducted a meta-analysis of 65 studies investigating the impact of mental health interventions tailored to participants' culture, ethnicity, or race. They found that CAIs with more culturally adapted intervention components were the most effective. Similar to our study, Smith et al. (2011) summed the number of cultural adaptations but used Bernal's Ecological Validity Model which utilises eight culturally adapted dimensions (Bernal, Bonilla, & Bellido, 1995; Bernal & Sáez-Santiago, 2006) and meta-regression to analyse the data. It is of interest to determine whether future meta-analyses with a larger sample of perinatal CAIs would identify an association between the effect and the number of cultural adaptations.

Our findings are consistent with Rojas-García et al. (2014) meta-analysis for socially disadvantaged women, inclusive of ethnic minority women, which found that CAIs are effective for treating perinatal depression. Our study builds upon this finding by recruiting ethnic minority women specifically and including an up-to-date overview and analysis of the most recent perinatal mental health CAIs. There are still many unanswered questions within the research literature, such as the specific culturally adapted components and mechanisms which underlie the efficacy of CAIs (Huey et al., 2023), and the number of studies evaluating perinatal mental health CAIs is limited, indicating further randomised controlled studies of CAIs are required.

Regarding ethnic minority women's experiences of maternity and perinatal services, our findings are in keeping with previous research. Drake et al. (2022), in a systematic review, identified inequalities in maternity care for ethnic minority women, such as poor communication and ethnic minority women perceiving services as culturally insensitive.

Watson et al. (2019) review of experiences of European perinatal services found that ethnic minority women experience access barriers and also highlighted cultural insensitivity within services. Furthermore, recent qualitative explorations of ethnic minority women's experiences with perinatal teams (Conneely et al., 2023; Pilav et al., 2022) emphasised barriers to support, including a lack of awareness and information on perinatal services and the impact of mental health on self-identity and social expectations. Conneely et al. (2023) also identified that women valued professional curiosity, kindness, and flexibility and that a shared cultural background can either help or hinder trust and rapport.

Similar to Conneely et al. (2023), we found that cultural curiosity was a key theme in our study; participants identified this as meaningful for building relationships with staff and sharing their identity. Furthermore, our study highlighted that cultural curiosity is essential for professionals to support service users in "making sense of how culture, ethnicity, race, and racism impact mental health". This theme conveys how culture and mental health are intertwined, and professionals need to competently explore how these intersect. Culture underlies and shapes thoughts, emotions and behaviours (Pedersen, 1990), and the experience of pregnancy, childbirth, and the parent-infant relationship is influenced by cultural beliefs and practices (Tikka, Thippeswamy, & Chandra, 2022). Holding these conversations can help women articulate their culture's role in shaping their beliefs, values, identities, and overall mental state and experiences of motherhood.

Furthermore, these conversations foster understanding between professionals and service users and help identify appropriate aims and ideas for treatment (Hook et al., 2017). For instance, understanding culture supports the process of "Tailoring interventions to ethnic minority women and their families". This theme from our study reflects the cultural and practical recommendations for adapting interventions in the literature (Masood et al., 2015; Watson et al., 2019), such as the requirement for flexibility when structuring sessions,

understanding the need for a confidential space in the context of multigenerational households and use of interpreters. Understanding a person's culture and needs enables professionals to adapt interventions accordingly.

The current literature suggests peer support and enhanced multiagency collaboration are a priority for perinatal teams within the current literature (Cantle, 2010; Edge, 2011; Raymond et al., 2007). The theme "Strengthening community networks and peer support" is consistent with the research. Participants emphasised the significance of perinatal teams supporting women to lean on community resources to overcome isolation. Isolation is a shared experience for many ethnic minority women seen by perinatal services, as evidenced in the research (Gardner et al., 2014; Raymond, 2007; Wittkowski et al., 2011). Participants found peer support through the perinatal team and outside organisations helped them develop confidence and experience common humanity in receiving support from others who have experienced mental health difficulties; this is particularly pertinent in the context of participants who have experienced cultural stigma towards their mental health difficulties. Our research demonstrates how service users have benefitted from multiagency working and community peer support.

Although previous research has explored experiences of perinatal teams (Conneely et al., 2023; Pilav et al., 2022; Watson et al., 2019), the empirical study was novel in its approach to understanding conceptualisations of culturally sensitive care, leading to accessible practical and clinical implications. Furthermore, the participants in our study had accessed perinatal teams in the East of England. In this region, non-white ethnic minorities account for only 13.5% of the population, indicating an underrepresentation compared to the national average of 18% (Office for National Statistics, 2021). This study presents unique data from this under-heard group, which has direct relevance for improving ethnic minority women's experiences of perinatal teams.

Theoretical Implications

Our research findings support the application of Campinha-Bacote's Model of Cultural Competence (1998) to perinatal mental health contexts. However, our findings from the empirical paper also suggest Bronfenbrenner's Ecological Systems Theory (1992) can be applied to ethnic minority women accessing perinatal teams to understand an individual's context and identify all the aspects within a person's system, which can influence mental health outcomes.

Regarding the Model of Cultural Competence (1998), this thesis portfolio provides evidence for culturally adapting perinatal mental health interventions. It emphasises the need to provide culturally sensitive care through demonstrating cultural curiosity and understanding and actively supporting individuals to share and make sense of the influence of culture, ethnicity and race on mental health. These findings suggest that Campinha-Bacote's Model of Cultural Competence (1998) directly relates to perinatal services. Perinatal services should apply the model's five stages of culturally competent care as follows:

1. Cultural awareness: professionals recognising personal biases and how their culture interacts with the cultures of service users.
2. Cultural knowledge: developing an understanding of various cultures and cultural contexts.
3. Cultural skill: applying cultural knowledge to clinical practice regarding communication techniques and adapting assessments and interventions to various cultural backgrounds.
4. Active engagement: Understanding the perspectives of individuals from diverse backgrounds within services and the community.
5. Motivation for life-long learning about culture and the provision of culturally competent care to reduce healthcare inequalities.

Furthermore, the findings support Bronfenbrenner's Ecological Systems Theory (1992). The empirical paper highlighted the importance of perinatal teams strengthening community and peer support and emphasised the importance of a systems approach to care. Understanding the influence of context can help professionals to support women to make sense of how this impacts their identity and mental health. These key findings support the use of Bronfenbrenner's Ecological Systems Theory (1992) in perinatal psychological practice, which outlines how social and environmental contexts influence individuals across different systems. The Ecological Systems Theory (Bronfenbrenner, 1992) can be used by perinatal services to explore and strengthen the support systems surrounding ethnic minority women accessing perinatal teams.

The following is an example of The Ecological Systems Theory (Bronfenbrenner, 1992) applied to ethnic minority women accessing perinatal teams 1) the microsystem includes the individual's immediate environment, such as a woman's family, including the baby, friends, workplace, healthcare services, neighbourhood and religious groups; 2) the mesosystem is defined by interactions within the microsystem, for example, communication between the women's perinatal team and crisis team or religious celebrations shared by the women and her social network; 3) the exosystem includes external impacts such as local policies, health resources, the media, education system, and faith, for example, local NHS initiatives to reduce health inequalities for ethnic minority women; 4) the macrosystem, represents laws, economics, and the broader cultural, societal and ideological contexts, for example, the British governments plans to reduce immigration; 5) the chronosystem, includes events and transitions across the lifespan, such as becoming a mother, divorce, and political and historical movements such as Black Lives Matter.

Many of the participants interviewed for the empirical paper identified weaknesses or gaps in the levels of support across these systems. For instance, women shared experiences of

isolation, and most participants did not discuss receiving support from their families or had moved away from their families, reflecting a lack of family and social within the micro-system. Within the mesosystem, perinatal teams could strengthen the support women receive by helping them access community groups to enhance their social connections and providing culturally sensitive family interventions to encourage partners and the wider family to support and understand service users' needs.

Clinical Implications

This research supports the recommendations for healthcare professionals to develop cultural awareness and adapt treatments to different cultural groups to ensure effective and equitable healthcare services (Latif, 2020). Culturally skilled mental health professionals are fundamental to providing culturally sensitive care and interventions for ethnic minority women. Sue and Sue (2013) describe culturally sensitive and culturally competent healthcare professionals as possessing self-awareness of their own culture, an understanding of the service user's culture and their socio-political system, awareness of the limitations of generic therapy, and adeptness in employing diverse therapeutic techniques (Sue & Sue, 2013).

The empirical paper emphasises the value of clinicians conveying cultural curiosity and supporting ethnic minority women to explore the influence of culture, ethnicity and race on mental health. Naz et al. (2019) offer guidance for demonstrating cultural curiosity by discussing culture, ethnicity and race early in relationships with service users. Naz et al. (2019) normalise professionals' discomfort and uncertainty surrounding these conversations and advise that tolerating this uncertainty and being open to learning and talking about culture results in increased cultural competence. The Cultural Formulation Model (Lewis-Fernández & Díaz, 2002) and the Cultural Formulation Interview (Lewis-Fernández et al., 2016) can be incorporated into assessment and formulation and help to explore cultural identity, coping, help-seeking, cultural explanations of illness, social factors, and the cultural

elements of the relationship between the individual and clinician. Staff require opportunities for knowledge sharing and access to resources for culturally sensitive practice (Masood et al., 2015). Moreover, services may wish to offer cultural competence training to staff, which has been found to improve professionals' cultural competency significantly and is associated with increased satisfaction in ethnic minority service users (Govere & Govere, 2016).

Regarding psychological interventions, most published research examining the effectiveness of therapeutic interventions have recruited middle-class White Americans as participants, assuming that the effectiveness of these interventions can be generalised across ethnic minority groups (Kumpfer et al., 2002). However, to provide quality care and reduce health inequalities, tailoring interventions to specific cultural contexts has been recommended (Kirmayer, 2012). The meta-analysis confirms that culturally adapted therapies, most commonly culturally adapted CBT and IPT, should be the first-line treatments for perinatal depression in ethnic minority women. The empirical paper recommends applying practical, linguistic and cultural adaptations to treatments. In coherence with this finding, the systematic review described how interventions are adapted following surface and deep-level categories of cultural adaptation (Barrera et al., 2013; Taylor et al., 2023). Clinicians can use this as a guide to adapt their practice.

Lastly, participants' accounts within the empirical paper highlighted the worth of a systemic approach to care. These findings suggest ethnic minority women value a neighbourhood model of care (NHS Long Term Plan; NHS, 2019), whereby perinatal teams focus on multiagency working and helping women to strengthen social networks and engage with community activities and peer support. Perinatal teams should view women as part of a wider system and support them to access resources to sustain their mental health over the long term and provide family support where applicable.

Critical Appraisal of Research

Critical Evaluation of Systematic Review and Meta-Analysis

There are key strengths in this study. The Assessment of Multiple Systematic Reviews (AMSTAR) (Shea et al., 2007) criteria was followed to review the quality of this meta-analysis. In terms of the strengths, our meta-analysis largely fulfilled the following aspects of the AMSTAR criteria, including; provision of the protocol on PROSPERO with pre-established research questions and inclusion criteria, keeping a record of included and excluded studies reviewed by abstract, conducting a comprehensive literature search with full details of the search strategy was shared (Appendix B) and searching three databases. Moreover, there was discussion of the rationale for papers selected in data extraction during research supervision, transparent reporting of characteristics of studies, a comprehensive quality assessment which guided methods, appropriate data analysis methods and tests of publication bias, such as the use of the Funnel Plot (Appendix E) and Egger's test. Furthermore, there were no conflicts of interest for this study.

Regarding limitations, only the primary researcher extracted the studies and differences in the identified studies may have been obtained if there was a second researcher supporting with this. Furthermore, grey literature was not included due to concerns over the introduction of bias and lower methodological quality (Egger et al., 2003). More recent research suggests grey literature may reduce publication bias (Paez, 2017) and should be considered for future meta-analyses in the field. Lastly, the AMSTAR criteria advise analysing the characteristics in all studies, such as race. Characteristics of studies were reported but not analysed due to the small number of studies and their expected heterogeneity. A degree of caution is needed when interpreting the results due to the small sample size, particularly for the subgroup analyses.

Critical Evaluation of Empirical Study

Yardley's Essential Qualities (2000). To build upon the critical evaluation within the empirical paper (p. 82), which used Smith's (2011) guide, this chapter applies Yardley's (2000) essential qualities. Yardley's essential qualities are often discussed in the context of IPA and offer more generic criteria for critiquing qualitative analysis (Smith et al., 2009). Yardley (2000) suggests a guide for assessing the validity of qualitative analysis, which includes the following principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to Context. Sensitivity to context can be demonstrated regarding the study's understanding of theories and existing research in the topic area and an awareness of the socio-cultural contexts of the study participants and the researcher. A sophisticated interpretation of the literature is crucial in qualitative research because qualitative explorations aim to have a robust rationale, build upon existing theories and examine any unexpected findings in depth (Yardley, 2000). The influence on the participants' social worlds and cultural influences on the topic being investigated should be embedded in the study (Yardley, 2000), and the position and background of the researcher should be acknowledged as neutrality is unachievable and not conducive to a natural interview style (Potter & Wetherell, 1995). Sensitivity to context also highlights issues of power between researcher and participant, as well as in terms of interpretation of the data (Yardley, 2000).

The current study refers to the relevant theoretical and empirical research, as discussed in 'the findings in context' and 'theoretical implications' sections. The existing literature provided a rationale for the empirical study to explore ethnic minority women's conceptualisations of culturally sensitive care in the context of perinatal teams, as this has not been explored explicitly in previous research, and more focus has been paid to access barriers and overall experiences (Conneely et al., 2023; Pilav et al., 2022; Watson et al., 2019). This

study builds upon our current understanding of ethnic minority women's experiences in this setting and sheds light on how women define culturally sensitive care.

This study's very nature and focus places socio-cultural context at the forefront. Reflexivity was core to the research process, and the author reflected on their own ethnic and racial background, commenting on how this may interact with their interpretation of the data but also how aspects of this were helpful for rapport building. Participants' socio-cultural contexts were embedded throughout this qualitative study, demographic details can be seen in Table 1 (p. 67), and examples of the unique cultural backgrounds of participants were elaborated on throughout the narrative, as well as how participants' culture influences their mental health. However, a more detailed narrative of participants' cultures could be conveyed in a more homogenous sample whereby groups with a shared ethnicity or cultural background are recruited.

Sensitivity to context also refers to complex power dynamics between the researcher and participant. As described in the extended methods (p. 103), I shared my 'Insider' positionality in terms of being a mother from a mixed-race background to demystify myself as the researcher and help participants feel less vulnerable at the prospect of sharing their stories, as well as to build rapport (Irvine et al., 2008; Dwyer & Buckle, 2009).

Regarding the role of power in data analysis and interpretation of the findings, participants were provided with their tables of personal experiential themes. However, member checking is not advised in IPA due to the interpretative role of the researcher (Smith & Nizza, 2022). Similarly, Riessman (1993) advocated eliciting participants' views on research but emphasised the researcher's ownership of the analysis and interpretation. An explicit limitation of the study was that the LEAG did not have a role in data analysis. On reflection, I would have attempted to recruit more LEAG members to support the reviewing

of overall themes in the cross-case analysis and to work together to identify quotes and develop the narratives around themes during the write-up phase.

Commitment and Rigour. Commitment refers to prolonged engagement with the topic of interest, competence in skills and understanding of the relevant literature. Rigour refers to the completeness of the data collection in terms of depth instead of breadth, and in-depth analysis (Yardley, 2000). Transparent engagement and commitment to the topic were shown by immersion in the data and longer-term personal and professional interest in the topic area, with reflexivity documented throughout the study's development.

Methodological competence can be demonstrated throughout; for instance, the interviews elicited rich data by using the topic guide flexibly, and practising interviews with the LEAG and reflecting on the interviewer's skill by listening to each audio following the interviews helped to develop continued competence in interviewing and data collection. Collecting high-quality data in IPA was accomplished with open-ended interviews, and a limited number of interview questions applied flexibly to support the participant in setting the parameters of the topic to avoid the interviewer imposing their ideas onto the participant (Smith et al., 2009). Listening to each audio recording and seeking guidance during research supervision allowed me to identify how to develop my skills in pacing online interviews and allowing participants enough time to make sense of their experiences.

Furthermore, the study detailed rigour by displaying the prevalence for each theme. For example, Smith (2011) advises providing extracts for half the sample in studies with four to eight participants, and Table 3 demonstrates that each theme had extracts from at least four participants. The depth of the analysis was supported by having six participants, as fewer participants allow for a deeper and more conceptual analysis over one that is superficial and more descriptive due to a large sample size (Reid et al., 2005). The smaller sample size maintained the study's idiographic commitment to analysis and allowed for a more

conceptual narrative with details of convergence and divergence across cases (Smith et al., 2009).

Transparency and Coherence. *C*oherence is related to the clarity and power of the descriptions and arguments within the study to convey the realities of participants, and transparency is the detail of each stage of the study (Yardley, 2000; Yardley, 2017). For transparency, each stage of the research process was documented in the extended methods section, and a sample of a transcript with exploratory notes and experiential statements is provided in the appendices (Appendix K). The methods for cross-case analysis and developing thematic tables are also evidenced (Appendices N & O). The researcher demonstrated how their conclusions were reached by pairing quotes with extracts in the tables (Appendices M & O) and using their reflective diary as an audit trail. The reflective diary includes examples of decision-making, applying the methodological and theoretical underpinnings, and my reflections and insights into the data analysis process. There is a clear link between data collection, raw data, analysis and final results. Coherence was observed as the fit between the research questions and analysis framework were appropriate. For instance, the aim was to explore experiences of perinatal team and conceptualisations of culturally sensitive care by understanding the lived experiences of ethnic minority women accessing perinatal teams. Therefore, the thorough nature of IPA interviews and analysis allowed for an in depth exploration, whilst triangulation of data, for example, asking healthcare professionals' perspectives, would not have been appropriate (Yardley, 2000).

Impact and Importance. Impact and importance refer to the influence and practical applications of the study findings (Yardley, 2000). This research aimed to explore experiences and identify potential solutions for perinatal services wishing to develop competencies in cultural sensitivity. This thesis presents the voices of an underrepresented, marginalised group, particularly in the East of England, where participants were recruited. A

limitation of this thesis portfolio is that much of the dissemination of findings follows the date for thesis submission. However, the findings from this thesis were shared with four specialist perinatal teams in the East of England on the 27th of February, 2024, during a staff continuous professional development day. The research findings were well received and generated conversation on how they can be implemented within the services. As a further outcome of this project and as requested by perinatal teams, cultural sensitivity training will be provided for teams in the summer of 2024 during my final placement in a community perinatal team. If the dissemination and teaching objectives are met, perinatal teams will have the information and training support required to enhance the provision of culturally sensitive care within their services. Furthermore, we aim to publish the empirical paper in the journal, Health Expectations.

Future Research

Future research on CAIs should use active controls in the form of non-culturally adapted evidence-based interventions. Thus far, evidence suggests CAIs for ethnic minority women are effective, but it is of interest to examine whether they are more effective than their unadapted evidence-based counterparts. For instance, studies could compare Brief-IPT, a culturally sensitive perinatal mental health intervention, to standard IPT. Moreover, observational findings suggested that culturally adapted CBT has a small and significant effect on perinatal depression, and IPT approaches have a moderate and non-significant effect on depression. Therefore, studies could randomise participants to either culturally adapted CBT or IPT to detect their comparative efficacy in treating depression. We were able to answer our research question regarding the efficacy of CAIs for perinatal depression, but in terms of answering how CAIs are adapted, we identified common culturally adapted components, but many studies lacked transparency on the specific adaptation process. Future

studies could demonstrate the use of cultural adaptation frameworks to outline the cultural adaptation process and evaluate which components have the greatest effects.

Further qualitative research may wish to explore the experiences of women from specific minority ethnic groups and recruit participants from homogenous cultural and linguistic backgrounds. However, this should be within NHS settings and regions where recruiting enough women from a homogenous sample is realistic. The ability to speak English was a recruitment barrier for this study. Therefore, future interviews could be interpreted, or an interviewer who speaks the same language as the participants could be employed to maintain validity. Moreover, research focusing on one stage or treatment area provided by perinatal services could offer a more in-depth analysis.

Personal Reflections

This thesis portfolio was written following the MBRRACE findings (Knight et al., 2021) and the Black Lives Matter movement. At the end of this project, the British Prime Minister, Rishi Sunak, introduced the Safety of Rwanda (Asylum and Immigration) Bill to name Rwanda as a safe country for refugees to reside in to fulfil the government's objective to reduce illegal immigration. Furthermore, Rishi Sunak also introduced a new policy to increase the minimum salary required for foreign workers to access the UK to £38000, and the minimum wage for British citizens with foreign partners to be granted access to the UK was under review. The Conservative government's objective to reduce immigration and the introduction of these new legislations will undoubtedly negatively impact many ethnic minority women and their children, including refugees.

With the current narratives surrounding immigration, ethnic minority women are further marginalised, and the UK political climate is likely to impact the mental health of its ethnic minority population adversely. Therefore, working towards healthcare equality across ethnic groups is more critical than ever. This research aimed to give a voice to underserved

ethnic minority women during the perinatal period. The American Psychological Association's (2017) multicultural guidelines outline that Psychologists need to address systems-level change rather than focus solely on their influence on an individual level. The guidelines suggest aiming to understand and improve the experiences of marginalised communities by conducting research that addresses health disparities is key. This research has direct clinical implications for perinatal teams to adapt care and aims to address system-level change through dissemination. I believe continuing the work of this thesis through progressing towards publication and working in my [1]role to offer culturally sensitive care within a community perinatal team will contribute to systems-level change.

Conclusions

This thesis portfolio examined the nature and efficacy of CAIs and explored how ethnic minority women experience specialist perinatal teams within the East of England. The findings highlight areas services can target to develop culturally sensitive care. To enhance the care for underrepresented ethnic minority women, perinatal services should adopt a systemic approach to recovery, cultivate cultural curiosity within professionals, support ethnic minority women to make sense of how culture, ethnicity, race and mental health interact and provide culturally appropriate adaptations and CAIs for equitable care.

[1] Material from my ClinPsyD Thesis Proposal, Culturally sensitive perinatal mental healthcare: Experiences of women from minority ethnic groups (submitted 05.07.22), has been used throughout.

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Appendices

Appendix A: Author Guidelines for Psychological Medicine

Article Type	Usual Max Word count*	Abstract	References	Tables/figures**	Supplementary material online only
Original article	4500	250 words, structured, using subheadings Background, Methods, Results, Conclusions	APA style – see elsewhere in this document for full details	Usually up to 5 total	Yes
Review article	4500	250 words, not structured	APA style	Usually up to 5 total	Yes
Editorial	3500	No	APA style	Usually up to 5 total	Yes
Correspondence* **	1500	No	max 20 APA style	Max 1	No
Commentary	2000 By invitation of editor	No	max 20 APA style	Not usually	Yes

For further details please see Cambridge University Press website:
https://www.cambridge.org/core/journals/psychological-medicine/information/author-instructions/preparing-your-materials

Appendix B: Search Strategy

The following search terms were used: pregna* or perinatal or antenatal or postpartum or postnatal or prenatal or antepartum or maternal or mother* AND “mental health” or “mental illness” or “mental disorder” or “psychological difficulties” or “psychiatric disorder” or “personality disorder*” or depression or cyclothymic* or dysthymi* or anxiety or panic or psycho* or schizo* or bipolar or mani* or “adjustment disorder*” or “eating disorder*” or anorexia or bulimi* or “binge eat” or “self-injur*” or injur* or suicid* or mood or neurotic or adjustment or agoraphobia or OCD or obsessive or trauma* or posttrauma* or PTSD or stress or “body dysmorphi*” or anhedoni* AND divers* or inclusi* or access* or cultur* or control* or RCT or randomi* or trial AND minorit* or ethnic* or race or black or asian or “mixed race” or mixed-race or indigenous or refugee* or “asylum seek*” or asylum-seek* or *migrant

Appendix C: Summary Table for Quality Review Using RoB 2 (Sterne et al., 2019)

Author, year	D1	D2	D3	D4	D5	Overall
Ginsburg et al. (2012)	!	+	-	-	!	-
Grote et al. (2009)	+	+	-	+	!	!
Grote et al. (2015)	+	+	+	+	!	!
Hankin et al. (2023)	+	+	+	+	+	+
Husain et al. (2023)	+	+	-	+	!	!
Jesse et al. (2015)	+	+	-	+	+	!
Le, Perry, & Stuart (2011)	+	+	-	+	+	!
Lenze et al. (2020)	+	+	-	+	-	-
Lenze & Potts (2017)	+	+	+	+	+	+
Munoz et al. (2007)	+	+	+	+	+	+
Ponting et al. (2022)	!	+	+	+	+	!
Tandon et al. (2014)	+	+	+	+	+	+
Van Horne et al. (2021)	!	+	-	+	!	-
Zayas et al. (2004)	!	+	-	+	!	-

Key

!	Some concerns	D1	Randomisation process
-	High risk	D2	Deviations from the intended interventions
+	Low risk	D3	Missing outcome data
		D4	Measurement of the outcome
		D5	Selection of the reported result

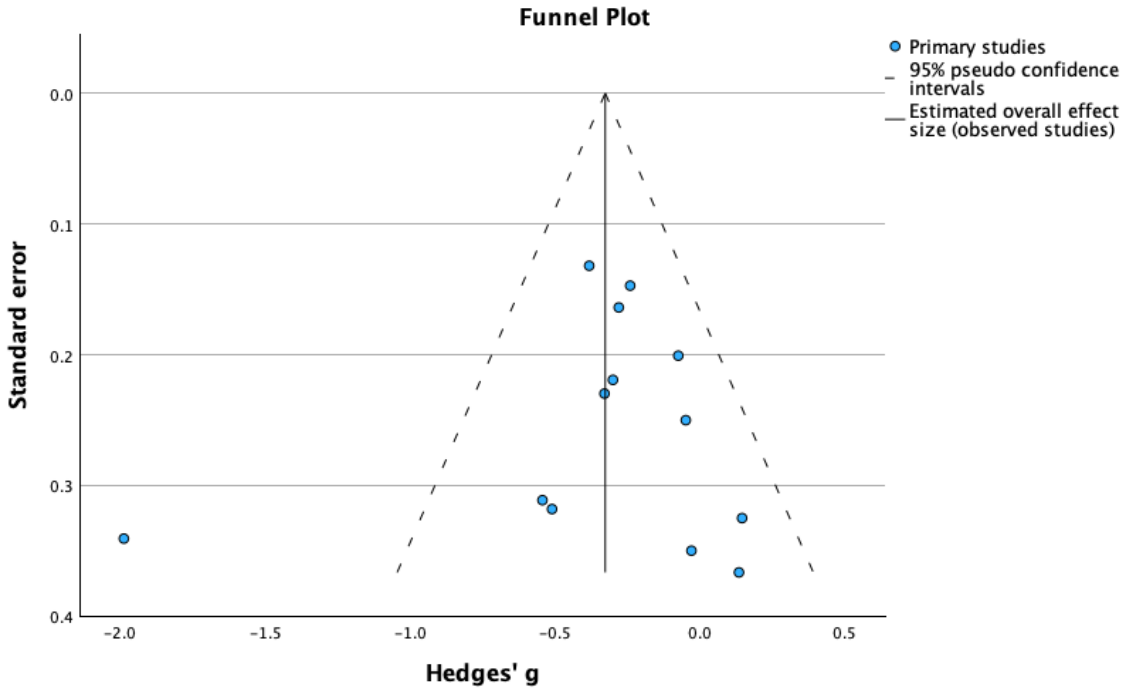
Appendix D: Summary Table for Quality Review Using Checklist for Quasi-Experimental Studies (Non-Randomized Experimental Studies) (Aromataris & Munn, 2020)

	Authors, year		
Questions	Alfayumi-Zeadna et al. (2022)	Grote et al. (2004)	Jesse et al. (2010)
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	?	Y	Y
2. Were the participants included in any comparisons similar?	Y	Y	Y
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	?	NA	NA
4. Was there a control group?	Y	N	N
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	Y	Y	Y
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	Y	Y	Y
7. Were the outcomes of participants included in any comparisons measured in the same way?	Y	Y	Y
8. Were outcomes measured in a reliable way?	Y	Y	Y
9. Was appropriate statistical analysis used?	N	N	N
Comments	It is clear that the adapted service is what is being measured but unclear what	Underpowered to detect meaningful change (n= 9). CI not reported.	Underpowered to detect meaningful change. CI not reported.

	the different variables for influencing change are e.g. the specific interventions. Unclear why chi-square/ dichotomous was used for analysing continuous EPDS data		
Score out of 8 (Q3 reverse scored)	6	6	6

Key: Y= Yes, N= No, ?= Unclear NA= Not applicable

Appendix E: Funnel Plot from SPSS Output Data



Appendix F: Author Guidelines for Health expectations

Article Type	Description	Word Limit	Abstract/ Structure	Other Requirements
Original Article	Reports of new research findings or conceptual analyses that make a significant contribution to knowledge	Up to 5,000 suggested; maximum 6,000	Structured; up to 250-word limit suggested; maximum 350	Data Availability Statement IRB Statement Up to 10 Tables and/ or Figures Up to 75 references
Review Article	Includes papers which clarify concepts or develop theories, those which critically assess developments and trends, and systematic reviews.	Up to 5,000 suggested; maximum 6,000	Structured; Up to 250-word limit suggested; maximum 350	Up to 150 references for systematic reviews and meta-analyses. Up to 75 references for all other reviews. Up to 10 Tables and/or Figures
Viewpoint Article	Well-argued opinion pieces and interviews with people who have made significant contributions to the fields of interest to the Journal. These will normally be commissioned.	Length should be 2,000-2,500 words.	Abstract unstructured; Up to 150-word limit suggested; maximum 200.	Up to 5 references Up to 5 Tables and/or Figures

For further details please see Wiley Online Library website: https://onlinelibrary-wiley-com.uea.idm.oclc.org/page/journal/13697625/homepage/forauthors.html

Appendix G: NHS Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Angelene Gardner
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Foundation Trust
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Norwich, England
NR4 7TBN/A

Email: approvals@hra.nhs.uk

09 February 2023

Dear Ms Gardner

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A qualitative interview study examining ethnic minority women's experiences of perinatal mental health services.**
IRAS project ID:	**319722**
Protocol number:	**N/A**
REC reference:	**22/SW/0173**
Sponsor	**University of East Anglia**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

Appendix H: Participant Information Sheet

IRAS ID: 319722

Date: 09.01.2023

University of East Anglia

Participant Information Sheet

Participant Information Sheet v2

Study title: Culturally sensitive perinatal mental healthcare: Experiences of women from ethnic minority groups

Invitation and brief summary

This is project is being undertaken by Angelene Gardner for the Doctorate in Clinical Psychology at the University of East Anglia. The project will explore the experiences of perinatal mental healthcare from the perspectives of minority ethnic women. Before you decide whether to take part, please read this information sheet carefully, you can discuss the research study with other people should you wish to. If you have any questions or concerns, the research team will be able to answer these to support your understanding of what is involved.

What is involved?

We would like to interview women who have been seen by NHS perinatal mental health services in the East of England about their experiences and perceptions of their care

Research evidence tells us that white British women in the UK are more likely to be asked about their mental health than non-white British women. As a result, women from minority backgrounds are less likely to receive mental health care. A recent review has found several barriers for ethnic minority women accessing mental health care, including; women being unaware of the help available, language barriers, women feeling services are insensitive to their beliefs, and experiencing stigma from healthcare professionals and their communities.

In 2020, NHS England's advancing mental health equalities strategy reported that NHS services are not always culturally appropriate and there is an unmet need for culturally sensitive care within NHS services. Therefore, this study sets out to find out what culturally sensitive care means to women from minority ethnic backgrounds who have accessed perinatal teams and what experiences women have had.

The researchers aim to recruit eight to 12 women to take part in the interviews.

Do I have to take part?

It is your choice whether you would like to participate in the study. If you decide you would like to take part, the primary researcher will ask you to complete a consent form. If you decide to take part in the interview, you can stop the interview, take a break, rearrange if necessary and withdraw your consent at any point.

What will happen if I agree to take part?

If you agree to take part in the study, you will be contacted by a researcher who will provide you with a consent form and find a suitable time for your interview. The interview will be audio-recorded, it will be conducted on an individual basis with the lead researcher and will

last approximately 1.5-2hrs. The interview will take place online or in person, depending on your preference and availability. If you do not have childcare, you are welcome to have your child present throughout the interview if you feel comfortable with this. You will be asked about your experiences of receiving mental health care from a perinatal team. Each participant will be provided with a £20 voucher for taking part in the study.

What are the possible benefits of taking part?

We hope to share the study findings with NHS perinatal teams and the community sector so that healthcare professionals can use this information to adapt their practice and make perinatal teams more accessible and appropriate for women from minority ethnic backgrounds.

Are there any disadvantages and risks to taking part?

Some people may have concerns about discussing their mental health and/ or difficult experiences. Please be reassured that you can take a break during the interview, the interview will only take place if you give your consent and you can choose to stop and withdraw consent at any point in the interview. This will mean that the interview recording will be deleted and your data will not be used in the study. And, if you choose to complete the interview, you also have a right to withdraw your consent afterwards and all your identifiable information will not be included in the study.

If you feel distressed following the interview, the researcher will provide you with resources for seeking support and a 30-45 minute debrief is included into the interview time.

Will my information be confidential and what will happen to my information?

By consenting to take part in the study, you are consenting for your data to be collected and used in this research study. After your information has been collected it will be anonymised. Anonymised information includes your name, the perinatal team you were seen by and all other identifiable details. The information you provide will be kept confidential and adhered to, in line with the General Data Protection Regulation (GDPR), the Data Protection Act (DPA, 2018) and the University of East Anglia Data Management Policy (2019). All audio recordings and information collected will be stored securely on the MS OneDrive file-sharing system. This will ensure that only the study researchers have access to your data. Audio recordings will be deleted at the point of transcription. Once the analysis and/ or publication are complete, the remaining data will be transferred to the Norwich Medical School facilities and deposited in the UEA archives in line with the Research Data Management Policy. The data will be held for a minimum of 10 years and either retained or destroyed following review.

How will we use information about you?

We will need to store basic information from your perinatal team medical records for this research project. This information will include your initials, NHS number, name and contact details. The researchers will use this information to make contact with you and store this in a secure database.

IRAS ID: 319722

Date: 09.01.2023

University of East Anglia

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you. If a participant withdraws consent and/ or loses capacity to consent then all of their identifiable data would be withdrawn and will not be published in the study.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by contacting the lead researcher by email to Angelene.gardner@uea.ac.uk
- By email to the University of East Anglia Data Protection Officer dataprotection@uea.ac.uk

For more information on how health researchers use data please see: www.hra.nhs.uk/patientdataandresearch

Who can answer my questions?

If you would like to discuss the study further please contact the lead researcher, Angelene Gardner, via email at angelene.gardner@uea.ac.uk

If you are unhappy with any part of your participation in the research and/ or you would like to make a complaint, please contact Dr Sian Coker, the Head of the Department of the Doctoral Programme in Clinical Psychology at the University of East Anglia.
Email: S.Coker@uea.ac.uk
Address: Clinical Psychology Programme, Norwich Medical School, University of East Anglia, Norwich, Norfolk NR4 7TJ

Appendix I: Consent Form

University of East Anglia

IRAS ID: 319722

Date: 24.10.2022

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM v1

Title of Project: Culturally sensitive perinatal mental healthcare: Experiences of women from ethnic minority groups

Name of Researcher: Angelene Gardner

	Please initial box
1. I confirm that I have read the participant information sheet dated 09.01.2023 version 1 for the above study.	☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
3. I give permission for my interview to be audio recorded	☐
4. I understand that anonymised information collected about me will be collected and used in research publications	☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
6. I agree to take part in the above study.	☐

Name of Participant: Date: Signature:

Name of Person seeking consent: Date: Signature:

When completed: 1 for participant; 1 for researcher site file

Appendix J: Online Recruitment Advert

EAST OF ENGLAND PERINATAL MENTAL HEALTHCARE:

EXPERIENCES OF WOMEN FROM ETHNIC MINORITY BACKGROUNDS

Our study aims to explore ethnic minority women's perinatal mental health treatment journeys to improve culturally-sensitive care within the region

Participation in this study would involve meeting with the researcher for an interview lasting approximately one hour. The interview will ask about your journey into the perinatal team, your experiences whilst under the care of the team, how you feel your culture and ethnicity impact your care and what you think could be improved.

Location: The researcher can meet you at a place convenient to you or online via Microsoft Teams.

Eligibility: Have you been seen by a perinatal team or mother and baby unit? Are you from an ethnic minority group and 18 and over?

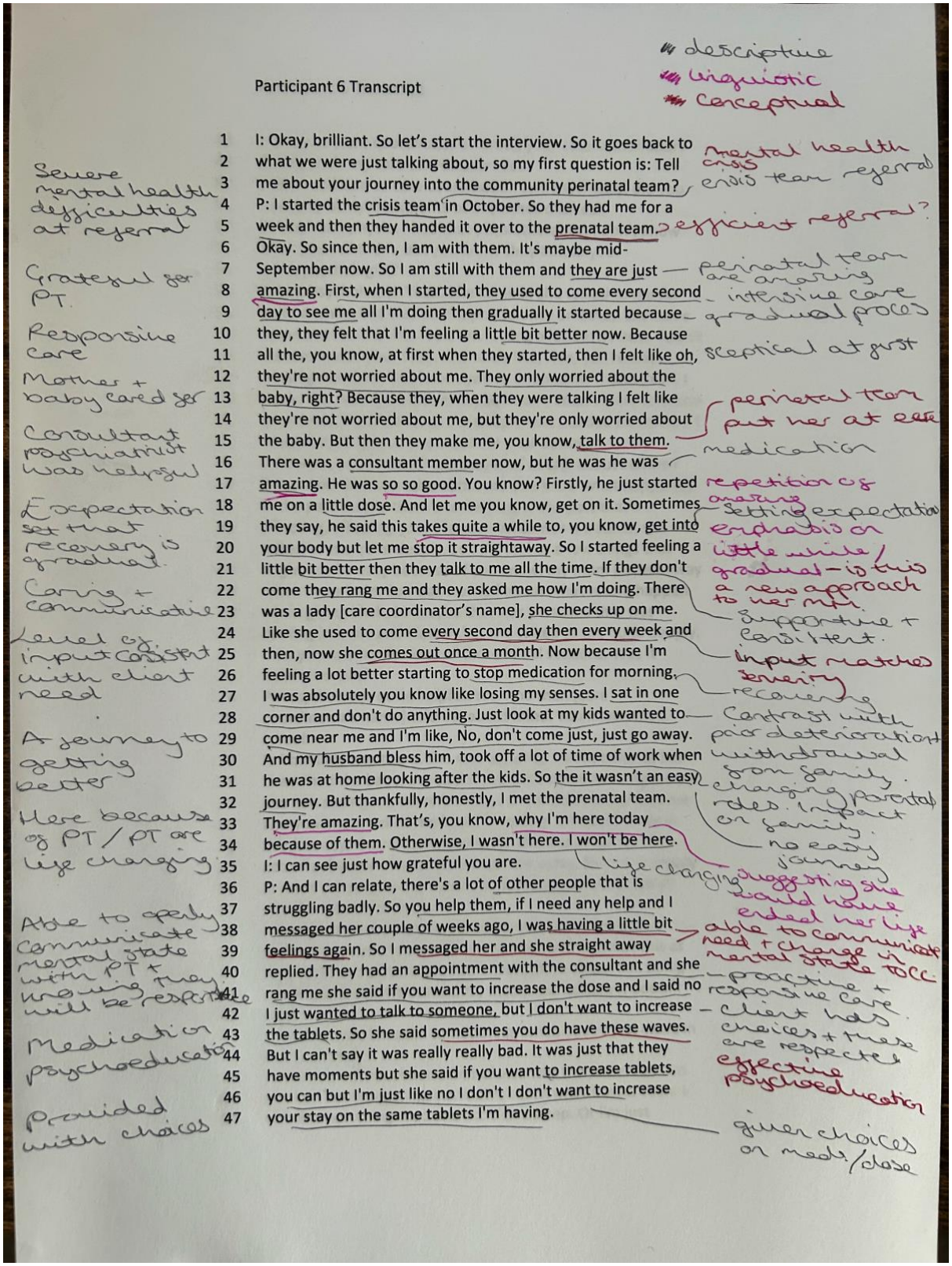
If you would like to take part, please contact Angelene Gardner, Trainee Clinical Psychologist via email: angelene.gardner@uea.ac.uk

This study is conducted as part of Clinical Psychology doctoral training, the study team includes Angelene Gardner, Bonnie Teague and Sheri Oduola.

Participant Flyer v1 IRAS: 319722 01.09.2022

University of East Anglia

Appendix K: Coding Example of an Interview Transcript



descriptive
linguistic
Conceptual

Participant 6 Transcript

I: Okay, brilliant. So let's start the interview. So it goes back to what we were just talking about, so my first question is: Tell me about your journey into the community perinatal team?

P: I started the crisis team in October. So they had me for a week and then they handed it over to the prenatal team. Okay. So since then, I am with them. It's maybe mid-September now. So I am still with them and they are just amazing. First, when I started, they used to come every second day to see me all I'm doing then gradually it started because they, they felt that I'm feeling a little bit better now. Because all the, you know, at first when they started, then I felt like oh, they're not worried about me. They only worried about the baby, right? Because they, when they were talking I felt like they're not worried about me, but they're only worried about the baby. But then they make me, you know, talk to them. There was a consultant member now, but he was he was amazing. He was so so good. You know? Firstly, he just started me on a little dose. And let me you know, get on it. Sometimes they say, he said this takes quite a while to, you know, get into your body but let me stop it straightaway. So I started feeling a little bit better then they talk to me all the time. If they don't come they rang me and they asked me how I'm doing. There was a lady [care coordinator's name], she checks up on me. Like she used to come every second day then every week and then, now she comes out once a month. Now because I'm feeling a lot better starting to stop medication for morning, I was absolutely you know like losing my senses. I sat in one corner and don't do anything. Just look at my kids wanted to come near me and I'm like, No, don't come just, just go away. And my husband bless him, took off a lot of time of work when he was at home looking after the kids. So the it wasn't an easy journey. But thankfully, honestly, I met the prenatal team. They're amazing. That's, you know, why I'm here today because of them. Otherwise, I wasn't here. I won't be here.

I: I can see just how grateful you are.

P: And I can relate, there's a lot of other people that is struggling badly. So you help them, if I need any help and I messaged her couple of weeks ago, I was having a little bit feelings again. So I messaged her and she straight away replied. They had an appointment with the consultant and she rang me she said if you want to increase the dose and I said no I just wanted to talk to someone, but I don't want to increase the tablets. So she said sometimes you do have these waves. But I can't say it was really really bad. It was just that they have moments but she said if you want to increase tablets, you can but I'm just like no I don't I don't want to increase your stay on the same tablets I'm having.

Severe mental health difficulties at referral

Grateful for PT

Responsive care

Mother + baby cared for

Consultant psychiatrist was helpful

Expectation set that recovery is gradual

Caring + communicative

Level of input consistent with client need

A journey to getting better

Here because of PT / PT are life changing

Able to openly communicate mental state with PT + knowing they will be responsive

Medication psychoeducation

Provided with choices

mental health crisis
crisis team referral
efficient referral?
perinatal team are amazing
intensive care
gradual process
sceptical at first
perinatal team put her at ease
medication
repetition of amazing
setting expectation
emphasis on little while / gradual - is this a new approach to her MH
supportive + consistent
input matches severity
recovering
Contrast with prior deterioration
withdrawal from family
changing parental roles impact on family
no easy journey
life changing
suggesting she would have ended her life
able to communicate need + change in MH state to CC
proactive + responsive care
client has choices + these are respected
effective psychoeducation
given choices on meds / dose

Appendix L: Tables of Personal Experiential Themes

Table of Personal Experiential Themes for Participant 1

	Line no.	Quotes
Theme 1. Awareness of the support available and early detection are critical		
An impossible system to navigate perpetuates social injustice	86-91	*You know, we've got good English. People tend to take us quite seriously, you know, when we're on the phone.* *So I dread to think, somebody who doesn't have those privileges and know how to work the system…*
Timing is critical	117-120	*OK, right, wait for the services to come through and, you know, he the whole, you know, the, the length of time it takes to, to, to access those services. And so I think it was quite, it was actually quite scary.*
Desperate to be helped	34-35	*We need help, saying those words we need, we need help and not really being heard.*
Theme 2. Seeing the family system as a whole		
Mum and baby as separate rather than collective	41-43	*It's very much, you know, from the pregnancy quickly through COVID is all about mum and maybe and then when the baby was born, it's right, baby, baby, baby ohhhhhh.*
Dad is neglected	43-44	*Nobody even looks at Dad*
Identification of struggle results in panic in the system	104-106	*I then have to unload this whole, you know, very dark weight of what's going on. And that scared the hell out of him.*
A systemic approach was missing	50-52	*It wasn't just we struggling, it was also my partner was struggling, and neither of us were getting help.*
Theme 3. Exploring culture: Making sense of cultural narratives and influences		
Using the clinician as a feedback loop to make sense of how culture influences thinking	448-450	*"You know, you've learned so much about my past, and it's just got me thinking like ohh yeah, that is why I think different."*
Being mixed-race involves the intersectionality of two or more different cultural identities being expressed to varying degrees depending on context	431-432	*You assume all if you're 50:50 of a certain culture, you know two cultures, then that's what you are. But it's not. We choose kind of which*

		cultures we adopt and, and I think that's really important.
Early cultural and developmental experiences influence beliefs and distress as an adult	481-484	*…how my brains been wired from when I was younger and maybe you know, again bringing up my upbringing and certain kind of beliefs and or limit certain limiting beliefs*
Culture is not static: Understanding a person's cultural timeline	436-438	*So understanding who that person is, that presents, but also who that person is today and maybe where their future is going as well.*
Theme 4."Look outside the box": clinicians need to challenge the default Anglocentric framework		
The environment should accommodate the person	465-466	*I might not be able to go through the system as easily when then that makes me think like am I doing something wrong*
Tokenism cannot mask as cultural sensitivity	420-421	*Not just asking about your ethnicity as a tick box exercise*
Critical thinking is required for cultural adaptation	404-408	*I think a lot of these kind of structures and frameworks are probably created traditionally by like white British males. So when you look at that kind of systemically and then somebody isn't responding to a treatment you've gotta kind of look outside the box a bit.*
CBT is effective however integrating culture enriches treatment	347-348	*Whereas the CBT was, it was still structured, but it was just, yeah, a lot more effective and. Yeah, no, culture wasn't really asked…*
Theme 5. Community integration: "building a village"		
Focusing on a routine	604-607	If I just meet women once a week… those negative, lonely, isolating thoughts go away.
Building a social network	586-588	I've got, we've got a really, really great network of friends that we've met. We have socialised really hard. We've opened up our garden.
Services can help community integration	564-565	So I think a service that can recognise that is the culture we have today, whether we like it or not and try and help tap people as quickly as possible into a community.

Table of Personal Experiential Themes for Participant 2

	Line no.	Quotes
Theme 1. Cultural stigma increased isolation and suffering		
Lack of understanding from community is isolating	37-39	*…in the South Asian community, mental health and all that stuff, there's stigma still and then the pregnancy, it's just difficult speaking up…*
Keeping pregnancy a secret to avoid "the evil eye"	273-277	*That's the thing, like, you wanna avoid the evil eye. So keep it quiet…tell more people you're pregnant, something bad happed or let's say a miscarriage or something.*
Hiding suffering for over a decade	306-309	*Yeah, it's like you can't be honest with them. You've got to deal with a lot of stuff, you know in the background, like I've got a history of self-harm. I think for about 10-12 years and they never knew.*
Theme 2. Support from a cultural outsider reduces shame		
Wanting Muslim identity and mental health to be separate	247-248	*…but I think for me, it wasn't for me because I didn't want to do the religious side of things*
Seeking freedom from scrutiny of one's Islamic devotion	250-251	*…because I don't pray. Ummm I'm trying to pray, but I'm not there yet…*
Able to be open with staff	269-270	*They took on board lots, see if there were concerns, I would always be open about mental health…*
Cultural outsiders are perceived as non-judgemental	488-491	*I think for me it helps to have someone from a non-Asian background supporting me cause, I think I'm not saying people are judgemental, but I think if it was an Asian woman supporting me, they might lean towards the Islamic side of things.*
Theme 3. Perinatal staff provided culturally appropriate equitable care		
Treatment was fair	210	*I've just probably been treated like any other woman.*
Staff have cultural knowledge	184-187	*…they know about Ramadan, you know, obviously the fasting.. they've been quite supportive*
Appointments are made flexible due to religious factors	200-201	*…they ask me if you want an afternoon appointment, a morning appointment.*
An interpreter was provided to husband	614-615	*And I think they said they provided him with a translator, so that option is there.*
Different treatments were offered	120-122	*…they kept asking me afterwards "do you want counselling?" And I kept saying no, you know it's fine for now.*
Theme 4. An impersonal ending		
Inconsistent communication towards the end	72-74	*That's fine, but she never checked up on me. I was thinking where's the phone call, where's the text?*

Feeling rejected by care coordinator	80	*She's so rubbish.*
A PTSD diagnosis communicated by letter	506-508	*They said I've got PTSD, but no one diagnosed me, you know, face to face or something.*

Table of Personal Experiential Themes for Participant 3

	Line no.	**Quotes**
Theme 1. Cultural stigma		
Talking about mental health is embarrassing	94-95	*I think, you know, probably quite embarrassing for people to talk about it.*
Secrecy around mental health	237-240	*…there's such a taboo about mental health, no one will talk about it…even when they are I don't think they're gonna be completely open.*
Unsafe environment to talk about mental health	243-245	*…you have to be careful about where you have conversations…you know, when someone might be listening*
Theme 2. Experiencing acculturative stress		
Missing cultural attunement	110-111	*I'm just saying like, you know, even before we say they will know what we're talking about.*
Struggling with lack of family support	212-213	*...back home we have a lot of support and here we don't.*
Upholding cultural values is hard	227-228	*I think generally we have values that we want to keep, but there isn't...sometimes that's a bit stressful, you know.*
Theme 3. Valuing the formulation and the intersection of cultural perspectives		
Making sense of difficulties	62-63	*So far it's good, you know, talking about the root cause and how it happened…*
A cultural outsider brings an unbiased opinion	163-165	*…maybe sometimes a person from my culture might not be the right choice. So because they think, that's how it should be, you know…*
Western culture identifies childhood trauma and validates distress	169-171	*If you are not listened to as a child, for example, quite normal there. Any you come here and you look at it and say, "you know, that's just a child and you didn't have to go through all that".*

Table of Personal Experiential Themes for Participant 4

	Line no.	**Quotes**
Theme 1. Significant access barriers and treatment delays despite perseverance		
Ineffective referral pathway	21-22	*They were saying, "How come you've not been referred before? Did you not speak to anyone?" I said I did.*
No access without perseverance	32-34	*So I didn't know what I was chasing, like I was speaking to my midwife every week, saying…I'm still struggling.*

Racial differences in referring	337-339	*So if women who are white are getting referred and I'm not then it makes me think, is there a racial issue…*
Those who cannot persevere may never access treatment	568-572	*I just think how many women out there have been in a similar situation…if they didn't feel the need to push as they were in a different state of mind… they could have been lost in a system and they could be suffering.*
Theme 2. Specialist perinatal teams require demystifying		
Knowing what to expect is important	549-551	*Straight away explaining what the service is and how it works and whether we would think that'd be beneficial…*
Lack of transparency on available interventions	209	*Sometimes we get confused about what the other services* (interventions) *are.*
Treatment choices should be encouraged	577-582	*…you should be explained all the different services* (interventions) *available… "Okay what do you feel works for you?"…there was no leaflet*
Theme 3. Perceived inequality of care in contrast with the ethnic and racial majority		
Not being a priority in contrast with others perpetuates low self-worth	154-157	*"You know, there was other people", I think okay there are other people in the world…go help them. And then I'm think I actually know I still need help.*
Less input than other mums	108-110	*…like compared with other mums, I know from like group sessions.. I've had so little compared to them.*
NHS pressures have a direct impact on care	170-173	*…I understand the pressure, the NHS context is trickling down, but actually how does that help…where maybe people are feeling devalued or like their identity is not at the forefront…*
Theme 4. White fragility: Staff are uncomfortable talking about race		
Staff don't take opportunities to explore race	384-385	*I've mentioned some issues in terms of like family and race, like it's weird, no one's ever really explored it.*
Staff are not culturally competent when it comes to race	406-408	*I can see people getting awkward because they don't know how to talk. And it's like the elephant in the room…*
Seeing the whole person	411-412	*It's nice for people to check in, because it's an important part of your identity.*
Theme 5. Exploring experiences of racism and its impact on perinatal mental health fosters psychological safety		

Talking about race fosters psychological safety in the context of racial trauma	487-490	*…if people were just talking about it and acknowledge it, you would feel like, okay, well it's not about my race because.. they're talking about it, they're appreciating it, you can tell how they are with you.*
Psychologist validated experiences of racial adversity	308-310	*…a couple of time my race has come up in conversation…and she's like "that's a huge thing", and she'll sort of validate it.*
Perinatal teams should provide opportunities to reflect on experiences of racism and how this interacts with the perinatal period	594-595	*I think it's important to talk about our birth experience and experiences of racism…*
Staff need to acknowledge institutional racism and explore how this impacts experiences of healthcare	417-418	*And so even just like "Oh, how do you feel about this stuff that's come out?" Because I was terrified when I was giving birth…*

Table of Personal Experiential Themes for Participant 5

	Line no.	**Quotes**
Theme 1. Parent-infant dyad central to understanding perinatal depression and its treatment		
Identifying negative thoughts about baby as a maintenance factor for depression	20-22	*I'm very depressed so all the time I'm thinking negative thoughts…I'm thinking my baby's, like he's autistic*
Psychological interventions are focused on bonding	36-37	*We are practising how to build up a good relationship with our babies.*
The peer support worker helps mum and baby to manage stressors and enjoy daily life	148-151	*I have a fear when he's screaming, sometimes going outside is difficult to manage. Yeah I have a peer support worker who helped me get out and afterwards I feel more confident.*
Theme 2. An overwhelmingly positive experience of support		
Person centred therapy	*34-35*	*Yeah I think she's not judgemental. She is a good listener…*
Therapist seen as a friend	*96-97*	*…it's a very good relationship so I can share everything, like friends.*
An unexpected positive experience of the perinatal team	*169-170*	*I never expect such helpful team support. It's too much for me, honestly* [laughter].
Theme 3. Cultural curiosity strengthened relationships		
Staff try to understand difficult cultural perspectives	121-122	*Yeah, yeah, they're trying. It was really difficult for them because everything is different.*
Cultural appreciation is welcomed	129-130	I enjoy someone who wants to know about my culture

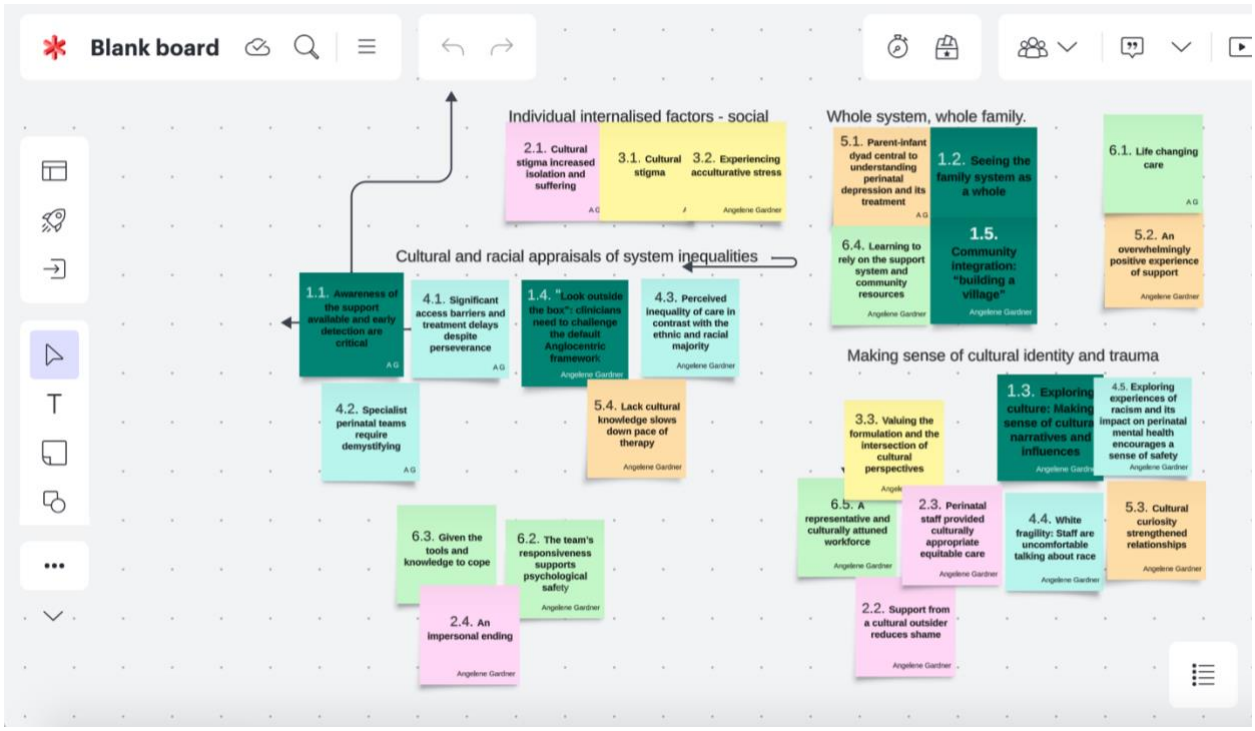
Clinicians are curious and this strengthens therapeutic alliance	132-133	*Curiosity makes me happy. Yeah, because I'm working with someone who has an interest in me.*
Theme 4. Lack cultural knowledge slows down pace of therapy		
Prior learning about culture is encouraged	45-46	*If they study a little bit then I think it will be more improved.*
Time spent explaining cultural background overshadows other elements of therapy	55-57	*…we finished maybe five, six, seven sessions discussing, that, a lot of time, it's time consuming as like they don't know about our culture…*
Equity of care means extended sessions for ethnic minority women	86-89	*…I think extended sessions for ethnic minority is also helpful. Yeah. Because our culture is different, so they needed more time to understand me.*

Table of Personal Experiential Themes for Participant 6

	Line no.	**Quotes**
Theme 1. Life changing care		
The perinatal team maintained life	142-144	*I always say, I was telling my husband, that I'm sitting here only because of them. Because my symptoms were so bad.*
Gratitude for quality mental health care	302-306	*They're amazing. Because they spend so much time on you, they give you 100%...I'm better now.*
A new sense of control	316-317	*There was a time I couldn't control my anxiety at all, but now it's quite controllable. I can control it.*
Theme 2. The team's responsiveness supports psychological safety		
Able to openly communicate mental state with the team with the confidence that they will respond	38-40	*I was having a little bit of feelings again. So I messaged her and she straight away replied. They had an appointment with the consultant…*
Regular contact let's her know she's a priority	147-148	*…the checking in and the medication, and they were talking to me.*
The power of reassurance and validation in the context of cultural stigma	160-163	*But there's someone that listens to you and tells you you're ok, you're doing great….they just don't think that you are crazy. A lot of people go through this and they're not crazy.*
Consistency and responsiveness creates safety	296-298	*She answers me back straightaway. So compared to what I am now, I'm a lot better. I am who I am now because of them.*
Theme 3. Given the tools and knowledge to cope		
Perinatal team encouraged a realistic approach to recovery	287	*They said "don't push yourself, just take a bit of time."*

Formulation helped make sense of factors which influence distress	68-71	*…my mum passed away when I was little. So I was worried about what would happen when giving birth. So maybe that trauma was coming into me…*
Psychiatrist supported understanding of medication	153-154	*She said don't stop because when you stop it suddenly sometimes the symptoms come back.*
Anxiety management techniques were effective	318-20	*And they taught me quite a lot of techniques like breathing and to sit down and put your legs like this and just shake it. All these techniques worked…*
Theme 4. Learning to rely on the support system and community resources		
MIND: leaning on community resources	77-80	*She was amazing.. she was seeing me every Monday…talk to me, and you know, asked how I'm feeling.*
Family adapted and provided support	178-181	*When my family realised what I'm going through, they were so helpful. My daughter, I feel like they've all grown up in six months…They're helping me so much.*
The neighbourhood rallied around to help the family	268-270	*My neighbours and friends were amazing. Picking up the kids and dropping off the kids.*
Learning to accept help for survival	272-274	*And you honestly, you feel so vulnerable in that time. I learned to take the help, when someone wants to help you just take it, don't say no.*
Theme 5. A representative and culturally attuned workforce		
Religious festivals held in mind by team	213-214	*They asked me what I'm doing for Eid and did you make clothes for the kids*
Minority experience represented within workforce	215-216	*…a few doctors they were from India so they knew quite a lot about my culture*
Culturally and linguistically connected	228-229	*If they are able to speak your language and your culture, you feel more connected ton them.*
A shared understanding of cultural stigma helps to overcome barriers and cultivate openness	238-241	*For us, coming from an Asian community, to come up and talk about mental health is very hard. So yeah, someone to understand what the barriers are, and what I might be struggling with.*

Appendix M: Identifying Initial Patterns for Group Experiential Themes (Lucid, 2023)



Appendix N: Table of Group Experiential Themes

Table of Group Experiential Themes of Ethnic Minority Women's Experiences of Specialist Perinatal Services

		Line no.
Group Experiential Theme 1. A systems approach to care		
1a. The perinatal team's role in supporting the family		
Participant 1	*Guys don't generally ask for help, let alone ask for help from their friends. You know, I was even more worried about him. I was like actually the system cares about me. I know I'll probably be OK and be looked after. I'm really worried about him and, you know…*	164-168
Participant 2	*He needed a translator for meetings and that sort of stuff and a few sessions with other dads. And I think they said they provided him with translator…*	613-615
Participant 5	*We are practising how to build up a good relationship with our babies.*	36-37
1b. The perinatal team's role in strengthening community and peer support		
Participant 1	*It is very typical in our Western culture, like the women are quite isolated and this kind of nuclear family is really praised and like doing it on your own and people don't live near their family. So I think a service that can recognize that is the culture we have today, whether we like it or not and try and help tap people as quickly as possible into a community.*	560-566
Participant 2	*There were quite a few projects with Muslim mums, basically. So Mind, they do these sort of other projects… that kind of stuff for like Mum's spirituality.*	243-246
Participant 5	*I have a fear when he's screaming, sometimes going outside is difficult to manage. Yeah I have a peer support worker who helped me get out and afterwards I feel more confident.*	148-151
Participant 6	*Yes, that was quite helpful. Yes. And then [care coordinator's name] told me about* Mind… *She [MIND practitioner] was amazing.. she was seeing me every Monday…talk to me, and you know, asked how I'm feeling.*	74-80
Group Experiential Theme 2. Valuing cultural curiosity in professionals		
Participant 1	*Not just asking about your ethnicity as a tick box exercise*	420-421
Participant 4	*I can see people getting awkward because they don't know how to talk. And it's like the elephant in the room…*	406-408
Participant 5	*I enjoy someone who wants to know about my culture…Curiosity makes me happy. Yeah, because I'm working with someone who has an interest in me.*	129-133
Participant 6	*They asked me what I'm doing for Eid and did you make clothes for the kids*	213-214
Group Experiential Theme 3. Integrating culture into care		
3a. Making sense of how culture, ethnicity, race and racism impact mental health		

Participant 1	*You know, you've learned so much about my past, and it's just got me thinking like ohh yeah, that is why I think different. /…how my brains been wired from when I was younger and maybe you know, again bringing up my upbringing and certain kind of beliefs and or limit certain limiting beliefs*	448-450/ 481-484
Participant 2	*These are all stuff, get labelled as crazy. Not not on purpose, but lets say if someone got depression, so they must be crazy. But they're all words that don't help*	44-46
Participant 3	*If you are not listened to as a child, for example, quite normal there. And you come here and you look at it and say, "you know, that's just a child and you didn't have to go through all that".*	169-171
Participant 4	*And so even just like "Oh, how do you feel about this stuff that's come out?"[MBRRACE-UK 2020 findings] Because I was terrified when I was giving birth… / I think it's important to talk about our birth experience and experiences of racism…*	417-418/ 594-595
3b. Tailoring interventions to ethnic minority women and their families		
Participant 1	*I think a lot of these kind of structures and frameworks are probably created traditionally by like white British males. So when you look at that kind of systemically and then somebody isn't responding to a treatment you've gotta kind of look outside the box a bit.*	404-408
Participant 3	*We just had a conversation about it today [with therapist name] so, you know, where will that be better. But you know. In some houses where there's so many people, there's nowhere to sit and talk.*	248-251
Participant 4	*I also think it would be good to have a group specifically for minority women, it might involve talking about different experiences of motherhood, family and how our race has impacted us.*	596-599
Participant 5	*…I think extended sessions for ethnic minority is also helpful. Yeah. Because our culture is different, so they needed more time to understand me.*	86-89
Participant 6	*Yeah, you know, this language barrier does come up, I try to speak very well, but sometimes you know, it helped to tell them in my own language.*	223-225