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MOTHERHOOD AND PSYCHOLOGICAL
DISTRESS AFTER CHILDBIRTH: A
THEMATIC-DIALOGICAL ANALYSIS OF
PAKISTANI-MUSLIM WOMEN'S
EXPERIENCES

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Motherhood and Psychological Distress after Childbirth: A Thematic-
Dialogical Analysis of Pakistani-Muslim Women's Experiences

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Abstract

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Motherhood and Psychological Distress after Childbirth: A Thematic-Dialogical Analysis of Pakistani-Muslim Women's Experiences

Key words: maternal mental health, motherhood, psychological distress, qualitative, Pakistani-Muslim, South Asian, thematic, cross-cultural, postnatal depression, dialogical

Background: Psychological distress after childbirth is high amongst Pakistani-Muslim women. In the UK, this distress is often labelled as a mental health condition, an illness known as postnatal depression. According to Western psychiatry the experience of postnatal depression is universal for all women, regardless of ethnicity, culture, and socio-economic status. However, these factors are important and do shape women's lived experiences, understanding of conditions and help-seeking behaviours. Without understanding these factors, vulnerable women run the risk of not receiving the most appropriate support. How Pakistani-Muslim women experience motherhood and psychological distress after childbirth is under-researched.

Aim: To explore experiences of motherhood and psychological distress after childbirth, in Pakistani-Muslim women.

Method: A qualitative study was conducted. Face-to-face, semi-structured interviews were conducted with 17 Pakistani-Muslim women. Data was analysed via thematic-dialogical analysis.

Findings: The findings of this study are broken down into three empirical chapters, to address the research questions. This includes 1. Experiences of motherhood during the postnatal period (social support, cultural postnatal practices, transition to motherhood); 2. Dramatization vs Authenticity of psychological distress (women's understanding of their distress and family reactions); 3. Experience of psychological distress after childbirth.

Conclusion: A greater understanding of how Pakistani-Muslim women experience motherhood and psychological distress after childbirth has been developed. Factors have been identified which may increase the risk of psychological distress and factors which may act as barriers to help-seeking. Experiences have shown to be layered and nuanced, with various influential factors beyond culture and ethnicity being identified (generational differences, rural identity).

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Chapter 1

Introduction

1.0. Introduction

The purpose of this thesis is to explore motherhood and psychological distress after childbirth in Pakistani-Muslim women, living in the UK. For experiences and voices of such women to be heard a qualitative approach to research was adopted. This chapter will provide background to the topic, including my motivations for studying this topic and the target population. The influence of my own experiences and how these have informed research will be discussed. The chapter will then go onto discuss the impact of poor and untreated maternal mental health has on the new mother, the infant, as well as economic burdens. Finally, the thesis structure will be presented.

1.2. Motivations behind this research topic

During my study of Psychology, I developed a keen interest in mental health. At the time my understanding of common mental health disorders (CMD) was informed by the bio-medical model of mental health. The bio-medical model posits mental disorders as brain diseases, which can be treated pharmacologically to target the presumed biological abnormalities (Deacon, 2013). This is the knowledge I was first exposed to, and it offered a legitimate explanation for mental health. In my experience of the Pakistani-Muslim community, acknowledgement and support for mental health issues is lacking. When mental health narratives were discussed around me within the community, I would often pitch in to say well actually these behaviors and symptoms sound like 'X mental health issue' and 'X treatment' is recommended. I felt if mental health issues were understood under a medical framework amongst the Pakistani-Muslim community, then there is hope for the sufferer to receive appropriate support.

Post-graduation I worked as a research assistant for the Bradford Institute of Health Research (BIHR) on the longitudinal birth cohort study 'Born in Bradford (BiB)' and the experimental birth cohort study 'Born in Bradford Better Start (BiBBs)'. Participants of the studies are of diverse backgrounds, with a large proportion belonging to a Pakistani-Muslim background. My role involved visiting people's homes and conducting applied health research. This included completing questionnaires largely around physical health and diet. It was here where I encountered diverse experiences and understandings of mental health (and physical health). These interactions opened my mind to thinking about mental health beyond medicalization. I began to appreciate and became interested in cross-cultural understandings of mental health. I began to realise there is no one way to understand or treat mental health conditions. Reducing mental health to one explanation fails to consider the complexities and nuances that may exist across cultures and communities.

During this time, I knew I wanted to pursue a PhD in mental health due to my passion for research but had yet to locate my research in a specific area of mental health. Around the same time a family member was telling me about recent events regarding a first-time mother and her new-born. The new mother had given birth but a couple of months into the postnatal period the grandmother had decided to permanently take care of the infant. This was a family decision social services were not involved. "Why?" I questioned. To which my family member gave a vague reply suggesting such details were unknown, whilst at the same time indicating that the new mother was not stable. "Was she ill?" I enquired further. Another vague reply later I noticed that these issues are preferred to be kept hidden and are not openly discussed. The mother in question became pregnant again, to fill the void of having her child taken away from her I was told. For contextual purposes, the mother lives nearby her own mother (the grandmother of child) and can see her child at any time but it was being raised by the grandmother. From this I deduced that the child's needs were considered but the mother was neglected during this difficult time. If she was considered unstable, then why was she not offered support? What could have been wrong with her? Such questions entered my mind. I was desperately trying to make sense of this distressing and sensitive situation, with the lack of information

provided to me. I thought to myself “*could it be postnatal depression?*”. I began to ponder on the role of the family and the position of the woman. The family clearly had the upper hand, and the woman was in a vulnerable and seemingly powerless position. It was at this moment where I realised that I may interpret certain behaviors as an illness, but others may not. In this context, the exhibiting behaviors were clearly of concern to make the decision of removing the child from the mother. It could be possible that the behaviors were interpreted as mental health, but stigma may have prevented help-seeking. It is also possible that symptoms and behaviors were viewed as a cause for concern but were not viewed as an illness and instead viewed as maternal failures. Earlier works of Nicolson (1998:2001) discussed how the label of postnatal depression may offer some women a legitimate explanation for their symptoms, and opportunity for support. However, Nicolson (1998:2001) also recognises that understanding postnatal depression as an illness renders women’s lives invisible. This is because the social context of childbirth and motherhood is removed, thus the experience is reduced to hormonal fluctuations deemed out of women’s control. The experience of psychological distress after childbirth in South Asian women and various perspectives will be discussed further in the literature review.

In the narrative presented, the mother’s distress was not labelled as an illness (postnatal depression) and nor was it acknowledged as a reaction to the stressors of motherhood. Her entire experience as a mother was rendered invisible, and she herself was left invisible and unsupported. We do not know the type of childbirth she experienced, her level of social support, or changes experienced during the transition to motherhood. This sparked my interest in the topic of this thesis, to understand how Pakistani-Muslim women experience motherhood and psychological distress after childbirth. A further area of interest is to understand how family members understand psychological distress after childbirth (from the perspective of the new mothers) and what this means for help-seeking. The added barriers of gender and cultural expectations play a part in shaping women’s lived experiences, which will be discussed in the literature review and methodological chapters of this thesis.

My interest in studying the Pakistani-Muslim population is not only based on the fact that I also share the same heritage but it does play a large part. Some biographical information about myself may shed light onto this. I have one parent who was born and raised in rural Pakistan and moved to the UK after marriage. That parent holds strong cultural Pakistani values, whilst trying to adapt to the changing needs of the younger generation of British Pakistani's. Another parent is a first-generation British born Pakistani and identifies less strongly with the Pakistani culture. I have one sibling, a brother. My upbringing can be described as typical of ethnic minorities in Britain, attempting to fit in, navigate, and balance Western and Pakistani cultures and value systems. As I grew older, I noticed and experienced differences based on gender. During these experiences I realised that my world and experiences are affected based on my gender and culture. Whilst these generational and inter-generational differences existed, they were overcome as ultimately, I was given the right and freedom to make my own decisions and choices. This can be considered a position of privilege, as not all Pakistani-Muslim women have the same experience.

1.3. British Pakistani-Muslim population in Bradford

This research is being conducted in Bradford. The City of Bradford Metropolitan District Council intelligence bulletin provides an overview of the 2021 census data for ethnic group, religion and languages spoken. The Bradford district is made up of 56.7% White British, followed by 25.5% Pakistani (second largest nationally), 2.6% Indian and 2.3% Bangladeshi. This suggests that the Pakistani population is the largest South Asian ethnic minority group in the Bradford district. Furthermore, 30.5% of the Bradford district population identify as Muslim, the second largest religion in the district. As the Pakistani-Muslim population grows in Bradford, and wider parts of the UK, it is important to meet cultural needs of this population in terms of health care to help reduce health inequalities. The majority of British Pakistani's originate from the Mirpur district of Azad Kashmir, a rural area. This is also representative of the Pakistani population living in Bradford. The influence of

rurality/rural identity and mental health has been an under-researched area within this population, more of which will be discussed in the literature review chapter.

1.4. Psychological distress after childbirth

In the UK, 1 in 4 people experience a mental health problem each year (Jenkins et al., 2009). McManus (2016) published a survey conducted in England every seven years measuring the number of people who suffer from different mental health conditions. The report found mixed anxiety and depression to be the most common disorders experienced. Women can be more susceptible to experiencing psychological distress during certain periods of their life, such as after childbirth. This is commonly understood and researched as postnatal depression (PND), a type of depression some women can experience after childbirth due to a myriad of social, psychological, biological, and physical changes. PND must be distinguished from what is known as the 'baby blues', categorised by low mood which does not last longer than two weeks. If symptoms persist, this may be a sign of postnatal depression. An important point of this thesis is to avoid the use of medicalized language when writing and talking about psychological distress after childbirth. This is because not everyone will identify with the term and as a researcher, I do not want to pre-label or determine experiences as being 'postnatal depression'. This term will only be used if the participant specifies, as well as for the purposes of exploring knowledge of the term postnatal depression. This point will be expanded upon in the literature review and methodology chapters.

The general prevalence rate for PND is 10-15% and for South Asian populations prevalence rates have shown to be higher ranging from 17.5-38.3% (Husain et al., 2011; Shakeel et al., 2018; Prabhu et al., 2019). Prevalence rates of PND in South Asian populations can be seen as problematic because existing screening measures such as the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) are Eurocentric. This means that the way South Asian women experience psychological distress is judged against European standards. Consequently, some South Asian women's experiences may not reflect items in the EPDS. The EPDS, the

surrounding cultural issues, and the impact of this will be discussed in the literature review chapter. Culturally inappropriate screening tools puts into question the accuracy of prevalence rates; thus statistics only show one side of the picture. Nevertheless, the devastating impact of undetected and untreated (formal and informal support) maternal mental health has been highlighted in the literature and represents a global public health issue (Spry et al., 2021).

Much of the available research focuses on postnatal depression and its impact on young infants, who are highly sensitive to the quality of care they receive (Bauer, 2014). Attachment research by Bowlby (1969) states that there is a critical period in a child's life which is from 0-3 years for developing an attachment, and parenting is deemed ineffective if delayed after this period. Poor attachment can lead to long-term emotional difficulties and antisocial behaviour (Bowlby, 1958). This is further supported by Prady et al. (2016) who investigated maternal psychological distress in primary care settings and its association with child behavioural outcomes at age three. The Strengths and Difficulties Questionnaire (SDQ) was administered, which is a self-report inventory behavioural screening questionnaire for children and adolescents aged two to seventeen years old. Results from the questionnaire indicated that children of mothers with untreated common mental disorders such as anxiety and depression were more likely to be rated as having socio-emotional and behavioural difficulties (Prady et al., 2016). Dadi et al. (2020) conducted a systematic review and meta-analysis examining postnatal depression and its association with adverse health outcomes, in low- and middle-income countries. Risk of adverse infant health outcomes was found to be 31% higher amongst postnatally depressed women, compared to non-postnatally depressed women. The main adverse infant health outcomes identified included malnutrition, non-exclusive breastfeeding, and common infant illnesses. These studies demonstrate the amount of responsibility and pressure on mothers to provide a strong and stable foundation for their children, regardless of personal circumstances (socio-economic status, social support, identity changes) (Ainsworth, 1992; Nicolson, 1998).

The implications of poor understanding of psychological distress after childbirth and subsequently poor detection and delayed support has shown to impact the wider economy. A report commissioned by the Maternal Mental Health Alliance, conducted by the London School of Economics aimed to quantify the direct economic impact on affected mothers, as well as potential harm on their children. The report stated that perinatal mental health problems in the UK cost £8.1 billion; with £1.2 billion from Health and Social Care, £6.4 billion from wider society and a further £0.5 billion from other public sectors. Of these costs, 28% were related to the mother for example, due to productivity loss from taking time off work or being unemployed due to depression. A worrying 72% of costs were related to the child, some of these included infant death, emotional issues, as well as psychological issues (Bauer, 2014). From a psycho-social perspective, external factors are important to acknowledge as they are vital in understanding women's experiences of motherhood and of psychological distress. Understanding the social context can help identify and develop appropriate ways to support all women. Pakistani-Muslim women's experiences of psychological distress and postnatal depression has often been studied under the umbrella term of South Asian (Wittowski et al., 2011; Masood et al., 2015). For under-researched areas, studying under umbrella terms of 'South Asian' can develop understanding of key issues or experiences on this topic. However, this also comes with limitations. Differences within and between cultures can exist, which includes generational, cultural, ethnic, linguistic, and religious differences. Thus, it is important to understand the experiences of each ethnic group. As the Pakistani population is highest in Bradford from the ethnic minorities, they will be the focus of this research.

1.5. Romanticisation of motherhood

During the early stage of developing this research, it was the mental health aspect of motherhood which commanded my interest, as opposed to motherhood itself. I have seen the effects of poor maternal mental health on child and adult development, within the Pakistani-Muslim community. A mentally healthy mother is more likely to bring up healthy children. However, to understand the mental health aspect I of course had to delve into the institute of motherhood. Earlier works of Hays (1996)

and Nicolson (1998:2001) discuss the romanticisation of motherhood, intensive mothering ideology, and the myth that is maternal instinct. When the expectation of motherhood does not match reality, it is no wonder that women feel distressed and, in their minds, inadequate. This context of motherhood is important to acknowledge as it forms part of the lived experience. Under patriarchy, women in general are expected to be the good wife, mother, daughter, daughter-in-law. These expectations are often based on fulfilling cultural, gender, and societal norms. The dominant discourse of intensive mothering, romanticisation of motherhood and psychological distress will be discussed in depth in the literature review.

As an active member of the Pakistani-Muslim community, I have knowledge of what the community expects within the domains of womanhood and motherhood. For contextual purposes the 'community' refers to low-middle class Pakistani-Muslim women, with rural roots in Pakistan. The mother, therefore, across most societies can be thought of as the core which keeps the family together. Of course, some younger generations may now take more of an equal role in parenting, however, in many cases the mother is still considered the main carer. I am not a mother and do not have a personal vested interest in the topic of motherhood, but a purely academic one. The topic of mental health and psychological distress after childbirth is also an academic interest of mine. Combining both motherhood and mental health, I want the research I conduct to make a difference to the lives of Pakistani-Muslim women (and wider ethnic minority groups in the future).

The narrative presented at that beginning of this chapter is centred around a vulnerable Pakistani-Muslim woman, of which there are many who do not have a voice, who do not have control over their health and help-seeking behaviours. It is important that voices of Pakistani-Muslim women are heard, and their experiences recognised to ensure appropriate support and care is provided. The most effective way to do this is through a qualitative approach, exploring women's experiences and understanding of motherhood and psychological distress after childbirth. Whenever issues related to ethnic minority communities or cultures are the basis of research, it is important that delivery is sensitive to not alienate communities. I am hoping that

my identity as a Pakistani-Muslim woman, from a working-class background will allow me to do this. My background in terms of links to rural Pakistan, British Pakistani, Muslim, and being female are factors relevant to the target population of Pakistani-Muslim women in Bradford. Differences may include level of education and my position as a researcher, which will allow me to study this population to hopefully make a positive difference. My identities and how they may impact the research process will be discussed in the methodology chapter.

1.6. Aim of the thesis

The aim of this thesis is to explore motherhood and psychological distress after childbirth, in British Pakistani-Muslim women. This includes developing an understanding of how women experience motherhood during the postnatal period, which may identify areas contributing towards psychological distress after childbirth. Other areas of interest include family reactions to disclosures of psychological distress and lived experience of psychological distress after childbirth.

1.7. Structure of the thesis

The first half of this thesis (chapters one-four) is theoretical, outlining philosophical underpinnings, methodology, and method(s). The second half (chapters five -seven) is empirical, presenting the findings of this thesis and finishing with the discussion and conclusions chapter.

- **Chapter One: Introduction**

Chapter one provides background to my motivations behind conducting this research and why I believe this is an important and worthy topic of study. The topic of motherhood and psychological distress after childbirth is introduced, including prevalence rates and consequences of women not receiving appropriate and timely support. Background and rationale for studying the target population is provided.

- **Chapter Two: Literature Review**

The aim of the scoping review is to identify gaps in research when exploring motherhood and psychological distress after childbirth in Pakistani-Muslim women, living in Britain. Factors influencing the experience of motherhood, psychological distress and help-seeking amongst this population will be discussed in the literature review.

- **Chapter Three: Methodology**

Chapter three provides a detailed discussion of the philosophical underpinnings and theoretical framework of this research. The chapter explains rationale behind a dialogical approach to research, a hybrid approach to analysis, and the incorporation of the Women's Ways of Knowing (Belenky et al., 1986) model and the Common Sense model of self regulation (Leventhal et al., 1984).

- **Chapter Four: Method(s)**

Chapter four provides a detailed account of the method(s) applied in this study, including how participants were identified and recruited. A discussion around ethical considerations is provided and a detailed account of how data is analysed using thematic-dialogical analysis.

- **Chapter Five: Exploring Motherhood during the Postnatal Period**

Chapter five explores how new mothers experienced motherhood during the postnatal period. Key themes reported include the transition to motherhood, social support, and cultural experiences of postnatal practices.

- **Chapter Six: Understanding Psychological Distress after Childbirth: the New Mother and the Absent Voices in Dialogue**

Chapter six explores how mothers understand and make sense of their psychological distress. Key themes included the medicalisation of psychological distress and family members reacted to disclosures of psychological distress after childbirth. These findings are linked to help-seeking behaviors.

- **Chapter Seven: Experience of Psychological Distress after Childbirth**

Chapter seven takes a closer look at a sub-sample of women who reported subjective and diagnosed experiences of psychological distress/postnatal depression. Key themes reported included the impact on sense of self, symptoms experienced and experiences of treatment.

- **Chapter Eight: Discussion and Conclusion(s)**

Chapter eight discusses the key findings of this PhD in relation to the research questions and relevant theory. Original contribution to knowledge is discussed, strengths and limitations, as well as implications and recommendations. A conclusion and final closing note is provided.

Chapter 2

The experience of psychological distress after childbirth in British South Asian women: a scoping review

2.0. Introduction

Women entering motherhood are susceptible to mood changes in the postnatal period, which can develop into postnatal depression (PND). The British South Asian (BSA) population is mainly made up of people of Pakistani, Indian and Bangladeshi background and is the largest and fastest growing minority ethnic group (Census, 2021). BSA women are reported to be at increased risk of PND (Sihre et al., 2019). The impact of postnatal depression is significant, not only for the person living with it, but also for the infant, which can subsequently have wider implications. For example, Prady et al. (2016) found children of mothers with untreated common mental disorders such as anxiety and depression were more likely to be rated as having socio-emotional and behavioural difficulties at age three. In 2012, a report commissioned by the Maternal Mental Health Alliance, conducted by the London School of Economics aimed to quantify the direct economic impact on affected mothers, as well as potential harm on their children. Perinatal mental health problems in the UK cost £8.1 billion; with £1.2 billion from Health and Social Care, £6.4 billion from wider society and a further £0.5 billion from other public sectors. Of these costs, 28% were related to the mother for example, due to productivity loss from taking time off work or being unemployed due to depression. A worrying 72% of costs were related to the child, some of these included infant death, emotional issues, as well as psychological issues (Bauer, 2014).

Women of diverse cultural and migrant backgrounds have shown to have a varied understanding of postnatal depression. This includes variation in symptom presentation, perceived causes, and experiences of help-seeking. Studies have found that the South Asian population in the UK are more likely to attribute social, moral, or supernatural causes to depressive disorders, compared to biological causes which are more likely to be reported by participants of White background (Karasz et al., 2019; Birtel and Mitchell, 2023). This indicates that causes of mental

health are perceived as social, thus a purely medical approach to addressing mental health issues may not always be appropriate for this population.

Karasz et al. (2019) found participants experiencing mental health issues to report somatic symptoms such as headaches and/or physical pain. The presentation of somatic symptoms may lead to a misdiagnosis in health settings where cultural understanding of mental health is lacking. Birtel and Mitchell (2023) examined cross-cultural differences in depression between White British and South Asian communities. People of South Asian background reported greater personal and public stigma of depression, compared to White British. These factors can contribute towards blame culture for people living with depression/postnatal depression, acting as barriers to help-seeking. Using routine and research data, Prady et al. (2016) examined variations and ethnic inequalities in the treatment of common mental disorders (CMD) during the maternal period, in Bradford, United Kingdom. Women of minority ethnic backgrounds were 55-70% more likely to be identified with a CMD compared to women of White ethnic background but were less likely to access treatment. To help reduce gaps in health inequalities, it is vital to gain a better understanding of how British South Asian women experience motherhood and psychological distress after childbirth. Enhancing understanding of cultural and generational influences on postnatal experiences, may lead to better identification of psychological distress, as well as the availability of culturally sensitive and tailored support options for South Asian women.

We conducted a preliminary literature search (04/11/2023) aimed at identifying similar ongoing systematic or scoping reviews using the keywords experience, postnatal depression, South Asian women, review on Google Scholar, PROSPERO, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis. We found a meta-synthesis of qualitative studies on the experience of postnatal depression in immigrant mothers living in Western countries (Wittowski et al., 2017). Whilst this review included women of South Asian backgrounds, it was limited to the migrant population. In the present scoping review, the objective is to provide a more comprehensive mapping of the evidence on the experiences of motherhood and psychological distress in South Asian women living in Britain, which to our knowledge has not been conducted. A decision was made to conduct a scoping review (Tricco et al., 2018) as it is a suitable exploratory approach, designed to

address broader questions. In this review we aim to bring together literature reporting on experiences of psychological distress after childbirth (postnatal depression), which will include mapping of motherhood experiences during the postnatal period.

2.1. Review questions

The review aims to address the following broad research questions:

- What are South Asian women's experiences of psychological distress after childbirth, in the UK?
 - What are the perceived causes women attribute to their distress?
 - What are the symptoms women report?
 - How do women understand their psychological distress?

- How do South Asian women experience the postnatal period, in the UK?
 - What structures are in place to support women? (social support)
 - What is women's experience of cultural postnatal practices and rituals?

2.2. Method

2.2.1. Scoping review

Given the broad research question around the experience of motherhood and psychological distress after childbirth in British South Asian women, I opted for a scoping review methodology. The primary emphasis of a scoping review is on the breadth and relevance of literature. I am particularly interested in qualitative research evidencing the experiences of women. This includes mixed methods designs with qualitative components.

Assessing the quality of evidence in scoping reviews is not mandatory and is a secondary concern. This is partly due to difficulties in operationalising quality due to the potential nature of including a wide range of literature in scoping reviews. This is distinct from systematic reviews, which are often concerned with 'what works' and for whom, such as 'what are the most effective intervention for reducing symptoms of

postnatal depression in British South Asian women?'. In such reviews, it is important to assess the quality of evidence in order to recommend interventions.

Scoping review methodology has gained popularity due to its suitability in consolidating diverse knowledge on broad topics and complex questions. It's an excellent method to employ in emergent research areas, in which researchers have not yet conducted systematic reviews or otherwise attempted to record the entirety of a scholarly conversation (Hanneke et al., 2017). This scoping review was conducted in accordance with the JBI methodology for scoping reviews (Peters et al., 2020). This included 1) developing a research question, (2) searching literature by using inclusion and exclusion criteria, (3) selecting articles, (4) charting of data extracted from included articles, and (5) collating, summarizing, and reporting the findings.

2.2.2. Search strategy and databases

The scoping review followed the standard of the Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for scoping reviews (PRISMA-ScR) (Tricco et al., 2018). To undertake this scoping review, it was necessary to develop a search strategy to capture studies relevant to the aims of the review.

The search was undertaken between 04.11.2023 - 05.11.2023 (1963-2023) in five electronic databases: CINAHL plus full text, Medline, Psychology and Behavioural Sciences, APA PsycINFO and Embase. The Boolean search term combinations are presented in Table 1.

Table 1. Search strategy

Search terms/strategy
S1. (MH "Depression, Postpartum") OR (MH "Postpartum Period") OR ""postnatal depression" OR "postpartum depression""
S2.'maternal depression'
S3. S1 OR S2
S4. (MH "South Asian People") OR (MH "Asian People") OR ""south asian people" OR muslim OR "British Pakistani" OR bangladeshi"
S5. (MH "Pakistan") OR (MH "India") OR (MH "Bangladesh") OR "bangladesh* OR india* OR pakistan*"

S6. (MH "United Kingdom") OR (MH "Northern Ireland") OR (MH "Channel Islands") OR (MH "Ireland") OR (MH "Wales") OR (MH "Scotland") OR (MH "England") OR ""United Kingdom" OR "Great Britain" OR "Channel Islands" OR England OR "Northern Ireland" OR Scotland OR Wales"

S7. "minorit* ethnic* OR "ethnic minorit* OR BME OR BAME

S8. S4 OR S5 OR S6 OR S7

S9. S3 AND S8

To ensure the full scope of published literature within each database was targeted, a date limiter was not set. Titles and abstracts published in English only were included due to time limitations. Title and abstracts were screened for relevance. Studies were included in the full text screening that used a qualitative or mixed method design. Searches in the grey literature included reference lists of included articles, Google Scholar, and thesis. The search string 'experiences of postnatal depression in South Asian women' was applied to Google Scholar. The first ten pages of Google were examined for eligible articles. The search terms were approved by the supervisory team.

2.2.3. Inclusion/exclusion

It is emphasised that the inclusion/exclusion criteria must be explicit and comprehensive enough so that any identified article could be included or excluded based solely on those criteria (Randolph, 2009). The review was developed to include any study conducted in the UK, on British South Asian women reporting on the experiences of motherhood and psychological distress after childbirth. Terminology varied in terms of labelling psychological distress, such as postnatal depression, maternal depression, emotional distress/wellbeing were all eligible. The eligibility criteria were as follows:

Inclusion criteria:

Sample:

- South Asian women (Pakistani, Indian, Bengali)
- British-born or migrant

- Women as the primary informants
- >50% South Asian

Phenomenon of Interest and Evaluation:

- Experience of Postnatal depression/maternal depression
- Experience of motherhood (Cultural postnatal practices and rituals)

Design:

- Qualitative (lived experience)
- Mixed-methods

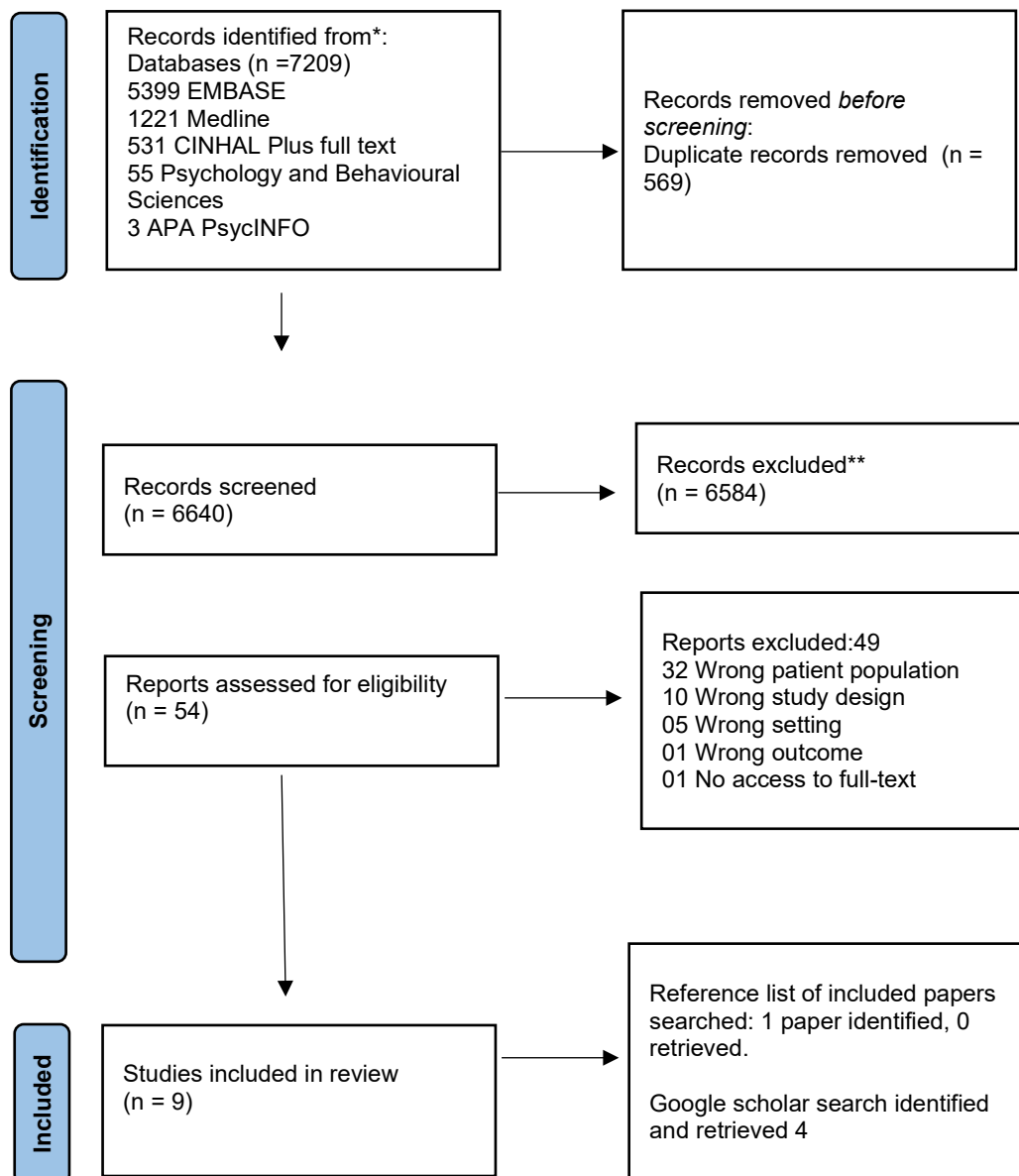
- Studies conducted in English ONLY
- UK studies only

Exclusion criteria:

- Reviews, protocols, commentary pieces, conference abstracts
- Studies reporting on prevalence rates

The search strategy was run, and search results were imported into a management software called Covidence. After removing duplicates, the researcher independently screened the title and abstract of 6640 records. In total, 54 studies were selected for full text examination. The process is demonstrated in Figure 1.

Figure 1. PRISMA flow diagram



2.2.4. Meta-synthesis

The findings of this review were synthesised using Noblit and Hare’s (1988) meta-synthesis method based on meta-ethnography. This was chosen as an appropriate approach for several reasons: it is one of the most developed methods as well as one of the most frequently used approaches to synthesize qualitative research findings (Bondas & Hall, 2007). All types of qualitative research can be synthesized using this approach, while allowing for the possible preservation of the interpretative

properties of primary data. The approach is structured and specifies explicit guidelines for conducting a synthesis and has been utilized successfully in several qualitative reviews (e.g., Beck, 2002).

The process began by reading and re-reading all identified articles. Themes and concepts from each individual study were identified, extracted, and summarised into tables. The tables of themes and concepts from each study were compared, to identify how they were related to one another and how they differed. The synthesis was preformed through three techniques: (a) Reciprocal translation, where the key concepts across each study were examined and translated into each other. (b) Refutational synthesis, where contradictions between concepts were identified and explained. (c) Finally, 'lines of argument' synthesis, where a general interpretation of the findings was built. Overarching themes of the concepts from the original studies were formulated to present a new interpretation of the findings (Sandelowski & Barroso, 2006) in diagrammatic and written form (see Table 2).

Table 2: Themes and sub-themes

Author	Themes: Experience of social support			Experience and understanding of psychological distress after childbirth		Barrier to help-seeking			Managing and coping with psychological distress after childbirth		
	Sub-themes: Practical support	Impact of migration	Emotional support	Presentation of symptoms	Psycho-social understandings	Cultural codes of conduct and stigma	Lack of culturally sensitive services	Structural barriers	Medication resistance	Stoic approach	Religion
Templeton et al. (2003)	X		X	X	X	X	X	X	X		
Parvin et al. (2004)	X	X		X	X	X	X	X		X	X
Hanley (2007)	X				X	X		X			
Wittowski et al. (2011)	X	X	X	X	X	X	X				X
Lamba (2015)	X	X	X	X	X		X				
Moghul (2018)	X	X	X	X		X		X		X	X
Khan et al. (2019)	X		X	X	X	X		X	X		

Sihre (2019)	X		X	X	X	X	X	X	X		X
Zahid et al. (2022)	X		X			X		X			

Table 3. Characteristics of included studies

Author	Study Aim	Sample Characteristics	Data collection	Data analysis	Subjective or diagnosed	Terminology used by paper
Templeton et al. (2003)	To describe the experiences of women suffering from postnatal depression in black and minority ethnic communities in Wiltshire, UK.	20 minority ethnic mothers, including South Asian	(6 interviews and 14 in focus group)	Descriptive thematic analysis	Women with a score of 12+ via EPDS	Postnatal depression
Parvin et al. (2004)	To explore first-generation Bangladeshi women's understandings and experiences of postnatal distress, and to describe coping strategies during the postnatal period.	25 Bengali migrant mothers	Focus group	Thematic-content analysis	Subjective	Emotional distress

Hanley (2007)	To explore emotional well-being and health beliefs of Bangladeshi mothers during this period.	10 Bengali mother (9 English speaking and 1 non-English)	Focus group	Thematic analysis	Subjective	Emotional wellbeing
Wittowski et al. (2011)	To explore experiences of postnatal depression in South Asian mothers living in Britain.	10 South Asian mothers (2 migrant and 8 UK-born)	Interview	Grounded theory	Women with a score of 12+ via EPDS	Postnatal depression
Lamba (2015)	To explore postnatal depression in migrant Pakistani-Muslim mothers.	4 migrant Pakistani-Muslim mothers	Interview	Interpretive Phenomenological Analysis	Subjective	Postnatal depression
Moghul (2018)	Exploring help-seeking for perinatal mental health in South Asian women living in Luton	17 South Asian mothers (Pakistani, Bengali and Indian. 6 English speakers and 11 non-English)	Focus group	Framework thematic analysis	No diagnosis/lived experience in criteria	Perinatal mental health
Khan et al. (2019)	To develop and test the feasibility and acceptability of a culturally-adapted, CBT-based, manual-assisted intervention in British Pakistani mothers experiencing maternal depression.	15 British Pakistani mothers (8 first-generation migrant and 7 UK-born)	Interview	Not mentioned	Women with a score of 12+ via EPDS	Depression

Sihre (2019)	To explore South Asian women's experiences of severe postnatal psychiatric illness and experience of perinatal mental health services.	5 South Asian mothers	Interview	IPA	Women who were clinically diagnosed by a perinatal psychiatrist	Severe postnatal psychiatric illness
Zahid et al. (2022)	To explore experience of seeking help for postnatal depression in South Asian women.	7 South Asian mothers	Interview	Reflexive thematic analysis	Retrospective experiences of postnatal depression	Postnatal depression

2.3. Results

Nine studies were identified meeting the inclusion criteria. These studies specifically explored the lived experience of psychological distress after childbirth, in South Asian women in UK settings. Study characteristics are presented in Table 3. I will first summarise some key elements of study characteristics and then present the themes.

2.3.1. Study characteristics

The nine studies varied in how South Asian participants were grouped. Five papers studied women under the umbrella term of 'South Asian' or 'minority ethnic', which referred to South Asian participants (Templeton et al., 2003; Wittowski et al., 2011; Moghul, 2018; Sihre et al., 2021; Zahid et al., 2022). Two studies focused on Bengali women (Parvin et al., 2004; Hanley, 2007) and two studies focused on Pakistani-Muslim women (Lamba, 2015; Khan et al., 2019). Most of the studies explicitly stated whether participants were British born or migrant, with approximately half of the studies including a mix of British born and migrant participants, and the other half focusing only on migrant women. However, it is important to note that in most of the papers only those able to speak conversational English were included (Lamba, 2015). This excludes non-English speakers who are often neglected in research, and their experiences unheard. However, Templeton et al. (2003) states conducting one interview in another language and Moghul (2018) also conducted various interviews in languages other than English. To summarise, in terms of how women were grouped by ethnicity, the limited focus has been on 'South Asian', Bengali and Pakistani women. Studying women under the umbrella term of 'South Asian' runs the risk of masking cultural and ethnic diversities that may exist between the various South Asian groups.

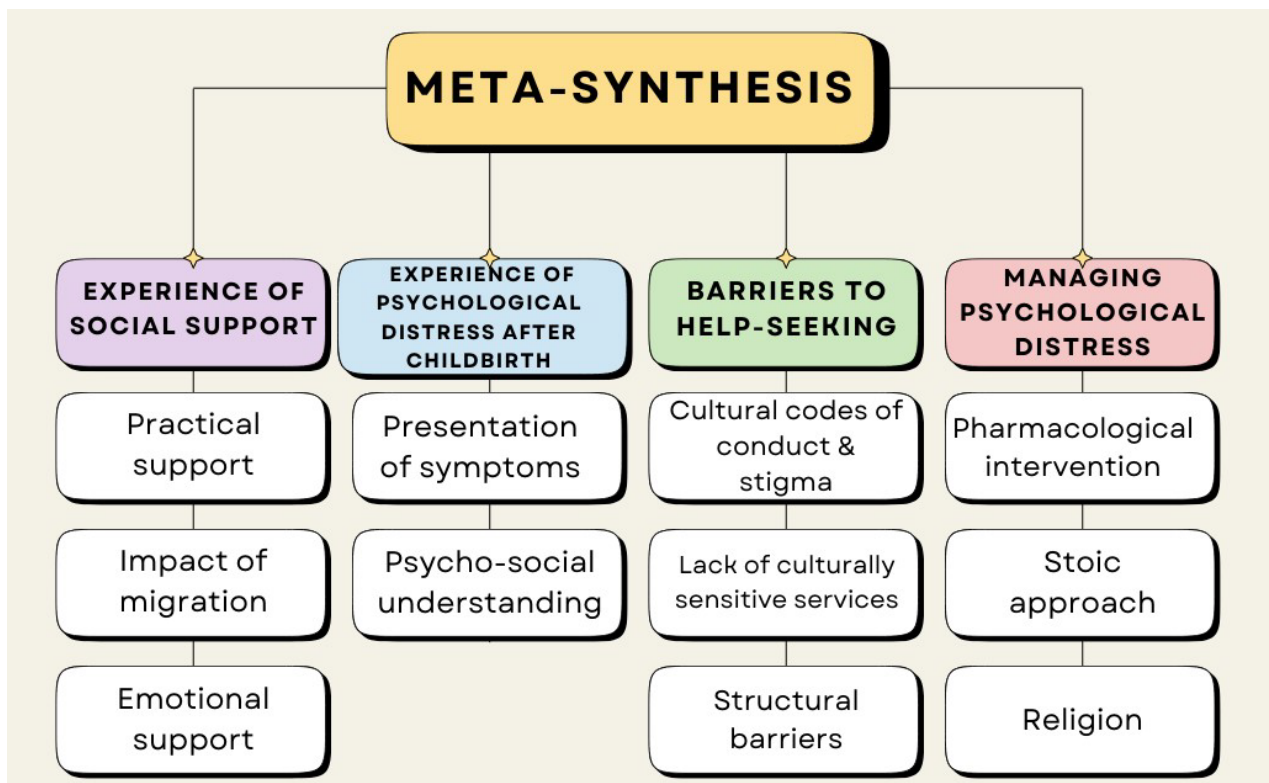
Half of the papers explored experiences of women who were diagnosed with postnatal depression and used the Edinburgh Postnatal Depression Scale (EPDS), to check whether women met criteria for postnatal depression. The other half of studies focused on subjective experiences, and these varied in how authors chose to label experiences, as highlighted in Table 3. In this chapter, the term psychological

distress after childbirth will be used. This is a relatively neutral term appropriate for diagnosed and subjective experiences.

2.3.2. Themes

The findings of this review have been synthesised and organised into four themes capturing how British South Asian women experience motherhood and psychological distress after childbirth. The themes focus on women’s experiences of motherhood in relation to social support, the unique ways in which women experience and make sense of their feelings and the implications of this on help-seeking and managing symptoms. Quotes from the included studies will be used to illustrate the findings of this scoping review.

Figure 2. Thematic map



2.3.3. *Experience of social support*

Three main relationships have been identified for British South Asian women as being influencing factors in facilitating or hindering mental health during the postnatal period. This included women's own mothers, their mother-in-law, and their partner, and the role they played in social support during the postnatal period.

Practical support

During the postnatal period, women's own mothers were a source of practical support, which included looking after other children, including the newborn, and cooking of meals, as demonstrated by this quote:

'So what this time happened, my mum take care of my one child, the younger one, the.... who born now. My, my mum take care of him. And she also cook food as well. She also.... help me too much' (Lamba, 2015)

Practical support was of great value to the new mother, allowing her to transition and settle into motherhood at a comfortable pace. The new mother appeared to be satisfied with the level of support, which could act as a protective factor against psychological distress after childbirth. However, contrary to popular belief, not all women of South Asian background had an abundance of social support at their disposal during the postnatal period. For example, one study emphasized differences in living arrangements in the UK, compared to in Bangladesh. These differences meant that family members in the UK were less likely to be living in joint families, thus women felt there were less people in the house to support them:

'There are people there (in Bangladesh). In this country, I mean if a woman has five sons, they live in five different houses, it's not like that in Bangladesh' (Parvin et al., 2004)

This indicates a shift in family living arrangements, suggesting that not all individuals of South Asian background live in joint family settings. For others, various family members, including the new mother, congregated at the family home often:

'My parents will always be there for me. I come every day, there are usually eight or ten people there, my sisters and their children, my aunties and my brothers' (Hanley, 2007)

In the quote from Hanley (2007), there is a sense of certainty and security around parental support being always available for the new mother, which may be in the form of practical and/or emotional. This sense of certainty may provide relief and comfort during vulnerable and transitioning periods of life, such as motherhood. In addition to this, knowing that external family members are also readily accessible in this case, appears to be a source of comfort. To know someone will always be there to offer support, whether emotional or practical, may help reduce the risk of social isolation and loneliness.

Impact of migration

Women of migrant background reflected on level of social support, both professional and from family, following the period after birth. The UK maternity services and the short length of stay at hospital after birth was a shock to some mothers, as they were expected to independently look after their infants with minimal support. Coupled with lack of social support at home, led some women to experience stress and psychological distress:

'You bring the baby home. You need to eat, the family need to eat, have to clean the house, have to wash the children, take them to school, take them to Arabic reading (classes). You have to do all this work in one day, how can you get rest? Is there time?' (Parvin et al., 2004)

In this quote from Parvin et al. (2004), there is a lot of pressure of the new mother to not only look after then infant, but to also take care of household chores and extra-curricular activities of the children. The hectic schedule is empahsised with no time to rest or recover. This suggests that in this case, gender roles may dictate the woman to take care of the home and of the children, despite how difficult this can be in some situations. Lack of rest is emphasised, with indicates lack of family social support to take care of some of the reported tasks, to allow the new mother to rest and recover. The provision of social support was linked to being able to partake in

resting periods, which in some South Asian cultures is traditionally observed for 40-days:

'the time after the delivery of the baby, like in Pakistan for 40 days (i.e. 'chilla') they say that is the time that women get depressed. And this definitely happens to women. You're stuck all day in the house with a small baby, the baby wakes every hour during the night, again and again. The mother will be awake during the day and the night, because that is a very stressful time. Here you don't get a rest' (Moghul, 2018)

The quote refers to the context of Pakistan, where structures for rest (*Chilla*) are in place, with the core component being family social support. The postnatal period is recognised as a vulnerable period for developing postnatal depression, which *Chilla* being cited as a protective factor. However, the same structures are indicated to be missing in the UK, which suggests cultural resting periods may not be feasible in cross-cultural settings, acting as a risk factor. Resting periods during the postnatal period have been found to be practiced in various cultures (Sharma et al., 2016; Liu et al., 2015), under various names. The core tenant of the resting period includes women being exempt from household responsibilities, to stay indoors/within your land, receive additional support, and are fed fortifying foods. A change of diet may also be encouraged during the antenatal and postnatal period (Qureshi et al., 2016). Protein, dairy, fruit, and nuts are recommended to provide extra energy. Foods to avoid during the postnatal period and during breastfeeding include rice, fried foods, chickpeas, lentils, and spinach. These fall under the category of 'gas-forming' foods and are perceived to be associated with infantile colic (Shahid et al., 2011). These findings indicate that some women were unable to take part in the 40-day resting period. For some women this was due to lack of family in the UK, and for others, as demonstrated in Parvin et al. (2004) it was due to changes in living arrangements, meaning despite having family in the UK, the level of family social support was not the same. These findings contribute towards dispelling the myth that in South Asian cultures family members are responsible for looking after their own, across a range of conditions and illnesses.

Whilst mothers played a central role in practical support, the role of the husband across studies indicated lack of support, particularly regarding practical support. A reason for this included gendered beliefs about looking after the infant or children being the mother's responsibility:

'My husband says "I work 8 hours or 12 hours, that is harder than looking after a house". I said "I cook; I have to look after 3 children and everything else' (Moghul, 2018)

In this quote, there is a lack of appreciation for motherhood, it is a taken-for-granted role by the husband. Motherhood as a sometimes challenging role is dismissed, and work outside of the home is categorised as 'hard work'. Absent voices are bought in, by which the husband and wife try to out do the other in terms of who has it more tough. This could indicate a relationship which lacks support, emotionally and practically. Another participant from Moghul's (2018) expands on the reasoning behind such thought process:

'The reason they don't understand is because back in the day, their mothers had their siblings help, especially back home [Pakistan]. They would see the child, baby all clean and the mother all clean. There would be other people looking after them. My husband he would say "I never saw my mum go through that". I didn't even know that the baby was even crying, my mother had control over it' (Moghul, 2018)

In this quote, it is evident that the husband in question was sheltered from the realities of motherhood. One of the reasons for the success behind this sheltering, is the level of social support the older generation received, particular in their home countries. This indicates that in the UK, the same level and structure of social support, typically from family is lacking. The voice of the husband is re-presented, in which he indicates that because he did not see his mother struggle with motherhood, that this automatically means that no struggles took place. As will be discussed later in this section, this can be explained by issues relating to pregnancy, childbirth, and motherhood being hidden from not only males but also females, with issues such as shame and honour being referenced. Furthermore, there is an inability to distinguish between the role of a son, who may naturally be sheltered from various issues, particularly in families with gender roles and an emphasis on patriarchy, and the role

of a husband. A husband it is assumed, would see the reality of motherhood, previously which has been romanticised (Hays, 1996; Nicolson, 1998:2001). These beliefs, coupled with lack of social support from other family members may lead some new mothers to experience psychological distress after childbirth. This is because in households with strong gendered expectations, women are expected to not only transition into motherhood but are also expected to carry on with their wifely/daughter-in-law duties.

Emotional support

As practical support varied, emotional support and understanding of psychological distress amongst family members was a neglected concept. Women's parents did not understand why they were experiencing what they were experiencing and thus, were unable to offer any support. In the quotes below, '*dimmak khaarab hai*' has been literally translated within the quote by Wittowski et al. (2011). However, this term indicates a lack of sensitivity as depending on the context it can also be interpreted as suggesting someone has lost their mind or has turned crazy. This can heighten stigma around psychological distress, depression, and mental health, which may prevent women from seeking informal as well as formal support. The quotes indicate that mothers felt unheard, misunderstood and in need of help.

'My parents didn't have a clue as to what was going on when it all started so it was just as frightening for them. They were not sure how best to help me or who to turn to' (Wittowski et al., 2011)

'My husband just don't understand how I feel, everybody just keep saying Dimaak kharaab hai [mind is not working properly], please help' (Wittowski et al., 2011)

Whilst some mothers appreciated the level of knowledge and practical support provided by their own mothers, the same level of emotional support was lacking, as demonstrated by this quote:

'I can only talk about my mum. If she sees me crying, she says, "Why are you crying? There's nothing wrong with you. You're just being yourself, you do this all the time, you cry for no reason, you're happy, you're here, you have a nice husband, and you have no major responsibilities like I did, so pull yourself together' (Khan et al., 2019)

In this quote, the woman's own mother struggles to grasp why the new mother was experiencing psychological distress. Comparisons were made to suggest that the mothers of the current generation do not face the same struggles as the older generation did, and thus have no legitimate reason to be psychologically distressed. There is interesting use of 'double voice' which the analysis by Khan et al. (2019) does not pay attention to. The voice of the woman's mother is brought in to demonstrate the lack of understanding during this vulnerable time. The extract begins with questioning the new mother's state, followed by her mother deciding how the new mother is 'actually' feeling or how she wants her to feel. This is perhaps an attempt at normalising any distress, in a bid to minimise it. Further attempts are made to convince the new mother *why* she is indeed okay, with a list of all that she should be grateful for and finishing off with generational comparisons of motherhood. The dialogical features taken together create a space for the new mother, which is perhaps not safe to voice her distress, as she is met with dismissive comments.

The mother-in-law also played a key role in women's wellbeing postnatally. In the quote from Lamba (2015), it is suggested that the new mother went to her own mother's house during the early postnatal period. This is a varied but common practice, allowing women to get some support during this crucial period. The voice of the mother-in-law is brought in to demonstrate criticism, by which the new mother is painted as a bad or lazy mother. The dialogue moves on to the new mother, as she replays her response to her mother-in-law:

'She [mother-in-law] used to say "she sleeps the whole day while her mum looks after the baby" and I said "no, I look after him but I do need to catch up with my rest as well". There's just that lack of understanding, that made me feel even more depressed' (Lamba, 2015)

These interactions demonstrate tension and conflict between the mother-in-law and daughter-in-law dynamic. Whilst these traditions are in place to provide support for new mothers, they may lead to a matriarchal power struggle, which, as found by Lamba (2015) can result in a tension filled relationship, contributing towards negativity and psychological distress after childbirth.

2.3.4. Experience of psychological distress after childbirth

Presentation of symptoms

Mothers in the included studies described their symptoms of psychological distress in various ways, as reported in Table 4. These have been categorised into 1. psychological symptoms which map onto the EPDS; 2. somatic descriptions; and 3. other. The most commonly reported psychological symptoms reflected feelings of anxiety or worry, feeling sad and crying. These symptoms map onto the following items of the Edinburgh Postnatal Depression Scale (EPDS):

Item 4. I have been anxious or worried for no good reason

Item 8. I have felt sad or miserable

Item 9. I have been so unhappy that I have been crying

Somatic descriptions of psychological distress were widespread across studies. Reference to the heart was consistently made, in addition to experiencing headaches and feeling tired. References to the heart in the context of psychological distress could indicate feelings of anxiety. It is also possible that mental distress can lead to physical distress and vice-versa (Ohrnberger et al., 2017):

*‘Sometimes it make you, headache or sometimes make such a kind of stronger problem. It affects a person’s body as well. You’re physically depressed. If you are mentally depressed it has more effect on your body’
(Lamba, 2015)*

However, in the context of the included studies some women reported somatic descriptions as they did not want to discuss personal matters with health professionals:

‘Well, you won’t tell (the GP) your innermost problems. You might say, “I couldn’t sleep at night, because of pain, because of this and this”’

This indicates that women required support but issues of mental health can be highly stigmatised amongst many communities. The presentation of somatic symptoms to mask psychological distress can cause confusion amongst health professionals. This may increase the risk of misdiagnosis and widen health inequality gaps for British South Asian women. A variety of ‘other’ symptoms included the significance of the head, separate from headaches. In this case, the head could be referring to the brain or mind, descriptions such as the head isn’t working properly and difficulty in communicating may indicate ‘brain fog’ or cognitive dysfunction during episodes of psychological distress or depression (Gonda et al., 2015).

Psycho-social understanding

Mothers reported on what they thought caused their psychological distress after childbirth. None of the mothers in the studies reviewed reported biomedical explanations for their distress. Instead, socio-cultural causes were identified. These included issues related to migration, including struggles with acculturation, missing family and friends which in some cases contributed towards feelings of isolation and loneliness:

‘I miss my parents too much. I have good memories of my life in Pakistan before marriage. I sit and think about it a lot, I was studying in Pakistan. I got married and moved here and had no choice but to move here because of marriage. First moved couldn’t speak English or anything. I try to stop thinking about my good life in Pakistan’ (Wittowski et al., 2011)

In the quote by Wittowski et al. (2011) a mother compares her life in Pakistan compared to the UK. Life in Pakistan is described with nostalgia as the mother reflects on good memories, including being with her family and studying. The act of studying is important as it tends to signify independence, autonomy, empowerment, routine and a social network. This is in contrast to how life is described in the UK, the move is described as forced upon the mother due to marriage. Thus, the change

begins in a negative manner, with resistance. In addition to this, language barriers can contribute to feelings of isolation and make even the simplest tasks difficult.

Feelings of isolation and loneliness may have exacerbated due to cultural restrictions. Mothers reported difficulty in leaving the house or attending something without the permission of their husband or elders, indicating a lack of autonomy. Templeton (2003) did not include any direct quotes in their write up but summarized their findings:

'The women at one of the groups said that cultural restrictions meant they could rarely go out on their own or do certain things without being accompanied by another family member (one woman was only allowed out on her own to go to the shops or to attend the support group); these can be contributory factors to feelings of depression' (Templeton et al., 2003)

In some studies mothers reported on cultural expectations of giving birth to a male infant. The findings suggest that a mother who gives birth to a son is valued greater within her family and community. Adjectives to describe a son, 'powerful' and 'blessed' are in stark contrast to a female, which is described as 'problematic.' These early pre-conceptions are likely to manifest as the children get older, which may lead to unequal treatment. Whilst the mother herself may not always hold gender preferences, the expectations of the family or community can contribute towards psychological distress:

'You know first pregnancy when you get a son in our culture it's a huge blessing, it's like everybody value you more. If you have a first daughter there, are you know some problems in our culture. Culturally a son is considered more powerful and more blessed and everything' (Lamba, 2015)

'Mother-in-law wasn't very happy, made some comments about, erm, oh, it should have been a boy kind of thing, and I think that erm, when I think back now in the back of my mind, I really, it hurt a lot like my second wasn't going to be good enough' (Zahid et al., 2022)

Some mothers perceived their psychological distress to be a punishment from God, due to their past perceived sins. This may indicate that such illnesses are out of their control and with a perception that the illness is more difficult to treat or manage.

'Sometimes, I think I am being punished by God for what I did to my dad, making him upset you know, getting married without his will. That's why, even though I've got kids now, healthy kids, I'm still not happy' (Khan et al., 2019)

Other perceived causes reported included marital issues, financial stressors, unintended pregnancies, traumatic childbirth, and past unresolved traumas. In this particular quote highlighting marital issues, the mother is stuck in between wanting to separate from her husband but also being aware of potential consequences regarding the upbringing of her children. An inner conflict is present, and a hopelessness of the situation which may contribute towards psychological distress:

'When I see my life, I feel like throwing him out of the house before dark. But when I see him with the kids, I can't do that. He is there for them. Tomorrow if I separate and I can't provide for my kids and they go astray, what will I do? If they start staying out till late, how will I discipline them? What would I do if they don't listen to me?' (Khan et al., 2019)

Table 4. Studies reporting symptoms of psychological stress

Study	Psychological/EPDS mapped	Somatic	Other
Hanley (2007)		- weakness - pain - problems of the heart.	
Khan et al. (2019)	- panic attack (item 4)	- shivers - heart thumping - constant migraines	
Parvin et al. (2004)	- feeling 'restless or without peace' in their minds (item 4) - feeling sad (item 8) - feeling tearful (item 9)	- aching heart - trembling heart - feeling pressure in the heart	- feeling bad or angry - not getting any comfort from looking after their children.
Templeton (2003)		- general slowing down & feeling lethargic - stomachache - pains in the chest - pains in the heart	- finding it harder to speak, also made it difficult to communicate their problems.
Wittowski et al. (2011)	- symptoms labelled as postnatal depression - thinking too much (item 4)		- something in your head - head not working properly - head feels like going to explode -feeling of tension
Lamba (2015)	- feeling low (item 8) - crying (item 9)	- feeling tired - experiencing headaches	- experiencing nightmares - spiritual disconnect - hating everything
Moghul (2018)		- head feeling burdened	- feeling lonely - feeling angry - stressed

2.3.5. Barriers to help-seeking

Several barriers were identified across the included studies preventing women from seeking support for their psychological distress. This included a mix of cultural and structural barriers.

Cultural codes of conduct and stigma

The topic of pregnancy and childbirth were viewed by some as taboo, even to discuss amongst women. This suggests a level of silencing, that women are not allowed to discuss certain experiences or knowledge:

'It is very disrespectful to discuss these things in front of your mum. We call it 'Sharam' (respect, honour)' (Hanley, 2007)

Topics related to women's body, which also extends to the psychological in this case, are stigmatised. The female body is connected to concepts such as respect and honour. In South Asian cultures this is often referred to as *Izzat*. Studies demonstrated that these concepts were used as a method of preventing women from speaking about their psychological distress, within family and outside of the family.

'Keeping face and maintaining the family honour results in a lot of things being kept hidden and a need to maintain appearances within the community and thus issues such as mental health problems can be covered up' (Khan et al., 2019)

The theme of silence continues even without the mention of honour and shame. As demonstrated in the quote by Wittowski et al. (2011), there is an intrinsic expectation for women to be content and happy in whatever situation they are in, thus acting as a barrier for seeking support.

'I do know that there are others in our culture that have to keep what they really think and feel to themselves just to keep other people happy, such as their husband or in-law. We should be grateful for what we have' (Wittowski et al., 2011)

Others spoke about the mish-map of cultural and religious beliefs, as some families justified women's silence under a religious framework:

'Our religion (Islam) states that you should not suffer with illness, but that you should speak up ... We think one thing [culturally], but we should be doing another. [In Islamic], we should speak the truth' (Moghul, 2018)

This also emphasizes that in some families, if a cultural practice suits their overall purpose (i.e., keeping women's issues hidden, preventing their voices from being heard), then religious beliefs counteracting cultural beliefs may be ignored or given less attention. This links in with the stigma surrounding maternal mental health, which was another reported barrier for help-seeking. In some studies women associated help-seeking with their children being taken away if they disclosed feelings of psychological distress to health professionals. Mothers perceived judgment from health professionals and a fear of being labelled as a bad mother.

'It was really hard to go to my GP, I kept thinking will he say I am bad mother? Look at that Bengali woman, why they have so many children? It's all her own fault' (Wittowski et al., 2011)

Stigma of maternal mental health was also experienced within family members, which led some women to seek support in secret. This indicates a need to perhaps tailor interventions in a way which does not overtly appear to provide support for women with postnatal depression, in order to de-stigmatise the process of help-seeking and increase uptake of services.

'I mean if my husband finds out that this is a group for (depressed) women, he's not going to let me come to it' (Khan et al., 2019)

Lack of culturally sensitive services

In addition to stigma and cultural barriers, language barriers made it difficult for mothers to seek support and navigate services. Lack of interpreters meant that new mothers could not benefit from any of the information they were receiving or in turn ask questions, due to communication barriers:

'Sometimes when you have a baby, a woman comes from the hospital. Bengali girls don't come with the midwife, we don't understand what they say, we just sit there staring at their faces' (Templeton et al., 2003)

Navigating the health system can be a time-consuming and overwhelming process for an English speaking person who is experiencing psychological distress. Difficulties are heightened in non-English speaking women who may also be unfamiliar with the structure of health services in the UK. The impact of this is highlighted in this quote:

'I need help and support zarroorat hey [desperately needed], my husband left me in pregnancy, and I have nobody, my family are in India. I can't speak English properly, and I can't read English to fill out forms. My GP says go the HV and HV says go to GP. I don't know what to do, I need help, don't know where to go, or who to turn to' (Wittowski et al., 2011)

There is a back and forth dialogical structure present as the new mother recalls being sent to one health professional for support, just to be sent back to another. This indicates lack of support and feelings of helplessness, as authority figures (health professionals) are seemingly unable to signpost and direct to relevant support services.

In one study, a woman reported feelings of discrimination from health services, due to her ethnic background. Not feeling heard by health professionals and was instead made to feel like a timewaster, which led to a negative experience of help-seeking in primary care settings:

'I got answers from professionals like, there is nothing wrong with you, go back home stop disturbing us, basically you are wasting our time, and they were horrible. It was a doctor that said that to me, my husband was sat with me that day as well. I don't know if they would have said that if I was white' (Wittowski et al., 2011)

In addition to perceived discrimination, treatments were deemed to lack cultural sensitivity as they did not consider factors such as ethnicity-matched therapist-client dyads (Khan et al., 2019). At the same time, Lamba (2015) found that disclosing information to a health professional from the community can lead to a breach of trust and confidentiality.

'I was very angry with her and disappointed with her, she was one of my mother-in-law's friends, she told my mother-in-law everything and I didn't like

that. I think it's wrong. Even if she was my own aunt or mother or something, she had no right to tell anyone what I told her' (Lamba, 2015)

In such cases, a person-centered approach is encouraged as each client will have their own lived experiences and preferences regarding how important factors such as ethnicity, religion and gender are to them in relation to therapy and therapy outcomes.

Structural barriers

Across the studies included in this review, mothers reported that the role of health visitors and midwives was to primarily check the health and wellbeing of the infant and/or offer advice regarding physical acts of mothering such as how to put on a nappy for example. They were not viewed as professionals who dealt with emotional or psychological issues, one of the reasons being that such issues were not broached by health visitors or midwives.

'If the midwife comes, doesn't do anything. Just checks the baby and goes. 'Is the nappy on right? Is that OK?' (Parvin et al., 2004)

'The health visitor didn't ask us these things (about emotional problems) when they came to visit' (Parvin et al., 2004)

This indicates that as such topics were not asked during these visits, women felt unable to speak about them or that such context was not appropriate. It is possible that health visitor practice varies across regions, as some women may be asked about their emotional and psychological wellbeing and not others. This would suggest health inequalities and a need for standardised care across the nation.

2.3.6. Managing psychological distress

Across the included studies in this review, mothers reported varied ways in which they coped with their psychological distress.

Pharmacological intervention

Across studies there was a reluctance in taking medication to manage symptoms. Medication was seen as symbol of not coping with motherhood, and mothers feared

their children would be taken away as a result (Templeton et al., 2003). Medication was also viewed as masking feelings and not addressing the underlying issue:

*'Anti-depressants as "numbing the pain" rather than addressing the issue'
(Khan et al., 2019)*

In other cases, mothers felt they needed medication to help cope, but family members prevented or disliked this form of treatment. This led to further distress:

'My mother-in-law in the beginning she was kind of like "oh you need to get off the medication, you know get off the medication" and that would really annoy me' (Sihre, 2019)

Stoic approach

Emotional and psychological problems were sometimes dealt with in a stoic manner. Stoicism is a school of philosophy from ancient Greece and Rome, with the modern concept of stoicism underpinned by denial, suppression, and control of emotions (Wagstaff and Rowledge, 1995). In the quotes provided, looking after the children was viewed primarily as the role of the mother:

'They [my children] are mine ... I should look after them ... not going to be babies for ever' (Templeton et al., 2003)

This may indicate gendered expectations within households, and failure to uphold gender roles may lead some mothers to feel not good enough. To avoid being labelled as bad mothers or mothers who cannot fulfil their role, women chose to keep their psychological distress hidden. There is an expectation from mothers themselves that everyone experiences difficulties, but this does not excuse neglecting motherly duties.

'There's no point talking about this problem because everyone has to do it, it's what women need to do, they have to do it' (Parvin et al., 2004)

Religion

As reported earlier in this chapter, some mothers perceived the cause of their psychological distress as coming from God. Symptoms included evils voices which only the mother experienced. To help manage these voices, mothers prayed to God and tried to avoid allowing these voices to manifest, which could lead to greater

severity of psychological distress. However, prayer offered support only short term and the distressing voices returned:

'Religion (Islam) says it is like waswasah (evil satanic whispers), do you know what waswasah is? In our religion we call it satanic whispers, and we pray to our god to make them go away. We shouldn't think about them. I pray namaaz [a particular prayer] and I feel better for a while, and then I start thinking again' (Wittowski et al., 2011)

Other symptoms of psychological distress after birth, such as worry, sleep problems and sadness were perceived to reflect possession of evil spirits, known as *Jinn*:

'He [religious healer] prayed over an amulet and sealed it with wax. Why it works is because I believe it will work. In my home village they would do 'house medicines' – specialised, then they tell you what to do – pray and that. If one was available in this city, I would go to him' (Hanley, 2007)

In this example, symptoms were understood and treated under a religious framework, as they treatment was prayer and use of amulets. The mother mentions something key, that this form of treatment works because she has belief in it. This can also be contrasted to the placebo effect, that if you believe in the effect of something, psychologically it can make a difference to your wellbeing.

In this section, the themes and sub-themes of the scoping review have been presented around British South Asian women's experience of motherhood and psychological distress after childbirth.

2.4. Discussion

The aim of this scoping review was to synthesise qualitative studies exploring motherhood and psychological distress after childbirth, in British South Asian mothers. Qualitative studies were chosen to develop a greater insight into the lived experiences of British South Asian mothers. This approach aimed to enrich findings from existing qualitative studies, with the aim to inform evidence-driven practice. The synthesis of these nine studies developed four themes 1. Experience of social

support; 2. Experience and understanding of psychological distress after childbirth; 3. Barriers to help-seeking; 4. Managing and coping with psychological distress after childbirth. These findings will now be discussed in the context of wider literature.

It is firstly important to note that this scoping review has identified that limited research exists on motherhood and psychological distress after childbirth in British Pakistani-Muslim women. This population will be the focus of this thesis, the background of which has been discussed in the introductory chapter and supplemented by the findings of this scoping review.

This scoping review found that British South Asian women were more likely to attribute socio-cultural causes to their psychological distress, compared to bio-medical explanations. Perceived causes are likely to shape an individual's approach to managing their symptoms. A preference for a directive approach to managing symptoms, with practical solutions, was found in this review. This indicated a preference for non-pharmacological interventions for managing psychological distress after childbirth, with a focus on the social context.

A lack of culturally sensitive care at the first point of contact, usually in primary care services, was found. Women felt dismissed, misunderstood, and discriminated against. This acted as barriers to help-seeking. Culturally adapted interventions for British South Asians with various types of depression have found to be effective (Masood et al., 2015; Mir et al., 2015; Mir et al., 2019). However, it is equally important for services which are first point of contact to be trained in provided culturally sensitive support.

In this scoping review, the EPDS was the most used screening measure to identify British South Asian women with postnatal depression. Women described their symptoms of psychological distress, a small number of descriptions represented experiences found in the EPDS. However, the majority of descriptions fell under somatic descriptions and experiences outside of the EPDS. This indicates that the EPDS may not accurately capture experiences of British South Asian women, which runs the risk of under-diagnosis. Despite studies using this screening measure, the EPDS has never been formally validated for use in British South Asian women during

the postnatal period, thus we cannot be certain as to how reliable or valid the screening process is.

The EPDS has however been adapted, validated, and translated in various languages and populations and much work has been conducted around assessing the quality of these adaptations. Shrestha et al. (2016) conducted a systematic review, assessing the quality of formally validated local language versions of the EPDS in low and lower-middle income countries. The review found that diagnostic protocols and screening measures had not been culturally adapted appropriately, thus there was a risk that local populations may not understand or relate to some of the items.

A more recent scoping review by Salehi et al. (2023) explored cultural adaptations and accuracy of the EPDS during the perinatal period, in both mothers and fathers in East Asia, Southeast Asia and South Asia. Issues in translating items was highlighted as some languages were found to be grammatically and structurally complex, making literal translations difficult to understand. Another key finding was the influence of culture on emotional expression, with some east Asian cultures possessing limited vocabulary for emotions, and emotional expressions being dependent on societal norms. This highlights the need to study specific populations, to understand cultural expectations of managing and expressing psychological distress.

The EPDS does not capture somatic symptoms as such experiences were originally considered to occur as a normal reaction to pregnancy and childbirth. Other screening measures for major depressive disorder have also been utilised to detect postnatal depression, such as the PhQ-9. The PhQ-9 does capture some somatic related experiences such as trouble sleeping, lacking energy, trouble with appetite. However, the type of experiences found in the current review are not currently captured by either the EPDS or the PhQ-9. This includes various references to the heart and head. Various studies have compared the factor structure, reliability, and validity of the PhQ-9 and EPDS to determine which measure should be used to screen for PND, many of which recommend the EPDS (Stefana et al., 2023; Park and Kim, 2023). Despite these recommendations, the issues around cultural appropriateness and relevance of the EPDS still remain. To address these issues, it

is important to conduct qualitative research with specific populations to understand how they express and understand their psychological distress after childbirth.

Another key finding was around the level of family social support during the postnatal period, and the impact of this on maternal mental health. Women's own mothers played a key role in the provision of practical support, which aided recovery and transition into motherhood. It is common for South Asian women to spend the early weeks of the postnatal period in the care of their own mothers. A qualitative study by Kandasamy et al. (2020) explored optimal perinatal mental health from the perspectives of South Asian grandmothers. Grandmothers represented a knowledge source of how to take care of the infant and advised new mothers on how to maintain their own health post-birth.

In contrast, emotional support from family members was reported to be lacking across studies. Women reported feeling misunderstood, judged and with the expectation to remain stoic and to 'get on' with motherhood. This links back to the intensive mothering discourse (Hays, 1996) introduced in chapter one, which defines motherhood as being child-centred, selfless, and joyous. Voicing a paradoxical experience to this was not encouraged and those that did were often blamed for feeling this way. Similar results were also found in a study by Taylor et al. (2021), which explored isolation and loneliness in women with perinatal depression. Women of minority ethnic background reported being blamed by family members for feeling distressed. These types of family reactions prevented women from seeking support.

This scoping review has identified generational differences in how psychological distress after childbirth is understood, however further work is required to develop a more nuanced understanding. The influence of rurality and rural identity on understanding of mental health is an under-represented research area across populations. In the South Asian population, existing research associates' differences in the construction of mental health to ethnicity (Fenton and Sadiq, 1996; Anand and Cochrane, 2005; Karasz et al., 2019). A large proportion of research directly examining the influence of rurality and mental health has focused on the rural Australian population. Cheesemond et al. (2019) conducted a qualitative systematic

review exploring the role of rurality and rural identity in mental health help-seeking behaviours, in Australia. The findings of the review suggested stoicism as a barrier to help-seeking. In the context of mental health, stoicism refers to the endurance of psychological distress, pain, or hardship without externally showing these feelings and without complaint (Kaukianinen and Kölves, 2020). Female centric studies in the review suggested silence as a desirable trait in women and in adherence to cultural constructions of a 'good woman'. The factors mentioned in the review by Cheesmond et al. (2019) namely stoicism and silence in women was also found in the current scoping review. However, these studies did not explore rurality.

Further research by Magnus and Advincula (2021) conducted an ethnographic analysis of the lived experience of mental health in rural Australia. Community-level barriers to help-seeking were identified, such as being ostracised and stigmatised for experiencing mental health issues. The rural community felt a need to protect their image by keeping 'unattractive' social problems hidden. In South Asian and other ethnic minority communities, stigma towards perinatal mental health is also rife. Wittowski et al. (2017), conducted a meta-ethnography exploring migrant women's experiences of postnatal depression. Family members labelled suffering women as weak and viewed them as moral failures for experiencing psychological distress/postnatal depression. Some ethnic minority communities struggled to understand the legitimacy of psychological distress post-birth, as 'postnatal depression' was believed to not occur in their native countries. Thus, it was viewed as a "White woman's illness". Whilst these findings highlight cultural differences and norms regarding mental health, the element of rurality is ignored amongst South Asian research on psychological distress after childbirth. It is important to delve deeper into how family members react to disclosures of psychological distress post-birth, whilst paying attention to the neglected area of rurality and rural identity. This is relevant to British Pakistani-Muslim's, as it is estimated that 60-70% have roots belonging to the Mirpur district of Pakistan, a rural area (Werbner, 2005).

For some British South Asian women, traditional resting periods were part of their postnatal care. However, a structure for this was lacking in the UK context. Research has found that support structures tend to be readily available in South Asian

countries as such practices are embedded within the norms of postnatal care (Withers et al., 2018). For resting periods to be implemented and be effective, the active ingredient is social support (Lee et al., 2004; LeMasters et al., 2020). This has shown to be difficult for migrant women who may not have sufficient social support available to them. For South Asian women who have been socialised to accept, adopt, and put their trust in cultural postnatal practices, being unable to adhere was found in this review to be psychologically distressing.

The experience of cultural postnatal practices has largely been explored within the context of migrant populations. Thus far, it is understood that migrant women find it difficult to implement such practices in the UK without social support. Further research is required to understand how widespread cultural postnatal practices are in the UK, amongst Pakistani-Muslim mothers living in the UK (migrant and British born). In addition to this, further research is required to understand experiences of cultural postnatal practices, including the risks and benefits when cultural practices are implemented in cross-cultural settings.

This scoping review found poor partner support during the postnatal period, both emotionally and practically. The studies attributed poor partner support to traditional gender roles. Mothers were viewed as primary caregivers and expected to undertake the role without complain. Stigma was attached to South Asian males undertaking traditional roles attributed to women, such as cleaning and childcare duties. Unlike a paid job, motherhood duties exceed a 9-5 job, but their efforts reportedly went unrecognised and often critiqued by partners, a factor which led to postnatal depression. One of the reasons why partners may not respond in a supportive manner could be due to some South Asian men being sheltered from the realities of motherhood. This could be due the fact that this review found issues related to pregnancy, childbirth and motherhood were not even encouraged to be shared with other women. This relates back to cultural concepts of modesty and honour, which adds to the disempowerment of women on many levels, portrayed through various figures.

A gendered gap in the understanding of motherhood and childbirth is present in the literature, irrespective of culture and ethnicity. For example, Lee et al. (2019) explored loneliness in a sample of White, first-time mothers with professional backgrounds. Women reported poor emotional support from partners, who struggled to understand their experience of motherhood. Further research by Taylor et al. (2021) exploring isolation, loneliness, and perinatal depression in minority ethnic women found that partners struggled to understand their vulnerable state.

When conducting cross-cultural research, it is important to also highlight and appreciate other factors outside of culture and ethnicity, such as gender which may impact experiences and behaviours. This can help tailor how awareness campaigns and interventions are designed and delivered. This scoping review emphasised the importance role of partner support, which some women described as surpassing all other forms of support (Lamba, 2015). As this is something perceived to be important in women's recovery during the postnatal period, further research is required to understand how partners respond to disclosures of psychological distress after childbirth.

Traditional gender roles are typically widespread in households of lower socio-economic-status (SES). This is relevant for the current sample, who reside in deprived areas of inner-city Bradford. Thus, it would be useful to evaluate the role of traditional gender roles and how relevant they are in present time.

In this section, the main findings of this scoping review have been discussed in context of the wider literature. The research gaps thus far have been identified as conducting research with an under-served population, British Pakistani-Muslim mothers. This research will aim to develop a nuanced understanding of motherhood and psychological distress after childbirth in this population, by taking a thematic-dialogical approach. This approach will prioritise women's voices, a method previously not used in this field. The hybrid approach to research and analysis is documented in the methodology and methods chapters. This chapter will now focus on theoretical gaps identified, and how theory will be applied to the current research to develop a nuanced understanding of phenomena.

2.4.1. Women's Ways of Knowing model (Belenky et al., 1986)

The studies identified in this scoping review did not apply any theoretical frameworks to enhance understanding of women's experience of motherhood and psychological distress. The review has highlighted nuances in terms of key figures (own mother/partner/doctor) and their influence on knowledge production regarding childbirth, the postnatal period, including what knowledge can and cannot be shared by new mothers. Knowledge sources varied from generational sources, through gendered discourses and medical. The implications of these on how women make sense of their experience of motherhood, psychological distress and help-seeking require further unpicking. The Women's Ways of Knowing (WWK) model by Belenky et al. (1986) offers a useful framework for this. The WWK model is a developmental theory and model, which examines identity and intellectual development through 'ways of knowing'.

The WWK model was developed to address the gaps in the works of Perry (1999) in cognitive development and the works of Gilligan (1984) in moral/personal development in women. Belenky et al., (1986) aimed to understand how women viewed themselves and their relationship to knowledge. The model was developed based on interviewing 135 women from diverse backgrounds, which included women aged 16-60 from rural and urban backgrounds, varied socio-economic status, class, ethnicity, and education history. The WWK model consists of five knowledge positions: silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. A detailed description of what these knowledge positions represent are outlined in the methodology chapter. The WWK model acknowledges that gender, as a social, historical, and political category affects how women know what they know. Originally the WWK model (Belenky et al., 1986) was applied in educational settings, but it is not limited to this. Since its development, many works have been inspired by the WWK model (Goldberger et al., 1996) and it has been applied in various contexts. In recent examples, Iqbal (2021) explored research priorities in the area of obesity in Pakistani-Muslim women. Iqbal (2021) used a feminist participatory action approach to work with women as co-producers, empowering women to move through each knowledge position to develop

research outputs. This is one example of the flexibility of how the WWK model can be applied in research.

From my interpretation, a focus on knowledge positions of Pakistani-Muslim women will provide a greater insight into their experiences of motherhood and psychological distress, including decisions behind help-seeking. This includes information about how vocal women are about their distress to family members and/or health professionals. The WWK model has the potential to capture ambivalence and emotional complexities as it is possible that women may not cleanly fit into one knowledge position but may be situated across two or more. For example, if a woman believes her feelings are an illness but her family do not, this may result in ambivalence and tension around what route to take regarding help-seeking. Mapping women's experiences and behaviours to these knowledge positions may provide greater context behind the *why* of certain behaviours and decisions. The WWK model brings women's biographies and experiences to the forefront, which is one of the main aims of this research. Furthermore, the model was developed based on a diverse sample of women as documented above, making it suitable for the target population of this research. However, the suitability of the WWK model is something which will be tested and commented on in the discussion chapter. To enhance understanding of how women construct their psychological distress and subsequent behaviours, in addition to the WWK model, the Common Sense model (Leventhal et al., 1984) of health may prove useful.

2.4.2. Common sense model (Leventhal et al., 1984)

It has been established thus far that South Asian women face additional barriers to help-seeking for psychological distress after childbirth. Furthermore, the way in which Pakistani women understand their symptoms and subsequent behaviours may not always align with what is typically understood in the literature. How individuals understand their illness, including beliefs and expectations about their illness and symptoms is important. This is known as illness representations and can influence how one manages their illness and the decision to seek support. The Common-sense model of self-regulation (Leventhal et al., 1984) was first applied in health

research. It is now increasingly applied in mental health research, to understand how individuals view their mental illness and how these influence behaviours of self-management and health outcomes. The Common-Sense model suggests that there are five dimensions of cognitive illness-representations, outlined in Table 5.

Table 5. Common Sense Model (Leventhal et al., 1984)

Identity	How the condition is identified, such as label and symptom
Timeline	Perceived duration of condition; when it began and when it may end (short term or chronic)
Consequences	Beliefs regarding impact of condition on health and life
Cause	Perceived reason for onset/development of the condition
Control	Personal beliefs regarding ability to manage or control the condition and its symptoms

Illness representations are developed through lived experiences, including learnt information via health professionals, family, and media. Illness representations can be broken down into two categories which influence how an individual approaches, manages, and thinks about their condition. This includes threat-related and protective illness representations. Threat-related illness representations are associated with having negative beliefs about your condition, such as being chronic, causing severe consequences, and being uncontrollable.

Protective illness representations include beliefs that the condition can be controlled, is not long-lasting, and individuals tend to have a coherent understanding of their condition. Cannon et al. (2022) conducted a meta-analysis examining the common-sense model and mental illness outcomes. Threat related beliefs (negative illness representation) resulted in worse mental health outcomes and poorer self-management. Thus, protective illness representations led to better mental health outcomes and self-management.

The way mental health issues are understood by the individual and/or their community have shown to play a part in shaping illness representations. For example, Mak et al. (2014) applied the common-sense model to understand public

stigma of mental health issues. Culturally held beliefs of mental illness were associated with mental illness being less controllable, compared to psycho-social beliefs. When mental illness was perceived as less controllable, chronic, and incomprehensible, this was associated with greater stigma and lower levels of help-seeking. On the other hand, individuals who viewed mental illness as controllable were more likely to seek professional support. A similar pattern of illness representations was found in the study by Baines et al. (2013) which explored illness perceptions in mothers with postnatal depression. Findings indicated that mothers viewed their postnatal depression as having negative consequences and negative emotional impact but being time limited and controllable. Women with a less coherent understanding of their postnatal depression were more likely to view their postnatal depression as chronic, with many symptoms. Women who had a coherent understanding of their postnatal depression believed their own actions and treatment could control their symptoms. The studies outlined demonstrate that the Common Sense model is suitable and useful when applied in mental health contexts and could be used to predict health behaviours.

According to the Common Sense model, illness representations are not fixed and are constantly re-evaluated based on experiences. For example, symptoms of low mood after birth may be viewed as a normal part of motherhood, something which you will overcome in a week or so. In this case one may seek support from family and friends and partake in self-care. If symptoms persist, increase in severity and/or impact day-to-day functioning, the illness representations may be revised to consider psychological distress as something not within your personal control and to be longer lasting. Individuals with protective illness representations may decide to seek professional support, whereas individuals with threat-related illness beliefs may ignore their symptoms, become increasingly isolated, and in worse case scenarios self-harm or have suicidal ideation. Thus, it is important to understand mental illness representations as it can affect management and mental illness outcomes.

Existing mental health research utilising the Common Sense model has examined illness representation via measures such as the Illness Perception Questionnaire (Revised) (Weinman et al., 1996; Moss-Morris et al., 2002). This has shown to be a reliable measure to capture illness representations. However, in real life contexts, in South Asian communities, this scoping review has thus far demonstrated the

important role of family members in influencing help-seeking. Therefore, it is possible that illness representations in South Asian women are more complex when predicting health behaviours and may merge or conflict with illness representations of the family members. For example, a Pakistani-Muslim mother may display protective illness representations, which would indicate a greater chance of help-seeking and treatment adherence. This may be captured through a questionnaire but in reality, woman may face additional barriers such as family preventing help-seeking. I aim to utilise the Common Sense model to explore narratives around emotional ambivalence of illness representations and help-seeking. An understanding of this will be gained from narrative accounts of women to unpick personal illness representations, whilst also having access to wider information regarding family views and reactions to psychological distress after birth. The WWK model (Belenky et al., 1986) will be the central model applied in this thesis, supplemented by the Common Sense Model (Leventhal et al., 1984) in the context of illness representations. Together, these models will pay attention to voices of ambivalence and emotional complexities in the experiences of Pakistani-Muslim women. Details on how these voices will be captured and analysed will be discussed in the methodology and method(s) chapters.

2.5. Chapter summary

This scoping review explored motherhood and psychological distress after childbirth in British South Asian women, paying attention to key influencing areas such as social support, cultural postnatal practices, and barriers to help-seeking. Across the last 20 years, similar results are being published in the context of barriers to help-seeking such as poor social support and cultural barriers including stigma, for South Asian women. These findings are well established in the literature, and it is now the time to delve deeper. This will be achieved by paying attention to generational differences, the role of power, gender, and women's voice. The experience of motherhood is something which is underexplored within the Pakistani-Muslim (and wider South Asian) culture. The realities of motherhood and its potentially paradoxical nature are neglected, with stoicism and the good motherhood discourse perpetuated. Furthermore, qualitative research focusing on Pakistani-Muslim women's experiences of motherhood and psychological distress post-birth is

significantly lacking. As mentioned in the introductory chapter, it is important to study each culture and ethnicity in its own right. This will help deepen knowledge regarding unique experiences as well as highlight any universal experiences of motherhood and psychological distress. Although, it is acknowledged that these cultures operate and evolve within wider social, economic, ideological, and cultural contexts.

To my knowledge, the experience of motherhood and psychological distress after childbirth has not been previously explored in Pakistani-Muslim women living in Britain, in a way that draws on and prioritises the voice and lived experiences of these mothers. Through understanding experiences of motherhood and psychological distress, a greater awareness can be drawn in how to broach the topic of low mood after childbirth with this population and to ensure women feel supported. The next chapter will describe the philosophical positioning and methodological approach that will underpin this PhD study.

2.6. Research Questions

From the literature discussed, the following research questions/objectives have been identified:

1. How do Pakistani-Muslim women experience motherhood during the postnatal period?
2. How do family members react to disclosures of psychological distress after childbirth?
3. How do Pakistani-Muslim women understand and experience psychological distress after childbirth.

Chapter 3

Methodology

3.0. Introduction

It is evident from the literature review that whilst there is an increasing amount of cross-cultural research exploring maternal mental health, there are gaps in the current evidence base. Existing cross-cultural literature exploring postnatal mental health often addresses the topic under the medical framework, as 'postnatal depression' (Wittowski et al., 2011; Lamba, 2015). This may be the case because a label is available in the English language but is absent in many other languages. However, approaching the topic as 'postnatal depression' has positivistic connotations, even if the research claims otherwise.

Firstly, positivism is associated with quantitative research in which the researcher is independent from the study. Quantitative research is concerned with numerical data and research questions are quantifiable (Goertzen, 2017). In the study of postnatal depression, risk factors which may contribute towards psychological distress have been studied using quantitative methods (underpinned by positivism). The current study aims to speak to women and understand their experiences in depth. Experiential research is not suitable under positivism. Ontologically speaking, under positivism postnatal depression is viewed as something which is fixed and real, and thus assumes a universal experience exists. However, the literature review identified that postnatal depression as understood under a medical framework is not universal across cultures, but the nature of sadness or distress post-birth can be (Oates et al., 2004)

The philosophical bases of some existing studies such as Lamba (2015) claim to be social constructionist-critical realist but use medicalised language to research cross-cultural experiences of psychological distress. It is important for researchers to use terminology which is philosophically consistent with the underpinnings of their research. Furthermore, much of the current literature explores experiences of postnatal mental health with South Asian women in general, neglecting the study of specific ethnicities (Sihre et al., 2019; Arifin et al., 2020). As discussed in the introductory chapter, the term South Asian includes several ethnicities, with their own unique cultures and traditions during pregnancy, childbirth, and the postnatal period. Studying women under the umbrella term of 'South Asian' runs the risk of masking cultural and ethnic diversities that may exist between the various South Asian groups. Due to reasons discussed in the introductory chapter, the target study population for this thesis is Pakistani-Muslim women living in Britain. Despite the increasing population rates, little qualitative research exists exploring Pakistani-Muslim mothers' experience of motherhood and psychological distress after childbirth. These gaps have subsequently informed the research questions, philosophy, and method(s) of this study, which will be outlined and discussed in this chapter.

3.1. Positionality

Before approaching research, it is important for researchers to understand their positionality, as this influences how we as individuals understand and interpret the social world (Jacobson and Mustafa, 2019). Identifying, making transparent, and reflecting on aspects of your social identity relevant to the research is vital. These elements combined, make up your unique positionality which subsequently impact motivations for research and what research looks like in terms of design, data collection and interpretation of findings (Holmes, 2020). Understanding positionality can be a complex task for novice qualitative researchers. One reason for this is that some parts of our identities are fluid and constantly developing and changing (Naples, 2003). This is a particular challenge when conducting a PhD, as your thoughts and experiences are likely to develop throughout the years. It can

also be difficult to know which part(s) of your social identity was influential during which part(s) of the research process. This requires critical self-reflection. It is important for researchers to make their positionality transparent as this allows the reader to understand how data were produced and conclusions reached (Soedirgo and Glas, 2020).

Jacobson and Mustafa (2019) developed a novel tool known as the Social Identity Map (SIM) to enable researchers to map their identities and to engage in reflexivity regarding their positionality. The SIM is described as a starting tool as it allows the researcher to make initial steps in breaking down their positionality. The SIM gave me the tools to think deeper about my identities and how these can influence the research process. The SIM involves three tiers: tier one identifies broad areas of your social identity such as age, gender, nationality etc. Tier two requires the researcher to reflect on how these social positions impact their life and tier three requires deeper reflection to understand what emotions are tied to certain social identities. Identities of mine which I feel are most relevant to the topic of this thesis are presented in table six.

Table 6: Social Identity Model

TIER 1 Social Identities	TIER 2 How do these social identities impact my life?	TIER 3 Identify feelings that may be tied to the details of my social identity
Ethnicity: Pakistani (rural background)	Cultural conflict/clashes, ethnic minority	Discrimination societal and cultural
Gender: Female, Identify as a Woman	Gendered expectations	Limited/glass ceiling, cautious safety
Class/SES: working class	Education, aware of struggles	Knowledge & responsibility, awareness of how others live, grounded perspective
Nationality: British	A sense of privilege, knowledge and access of services, command of the language	Safety, security, laws
Age/Generation: Mid-Late 20s	New perspectives, desire for change	Empowered
Religion: Muslim	Identity, alternative perspectives on illness and help-seeking	Discrimination, cautious

Each identity is accompanied by some key words to describe how I feel the identity has shaped me as an individual. For example, in relation to my ethnicity, gender and nationality; I feel I have been subjected to gendered norms and expectations, which intersect with cultural norms that also endorse and reinforce those gendered norms and expectations. This was highlighted in chapter one and in some ways, I felt this has both limited as well as enabled me, as I had to be aware of and sensitive to cultural norms. For example, from a young age I was overtly made aware that I should not talk about personal matters relating to women. Or that men can get away

with things which women cannot, and women need to work harder to preserve a feminine and good image.

The identities highlighted in Table 3 have also influenced the approach to research and interpretation of findings. As a religious and ethnic minority in the UK, I understand that these factors can sometimes lead to health inequalities. Thus, one of my motivating factors was to elevate the female voice of marginalised communities via a qualitative approach, underpinned by the Women's Ways of Knowing model (Belenky et al., 1986). Cultural and religious background can also shape how we interpret our experiences. Thus, during data analysis these factors were of interest, as they can inform decisions around help-seeking and treatment preferences. This is important to understand within religious and ethnic minorities to develop culturally appropriate and sensitive services. Finally, being a second generation migrant Pakistani-Muslim woman, I understand that generational and cultural clashes can exist. These differences may act as barriers to help-seeking and thus were important to further understand in the context of the British Pakistani-Muslim community. These social identities will go on to influence the research process, including my world views, ontology and epistemology which will be discussed next.

3.1.1. Ontology

Ontology is the study of being and is concerned with the nature of existence and structure of reality (Crotty, 1998). In research, ontology refers to the researcher's view of the nature of reality and what can be said to exist. In the introductory and literature review chapters my views on the ontological status of postnatal depression were made clear, with discussions around medicalisation, eurocentrism, and colonialism. To reiterate, the concept of postnatal depression is underpinned by a realist ontology, the notion that something is real (Jenkins, 2010). From this perspective, beings are viewed as (passive) bodies who are likely to break down (postnatal depression) and can be restored through diagnosis and intervention (medication/psychological therapy). I am interested in the experiences of

Pakistani-Muslim women in regards to motherhood and psychological distress after childbirth. I am interested in social and contextual factors which shape experiences. Thus, I reject a realist ontology as this does not align with my research aims and understanding of this research area.

As highlighted throughout the chapters so far, beings are complex and so are their experiences and understandings of phenomena. As discussed in the earlier in this chapter, it is our social identities that shape our being in the world. Critique of realism gave rise to critical realism, which retains a form of ontological realism in the sense that a real world exists independent of our knowledge of it. Critical realism also accepts a form of epistemological constructionism as our understanding of the world is a construction from our own experiences and perspectives (Burr, 2015, Maxwell, 2012, p.5, Bhaskar et al., 1998). Critical realism is relevant to this research as it appreciates the complex and nuanced nature of being. The literature review, as well as the empirical chapters of this thesis (chapters 5-7) capture various types of beings. This includes conflicted beings, stoic beings, and beings who need support. Particularly in the empirical chapters, one thing that the women have in common is that they are dialogical beings. The internal (self) and the external (absent others) are fused as women negotiate and make sense of their being in the world (motherhood and psychological distress). The self includes internal positions, such as “I as a mother, wife, daughter, sister” and external positions “my mother, my father, my husband”. Basic processes such as conflict, agreement, criticism take place between the internal and external positions of being (internal example: I want to seek support for my distress but the voice of my mother in myself criticises me) (external example: the way I have been treated by my family when I have shared by distress prevents me from seeking support) (Hermans, 2013).

The dialogical being overlaps and interlinks with knowledge positions, such as the Women’s Ways of Knowing model introduced in the literature review. For example, at one point the dialogical being may experience positions

which silence and suppress other positions (example: my mother believes postnatal depression is not real, I cannot say how I really feel). In such cases there is only one-way communication, a monological relationship. This may lend itself to the position of 'silence' (Belenky et al., 1986). However, in other cases dialogue between internal and external positions may allow the self to develop. This happens when other positions are recognised and evaluated. A detailed overview of the Women's Ways of Knowing (Belenky et al., 1986) positions will be provided later in this chapter. For South Asian women, the literature review has highlighted cultural practices and traditions designed to facilitate the transformation into motherhood. However, various factors such as cultural and generational differences health knowledge may shape how these practices are experienced and how they impact the being. Our experience and being in the world intersects with our knowledge of it, known as epistemology which will be discussed next.

3.1.2. *Epistemology*

Epistemology is defined as the theory of knowledge and is concerned with how we know and what we know. Mainstream psychology attempts to universalise experiences, to reach one truth (Burr, 2015). As discussed in the literature review, knowledge, understanding and experience of motherhood and psychological distress after childbirth is shaped by various factors (gender, ethnicity, culture, socio-economic status). From a critical realist viewpoint, women in this study may not explicitly refer to gender or intra (family dynamics) and inter (relationships with medics) cultural relations, but these are historically grounded relationships which shape and underpin their experiences of motherhood and psychological distress. Thus, what we know and how we know is socially constructed, and culturally and historically situated (Burr, 2015). The literature review as well as the empirical chapters, demonstrate various ways of knowing. For example, one way of knowing is through cultural folk knowledge of childbirth and postnatal care (diet, postnatal practices, and rituals). Such knowledge is passed down by the older generation (own mother/mother-in-law) to aid recovery and intersects with *wellbeing*. The literature review indicated that cultural knowledge was a

trusted source for the older generation who deemed it their duty to pass down this knowledge to the younger generation (Kandasamy et al., 2020).

Culture and ethnicity are complex and cannot be easily defined (Eriksen, 2019). For example, knowledge and experiences of migrant Pakistani-Muslim women may differ from those who are British born. This is an important aspect in the present study epistemologically speaking. Examples of these shifts in knowledge are demonstrated in the literature review and empirical chapters. In some cases, shifts in knowledge positions resulted in conflict between relations, which were illuminated dialogically. Alternative knowledge positions were informed by the need for support, thus speaking to other women with similar experiences was an option. Interactions with trusted others led knowledge to be constructed and re-constructed, until knowledge had significant meaning for the individual. When knowledge was lacking and experiences could not be understood, knowledge was acquired through maternity and postnatal services. These potential shifts in knowledge positions between generations are interesting yet complex.

The Women's Ways of Knowing (WWK) model (Belenky et al., 1986), which will be explained in further detail in the next section, maps onto critical realism and will be useful in detailing how these shifts occur and what this looks like. The empirical chapters demonstrate how Pakistani-Muslim women in this study 'know' about motherhood and psychological distress within relational structures they are part of, but through dialogue they can also know outside of that structure. For example, a new mother may have been socialised to know that stressors are part of motherhood and that a stoic approach should be taken (intersects with being). However, through dialogue with other mothers and health professionals, a shift in knowledge which fits better with the new mother's experience may be adopted. From this, some women demonstrate agency and freedom in negotiating these frameworks, making sense of them, and re-interpreting them. Due to emphasis on voice and dialogue, dialogical epistemology is relevant, which is consistent with

critical realism and social constructionism. The empirical chapters go onto demonstrate nuances of this agency/freedom, which isn't without ambivalence and internal conflict, which is nicely demonstrated via the WWK model (Belenky et al., 1986).

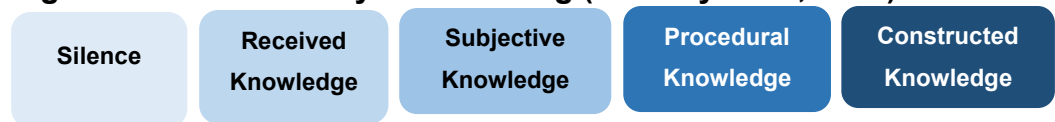
Thus far, through ontological and epistemological explorations, it has been established that Pakistani-Muslim women can view reality and construct knowledge in various, but specific ways which are distinct in their connections with their ethnic identity and culture. As a result, knowledge can be mutable and changeable throughout time and space. The fluidity of knowledge can be understood further using Bakhtin's chronotope, which pays attention to how time and space are represented in language and discourse, and the value we ascribe to them. This can include focusing on participant narratives where they refer to their past, present, and future or ascribing values and emotions to certain roles or tasks. In addition to chronotope, it is useful to pay attention to women's knowledge position(s) through the WWK model (Belenky et al., 1986). The model will develop a deeper understanding into how women know what they know, including their being in the world (their reactions and behaviours as per knowledge position). This ties in with the dialogical approach, which will illuminate epistemological and ontological conflicts, ambivalence, and paradox. The knowledge positions of the WWK model (Belenky et al., 1986) will now be discussed in further detail, including its theoretical and empirical relevance to the present research.

3.2. Women's Ways of Knowing

The WWK model (Belenky et al., 1986) acknowledges that gender, as a social, historical, and political category, affects the life choices of women in all communities and cultures. The WWK model was developed with the intent to describe different ways women know, but also how women are socialised to know. Several factors such as gender, culture, ethnicity, and early experiences influence how you know, what you know and how you approach

knowledge. In the literature review, the potential of the WWK model to capture ambivalence, conflict as well as self-development was discussed. This perspective can be enhanced further by delving into further detail of each knowledge position and its characteristics based on the study by Belenky et al. (1986).

Figure 2: Women's Ways of Knowing (Belenky et al., 1986)



- **Silence**

In the model by Belenky et al. (1986), silence is categorised by isolation, a fragile sense of self and fear of authorities. In the context of this research, authorities may include health professionals and/or family members. The literature review and empirical chapters reported barriers to help-seeking such as, fear of consequences. This includes fears around child being taken away or being labelled as an un-fit mother by authorities who hold positions of power, including social services and doctors. Authority figures may also include family members, such as a matriarchal figure. The matriarch usually holds power with the ability to dictate what knowledge can and cannot be shared/voiced and with whom, as well as what knowledge the new mother should implement during the postnatal period. The power that these authority figures hold, may render some women voiceless and powerless. Fear of consequences may lead to a profound lack of confidence in meaning-making and meaning-sharing abilities. Belenky et al. (1986) described women in this knowledge position to generally be younger, of limited education, low socio-economic status (SES), and may have experienced a history of abuse. Factors such as low SES, young mothers, and history of abuse are relevant to some of the women in this study. Almost all women had experiences with authority figures (health professionals and family members).

- **Received knowledge: listening to the voices of others**

Received knowledge is when the knowledge and words of authorities is received, repeated, and accepted as truth. For example, when psychological distress is medicalised as postnatal depression or accepting cultural knowledge of psychological distress during the postnatal period. Received knowers define themselves externally, usually in relation to social and cultural norms, gender roles and expectations. In this position, Belenky et al. (1986) state that women are likely to lack confidence in their own ability to speak and are less likely to critically analyse the information provided to them.

- **Subjective knowledge: the inner voice**

Subjective knowledge is characterized by the recognition of the self as an authority figure. Subjective knowers rely on their own subjective thoughts, feelings and experiences for knowledge and truth. For example, women may seek to explore alternate forms of knowledge, going beyond categories of 'silence' and 'received knowledge'. In such cases, knowledge which has been provided to them by others, may not resonate with their lived experience. According to Belenky et al. (1986), this epistemological shift is a result of the protesting inner voice. The inner voice may make women aware that other forms of knowledge and truth exist, allowing them to make their own claims to truth and knowledge. Subjective knowers may block out conflicting opinions of others and seek the support and affirmation of those in agreement. Belenky et al. (1986) interviewed 135 women and noted that half of the women occupied this position and across a wide age range.

- **Procedural knowledge: separate and connected knowing**

Procedural knowledge reflects the recognition that multiple sources of knowledge exist, and that procedures are necessary for evaluating the relative merit of these sources. Procedural knowers focus on methods and techniques for evaluating the accuracy of external truth and the relative worth of authority. Belenky et al. (1986) describes two alternative modes of procedural knowledge: separate knowing

and connected knowing. Separate knowers tend to be adversarial and focused on critical analysis that excludes personal feelings and beliefs. Connected knowers on the other hand seek to understand others' ideas and points of view, emphasizing the relevance of context in the development of knowledge and the fundamental value of experience. In the study by Belenky et al. (1986), most procedural knowers were economically privileged, Caucasian, young college students or graduates. These demographics are different to the sample of this PhD. Therefore, it will be useful to know if and how this epistemologically position is translated in the current sample of women.

- **Constructed knowledge: integrating the voices**

Constructed knowledge recognises the interrelatedness of knowledge, knowing and the knower. In this position, all knowledge is considered constructed, inherently mutable, and subject to time, experience, and context. This perspective makes the WWK model (Belenky et al., 1986) consistent with the social constructionist framework of this thesis.

Constructed knowledge involves critical self-reflection, in which women view knowledge as a constant process of construction, deconstruction and reconstruction. Women in this position were able to engage in what Belenky et al. (1986) referred to as real talk: the ability to listen, share and cooperate while maintaining one's own voice. The position of constructed knowledge often involves enormous "empathetic potential": a capacity to feel connected with another person despite potentially enormous differences. Belenky et al., (1986) found that many women in this position nonetheless experienced loneliness and discouragement, largely due to difficulty in finding companionable and supportive partners.

These five positions make up the Women's Ways of Knowing model (Belenky et al., 1986). The model emphasises that women have different ways of knowing based on their life experiences. This is synonymous with my worldview, that Pakistani-Muslim mothers in this study possess various identities and social positions such as being female, identifying as Pakistani

and Muslim, low SES, living in deprived areas of Bradford, and rural familial background. These identities intersect with each other to shape women's experiences of motherhood, the postnatal period and play a role in how they know and what they know. The novel use of this model will help contextualise experiences, delving deeper into how these knowledge positions shape postnatal experiences, and what this means for maternal mental health and help-seeking behaviours. The dialogical being has been discussed earlier in this chapter. I aim to pay attention to dialogical features in participants voice to develop deeper meaning and understanding behind their behaviours and knowledge positions. I propose that this will add to the theoretical development of the WWK model (Belenky et al., 1986).

3.3. WWK: Application to the research process

The literature review outlined how the WWK model has been applied in various contexts since it was originally developed (Goldberger et al., 1996; Iqbal, 2021). Research utilising the WWK model is often underpinned by feminist theory, pushing for a greater understanding of women's experiences, and amplifying their voices. Due to flexibility in how the WWK model can be applied, I will now make transparent how I apply the model in the current research study. This was twofold; WWK as a concept is used throughout the research process including data collection, analysis, and write-up. This reflected how I as a researcher applied each of the WWK positions to reach the aims of this thesis. As researchers, we are reliant upon methods and techniques to gain knowledge and create meaning. To understand how Pakistani-Muslim women experience motherhood and psychological distress after childbirth, it is essential to interact and communicate with the target population. This can be achieved via a qualitative approach. The WWK model is incorporated into this knowing process in relation to the researcher and the researched. The first position I

practiced was outer silence; my role was to listen to the narratives of women in this study. I spoke only when necessary to gain more information/knowledge. I participated in active listening, which involved repeating and summarising what was told to me to ensure I had an accurate and clear understanding of the information shared. This falls under the position of received knowledge.

To make sense of the knowledge provided, I was reliant upon the application of qualitative analysis, more specifically thematic-dialogical analysis. In the next section of this chapter, I discuss the compatibility of the two methods of analysis and their contribution to analysis when combined. The analysis process involved separate and connected knowing. Separate knowing in terms of analysing each case/interview separately and connected knowing by bringing together all themes to develop an overall picture of master themes and sub themes. The final product of this is presented across three empirical chapters (chapters 5-7). The final aspect of this PhD involves constructed knowledge, which is concerned with the interrelatedness of knowledge, knowing and the knower. To make sense of data, experiences were broken down into three empirical chapters, with a specific focus. Each chapter involved the integration of voices, which included the voices of women in this study (evidence/data) including micro dialogue (voices within dialogue of absent others) and the interpretation of those voices by the researcher (analysis/findings). The WWK model is also used to identify knowledge position(s) Pakistani-Muslim women fall under in terms of issues relating to motherhood, childrearing, cultural postnatal practices, and postnatal mental health. The type(s) of knowledge position will provide a detailed insight into how positions hinder or facilitate women's help-seeking and/or understanding of motherhood or psychological distress. Paying attention to knowledge positions and doing this through a qualitative, dialogical approach, will hopefully bring out nuances which have been previously missed or ignored in the literature.

3.4. Approach to research

To reiterate, the aim of this thesis is to explore the experiences of motherhood and psychological distress in a sample of Pakistani-Muslim women. The research questions include: 1. How do Pakistani-Muslim women experience motherhood during the postnatal period? 2. How do women perceive their family members to react to disclosures of psychological distress after childbirth? 3. How do Pakistani-Muslim women experience psychological distress after childbirth? The area of motherhood and psychological distress in ethnic minority women is an under-researched area, in qualitative research. Several socio-cultural factors discussed in the introductory and the literature review chapters can make it difficult for Pakistani-Muslim to voice their psychological distress and seek support. Women of ethnic minority backgrounds have also shown to face structural barriers including lack of culturally appropriate support and understanding of psychological distress in health services (Mir et al., 2019; Masood et al., 2015). This is one the reasons why I want to hear women's experiences, through their own words and giving them a platform to be heard (McGrath et al., 2019; Reeves et al., 2015).

Semi-structured interviews allow for the exploration of experiences, perceptions and beliefs related to the phenomenon of interest. This gives the participant a space to voice their personal experiences and to talk about what is important to them (within the parameters of the interview), without being restricted by structured questions. This provides a sense of flexibility for both the researcher and the participant and in some cases could help balance power dynamics. The topic of psychological distress after childbirth can be seen as sensitive in nature, which is one of the reasons why one-to-one semi-structured interviews are deemed most appropriate over focus-groups. The community in Bradford can be described as tight-knit, and the recruitment areas were limited to Born in Bradford Better Start (BiBBS) postcode areas (most deprived areas of Bradford). Therefore, it may have been possible that in a focus group women may have known each other or

may have had concerns around the confidentiality of their accounts within the community. A qualitative design and semi-structured interviews for data collection has been discussed. The approach to research will now be outlined.

As with many qualitative approaches and analysis methods, there is overlap in what these methods claim to do. The focus of this research is on Pakistani-Muslim women's experience of motherhood during the postnatal period and their experience and understanding(s) of psychological distress after childbirth. With this in mind, various approaches to research may be used. I will first discuss the narrative approach broadly to highlight the focus and then will discuss a form of narrative approach, which is known as dialogical. When participants talk about their experiences this can sometimes be categorised as storytelling, a term typically used in narrative research. A narrative approach to research pays attention to *how* stories are told, to understand *how* participants perceive and make sense of their experiences. There are characters (mother and family members) and plots (voyage and return, rebirth), which are very much present in current data-set. However, I am less interested in story-telling, and more interested in participant voices and dialogue to understand how characters are negotiated and how this influences 'plots' for new mothers.

A key feature of narrative research is reporting experiences or the story in a chronological order (Riessman, 2008). To some extent this feature is present in the current research as the experience of motherhood during the postnatal period is presented first and then any cases of psychological distress. However, this is more for clarity purposes as it makes sense to start with the experience of motherhood and then events which may contribute towards the experience of psychological distress. This chronological order of events also refers to the beginning, middle and end of a story. For women in this study, chronotope was sometimes cyclical or at least not linear. Thus, ordering events chronologically may miss nuances in experience. Bakhtin's

chronotope is an important aspect of this research as understandings and experiences of motherhood and psychological distress can evolve over time and space. Symptoms of distress may have been ignored in the past or understood as a natural part of motherhood. However, when reflected on in the present, the participants may choose to understand their experience under the medical framework for example. To understand temporal change is to understand how it was reached, through dialogue. The narrative presented in the introductory chapter was framed around a new mother, her child, and family members. This narrative highlighted gaps in understanding, such as lived experience of motherhood, relationship with family members, including any dialogue between the woman and family members during this transitional and vulnerable time. A dialogical approach is a form of narrative and pays attention to the voice. Dialogical features add depth to the characters and plots which are present in the data. A greater understanding of how experiences are told and what this represents in terms of meaning-making can be developed. The works of Bakhtin's chronotope and dialogue outline rhetorical features of discourse interpreted dialogically. Sullivan (2012) provides an in-depth overview of the dialogical approach, informed by Bakhtin's ideals. Some dialogical features relevant to the current research are presented in Table seven.

Table 7 dialogical features adapted from Sullivan (2012)

Dialogical features	Meaning
Internal critic	To question and doubt your own experiences and attitudes. The self can be divided against itself and take the perspective of others.
Hidden dialogue	Bringing in the anticipated voices of others, representing reservation and hesitation.
Micro dialogue	An internal dialogue with self, also known as private discourse. Also used when re-creating point of view of the other.

Sideward glance	Fearful of the judgment of others, also known as a disclaimer.
Stylisation	To agree with others.
Words with a loophole	To escape a definitive statement

These features are represented via ‘double voices’ also referred to as ‘absent others’, this is where the participant engages in a multiplicity of dialogue between the self and the other (Sullivan, 2012). This might be presented as the participant relaying the views, experiences, and positions of the other, as they relay their own views, experiences, and positions. This is something we all do in day-to-day dialogue whether we are conscious of it or not. The purpose behind this might be to justify our own views or actions or to present certain ideas as more accepted than others. The intonation and the way in which these absent voices are brought in also reflect the meaning and purpose which they serve. For example, when we are telling a story to someone explaining a situation, we may want to paint ourselves as ‘correct’ and the other as ‘incorrect’. By doing so we might be trying to achieve dominance within the narrative and dialogue or gain sympathy from the listener. This is a type of micro-dialogue which pays attention to the relationship between the self and dialogue of others. Such extracts are present in various studies exploring motherhood and psychological distress (Wittowski et al., 2011; Lamba, 2015) but are not paid attention to. By paying attention to dialogical features, it is possible to develop greater depth and meaning of the data.

Hubert Hermans (2001a:2001b:2002) theory of the ‘dialogical self’ introduces the concept of ‘self-self dialogue’, which consists of several ‘I-positions’. This is essentially an inner conversation with the self, through the recreation of voices. In the research context, the participant whilst engaged in an inner conversation with the self is also engaged in a parallel outer conversation with the researcher (Sullivan, 2012). When this type of dialogue is narrated in research interview settings it is of particular interest as there is potentially a

lot to unpack. In the context of this research I-positions may include the new mother and her family members. Through these I-positions and how they are represented within dialogue (micro-dialogue, double voices), we can begin to understand how the participant is negotiating and making sense of their experiences. Thus, dialogical features have the potential to uncover power relations, struggles for dominance, ambivalence, and ambiguities (Sullivan, 2012). These are relevant to the current research, which takes an intersectional approach which pays attention to factors such as culture, ethnicity, gender, and generational differences to understand experiences. A dialogical approach to research has been outlined, it is now worth discussing methods of analysis.

Analysis

When choosing methods of analysis, some important points to consider include, philosophical paradigms, analytical frames, application and the researcher's role and power balance. At the beginning of this chapter the epistemology (social constructionism) and ontology (critical realism) was made transparent. Due to this research topic being an under-research and under-developed area, the aim of analysis is to develop a rich description of the data-set. The research questions of this thesis are focused on experience (experience of motherhood, the postnatal period, and psychological distress). From this statement alone a range of analyses might be relevant including narrative and thematic analysis.

As I have discussed narrative research, it will be worth outlining narrative analysis and my reasons for not using this as a method of analysis. The narrative approach is not only a methodology but also a method of analysis. Narrative analysis identifies key moments in unfolding events and is focused on plots, storylines, and temporality. Within these storylines are characters, and the analysis is focused on obligations of each character, conflicts, resolutions, and an evaluation of that storyline. In other words, the beginning, middle, and end of a story. In the context of the present study, the characters

include the new mother, family members, neighbours, and health professionals. In some cases, the new mother may be viewed as vulnerable or a victim and family members as antagonists who fail to support the new mother in her time of need. How this is then navigated by the new mother could then be explored sequentially. In therapy contexts, therapists might be viewed as heroes and the distressed mother as the beneficiary. This may provide insight into transformations which tell us more about the meaning of events and roles. I will now go on to discuss thematic analysis, before comparing both methods. The aim of thematic analysis is to identify, analyse and report patterns (themes) in data (Braun and Clarke, 2006). From this, we can develop themes around how women experienced motherhood during the postnatal period and their experience of psychological distress after childbirth.

Narrative and thematic analysis converge in terms of how actors are portrayed, for example the new mother being in a vulnerable, subordinate position, with help-seeking being made difficult by generational differences in the understanding of psychological distress. Both methods give voice to the participant, and their experiences and meanings of events are honoured by the analyst. Key areas of divergence include the analytic purpose. For example, thematic analysis is concerned with action and meaning across cases, made possible by decontextualising the data. Narrative analysis is concerned with key moments in unfolding events. The analytic focus of thematic analysis is foregrounded in patterned, recurrent communicative practices. The analytic focus of narrative analysis is foregrounded in the underlying narrative structure, participants' roles, and obligations as they emerge from unfolding events in the plotlines. A comparative paper by McAllum et al. (2019) nicely demonstrates how thematic and narrative analyses author the same data differently. Indeed, a narrative analysis of the current data would produce a fascinating and insightful story and analysis. However, given that the aim of the research is to provide a richly textured description of situations, events, actions and experiences, thematic analysis is most appropriate compared to narrative analysis.

It is also worth providing a comparison of thematic analysis and Interpretive Phenomenological Analysis (IPA). IPA is widely used in counselling and psychotherapy research (Lamba, 2015). The goal of IPA is to understand how people make sense of their lived experience and seeks to explore the individual-level embodied experience. To achieve this, an idiographic approach is taken which means that each case is analysed in particular detail, unpicking individuals meaning making about their experiences (Smith et al., 2009). This is achieved by coding and developing themes for each case, before developing themes across cases. Thus, IPA is most suited to answer research questions around lived experience and sense-making, which usually requires homogenous samples. The current study has a heterogenous sample, as some women (9/17) did not have experience of psychological distress after childbirth, and some did (8/17). Thus, I am interested in lived experience in a sub-sample of women but have other areas of interest outside of personal lived experience. This includes understanding treatment and support preferences across the entire sample, as well as their understanding of postnatal depression.

I am also interested in locating women's experiences within wider social-cultural contexts. Taking a Women's Ways of Knowing (Belenky et al., 1986) informed approach is one way I have analysed and interpreted the findings. Locating women's experiences within cultural contexts helped understand the challenges British Pakistani-Muslim face during the postnatal period and what may contribute towards psychological distress. My knowledge and understanding of the culture via my partial insiderness informed the research process and analysis, through a social constructionist-critical realist lens, personal experiences are not isolated from context. They are influenced by social and cultural norms and beliefs, which can include family and community influence, level of education and religion. This approach is different to IPA which encourages bracketing, putting aside personal understanding of phenomena or reflecting on these prior to data collection and/or analysis (Smith et al., 2009).

In terms of data source, interview method only was used which is suited to both IPA and thematic analysis. The analytic focus of IPA is dual, as it is both idiographic whilst also identifying themes across the data set. Thematic analysis focuses on the latter only. With the larger sample size of 17, which is typically not suited for IPA, patterned meaning across cases was the aim of analysis. Developing a wider understanding of the experiences of British Pakistani-Muslim women during motherhood and the postnatal period was the goal. See Table 8 for a comparison of IPA, thematic analysis and its relevance to my research.

Furthermore, this PhD essentially conducted one study of a topic that is multi-faceted. There were three main research questions: 1. How do women experience motherhood during the postnatal period? 2. How do family members react to disclosures of psychological distress? 3. How do women understand and experience psychological distress after childbirth. I decided that I wanted to conduct an in-depth, interpretive analysis of the research questions. These research questions are very much connected to each other and can be answered within the chosen sample and sample size. Each research question is presented as a chapter, which allows for a detailed analysis, insight and understanding of each research question. Arguably the sample with lived experience could have been conducted as a separate study. However, using the same topic guide across the samples allowed for an in-depth understanding and comparison as to why some women developed psychological distress/postnatal depression, whilst others did not. Furthermore, it is worth noting that the transfer to PhD panel suggested a focus on one larger qualitative study, in order to develop a deeper insight, over multiple smaller studies with less depth. With a sample size of 17 I was able to capture some diversity within experiences and highlight these in each of the chapters. Due to these reasons, a thematic analysis is considered most appropriate, compared to IPA.

Table 8. Comparison of IPA and thematic analysis

	IPA	Thematic Analysis	Features of the study in this thesis
Sample size	Smaller samples (homogenous)	Suitable for larger sample sizes (10+) and can be heterogenous	Sample size of 17 and heterogenous (lived experience and without)
Research aims	Lived experience	Lived experience and other research questions which are not about personal experience or meaning-making.	Aim to capture lived experience but also other research questions around preferences for support, treatment and knowledge of postnatal depression.
Analytic focus	Idiographic focus and patterned meaning across cases	Patterned meaning across cases	Patterned meaning across cases
Researcher's knowledge and understanding of phenomena	Bracketing	Locating experiences within wider social-cultural contexts	Aim to locate experiences within wider social-cultural contexts (Pakistani-Muslim, British, Gendered contexts)

Thematic analysis is a widely used approach in psychology and health research. One reason for its popularity is theoretical flexibility, making the analysis method suitable for many research studies. For example, thematic analysis can be used in essentialist/realist designs and constructionist. The key is for researchers to clearly document the analysis process and ensure each element of thematic analysis is theoretically consistent. Braun and Clarke (2006) identified that many studies claim to use thematic analysis but are not always transparent in their process. Prior to 2006 this was put down to lack of guidelines. This led Braun and Clarke to develop a set of guidelines, which is widely referred to as the 'Braun and Clarke's (2006) approach to thematic analysis'. The 2006 paper has been cited over 140,000 times. Due to such popularity, Braun and Clarke have since reflected on their approach to thematic analysis and continue to provide updated reflections and guidance. For example, in a 2019 paper Braun and Clarke address their approach as a 'reflexive thematic analysis' and emphasise the researcher's

role in knowledge production. Braun and Clarke (2019) re-addressed vital elements outlined in the 2006 paper and pushed the researcher to actively engage and reflect during the process of thematic analysis. Braun and Clarke (2020) outline three versions of thematic analysis: coding reliability, codebook thematic analysis, and reflexive thematic analysis. Coding and codebook thematic analysis use coding frameworks/books to guide the analysis process. Qualitative analysis via code books and coding frameworks are widely used in applied health research (Dickerson et al., 2021; Bower-Crane et al., 2019). A reflexive approach embraces qualitative values and subjective skills the researcher brings to the process of analysis. Thus, a research team in terms of coding and theme development is not desired or required for a reflexive approach. The current study adopts a reflexive approach to thematic analysis. To ensure clarity and transparency of my thematic analysis, I have outlined my specific approach in Table eight. Furthermore, Braun and Clarke developed a resource for editors and reviewers of thematic analysis papers, to facilitate quality in thematic analysis. This includes a set of 20 critical questions (see Appendix 10). This has been used as a guide to ensure quality in my thematic analysis.

Table 9: my approach to thematic analysis

Vital elements for a quality (reflexive) thematic analysis	My approach
Rich description of data set OR detailed account of one particular aspect?	Rich description of data set
Approach to thematic analysis: Inductive or deductive?	<p>Majority inductive. An inductive approach means themes are strongly linked to the data. Data is coded without trying to fit into a pre-existing coding frame. This type of thematic analysis is data-driven. An example of this is themes around ‘the experience of motherhood during the postnatal period’.</p> <p>To add additional context to the wider qualitative findings, a deductive approach was taken for specific areas of interest. This includes ‘how many participants have heard of the term postnatal depression’ ‘what type of treatment for distress do participants prefer’.</p>
Level at which themes identified: Semantic or latent level themes?	<p>Themes identified at a semantic level produce surface level meaning, not looking beyond what the participant has said. This produces a descriptive analysis. Themes in the current study were identified at the latent level, which goes beyond surface meaning. This is done by identifying underlying assumptions,</p>

ideologies, and conceptualisations. Thus, this is an interpretive approach. Latent themes were developed by looking at the data through the lens of the Women's Ways of Knowing model (Belenky et al., 1986), Common sense model of self-regulation (Leventhal et al., 1984) and an inter-sectional approach paying attention to culture, ethnicity, intensive mothering discourse, and generational differences.

Epistemology

Constructionist, which views meaning and experience as socially produced and re-produced. Focusing on the socio-cultural context.

The core method of analysis is thus established to be reflexive thematic analysis, supplemented by a dialogical approach. As IPA has been compared against thematic analysis, it would be worth shedding some light on IPA and dialogical analysis. Both IPA and dialogical analysis focus on lived experience, however dialogical analysis emphasises the self-other viewpoint. One of the main differences of IPA and dialogical is that dialogical focuses on voice feeling truth (Sullivan, 2012). There are also differences in how data is analysed. As discussed, the main mode of analysis is thematic analysis, which focuses on patterned meaning across cases. IPA is concerned with reading of whole text to generate themes via hierarchy. Discourse analysis on the other hand is focused on coding utterances in terms of genre, chronotope and emotional register. Through this form of analysis, women's voices are amplified as we pay attention to various dialogical features to understand experiences and meaning.

As stated in the title of this thesis, a hybrid thematic-dialogical approach to analysis is taken. I will now discuss dialogical analysis and how this method can be used to add depth to the analysis, through the appreciation of language. Dialogical analysis highlights the role of dialogue and subjectivity in qualitative work. The focus is on how language is used to represent and construct the realities of speakers and listeners. Thus, exploring how participants discuss or avoid discussing certain experiences and how they frame these accounts. The philosophical paradigms underpinning dialogical analysis include constructionism, subjectivism and interpretivism, which is consistent with the underpinnings of this research as discussed earlier in this chapter. In terms of combining methods of analysis, it is important that methods have some form of philosophical and theoretical consistency. From this perspective, dialogical analysis is compatible with my chosen approach to reflexive thematic analysis.

Where dialogical differs from my approach to thematic analysis is in the application and outcome. For example, I have chosen to conduct a thematic analysis which produces a rich description of the dataset. Dialogical analysis provides a detailed analysis of a particular aspect of the data. However, it is these differences that when combined, add depth to the analysis process. My approach to thematic analysis has been outlined and features of dialogical analysis have been discussed thus far. I will now discuss how I plan to combine thematic and dialogical analysis, which produces a novel, and hybrid approach.

Hybrid approach (qualitative-qualitative)

Discussions around combining methodologies and methods have typically focused on quantitative-qualitative blends, often referred to as mixed-methods. In mixed-methods research, typically the main part of the design is quantitative, and a qualitative aspect is usually an add-on. This is common in randomised controlled feasibility trials testing the effectiveness of various

interventions (Bower-Crane et al., 2019). Qualitative-qualitative combinations have received comparatively little attention in the literature, which can make this option inaccessible to new researchers. There is an increasing number of qualitative methods of analysis available for researchers to choose from. Each method claims to offer something unique, but many do share overlap. This can make it challenging for new researchers, as a significant amount of time is required to understand the similarities and differences between methods and methodologies. Where one method of qualitative analysis lacks in a particular area, it can be tempting to take elements of another method of qualitative analysis and combine both. This is not a negative but the how and why of this needs to be clearly outlined.

It will be useful to now discuss studies which used more than one method of qualitative analysis to understand how these are applied and how they impact the overall outcome of the study. Madill et al. (2018) illustrated a novel meta-methodology for pluralist qualitative research. Four qualitative researchers applied four different forms of analysis to an interview from the 'Social media, Men who have sex with Men and Sexual Health' project. This included critical discursive analysis, dialogical analysis, interpretive phenomenological analysis (IPA) and psycho-social narrative analysis. Each method of qualitative analysis was mapped onto four dimensions of Braun and Clarke's (2006) thematic analysis (type of analysis produced, inductive/deductive, semantic/latent themes, philosophical stance). Themes were analysed via one of the four analysis methods and the findings were presented separately based on each method. Madill et al. (2018) demonstrated how critical discursive, IPA and psycho-social narrative analysis provided a rich description of the interview, whilst dialogical analysis provided a detailed analysis of a particular area. In this example, Madill et al. (2018) demonstrated how the same interview can be analysed via different methods of analysis and thus, produce different findings. As the title of the paper suggests, this is known as plural qualitative research, which can enhance understanding of a phenomena through various analytical methods.

In other examples, qualitative-qualitative methods of analysis have been combined to create a hybrid approach. Sullivan and Akhtar (2019) investigated the effect of territorial stigmatisation on ontological security through a qualitative case-study of Bradford politics during the 2015 General Election. The data was analysed via a two-step approach. A deductive (top-down) thematic analysis was conducted, which developed three themes. The three themes were presented as conversations, by which the data looked like participants were in conversation with each other even though they were absent interlocutors. Once these conversations were formatted, further analysis was conducted using Bakhtin's chronotope. Sullivan and Akhtar (2019) state the purpose of thematic analysis and Bakhtin's chronotope, including what they aim to understand via each approach. For example, thematic analysis aimed to help understand and elaborate on the effect of reputation on ontological security. Bakhtin's chronotope aimed to analyse narrative organisation of trust and reflexivity in response to processes of territorial stigmatisation. This demonstrates how two different methods of analysis can be combined to contribute to a more in-depth analysis.

Weil (2022) explored the use of thematic and dialogical analysis of place conversations with older adults. Weil (2022) provided a comparison of thematic and dialogical analysis based on their philosophical paradigms, analytical frames, application and the researcher's role and power balance. Weil (2022) chose a constructionist thematic analysis (as opposed to realist). This is compatible with dialogical analysis, which is also stated as having a constructionist philosophical paradigm. Differences lay in thematic analysis providing a rich description of data, whereas dialogical is limited in its exploration, as discussed in the paper by Madill et al. (2018). However, it is these differences which can add to the analysis, as it would be counter-productive if both methods had shared interests in every aspect. Separate analyses were presented and then a comparison was provided. Weil (2022) stated that thematic analysis may bring in strengths regarding coding to reveal deeper meaning and concepts within the data. Dialogical analysis

then adds context to this data by paying attention to emotion and temporal elements.

I would like to now pay attention to Sullivan and Akhtar (2019) and Weil (2022) as these papers demonstrate the use of hybrid qualitative analysis. Sullivan and Akhtar (2019) show a worked example, as the data was analysed via thematic analysis, extracts were formatted and then those extracts were subjected to further analysis (Bakhtin's chronotope). A similar approach is taken in the current study where data is first analysed via thematic analysis to obtain a rich description of women's experiences of motherhood and psychological distress after childbirth. Themes and extracts are organised and then the chosen extracts are subjected to dialogical analysis, paying attention to absent voices and dialogical features. Dialogical analysis pushes the interpretive nature of the analysis. Chronotope focuses on time and space, i.e., the chronotope of motherhood, of psychological distress. Paying attention to dialogical features such as absent others, internal dialogue, the internal critic, sideward glance, provides an in-depth analysis of participants thought processes and their behaviours. In this chapter, I have provided background into my chosen approach to thematic and dialogical analysis. In the next chapter, I will outline the exact method which I followed. To end this chapter, I will reflect on my positionality outlined earlier in this chapter, to detail how I believe this influenced the research process.

Strength and limitations: thematic-dialogical approach

Both thematic and dialogical analysis are subjective methods, relying on the researchers pre-understanding of the phenomena, including socio-cultural insights and experiences. This means that interpretations of the data can vary from researcher to researcher, thus multiple meanings can exist which can be considered a limitation. This was one of the challenges of analysis, as a researcher new to qualitative research, reaching an interpretive level required multiple refinements. In earlier attempts in some areas analysis

resembled data summaries, at a very descriptive level. Through experience my level of interpretation became more refined, aided via input from supervisors.

As mentioned in the methods section, thematic analysis was conducted first and then data was subjected to further dialogical analysis. A challenge of conducting a reflexive thematic analysis was determining what interpretive level coding looked like. Details of overcoming this through borrowing of guidance on coding in IPA research is discussed in the methods section. Through thematic analysis a lot of themes were developed, which went through a process of refinement, detailed in the methods section. A challenge was to organise themes in a way which captured nuances and diversity. This took multiple attempts where themes were collapsed into others or moved as standalone themes. A Bakhtinian approach to dialogical analysis was used, focusing on dialogical features and chronotope.

This was particularly useful as attention was paid quotation marks within extracts to separate our direct and indirect discourse, which is missing in thematic analysis alone (Cresswell and Sullivan, 2018). In addition to this intra-thematic tensions and positions can be understood via the use of rhetorical features rather than viewing themes as a homogenous block. In terms of limitations, similar challenges relating to subjectivity were encountered. Whilst it was straight forward to label dialogical features, the meaning of such voices in dialogue were embedded in subjectivity. The analysis was discussed in supervisions, my main supervisor who is an expert in dialogical analysis provided support to ensure analysis, whilst subjective, remained as close to participant voices as possible.

Despite the limitations, hybridising thematic and dialogical analysis has allowed me to gain a deeper understanding of Pakistani-Muslim women's meaning-making during motherhood and psychological distress after childbirth. Paying attention dialogical features supported by thematic analysis has provided a key into the women's sub-conscious, but these are verbally stated. I mention the sub-conscious mind because through communication we all demonstrate a range of dialogical features but this something we

might not consciously be aware of and rarely reflect on. Hybridising thematic-dialogical analysis to understand women's lived experience of motherhood and psychological distress offers a nuanced, contextually rich, and holistic perspective. Highlighting the complex meaning-making processes women go through, this method can contribute to the development of more comprehensive and empathetic approaches to supporting women's mental health during the postnatal period.

3.5. Reflections

Before the empirical chapters are presented, it would be beneficial for the reader to understand how my positionality as a researcher has influenced and shaped the data collection and analysis. In this section I reflect on my power as a researcher and what this means for participants. I then delve into my insider-outsider status and how this was used during the data collection and analysis process.

3.5.1. Power

As with many research projects, an asymmetrical power relationship between the researcher and the researched is present in this study. As a researcher, I used my position of power and authority to set the research agenda and chose which questions to ask participants. Brinkmann (2007) highlights that whilst anonymity is ethically required, it can function as a power technique, the same goes for confidentiality. Whilst these are in place to protect both the researcher and the participant, upon reflection it may deny the voice of participants in the end research product. For example, in my study the participants were not involved in the analysis of data, which meant I had the power of interpretation. Whilst the analysis and interpretation of findings are grounded in participants lived experiences facets of my social identity such as gender, culture, and being second generation, shape the analysis and interpretation of findings. For example, gendered and cultural

expectations in relation to the postnatal period and mental health led me to interpret findings from a gendered lens. This led me to focus on the woman's voice or lack of, and what knowledge is acceptable to share and with whom. Furthermore, because there was a large amount of qualitative data, it is possible that some important narratives that participants wanted to get across in the interview may not necessarily be relevant to the research questions. I have the authority to choose which aspects of interviews are relevant /not relevant, and thus have the power to analyse and publish particular narratives. In such cases, participants may feel that their voice has been dimmed down. Whilst this may be considered part and parcel of the research process, it highlights the asymmetry of power between the researcher and the researched.

3.5.2. Insider-Outsider

Researchers who study the experiences of their own culture are often classed as insiders, whereas researchers who study cultures different to their own are classed as outsiders (Dhillon et al., 2019; Toy-Cronin, 2018). As a researcher, I share the following characteristics with my participants: gender (female), religion (Islam), ethnicity (Pakistani), culture (Pakistani and British), familial background belonging to rural Pakistan, and language (English and Potwari/Mirpuri). It must be noted that these are shared elemental features and that experiences of phenomena despite shared characteristics can vary. My knowledge of the Pakistani-Muslim culture and how this may influence understanding of mental health was one of the motivators to study this population. Actively growing up and living amongst the Pakistani-Muslim community has given me a unique, detailed but subjective and personal cultural insight into how mental health is viewed and approached. Being bilingual meant that I was able to conduct all interviews myself, with the ability to understand and appreciate unique linguistic expressions of experiences. Due to lack of research conducted in languages other than English, my bilingual skills came to use. However, it must be noted that I do not have any professional qualifications in translating interviews or dialogue. Complexities in translation may arise when certain words or concepts are

difficult to translate into English. Further details of how some issues around translation were dealt with is provided in the method(s) chapter.

I perceive the insider-outsider status as a continuum rather than as dichotomous. As I will go on to discuss in further detail, as a researcher I moved back and forth between insider-outsider status, depending on how participants interacted with me. The sample varied in how they chose to speak about their experiences during the interview. Some participants saw the interview as an opportunity to be heard and to share their narrative as a means of helping others who may be experiencing similar situations. Others came across as wary of the research interview context, such as the nature of the topic, my role, and being audio-recorded. To manage varying levels of rapport, I had to analyse the situation and respond accordingly.

In a paper examining boundaries and ethical complexities in qualitative research, Thuraiajah (2019) outlined different processes in which boundaries are made and de-constructed: the cloaked researcher, strategic undressing, and the 'naked' researcher. The cloaked researcher does not reveal themselves in any form. In this way, they are perceived as strong, and leave vulnerabilities to the participant who are expected to share their experiences and opinions about the given research topic. The spotlight is on the participant and the researcher is in the background. I maintained this position when participants were eager to reveal their 'truths' with little encouragement. In such cases, very little effort from my side as a researcher was required, which meant that I did not need to demonstrate my insider positionalities consciously or actively.

In other cases, the power imbalance was more evident as participants were closed in their responses. One-word answers were given, or a summary was provided at the beginning of the interview to suggest that everything was okay and that no issues occurred during the perinatal period. This immediately shut down lines of inquiry and quite often set the tone for the

interview. The element of being audio-recorded appeared to be a factor in how open participants decided to be. This observation was made as once the audio-recorder was switched off some participants suddenly became more open. In such cases, attempts were made to help participants reclaim their agency. I made the decision to highlight my similarities as an insider to help foster trust and rapport with participants. For example, when a participant shared that they migrated from a certain country, I also shared that I had family members who have migrated from that country. Or if a participant shared that they belonged to a certain village in Pakistan, I shared that my family also reside in a village as opposed to urban areas. This technique is referred to as 'strategic undressing' (Thurairajah, 2019).

In deciding to reveal these parts of the self, the participant may interpret this as the researcher is "just like them". This may lead the participant to assume that the researcher is "just like them" in other ways too, which may lead them to being more open about their experiences. In some cases, the use of this technique was successful, and in other cases exhaustive attempts were made, yet participants remained closed. In the successful cases, it can be argued that this led to epistemic goodness but may have compromised ethical goodness. I made the conscious decision to reveal positionalities that I believed would be of interest and relevant to the participant. This was done in the hope of eliciting rich data, which would illuminate women's experiences and satisfy my interests within this topic. The positionalities revealed were honest and accurate, which means that I was not dishonest in my approach. However, it may be perceived as engaging in manipulation or faking of friendships, in a bid to build rapport and to obtain knowledge.

In relation to recruitment, historically ethnic minority groups are classed as 'hard to reach' (Bonevski et al., 2014). Literature has shown that individuals of ethnic minority groups are more likely to take part in research if the researcher shares the same ethnic background as them (Quay et al., 2017). Potential participants may be cautious or aware that researchers of a

different ethnic and/or other backgrounds, may interpret certain concepts in a different way.

As I am of the same ethnic, religious, and gendered background as the participants of this study, this may have allowed participants to feel more comfortable when talking about culturally specific experiences. Being a female researcher, interviewing female participants on a gendered experience is likely to have shaped the nature of the interview and data collected. For example, women especially of South Asian background are more likely to be comfortable talking about their childbirth experiences and the postnatal period with another female. For South Asian and Muslim women, there is a sense of modesty which may prevent them from talking about such issues with male figures. As evident from my data, some participants expressed that only women understand women. This has implications for what knowledge can be shared and with whom. Sharing the same gender may have allowed women to share their knowledge and their truth with me. I was also reliant upon dialogue and interactions with trusted authority figures (PhD supervision team), to ensure knowledge claims stayed closely linked to the data set. This was particularly useful in experiences surrounding parenthood. As I am not a parent and have not experienced childbirth, there were certain experiences which I lacked knowledge of and may have otherwise interpreted in a way which was not representative of the data.

Through revealing my insider positionality, participants may have assumed that I had existing knowledge of various cultural rules and traditions. It is also useful to point out that insider positionality is not only something which I can explicitly reveal. It can be seen physically, for example I wear a headscarf which is typically associated with being Muslim. My insider positionality was somewhat beneficial as it helped build rapport and allowed participants to talk about topics in detail. This may have generated data which some participants may not have necessarily shared with a researcher outside of

their culture and/or religion. However, this may also result in participants providing less information if they perceived an unspoken cultural understanding is already present (Chavez, 2008). Participants may assume that because the insider is 'one of us' that they possess more or better insider knowledge (which they may not), and that researcher-researched understandings are the same (which they may not be). Therefore, information which is assumed by the participant to be 'obvious' to the insider researcher may not be articulated or explained. For example, in some cases when a participant assumed that I knew about a particular cultural norm, this was indicated by "*you know how it is*". I did not always clarify as to what specifically I, the researcher was perceived to have shared knowledge of. This may have partly been because I genuinely perceived to know what the participant was referring to, though this cannot be objectively verified. At the same time, during interpersonal communication as rapport built, an understanding was gained as to what knowledge and experience the participant was communicating. In such cases and in natural conversations, shared understandings are not always clarified, and it is assumed that both parties are on the same page, unless stated otherwise. This type of interaction was important during interviews to build rapport and allow women to feel comfortable to share potentially sensitive and personal stories. An element of this may have related to wanting to feel part of the participants world, through our shared positionality of ethnicity, culture, and religion, with a hope to build rapport. Holding on too tightly to my 'cloak' or coming across like I did not know '*how it is*', may have resulted in participants feeling that I was not really '*like them*'. In cases where I genuinely did not know what the participant was referring to, I did clarify. However, in terms of good qualitative research, trustworthiness, and validity of data (Brinkman, 2007, Thurairajah, 2019) it is good practice to always clarify despite insider status.

The literature typically discusses the use of insider status as a way of building rapport, in the hope that participants will reveal their 'truth'. In a similar way, I used my position as an outsider, in relation to not having experience of childbirth, motherhood, and the postnatal period, to elicit more

information regarding these experiences. The rationale behind this was an attempt at making participants feel in a position of power. The power in the sense that they possessed knowledge that I did not. In this aspect, participants were less likely to hold back information because the experience of pregnancy, childbirth and the postnatal period was alien to me, as far as the participant was concerned. At the beginning, it can be said that this lack of knowledge was genuine. In many cases this resulted in the production of in-depth data. However, as I conducted more interviews and learnt more about childbirth and the postnatal period, I continued to use this technique as a means of manipulating the power dynamic to my advantage. This may be perceived as dishonest, as I did know about certain concepts but did not fully reveal the extent of my knowledge to participants. At the same time, methodologically speaking it was important for me to continue this same approach across all interviews to ensure participants were using their own words and voice to narrate their experiences, as opposed to me influencing this process in any way through my knowledge.

3.6. Chapter Summary

This chapter has explored my positionality as a researcher, making transparent my worldviews and social identities relevant to this research topic. Philosophical positions underpinning this research were outlined as critical realist-social constructionist, with a dialogical focus. A dialogical approach to research has been outlined, with a discussion around broader narrative research. I have provided justification for using a hybrid approach to analysis, via thematic-dialogical analysis. Discussions around the philosophical and theoretical compatibility of the two methods has been discussed, including what each method brings to the analysis. Experiences will be mapped onto the Women's Ways of Knowing model (Belenky et al., 1986), to gain deeper knowledge and understanding behind women's knowledge positions and what this means for help-seeking. The chapter concluded with a reflexive section, detailing how my positionality and identities as an insider-outsider researcher influenced the research process.

Further details of the method, including recruitment, data collection and analysis will be provided in the next chapter of this thesis.

Chapter 4

Method

4.0 Introduction

The methodology chapter discussed in detail the philosophical underpinnings of this thesis (social constructionist-critical realist), the approach to research (dialogical) and provided background and rationale behind hybrid approaches to qualitative analysis. In this chapter, I outline the method the study including recruitment, data collection and analysis.

4.1. Design

In order to explore psychological distress after childbirth in Pakistani-Muslim women, it was important for me to hear their voices and their stories. A qualitative approach allows participants and researchers to engage in meaningful interactions, to understand lived experiences and is a useful design for under-researched areas.

4.2. Sample

The aim of this study is to explore psychological distress after childbirth in Pakistani-Muslim women living in Bradford. This includes exploring motherhood during the postnatal period, women's perceptions of how their family members react to disclosures of psychological distress and lived experience of psychological distress after childbirth. As such, women who

had recently given birth (up to 12 months) were of interest. Women part of the Born in Bradford Better Start (BiBBS) cohort were approached for recruitment. The desired sample size for this study was medium of around 10-20 participants to obtain a wider understanding of psychological distress after childbirth.

4.2.1. BiBBS

Born in Bradford Better Start (BiBBS) is an experimental birth cohort at the Bradford Royal Infirmary (BRI). The BiBBS cohort recruited new mothers, their partners, and infants between 2016 until 2021 (Dickerson et al., 2016). The aim of the cohort is to research health of children and families, through various Better Start Bradford interventions. The areas which BiBBS cover are ethnically diverse and include a high proportion of participants of Pakistani heritage.

4.2.2. Sampling technique

Purposive sample was used to recruit participants. This sampling technique is used widely in qualitative research and involves recruiting individuals who have knowledge and/or experience of the phenomenon of interest (Patton, 2015). The current research is interested in Pakistani-Muslim women who have recently given birth, to understand their experiences of motherhood and psychological distress during the postnatal period. The BiBBS cohort did not have access to data regarding mental health status of women, therefore it was decided that if women reported experience of psychological distress during the interview, then relevant questions would be asked. If no mothers reported distress, then a contingency plan was in place to recruit mothers via other methods such as community support groups. However, this was not required as a sub-sample of women did disclose experiences of psychological distress after childbirth.

4.2.3. Eligibility criteria

- Women who consented to be part of future studies via BiBBS
- Identify as a Pakistani-Muslim woman
- Between 4-12 months postnatal (justification: to allow women enough time to settle into motherhood and to avoid approaching women soon after birth)
- 18 years of age and over
- English or Potwari speaker (Potwari/Mirpuri dialect as representative of the Bradford Population)
- Women who did not experience a still birth or neonatal death

4.3. Procedure

Potential participants were sent an invitation letter (see appendix 3), alongside a study information sheet to read in English (see appendix 4). In accordance with BiBBS protocol women unable to read English were offered a translated version on request, however, no women requested this. Participants were then contacted via telephone and the study aims and procedures were explained to them, with the opportunity to ask questions. If interested in taking part, a convenient time and location was arranged with the women to take consent and conduct the interview. It must be noted that recruitment and data collection was carried out prior to the COVID-19 pandemic. The most popular choice of location was a home visit, however the option of conducting the interview at the Bradford Institute of Health Research (BIHR) or at the University of Bradford (UoB) was also available. Consent forms (see appendix 5) were completed at the time of interview. Those who wanted more time to consider their participation were given my contact number (also stated on the study information sheet). Alternatively, arrangements were made to contact women at a later date if the current time was inconvenient. A total of 17 women were recruited and interviewed, aged between 20-35 years old. Ten of the interviews were conducted in the English language and seven were conducted in Potwari/Mirpuri dialect.

4.4. Data saturation

Data saturation refers to the point where no new information, codes or themes are generated from data, sometimes known as information redundancy (Lincoln and Guba, 1985). Data saturation is a subjectively framed idea and not relevant in all research designs, which will be discussed (Braun and Clarke, 2019). The concept evolved from theoretical saturation in grounded theory. Guest et al. (2006:2012) describe data saturation as the gold standard for determining sample size. However, no explanation is provided for why data saturation is the gold standard. Studies have demonstrated data saturation in various ways, for example Eynon et al. (2015) continued data collection until no new themes 'emerged' from that data. Underhill et al. (2018) monitored data saturation during data collection, listening back to audiotapes, and ending data collection when saturation had been achieved. One of the issues of employing data saturation in qualitative work, which is on the more interpretive level, is that data saturation is not always a useful concept. I will now discuss why this is the case for my research and provide rationale for my sample size.

Braun and Clarke (2019) provide a useful paper on understanding data saturation in thematic analysis, which this thesis will draw upon. As discussed in the earlier section of this chapter, Braun and Clarke (2020) outline three versions of thematic analysis, two of which rely on coding reliability and codebooks. The third and the version used in this research is reflexive thematic analysis, considered interpretivist out of the three. In the former two approaches codes and themes can be pre-determined and researchers are more likely to adhere strictly to interview guides, even if something of interest not on the interview guide is mentioned in an interview. For example, prior to data collection I may want to understand women's knowledge of the term postnatal depression. I may already have in mind to organise this data under the theme of 'knowledge of postnatal depression'. These type of codes and themes are considered semantic, with little interpretation or engagement required. Thus, in such cases, data saturation could be considered inevitable. It would be clear to see a pattern in the data

which suggests saturation has been achieved. Reflexive thematic analysis is starkly different in terms of achieving data saturation. Braun and Clarke's (2019) definition of meaning resonate with my approach to data analysis:

Meaning is not inherent or self-evident in data, that meaning resides at the intersection of the data and the researcher's contextual and theoretically embedded interpretative practices – in short, that meaning requires interpretation (Braun and Clarke, 2019, p10.)

Discussed at the start of this chapter are the philosophical underpinnings of this research, including how my own identity has shaped how I see the world. This research is based on social constructionist-critical realist assumptions. In short, meaning and experiences are culturally and historically situated. This applies not only to how participants see the world, but also a researcher's interpretation of that world. Thus, my interpretation of data will differ to someone else's who may have different experiences and insights.

4.5. Rationale for sample size

To achieve data saturation, participants need to be asked the same or similar questions (Braun and Clarke, 2019). A total of 17 participants took part in this research. All 17 participants were asked questions around their experience of childbirth, motherhood during the postnatal period, knowledge of postnatal depression, perceived family member reactions to psychological distress after childbirth, support, and treatment preferences. Within these 17 women are a sub-sample of 8 women who reported experiences of psychological distress or postnatal depression. These women were asked additional questions such as to narrate their symptoms and help-seeking experiences. The interview schedule remained flexible. Areas of interest which arose during interviews deemed important to answer research questions and/or add contextual richness were probed further. From this perspective, each interview had the potential to elicit new information because experiences were embedded in women's unique social and cultural histories, despite sharing commonalities. This is one of the reasons why data saturation is not

applicable in interpretive, exploratory interviews/data collection. Overall women shared rich and diverse experiences, captured well via thematic analysis.

One of the factors which determined whether to continue data collection included quality of data produced. Not all interviews elicited rich and detailed responses. In some interviews women responded with few words and despite exhaustive efforts to open conversations, some women remained closed in their responses. After each interview I completed a field note diary where I inputted my reflections. Reasons for closed responses may have been due to participants assuming a link between myself, Born in Bradford Better Start (BiBBS) and maternity services. Despite making it clear that I am a researcher from the University of Bradford, some women may have still felt uneasy about disclosing certain information and experiences. Another reason for closed responses could be due to being audio-recorded. I noticed some women to speak more openly when the recorder was turned off. Thus, lack of detailed data to answer the research questions was one of the reasons why I continued data collection.

The concept of information power introduced by Malterud et al. (2016) provides a useful guiding point when it may be appropriate to stop data collection. This is when researchers feel that the sample holds enough relevant information to answer the research questions. The sub-sample of eight women with lived experience overall provided detailed narratives of their experiences. Participants provided a lot of detail in their experiences, rich with various perspectives, reflection and meaning making. This is dependent on the trust and rapport between the researcher and the researched and is thus difficult to predict prior to data collection and analysis. As demonstrated from this thesis, not all participants were willing to talk in-depth about their experiences. In this study a thematic cross-case analysis was conducted, as I wanted to gain an overall understanding of how Pakistani-Muslim women experienced motherhood during the postnatal period and which experiences may contribute to psychological distress. Guidance on sample size for thematic analysis advice a minimum of 6-10. As mentioned earlier in the methods section, during recruitment it was unclear of

women had lived experience of psychological distress/postnatal depression, thus a medium sample size of 10-20 was deemed an appropriate target. This number was also manageable in terms of recruitment, data collection, transcription, and analysis under the time-constraints of a PhD.

4.4. Data Collection

Face-to-face, semi-structured interviews were conducted. As discussed in the methodology chapter, the reasoning behind this included the target population being seldom heard. The nature of topic also contributed towards the decision behind one-to-one interviews compared to focus groups. The specific techniques I used to address power dynamics are discussed in the methodology chapter. These techniques helped open lines of enquiry, including building trust and rapport with participants. The interview began with opener questions to build trust and rapport and to understand the background of the women, such as their age and number of children they have. After this, specific questions were asked but a conscious effort was made to ensure interviews were conversation-like. I was flexible in how I approached the interview. For example, I did not worry about sticking to the order of the interview questions as in some cases this impacted the flow of the interview. After some initial interviews this was easier to do and at the end of the interview, I scanned the interview schedule to double-check everything had been covered. The topic of psychological distress after childbirth can be considered sensitive and even taboo in some cases, therefore it was important that participants felt comfortable during the interview process. To aid this, I introduced topics in a neutral manner, and I was open when participants asked me questions, this can help built trust.

Interview questions were mainly open-ended, allowing participants to talk about their experiences in-depth. Questions were specific enough to guide participants to discuss issues and experiences relevant to the research aims but also broad enough to allow fluidity and flexibility. Interviews were held in participants homes, in privacy with minimal interruption from family members

and/or children. Before the interview started, I briefed participants and explained to them that they do not have to answer any question(s) that they do not wish to and can take a break or stop the interview at any time without giving a reason why. Interviews varied in length, between 30 minutes and 1 hour 45 minutes. After each interview, I wrote field notes which summarised how the interview went. I also noted down any salient aspects of the interview which may be valuable during the analysis stage. I audio-recorded all interviews and transcribed them verbatim.

4.5. Interview schedule development

The questions of the interview schedule were developed by the PhD research team. Supervisors with qualitative expertise and experience within the topic area provided input on the type of questions to include, how these should be worded to avoid leading questions and what prompts to ask. Some questions were also based on research discussed in the literature review chapter. A wide range of literature was covered, spanning the last 20 years. Some issues relating to cross-cultural mental health experiences were consistently found in the literature spanning the last two decades. This led the focus back to a study by Tabassum et al. (2000), which explored attitudes towards mental health in the Pakistani community living in the UK. Interview questions from Tabassum et al. (2000) were adapted for the current study, as they were deemed relevant to continuously address in the context of mental health issues. These included questions around experiences and/or view of help-seeking, the aetiology of psychological distress after childbirth and family perception and reaction to psychological distress. Some interview questions from Lamba (2015), which explored postnatal depression in migrant Pakistani-Muslim women were also adapted for the present study. These included questions around knowledge of postnatal depression terminology, experiences of support, and experiences during the postnatal period (see appendix 6 for interview schedule of Lamba, 2015).

4.5.1. Piloting of interview schedule

To ensure questions were clear, suitable, and appropriate for the chosen sample, the interview schedule was piloted on members of the Community Research Advisory Group (CRAG). The CRAG includes members of the public who provide input and advice for BiBBS projects. I contacted a member of the BiBBS research team to circulate an email to members of the CRAG. Five women were contacted, of which two expressed an interest in taking part. A convenient date and time were arranged for the two members. Both individuals were women of Pakistani-Muslim background and bilingual English-Potwari-Mirpuri speakers. Feedback was positive and some suggestions were made, such as asking participants about family understanding of psychological distress after childbirth, which was added to the interview schedule. Once finalised, the interview schedule had to be translated into Potwari-Mirpuri. Members of the Born in Bradford team who had experience in translation and were bilingual English-Potwari-Mirpuri speakers, provided support for translations. Whilst I am also a bilingual English-Potwari/Mirpuri speaker, it is thought input regarding translations from external individuals was best practice to resolve any disagreements around translations.

To gain a more realistic insight into how the interview schedule would be received in the field, two pilot interviews were conducted. The pilot interviews focused on whether the questions in the interview schedule were easy to understand and sensitive given the nature of the topic and whether the questions would yield rich data. From the pilot interviews, participants were happy with the questions and how they were phrased but suggested including more opener questions to help build rapport. The interview schedule was amended accordingly following the pilot interviews. The final interview schedule contained 14 open-ended questions (see appendix 7). The order and wording of questions were adapted during the interview to best fit the interviewer-interviewee context (Braun & Clarke, 2012).

4.6. Translation process

4.6.1. *Information sheet, consent forms and topic guide*

This study interviewed 10 British Pakistani-Muslim women in the English language and seven women in Pothwari, a dialect most closely associated with the Punjabi language. Patterns of migration show that Pakistani migrants from rural, northern areas of Pakistan (Mirpur, Azad Kashmir, Rawalpindi) settled in northern areas of England (Khan, 1979). Thus, in Bradford and surrounding areas, Pothwari was a common language spoken by Pakistani-Muslim women. My first language is English, and my second language is Pothwari. I would describe myself as being fluent in speaking Pothwari, the language in which the data was collected, which according to Temple and Young (2004) is often a rarity.

As the Born in Bradford (BiB) research team are experienced in conducting research with ethnically and linguistically diverse populations, the issue of translating materials was discussed. It was advised that upon participant request an Urdu translated version of the information sheet and consent form could be produced. However, key issues regarding this included some participants having low literacy levels thus unable to read Urdu. Furthermore, the sample from this thesis spoke the regional dialect of Pothwari which does not have a standardised written form and linguistically and grammatically differs slightly compared to Urdu. Thus, it was advised by the BiB research team that information sheets and consent forms are translated verbally. This was standard practice for BiB and as the recruitment site was via Born in Bradford Better Start, the advice of the team regarding translation of materials was implemented. The topic guides were written in English and shared with English-Pothwari speaking members of the BiB community research team. The interview schedule was translated with a focus on retaining semantic and content equivalence. As some variation within the language of Pothwari can exist depending on region, words familiar to the majority of Pothwari speaking community were used. One of the challenges of translation included lack of available terms for postnatal depression, thus the English term was used. It is also worth noting that NHS research ethics

committee did not suggest any amendments regarding translation of materials for non-English speaking participants.

4.6.2. Transcribing the data

One method of translation is to retain semantic and content equivalence to produce translated text which is similar as possible to the source text (Temple et al., 2006). Forward-back translation is another method, which is the process of translating text to the target language and back to the source/original language. This method has been applied in various studies translating the EPDS into different languages. Thus, in such contexts forward-back translation is considered to produce the best method of translation (Elderkin-Thompson et al., 2001, Irvine et al., 2007, Karwalajtys et al., 2010, Kwok & White 2011). However, in such studies researchers are only working on one document. In the current thesis, there were seven interviews which required translating. The process is demanding, lengthy, laborious, and complex requiring various team members. A lot of weight is given to word for word translation, which is problematic as in many cultures there is no word equivalence for words such as depression/postnatal depression in the target language. This jeopardises the reliability of translations and has been highlighted as a weakness in various reviews on translated EPDS studies (Shrestha et al., 2016), indicating that some items no longer made sense after translation. Thus, it is vital that the cultural and social context is considered when understanding nuances and locating meaning between languages (Temple et al., 2006). For the reasons discussed, the method of translation used in this thesis focused on retaining semantic and content equivalence.

4.6.3. Quality of translation

Pothwari, sometimes referred to as Pahari is an Indo-Aryan language spoken on the Pothohar Plateau in the far north of Pakistani Punjab, as well as in most of Pakistan's Azad Kashmir and in western areas of India's Jammu and Kashmir. Pothwari shares some linguistic similarities with Hindko and Punjabi and is mutually intelligible. There are several dialects of Pothwari-Pahari, the

dialect relevant in this study is of the Mirpur region. For a detailed overview of the Pothwari-Pahari speaking diaspora see Hussain (2015). Even within the Mirpur and surrounding regions, some variation in dialects exist, which can make translation challenging. Therefore, translations were verified by bilingual English-Pothwari speaking members of the BiB community research team, due to their experience in conducting cross-linguistic research. Three translated interviews were shared with bilingual researchers at Born in Bradford to ensure translations were accurate. Once these were confirmed, the rest of the interviews were translated.

4.6.4. Number of translators

I was the only translator, with others verifying translations as discussed. Variations in dialect even within Pothwari meant that there was a risk of different interpretations, however minor, if there were multiple translators. Twinn (1997) suggested that the use of one translator increases the reliability of the data, which led to the decision that only I translated the data. An example of this is when women spoke about being induced into labour. A translated term for being induced was not used, instead women used the term 'bemaar', which literally translated means to be ill or illness. As I am a Pakistani-Muslim and Pothwari speaking, I have heard the term 'bemaar' to be used in various contexts, to describe very different experiences. For example, it is used to describe a woman on her period, someone who is in labour naturally or in the current example, where labour is induced. And of course, it is used to describe anyone who is ill, poorly, unwell. An external translator who may not have conducted the interview may miss this linguistic nuance and interpret and translate the data differently.

4.6.5. Translator qualifications and characteristics

One of the benefits of translating data myself included being of the same ethnic background (Pakistani) and familiarity with the regional dialect of Pothwari. This meant that I had an understanding of the language and nuances of meaning. A limitation of my approach or background is that I do not have any formal training or qualifications as a translator. Despite this,

translations being reviewed by bilingual researchers independent from this research helps strengthen the reliability and validity of translations.

Whilst conducting this research with the British Pakistani-Muslim community, I assumed multiple roles as a researcher, translator, and author. Usually when a researcher cannot speak the language of their participant, they may hire translators, interpreters, and transcriptionists. I conducted the interviews myself, including translation and transcription. One of the main reasons for this is that working with translators from the same community as the participants potentially raises ethical issues. It is possible that the interpreters and translators may be known to the participants if they are from the same community. When participants sign up to the research project, they are doing so with the confidence that their identities remain protected. Despite signing of consent forms which state confidentiality agreements, risk of exposure may act as a barrier to some participants deciding to take part in research. Despite the limitations, it is important for researchers to engage with non-English speaking populations to tackle health inequalities.

4.6. Ethical considerations

The topic of psychological distress after childbirth can be considered sensitive, therefore it was important to consider the following ethical issues whilst conducting qualitative research: protection from harm, informed consent, anonymity, and confidentiality. To ensure these were in place, the study went through a rigorous ethical approval via the University of Bradford and NHS ethics.

4.6.1. Approval

Ethical approval to conduct this study is granted by the University of Bradford and the Yorkshire & Humber – Bradford Leeds Research Ethics Committee (REC reference: 18/YH/0404) (see appendix 8 for REC favourable opinion letter). Health Research Authority approval is also granted (see appendix 9). Research and Development approval is granted by Bradford Teaching Hospitals Foundation Trust (BTHFT local project reference number: BTHFT 2323).

4.6.2. Informed consent

It is important that potential participants understand the aims of the study, what is required of them, and have the capacity to provide informed consent. Before conducting the interview, each item of the consent form was read aloud. The reason behind this included some women being unable to read English. Participants were informed of their right to withdraw from the study at any point during the interview and three weeks post interview date, in which all data will be destroyed at the participants request. It is worth noting that zero participants withdrew from the study. Only participants with capacity to consent were eligible to take part, this was based on my judgment at the time of consent. If participants were unable to understand key parts of the study, they were not consented.

4.6.3. Confidentiality and Anonymity

The data is saved on Bradford Teaching Hospital Foundation Trust (BTHFT) secure computer server and the University of Bradford (UoB) secure computer server. Data is not shared with anyone outside of the immediate research team (PhD student and supervisors). Data with personal identifiers is only accessed when absolutely necessary, for example during recruitment, withdrawal of consent, and during lone working in which one other member of the research team had knowledge of my location in case of an emergency. Identifiable data is only accessible to the immediate research team and is kept separate from anonymised interview transcripts. Paper files containing personal identifiers (e.g., name, NHS numbers, addresses, telephone numbers etc.) are stored in locked cabinets separately from other data at the Bradford institute of Health research (BIHR). Interviews are audio-recorded using an Olympus Digital Voice Recorder (WS-831) and all interview recordings are transferred and transcribed on a password protected, encrypted tablet provided by the BIHR. Interview transcripts are anonymised by the process of removing identifiable information and replaced by a

pseudo-name. These pseudonyms will be referred to during analysis and dissemination of findings.

4.6.4. Potential harm

The research topic could be considered sensitive in nature, and it was a possibility that some participants may have experienced low mood or have a diagnosis of postnatal depression. This may have been during the current postnatal period or with previous childbirths. The BiBBS research team did not have data to filter the sample of women who had a diagnosis of postnatal depression from those that did not. As I did not have direct access to the full BiBBS cohort, reliance was on the BiBBS admin team to screen the sample. This was to ensure no one was approached inappropriately, such as women who had experienced a still birth or neonatal death. Prior to initiating the interview, participants were informed that they could take a break, choose not to answer any questions, or stop the interview completely if at any point they felt distressed or uncomfortable. Close attention was paid to non-verbal cues which may have indicated discomfort or emotional distress. All participants were provided with a 'Useful Contacts' leaflets which contained details of mental health services at the end of the interview. Contact details of the main supervisor were also provided on the information sheet should any participants have any questions or concerns regarding the research. It is worth noting that zero participants reported being adversely affected by the interview, either during or after. A full debrief was given at the end of the interview.

I developed the interview schedule alongside team members who have experience in collecting sensitive data. I also took part in training for conducting qualitative interviews to ensure data is collected in a professional and appropriate manner. It was a possibility that during interviews participants may disclose sensitive information to me. This may have included disclosures of psychological distress, struggles with mental health,

domestic violence etc. Equally as a researcher I also had to be vigilant and be aware of any safeguarding concerns. In such circumstances I referred to the local safeguarding policy. At the time of data collection I was employed by Bradford Teaching Hospitals Foundation Trust (BTHFT). I was therefore trained in BTHFT wide policies on lone working and safeguarding of adults and children. I have also undertaken Good Clinical Practice training, safeguarding and I am Disclosure and Barring Service (DBS) checked.

4.7. Data Analysis

The methodology chapter provided the background and rationale for the hybrid approach to data analysis. To reiterate, the hybrid approach used is thematic-dialogical analysis. In the methodology chapter I have made transparent my version of thematic analysis, paying attention to vital elements highlighted by Braun and Clarke (2006). I have chosen a reflexive thematic analysis which aims to provide a rich description of the data set. I have also made clear in the methodology chapter my reasoning behind dialogical analysis, to provide an in-depth analysis of particular aspects of the data. I will now outline how I conducted the analysis. The analysis is a two-stage process. In stage one, a reflexive thematic analysis was conducted, following the steps of Braun and Clarke (2006). The majority of the analysis can be labelled as inductive, as I was not coding data to fit into pre-existing coding frameworks. However, there were some deductive elements, such as 'how many participants had heard of the term postnatal depression'. The inductive analysis is presented as the master themes and sub themes in the empirical chapters. The deductive elements are presented as thematic summaries, to add context to the master themes (knowledge of postnatal mental health terminology, support preferences, treatment preferences). I will now outline the steps I took to conduct the thematic analysis.

Step 1: Familiarising yourself with the data

Data collection, transcription of interviews and analysis of data was conducted by me. This was beneficial for the analysis process as I was aware of how participants responded and was able to identify nuances in responses. This level of familiarisation with the data allowed me to interpret the data as close as possible. To refresh my memory of any significant moments during the interview, field notes were referred to which aided interpretation of the data. The transcripts were initially read twice before any notes were taken. Some initial comments were made relating to the research questions to aid familiarity and understanding of the data. See Appendix 11 for a sample of codes and theme development.

Step 2: Generating initial Codes

Codes form the foundation and building blocks for the development of themes. The aim was to produce interpretive codes, the steps involved are detailed in the methods chapter. After I had coded between 1-5 transcripts, the coded transcripts were shared with my supervisors. In the first instance this was due to challenges developing interpretive codes. Another challenge included difficulty in coding and analysing interviews which lacked detailed responses. My main supervisor (PS) refined some of these codes to reach that interpretive level and provided codes for transcripts which lacked detailed responses. This aided me in refining codes and finding meaning in data despite lack of detail. Codes ultimately reflected the research questions and were brief but offered sufficient detail in what was being captured (Braun and Clarke, 2012; Braun et al., 2016).

An interpretive approach to coding was taken and meaning was explored at the latent level (implicit, underlying, 'hidden') (Braun and Clarke, 2006:2021). In thematic analysis Braun and Clarke (2006) define semantic and latent coding. Semantic coding is self-explanatory as the codes stay close to participant words. Interpretive coding moves beyond the semantic level, but little guidance is provided. Perhaps because interpretive coding is based on the 'lens' of which you are conducting your thematic analysis, and therefore interpretation will differ from study to study and researcher to researcher.

Despite this, as a novice qualitative researcher I still struggled to understand how to code interpretively.

Due to unclarity in how to generate interpretive codes, the first set of coding was descriptive. This was not viewed as incorrect as descriptive codes can be viewed as part of the familiarisation process and form the basis of interpretive codes. Descriptive codes provided me with the awareness of superficial and descriptive aspects of the data. To an extent, descriptive codes were now free from my mind and allowed me to focus on latent codes. Interpretive coding allowed me to think deeper about the meaning-making processes, this is where the social constructionist-critical realist underpinnings shaped the reflexive thematic-dialogical analysis. In Braun and Clarke's 'Answers to frequently asked questions about thematic analysis', semantic and latent codes are described as being similar to descriptive and conceptual codes in IPA.

Smith et al. (2009) provide further detail on various levels of coding and what this may look like in worked examples. Smith et al. (2009) outline three types of comments (codes): descriptive, linguistic, and conceptual. Descriptive coding stays close to participant words and is similar to semantic codes in thematic analysis. Linguistic and conceptual comments are key in generating interpretive codes. Linguistic comments are related to language use, focusing on how the participant is talking about their experiences. Key linguistic elements include pronoun use, pauses, laughter, metaphors, as well as functional aspects of language use such as repetition, tone, and degree of fluency (articulate or hesitant). Conceptual codes move away from explicit claims of the participant. There is a shift in focus towards the participants over-arching understanding of matters which are being discussed in the interview. In other words, Smith et al. (2009) broke down the interpretive approach via linguistic and conceptual comments. For me as a novice qualitative researcher, guidance provided by Smith et al. (2009) on interpretive coding was useful. It occurred to me that I could use linguistic

and conceptual comments to begin coding my data interpretively. These codes, although part of IPA, I argue do not appear to be wed to a fixed method of analysis. This is further supported by Braun and Clarke reporting similarities between latent codes in thematic analysis and linguistic and conceptual comments in IPA.

A considerable amount of time was spent reflecting on what participants had said, particularly for interviews where participant responses were short and vague such as “fine” to questions such as “how was your pregnancy?” “how did you feel during the early weeks after giving birth?”. A lot of time was spent figuring out how to derive meaning from what seemed at the time as lack of data to analyse in an interpretive manner. Through many attempts, the way in which the data was viewed evolved, from the very descriptive sense to really questioning each word and what this meant for the participant at an individual level and as culturally and historically situated.

As I had an insider-outsider perspective on the research, conceptual coding was developed by drawing upon my own perceptions and understanding of cultural factors which may shape experiences to sound out meanings of key events and processes. From an outsider perspective (not having experience of motherhood) I attached comments to codes, questioning the data and noting down several possible interpretations. This type of conceptual development was not about finding answers or pinning down understanding, rather it was about opening up a range of provisional meanings. Another level to conceptual coding which was utilised was thinking logically about the construction of the expression. For example, if the participant said they didn't feel like themselves after giving birth, then who did they feel like? In this example the role of identity could be relevant.

Guidance from Smith et al. (2009) was also followed in terms of formatting interview transcripts for data analysis. The transcripts were formatted to have left and right margins. In this study, the right-hand margin was used for

noting down codes and in the left-hand margin themes were noted. The significance of the right-hand margin being reserved for coding was due to being right-handed and coding coming before generation of themes, which made sense to start analysis from the righthand margin. Again, whilst this type of formatting is most commonly used in IPA research, I argue that this approach is not exclusive to IPA as it does not influence interpretation of data in any way or compromise the philosophical underpinnings of the research. Once all transcripts had been coded, the next stage involved theme development. The coded data was reviewed and analysed as to how codes were going to be combined to form themes or sub-themes. Both coding and theme development is an iterative and interpretive exercise between the research team. Themes do not reside in the data, nor do they emerge.

Table (n): example code development

Extract	Thematic analysis codes	Dialogical analysis codes
<p>How I went, I was shouting at everyone all the time. I was screaming - arguing over little, little things with everyone. So, I was like that for quite a long time: for 1.5 years I was like that. I was just really, really, I mean I knew it myself sometimes that I've gone like that. Shouting and, you know,</p>	<p>Symptoms: shouting, arguing, screaming</p> <p>Duration: 1.5 years</p> <p>Self-awareness of transitioning into a different state of being</p> <p>Lack empathy from family/own mother</p>	

<p>always arguing with everyone all the time.</p> <p>My mum's there explaining to me, and I used to just start crying at that time; you know when my mum used to tell me off or whilst arguing with my mum or getting into an argument with anybody.</p> <p>I used to start crying about it as well: that maybe I am wrong but then I don't know whether it was my heart or my mind telling me that "no, I'm not wrong, I'm not wrong". You know "you lot are all wrong, everybody is wrong". But I'm like, it was actually the worse experience ever, to be honest.</p> <p>And then I don't know, it was just all of a sudden that I came back out of it again. I went back to normal again.</p>	<p>'tell me off' – change in state treated like a child who isn't behaving, postnatal distress not recognised</p> <p>Questioning the self: validity of own feelings, ambivalence, inner tension and conflict</p> <p>Transition from a normal-abnormal-normal state without intervention</p>	<p>Sore-spot: fear of being wrong about your feelings</p> <p>Exchange of ideas between the mind and the heart</p> <p>Emotional ambivalence</p> <p>Internal conflict through internal confrontational dialogue</p> <p>Shift of experience: out of the normal, into the normal, chronotope</p>
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Step 3: Searching for themes

By this stage, all the data had been coded and the development of codes into themes began. Careful consideration was given to what constitutes as a theme. According to Braun and Clarke (2021) it is a common error in thematic analysis to confuse themes with topics. For example, interview questions around causes of psychological distress may result in a theme titled 'perceived causes of psychological distress'. However, this is conceptualised as a summary of a topic, rather than a theme. During early stages of theme development, similar to the act of descriptive coding, it was a beneficial exercise to train the mind to see codes in a way which would allow the development from data summaries to themes. In some cases, data summaries were important to the research questions, but these were not presented as themes. Instead, these were added to the thesis to add context to findings and are clearly introduced as thematic summaries.

Step 4: Reviewing themes

At this stage, efforts were made to ensure themes developed were in fact themes and not data summaries with the support of the supervisory team. Once themes had been developed, these were then printed out to be reviewed. The themes were pinned onto a cork board display to explore spatial representation of how themes fitted together. Any themes which were duplicated could be removed at this stage to ensure better management of data. Smith et al. (2009) outline various ways in which themes can be grouped. Some methods used include grouping similar themes together (abstraction) such as symptoms of psychological distress, grouping themes based on their differences (polarisation) such as good social support and poor social support. Contextualisation is another method which focuses on temporal, contextual, cultural elements. This includes critical moments or events of motherhood during the postnatal period such as cultural postnatal practices and transition to motherhood, impact on the self. Some themes were developed based on their frequency (enumeration). It is important to note that frequency does not indicate importance. Some themes presented in

this thesis were only evidenced once but were powerful narratives and demonstrated something novel and unique. Once themes had been grouped, a set of master themes and sub-themes were developed.

Step 5: Defining and naming themes

Once all master themes had been developed, the next stage involved looking for patterns across cases. This meant identifying which themes were prevalent across cases and which themes did not have enough evidence to be taken forward. Through this process some master themes and sub-themes were merged as they represented similar issues, leading to re-configuration and re-labelling of themes. This led to the development of the final list of master themes, presented in Table 6.

Methods use to validate interpretation of data

Once I had developed a first draft of the master themes and sub-theme table, I shared this with my supervisors. Feedback suggested themes required further refinement, which better reflected the nuance of the analysis. To achieve this, I refined the themes so that they were more detailed in some manner. For example, an earlier theme labelled 'experience of postnatal depression' was refined further to capture nuance, such as 'the self as fluid' which represented the different beings during a period of psychological distress after childbirth.

According to Braun and Clarke (2019) a quality reflexive thematic analysis is:

“not about following procedures ‘correctly’ (or about ‘accurate’ and ‘reliable’ coding, or achieving consensus between coders), but about the researcher’s reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process.” Page 594 (Braun and Clarke, 2019).”

From this perspective, it was not vital to have agreement between researchers in coding and theme development. However, the team were

involved to support me as I conducted a reflexive thematic analysis for the first time. The team also possessed knowledge and experience that I did not which benefitted the analysis process, to ensure all interpretations were well grounded in the data. I also possessed certain knowledge that the team did not such as of the Pakistani-Muslim culture, thus overall, it was a beneficial exercise to share code and theme development to refine analysis. The analysis was an organic and evolving process, in each meeting potential new meanings were discussed, until an interpretive judgment was made collectively by the team to stop theme generation and mapping of thematic relationships, to write up the final report.

Member checking

Another method of validating interpretation of data is through member checking. This is the process of sending participants a copy of the findings or case summaries to review, relating to their data, sometimes referred to as participant feedback or respondent validation. This exercise supposedly enhances credibility, validity and trustworthiness of findings (Guba and Lincoln, 1985). Thomas (2017) conducted a narrative literature review to examine whether member checking is useful in qualitative research. It was found that member checking is a taken-for-granted assumption, as researchers or checklists fail to mention how member checking improved the quality of findings. Member checking can also be considered a form of triangulation. Madill and Sullivan (2017) use an interesting concept to describe how member checking might be perceived by stakeholders, as mirrors and portraits. A mirror is defined as reflecting objective truth, and a portrait as offering an impression of reality, filtered through the researcher's subjectivity and analytic lens.

I did not use member checking in this PhD, which I will now critically reflect on. It would be useful to first outline the practical elements which at the time could be considered a barrier to contacting participants for member checking. Data for this PhD was collected and transcribed in 2019, and analysis begun in 2020. The COVID-19 pandemic also began in 2020, which

has now changed how we conduct research, with online data collection options being increasingly utilised. However, at the time there was uncertainty and unclarity, with many research projects being put on hold or research designs being adjusted given the restrictions. Given the restrictions on social distancing and lockdown measures, it was not possible to meet participants in-person and share the transcripts and analysis with them. If I was to do this work again at the current time, I may choose to do member checking via online sessions over Microsoft teams or Zoom. Such software allows sharing of screens so that participants can view the transcripts/findings online and share their thoughts. This saves travel time for participant and researchers. However, at the time structures were not in place to do this.

Member checking means that participants have to take part in additional sessions, these are optional and studies who have documented their process of member checking have reported low response rates. For example, in a study by Goldblatt et al. (2011) three out of 19 participants responded, 22 out of 51 in a study by Hagens et al. (2009) and five out of 16 for Mero-Jaffe (2011). This suggests that a challenge of member checking lies in participants reluctance to engage in additional participation. During the COVID-19 pandemic as everyone was adjusting to the new norm, whilst also suffering from the virus, it was a difficult time to contact participants to take part in member checking. These changes to the research design would have also required NHS ethics amendment, particular during COVID-19 with reduced capacity may have taken considerable time to be approved.

As with data saturation, member-checking is a taken-for-granted concept. There are several checklists which state member-checking as a method of representing quality and validity in qualitative research. However, studies rarely demonstrate how this information was useful or how it shaped the findings. Dialogically speaking, the act of member-checking goes back to the mirrors and portrait analogy (Madill and Sullivan, 2017). We as beings don't know who we are fully, we know the other. The interviews that I conducted were exploratory and the analysis, interpretive. Participants engaged in reflection and meaning-making, which highlighted fluidity in participants

ascribing meaning to their experiences. In some examples, participants demonstrated how over time their understanding of symptoms of psychological distress changed. This is important to document and capture. It is possible that during member-checking, participants now feel differently and may wish to change what they originally said. This may result in participants requesting to withdraw some data and replace with new data, which is one of the challenges of member-checking.

Given the emphasis and almost expectation, if this research was to be conducted again a stronger Patient and Public Involvement (PPI) component would be embedded into the research design. Good PPI is conceptualised as involving the public at each step of the research process, from inception to dissemination. This is particularly useful for projects with the aim of social change, thus member-checking brings a form of ‘transformational validity’ (Thomas, 2017).

Table 6: final list of master themes and sub-themes

Master theme	Sub theme
Becoming a mother	<ul style="list-style-type: none"> - Fracturing identity – becoming a mother again - Embracing motherhood
Expectations of motherhood	<ul style="list-style-type: none"> - Negotiating and navigating judgmental voices - Cultural postnatal practices
Experience of social support during the postnatal period	<ul style="list-style-type: none"> - Role of the partner - Role of own mother - Re-producing culture
Medicalisation of psychological distress	<ul style="list-style-type: none"> - Medicalisation of psychological distress and control - Medicalisation of psychological distress: light and dark

Perceptions of psychological distress within the community	<ul style="list-style-type: none"> - Rurality and psychological distress - Psychological distress: dramatization vs authenticity of feelings
The self as fluid	<ul style="list-style-type: none"> - Loss of control - Gaining of control
Psychological distress and control	<ul style="list-style-type: none"> - The 'not my usual' self - Re-discovering the self - Postnatal depression: the self that cannot be hidden
Navigating young motherhood	<ul style="list-style-type: none"> - Paradoxical motherhood: inner conflict - Early marriage and early childbearing

Step 6: Producing the report

The themes presented in Table six are organised into three groups. The blue category represents theme exploring 'experience of motherhood during the postnatal period'. The lilac group represents themes exploring 'understanding psychological distress after childbirth: the new mother and the absent voices in dialogue'. The orange group represents themes exploring 'lived experience of psychological distress after childbirth'. Themes were supported by appropriate and adequate extracts. Whilst all efforts were made to present extracts from a variety of participants, some participants appear more than others. Reasons for this include some participants talking in-depth about an experience, compared to participant who may have been closed or gave one-word answers. However, efforts have been made to present at least some data which reflects the accounts of all the participants. An example of this can be seen via the various thematic summary findings.

Once extracts for the themes had been selected, further in-depth dialogical analysis was conducted (see Appendix 12 for sample of dialogical analysis). The main dialogical feature of the extracts which stood out included the use of absent voices, hidden dialogue, micro dialogue, sideward glance, internal critic, and stylisation. Paying attention to these features within the extracts deepened analysis, to understand how participants negotiated motherhood and psychological distress. Including how participants negotiated conflict and ambivalence. Bakhtin's chronotope provided in-depth analysis of how time and space is understood and negotiated, including values ascribed to various chronotope (chronotope of motherhood, chronotope of psychological distress). The findings are presented in the empirical chapter five, six, and seven. The analysis is hybrid and therefore thematic-dialogical analysis is presented as one, as opposed to separately. Although it is evident which features of the analysis are thematic and which are dialogical. In addition to this, findings are mapped onto the Women's Ways of Knowing model (WWK) (Belenky et al., 1986) across the empirical chapters. For findings related to symptoms and experience of psychological distress, the Common Sense Model (CSM) (Leventhal et al., 1984) is also applied. In places, the WWK and CSM are combined to reach a deeper understanding of experiences.

4.8. Summary

This chapter has described the method of the study and analysis procedure. This is a qualitative study, in which data is collected through semi-structured interviews. The hybrid approach to analysis for a reflexive thematic-dialogical analysis has been outlined, including how the findings have been organised and how each method of analysis has been used. The findings of this study are grouped into three empirical chapters. The next chapter of this thesis will present the findings of the first empirical chapter 'the experience of motherhood during the postnatal period'.

Chapter 5

Experience of motherhood during the postnatal period

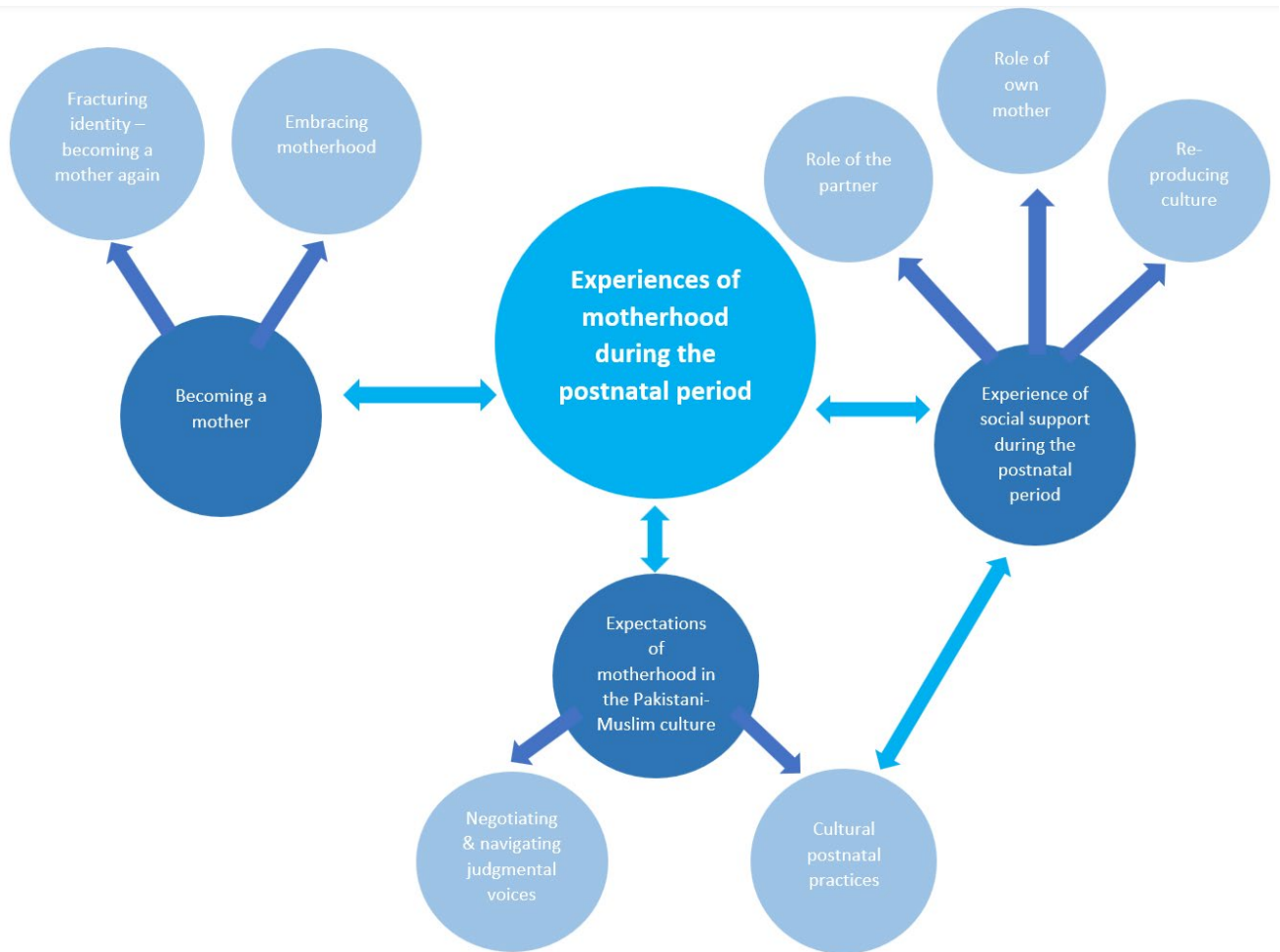
5.0. Introduction

The background chapter reported higher rates of psychological distress after childbirth in ethnic minority women, highlighting a need to study this topic further via qualitative methods. The literature review found factors such as culture and gender to influence understanding of mental health, including help-seeking. Little research has been conducted with the Pakistani-Muslim population exploring motherhood and psychological distress after childbirth, with this group commonly being researched under the term 'South Asian'. The aim of this chapter is to understand how Pakistani-Muslim women living in Bradford experienced motherhood during the postnatal period and how these experiences play a role in impacting maternal mental health.

5.1. Thematic Representation

The findings of this study are thematically represented in Figure 2. Three master themes were developed which capture the experiences of motherhood during the postnatal period. The findings of the first master theme are centred around 'becoming a mother'. Two contrasting sub-themes are presented, which explore experiences of becoming a mother again and a first-time mother. The dialogical feature of chronotope will be of focus to allow for an appreciation of how these two distinct times and spaces impact the experience of motherhood. The second master theme explores expectations of motherhood, in which judgemental voices are navigated and experiences of cultural postnatal practices are explored. The final master theme explores social support after childbirth. Key relations are identified, and their roles are explored during the postnatal period.

Figure 2: Thematic representation: Experiences of motherhood during the postnatal period



Findings

5.2. Master theme: *becoming a mother*

This master theme explores the diverse process of *becoming* a mother, which has been described as self-transforming and can influence a women's identity. Two contrasting sub-themes are presented. The first sub-theme explores 'becoming a mother again' which is represented by inner conflict and psychological resistance. How these feelings are negotiated and understood are explored. The second sub-theme explores the experience of slightly older, first-time motherhood and how this new role is embraced and navigated.

5.2.1. Sub theme: fracturing identity – becoming a mother again

In the process of becoming a mother again, some women experienced an inner resistance whilst trying to accept and incorporate the new identity of mother of a new-born. Becoming a mother again involved fracturing of identity to make space for the 'mother of new-born' identity. This was particularly challenging for women who had a larger age gap between children, as demonstrated in extracts 1a-c.

Extract 1a

“Ayesha: I did find it a bit hard because it was a big gap, and I wasn't used to it. Yeah, then it was everything like back to old baby stuff”
page 2

Extract 1b

“Ayesha: my children were happy, I was happy. But it was quite, it was different like wasn't used to. I didn't want more babies after two” page 6

Extract 1c

“Ayesha: I just felt like for first couple of weeks, I felt like I was okay with two children I didn't want the third one” page 8-9

Ayesha became a mother of three, which she reported as a challenging transition due to the reported age gap between previous births. A focus on chronotope suggests that the reversal of time is significant as Ayesha returns to the space of 'new motherhood'. A once familiar time and space was now unfamiliar, signifying the length of time out of this role. New motherhood is vastly different to what Ayesha was used to as a mother of young children of school age. The reversal of time to new motherhood indicates a loss of freedom and flexibility, with a focus on the infant's welfare and development. In this case, Ayesha is not only experiencing issues affecting first-time

mothers (feeding, changing nappies, lack of sleep and time) but also unique issues related to re-birth of the self, such as negotiating changes in roles. Existing literature exploring the process of becoming a mother and maternal identity has often focused on first-time mothers. For example, Arnold-Baker (2019) conducted an existential analysis exploring transition to motherhood and identity. Many of the themes identified could be unique to first-time mothers such as 'not feeling like a mother'. The theme 'adopting a motherhood identity' found women to fracture their identity (home identity, work identity, motherhood identity) to make space for motherhood.

The identity of motherhood is described as developmental, something which takes time to feel and process. Rodrigues and Valez (2021) explored becoming a mother for the second time in a sample of Portuguese women. The findings focused on rebirth of the family identity and how a second child brought change to existing relations and dynamics. It must be noted that these experiences might be considered universal in motherhood as opposed to being culturally specific, including the findings presented in this sub-theme. However, the various transitions to motherhood in Pakistani-Muslim women have received little attention in the literature. Particularly the paradoxical nature of motherhood, first introduced in the introductory chapter and literature review, based on the works of Nicolson (1998:2001). Ayesha reports happiness at the arrival of her third child but at the same time this reality is psychologically resisted, indicating a conflict. She admits not wanting another child and this is part of her resistance. Ayesha appeared to be temporarily stuck in a time and space which was no longer hers (as a mother of two). This resistance lasted for a couple of weeks, suggesting a circular chronotope, in which this new, yet already familiar role is something she is once again processing and fitting into her life.

5.2.2. Sub-theme: Embracing motherhood

In contrast to fracturing identity to make space for another, this sub-theme pays attention to letting go of former roles and identities to embrace

motherhood in its entirety. Extracts 2a-c outline Aleena's experience of first-time motherhood, which is underpinned by change referenced at multiple levels. In extract 2a, Aleena demonstrates that she is conscious of her child's needs, as she describes changes in priority as she transitions into motherhood. Pre-motherhood, chronotope is described as whole and individualised, post-motherhood there is a shift in chronotope as time and space are broken down into parts, with the majority chronotope being allocated to the infant (in the present and future). Through the use of humour, this shift in priority and focus from the self to child appears to be accepted/embraced, instead of being resisted. The way parents, particularly mothers divide their time is personal and varied. Aleena's experience reflects what is typically described as under the 'good mother' discourse, as she expresses not thinking of herself anymore and everything she now does is centred around her child. This type of thinking is sometimes referred to displaying expanded consciousness, a theme which has been present in previous literature. For example, Laney et al. (2015) explored motherhood and identity. The findings suggested that women referred to a shift in their priorities as they embraced the selfless nature of motherhood and children became part of the women's identities.

Extract 2a

"Aleena: like just thinking about the kids obviously future rather than your own because ah that's it, it's gone in it haha. Don't think about self anymore, you think about kids. Like if we used to go shopping, we used to buy stuff for ourselves but now we go shopping, think about kids and buy stuff for them so yeah, it's changed in a way yeah" (page 6)

Extract 2b

"Aleena: I've left work

Interviewer: and was there any reason for that or just personal choice?

Aleena: personal choice. I've been working all my life, so personal choice" page 2

Extract 2c

"Aleena: I'm glad I left work. I've been working all my life so I'm happy I left work

Interviewer: have you always worked in care?

Aleena: no, I've had different jobs. I've done admin, I've done sales assistant, I've done care, care home with kids, everything yeah. So yeah, it yeah, "I thought you know what? That's it now time to retire" page 7

At the end of extract 2c, Aleena participates in micro-dialogue, an internal conversation with herself. This dialogue is centered around herself as she reflects on her working life and the decision to leave that behind to embrace motherhood. There are no others present in this internal dialogue, which signifies agency, freedom, and personal choice. The jobs outlined in extract 2c can be described as lower-skilled and the range of jobs may indicate lack of career ambitions, which Aleena is comfortable with. These individual factors may have contributed towards Aleena's decision to focus solely on motherhood. This finding adds to research by Hennekam et al. (2019) which explored identity transition of women who become mothers and returned to work, from the Netherlands. This transition was shown to be influenced by multiple factors on various levels: individual (career ambitions/partner support), organizational (family friend work environment) and societal norms and attitudes towards working mothers. Education level and occupation of the sample was diverse, representing a range of experiences. After becoming mothers, Hennekam et al. (2019) found some mothers lacked desire to return to work and preferred to put their maternal identity at the

forefront. Women who struggled financially were more likely to return to work. On a societal level, Hennekam et al. (2019) found part-time work as the norm and if mothers decided to work full time then they were branded under the 'bad mother' discourse. It is possible that Aleena's husband was earning enough to support them both as a family, thus contributing to her decision to leave work. Experiences of negotiating work and motherhood can be considered universal rather than culturally specific, however, as noted by Hennekam et al. (2019) cultural norms can influence choices.

An earlier study by Braun et al. (2008) explored working class mothers negotiating paid work and motherhood. The study consisted of White, Black, and South Asian Muslim women. It must be noted that 9/10 South Asian women did not work outside of the home. The accounts of Black and White women shared similarities in terms of desire to return to work. For some, this was due to finances and for others it was an opportunity for socialization, adult interaction and feeling part of something outside of motherhood. A Black Caribbean mother deemed it was important to return to work to show her children the importance of hard work and independence. South Asian mothers emphasized the importance of being at home and the challenges of working and being a mother. Here, chronotope is presented as polar. Different ethnic groups view time and space and its values as something very different. The South Asian women saw value in staying home and being a constant presence in their children's lives. The Black Caribbean women saw value in being independent and developing the self. However, some South Asian mothers expressed that working would add to their identity outside of motherhood. Braun et al. (2008) found traditional mothering philosophy that emphasized full time care and staying at home with children evident in the South Asian Muslim sample. Aleena does not explicitly mention any reasoning behind her decision other than lack of desire to continue working. At the same time this may indicate Aleena's desire to fulfil moral obligations of prioritizing the child's needs and maintaining her motherhood identity and role as primary.

This master theme has focused on how women's roles changed as they transitioned into motherhood (first-time motherhood and motherhood again), with two contrasting cases presented. From a micro level understanding of motherhood, we move onto to a meso-level understanding of specific experiences during the postnatal period, such as general and cultural expectations which may influence the transition to motherhood.

5.3. Master Theme: Expectations of motherhood in the Pakistani-Muslim culture

This master theme explores how new mothers are subjected to general and cultural expectations of motherhood and what impact this has on them. The first sub-theme is related to general expectations and pays attention to judgemental voices and how these are navigated. The second sub-theme explores cultural practices which were expected to be observed within some women in this sample. The relevance and impact of such practices on the current generation of Pakistani-Muslim mothers living in Britain will be unpicked, to establish how practices have evolved, experienced and how they may impact psychological health after childbirth.

5.3.1. Sub theme: negotiating and navigating judgemental voices

This sub-theme explores how first-time mothers navigate judgemental voices, which dictate how they should be mothering. Two contrasting accounts are presented which demonstrate the various ways mothers deal with this. The first account depicts the debilitating impact judgemental voices and generational conflict can have on maternal mental health. The second account highlights the nuanced and complex ways in which judgemental voices are accepted superficially in private spaces but rejected outside of this sphere. Extract 3 demonstrates challenges first time mothers may face as they transition into this new role. Lubna expresses her newness to the role and lack of knowledge regarding infant care, such as use of baby safe

products. The intention behind using certain toiletries indicates that Lubna had an idea of what 'good motherhood' looked like and this included your child looking clean, neat, and tidy to the public. Absent voices presented in extract 3 provide a deeper insight into Lubna's thought process at the time.

Extract 3

"Lubna: so, once baby was crying because I was changing him and I was new mum, I didn't know at the time, so I was washing his face and I used to put a bit of Johnsons on it to wash his face and he was getting a rash because he doesn't need that he's only a baby, got sensitive skin. But I don't know why I wanted to smell nice cause I thought if my baby doesn't smell nice, they're going to think I'm a dirty woman and I don't look after my kids.

So, he's crying and he's got rash on his face and she comes over "you're going to kill the baby off what are you doing? He's being crying for an hour" and then she's ringing my mum and my mums like "what's going on?" and next minute my mums down. Next minute I know got the whole family down "what's wrong with the baby?" one's picking him up like this and I'm in the middle thinking "what am I doing wrong?" "why is everyone doing that to the baby for?" they looking at me like I'm the worst mum on the planet. But yeah, it was hard when you have people around you from a different generation it's very hard to urmm click with them so it's all about surrounding yourself with positive people rather than negative people because I've had a lot of that" page 29

In the first half of extract 3, Lubna is engaged in hidden dialogue where she anticipates the reactions and opinions of others on her mothering abilities. There are no active voices in this half of the dialogue, however elements of the sideward glance are present. For example, the anticipated words and judgements of others may have led to the fear of these judgements being

true. This may have led to hesitation in what is considered 'good motherhood', which led Lubna to actively challenge this potential judgment by demonstrating care for her child. However, this hesitation led to using products on the infant without thinking of safety first. In this context 'they' represent Lubna's family and neighbors. The hidden internal dialogue is representative of perceived stigma of being branded as a bad mother. As discussed in the literature review, perceived stigma reflects the individuals' beliefs about the attitude of others (Latalova et al., 2014). This may have led Lubna to actively do things, which in her mind demonstrated that she is a good mother.

The extract transitions to include the absent others, they are presented as 'judgemental voices'. The way in which they are voiced portrays a tension filled and fraught situation for Lubna. The voices of the absent others dominate this scenario, whilst Lubna engages in her own internal dialogue. She portrays herself as confused at the reactions of others. Amongst the hidden dialogue are features of 'words with a loophole'. Lubna reports the mistake of using the product thus causing a rash and distress in the infant. Perhaps in this context Lubna needed comfort and support, as opposed to judgemental voices. This led to Lubna somewhat changing her stance to someone who is vulnerable and confused. She may have thought the judgemental reactions were out of proportion for the situation. The addition of *"looking at me like I'm the worst mum on the planet"* is almost like a disclaimer in which Lubna may be hoping for disagreement in this context from the interviewer. Coming back to the element of confusion and vulnerability, Lubna is engaged in a position of silence (Belenky et al., 1986). In this position there is a fear of authority figures, which in this case is represented as the family and neighbour via judgemental voices. The absent others are presented as being in a position of knowledge yet judgemental, whilst Lubna presents herself as being in a confused, vulnerable almost oblivious state. As such, the absent others are framed as negative characters in this scenario. Extract 3 suggests that the absent others were of the older generation, which may indicate generational conflict in dealing with

these situations. Lubna acknowledges that she made a mistake with the cleaning product but suggests interactions between generations can be tension filled.

The literature review discussed early research, which found generational conflicts between new mothers and their own mothers/mother-in-law, in British South Asian contexts (Sonuga-Barke et al., 1998; Sonuga-Barke and Mistry, 2000). The current finding, two decades later, demonstrates similar themes around generational conflict, feeling unable to communicate effectively between generations, thus feeling helpless, overwhelmed and psychologically distressed. Generational conflict is relevant for all communities as the world and its norms (of various topics) are ever-changing. Due to a myriad of factors discussed in the literature review, including the current and subsequent empirical chapters, Pakistani-Muslim women may face greater difficulties in managing these conflicts, compared to Western communities. The judgemental voices suggest that a certain level of expectation of knowing *how to* mother is subjected onto Lubna, who reported subjective experience of psychological distress after childbirth. Experiences of psychological distress will be explored in the next two chapters of this thesis. This links to innate motherhood and the intensive mothering discourse discussed in the literature review, which has been linked to psychological distress. For example, Sonnenburg and Miller (2021) conducted a quantitative study and found the 'good mother' ideology to be linked to maternal shame and increased the likelihood of poor postnatal mental health. The current finding contributes to Sonnenburg and Miller (2021) by providing a qualitative insight into how the presentation of internal dialogue and judgmental voices may perpetuate the 'good motherhood' ideology and have a negative impact on maternal mental health. Extract 3 paid attention to how generational conflict can exacerbate the 'good motherhood' ideology, leading to feelings of inadequacy and contribute towards psychological distress after childbirth. Extract 4 demonstrates how judgmental voices are negotiated and navigated to ultimately allow one to mother how they see fit. Extract 4 begins with Amaarah interacting with an

'auntie' who in South Asian culture could be an auntie via relation, but it is also a common term used to describe any older lady.

Extract 4

"Amaarah: I didn't like put her in a swaddle and stuff but that auntie came and she goes "you've got the baby wrong" I go "why?" she goes "you're supposed to tighten her up with the blanket and stuff", I was like I couldn't say no to her cause she older she's an auntie and I go "okay". She picked her up out of the cot and she goes "look I'm going to tie her up don't open her now because she has to be totally like wrapped up in a blanket", I was like "what can I say now?". Straight away she went out the door, the door closed I literally opened her quickly. I used to go to SureStart and then one I had one appointment that nurses they, there were more other mums there, first mums and they taught us how to like, you know give a baby a bath, how to wrap the baby up and they even said it that our old generation used to wrap their babies up and stuff, but we don't have to obviously cause it's not a must. So obviously I remember that as well, you know what if nowadays people don't do it" page 41-42

The sideward glance feature is present in some form, as the auntie's voice is trying to permeate and shape how and what Amaarah should be doing as a mother. However, where this sideward glance differs is that Amaarah does not let this judgement impact or influence her in any way. The two 'characters' in extract 4 in addition to Amaarah, are the auntie and the nurses at the SureStart centre. Both are painted as authority figures but in contrasting ways and leaving a very different impact on Amaarah's views and behaviors. The auntie's status as an authority is based on age and the idea that one must respect their elders. Respect for elders is universal but emphasized in South Asian cultures (and others). This may lead to repressing your own conflicting views and opinions. As demonstrated in

extract 4, Amaarah is in a position of silence but this type of silence is not as intense or debilitating as outlined in the Women's Ways of Knowing (WWK) model (Belenky et al., 1986) in the methodology chapter. It can be characterized as 'cultural silence' as Amaarah has been socialized to respect her elders and to not question their advice, knowledge, or behaviors in their presence. However, cultural silence did not mean that Amaarah was necessarily isolated or fragile, as depicted in the WWK model (Belenky et al., 1986). The auntie's narrative is followed by the second authority figure, the nurses at SureStart. For Amaarah, the nurses represent a relevant and appropriate knowledge source. Professionals who are qualified in the given area. The mention of other first-time mothers attending postnatal classes indicates that others are trusting of these authority figures and their knowledge.

The topic of generational differences in childrearing is discussed by the nurses. This is relevant as it is demonstrated in extract 4 that Amaarah is exposed to various knowledge sources (folk and medical). When she is confronted by the auntie for her lack of swaddling, she is not only participating in cultural silence, but also demonstrating received knowledge (Belenky et al., 1986). Amaarah evaluates the two knowledge sources, paying attention to generational differences and shifting norms in childrearing. From this, Amaarah moves towards subjective knowledge (Belenky et al., 1986) by ultimately listening to her own inner voice and making an informed decision. Amaarah's case demonstrates epistemological nuances as she moves between cultural silence, received knowledge and subjective knowledge. It is not a linear transition, but one filled with fluidity depending on who's presence she is in (auntie vs nurse) and where she is (home vs health spaces). At times, Amaarah demonstrates agency and places herself as an authority figure (in the subjective knowledge position), but this is toned down when she is required to conform to cultural or generational norms of motherhood (in the cultural silence position). From navigating judgmental voices, the next sub-theme goes into detail of cultural postnatal practices women took part in and their experiences of these.

5.3.2. Sub-theme: Cultural postnatal practices

This sub-theme explores the types of cultural postnatal practices observed, including how these were implemented and experienced. Insights into why practices were not observed is also provided to help understand how cultural practices may evolve across generations and in cross-cultural settings. The literature review identified change in diet and resting periods as widespread across Asian cultures during the postnatal period, making these practices the focus of the study. A change in diet will be explored firstly, followed by experiences of the resting period known as *Chilla*.

Moral power and Food

Knowledge regarding change of diet during the postnatal period is passed down from one generation to the next. Through factors including migration or changes in values or circumstances, practices may be adapted or modified by each generation. In this study, knowledge came from women's own mothers. A small number (4 out of 17) of women took part in change of diet, highlighted in Table 7. The extracts presented pay attention to how morality is tied to food and motherhood and used as a mechanism to control women's adherence to cultural postnatal practices.

Table 7: Participation in change of diet

Participant	Change of Diet	Country of Upbringing
Ayesha	No	Britain

Aleena	No	Britain
Neelam	No	Pakistan (rural)
Maariya	No	Pakistan (rural)
Nadia	No	Pakistan (rural)
Isma	No	Pakistan (rural)
Asma	No	Britain
Mariam	Traditional soup	Pakistan (rural)
Tayyba	No	Pakistan (rural)
Naz	No	Pakistan (rural)
Alisha	No	Germany
Saifah	No (only multi-vitamins)	Britain
Sofia	Traditional chicken/meat/vegetable soup Chapatti Hot milk	Britain
Lubna	Traditional chicken soup Avoidance of spicy food Avoidance of fast-food	Britain
Arooj	No	Britain
Amaarah	Chapatti soaked in curry Encouraged to eat soft foods Avoidance of solid foods Avoidance of fast-food	Britain
Aaliyah	No	Pakistan (rural)

The literature review outlined studies in which migrant women reported psychological distress when being unable to participate in cultural postnatal practices (Parvin et al., 2004; Khan et al., 2009; Lamba; 2015; Wittowski et al., 2011; Wittowski et al., 2017; Schmied et al., 2017; Moghul, 2018). The findings of the current study, however, demonstrates that 7 out of 8 migrant women did not take part in changing their diet after childbirth. Lack of

participation was not attributed to psychological distress. This might be explained by migrant women in this study reporting that cultural practices are not important to maintain outside of Pakistan. It is also possible that if migrant women are surrounded by mother-in-law's or family members who have moved away from cultural knowledge, then advice around change in diet may also become absent. Nevertheless, the absence of traditional food advice post-birth was not seen by this sample as negatively impacting the postnatal period and recovery. In extract 5, Lubna outlines certain foods she had to eat, which were supposedly associated with greater breast milk production. This guidance came from her own mother who can be categorised as an authority figure in this case.

Extract 5

“Lubna: there were a lot of things I was told to [do] because I was breastfeeding him. Like expressing. I wasn't allowed to eat certain foods, my mum said “you're only allowed to eat soup, chicken soup [yakhni]” and I hated it

Interviewer: really

Lubna: it was disgusting, it was bland. I wanted to have donner and I wanted to have spicy food but I wasn't allowed and so I adhered to that. Although it didn't even help with the milk production or anything”
page 24

From a dialogical lens, elements of the sideways glance are present, as Lubna's mother relays strict rules of what Lubna is and is not allowed to eat. This then ties into the concept of food and morality, if Lubna did not participate in the given advice she may have been made to feel bad or careless. In relation to the sideways glance, Bakhtin (1984) states that others have the potential to 'penetrate' self-consciousness at various levels. In the current case, the mothers' words, and strict nature of adhering to a

change of diet and its perceived benefits, may have led Lubna to participate despite her own views and experiences. In this case, Lubna is in a position of silence (Belenky et al., 1986) as she trusts her mother as the authority figure and does not question her knowledge, despite not experiencing any benefits in change of diet and breastmilk production. This may also reflect the concept of cultural silence introduced in the previous master theme. Extract 6 offers further insight into how moral power and food can be used to control women's behaviours during the postnatal period. Amaarah's experience is also centred around diet and breast-feeding, with unique cultural beliefs and experiences. For Amaarah this involved eating traditional South Asian foods which were soft in texture, such as chapatti soaked in curry.

Extract 6

“Amaarah: I wanted a burger straight away. I was like give me a burger or something cause I'm not into these roti [chapatti] and stuff, but obviously mum used to make me it. I used to just have a little bit like choori [chapatti soaked in curry], little, little thing pieces I used to have only a little bit and then they say “you can't have even big you have to have tiny”. Obviously, I used to feed her, they say because whenever she used to cry, they said “she's crying because you have eaten a bigger piece of chapatti and it's going to hurt her inside”. That doesn't make sense because when she drinks my milk it comes out as pure liquid, liquid isn't it? It's not coming out as lumps. My family they say “if you eat more thicker food it's going to come out as, it's going to make her have stomachache because it's going to come in her milk as lumps”. But when I always seen I always expressed a lot milk cause alhamdulillah [thank God] I've had a lot of milk and I've expressed it out a lot and its always been liquid. I could never see lump inside it, then again its family, they used to make me bite and bite and bite the food” page 11-12

Similar to Lubna, Amaarah's mother has passed down cultural knowledge of postnatal care and diet. As seen in the earlier master theme, Amaarah does not directly challenge her elders despite her own beliefs, which I have labelled as a form of cultural silence. The sideward glance is present in extract 5 as the use of morality and food is used as a mechanism to control Amaarah's eating behaviours after childbirth. The potential negative impact of not taking part as advised is made much more apparent in extract 6 compared to extract 5, thus playing into Amaarah's consciousness. She is seen engaging in an internal dialogue, where she evaluates what she can see, what is logical (milk in smooth liquid form) and what she is being told by her mother and family (folk knowledge). This maps onto subjective knowledge (Belenky et al., 1986) as Amaarah is internally voicing her thoughts to make sense of this folk knowledge. Cultural expectations, however, make it difficult for Amaarah to fully step into the subjective knowledge position. This also ties in with the sideward glance feature in dialogue, which can lead to reservations and hesitations, as the individual may fear disagreement or judgement from others.

Cultural silence can be explained through Asian values and collectivism, by which the group of individuals tend to agree with the majority and avoid conflict. Hussain et al. (2021) explored cultural food practices amongst Pakistani women in the UK and found high expectations for pregnant women via the grandmother, to comply strictly with cultural food practices. Women felt under surveillance and under the control of family members regarding this practice. For example, if women did not adhere and something happened during pregnancy or childbirth, they were then blamed (Hussain et al., 2021). The present findings add to the research of Hussain et al. (2021) by paying attention to the concept of moral power and food, via a dialogical lens and mapping this onto Women's Ways of Knowing (Belenky et al., 1986). Compliance with cultural dietary practices was ensured internally by instilling a motherhood morality, and externally by treating cultural dietary deviance with social disapproval.

Both Amaarah and Lubna craved fast foods after childbirth (donner meat, burger) and did not care for traditional South Asian foods. They are both second generation Pakistani-Muslim women born and raised in Britain. The literature review found acculturation to influence food choices. South Asian individuals who were accultured to a Western lifestyle were more likely to consume foods associated with metabolic risk (Noor et al., 2020). Other studies found acculturation and food availability to contribute to a shift in diet (Pallan et al., 2012). This may explain lack of adherence to change of diet after birth and lack of perceived benefits for women who did take part. In contrast, extract 7 provides an account where the new mother reported benefits of changing her diet post-birth. Sofia consumed traditional foods such as soups and chapatti. Details of the benefits were not stated but Sofia had a c-section and reported that rest and consumption of fortified foods aided her recovery.

Extract 7

“Sofia: food as well you know having like chicken soup. Having yeah things like that. That really helped, having like chapattis, chicken soup, meat soup, vegetable soups, soups really help and having like hot milk and stuff” page 22

This sub-theme has found traditional soups, chapatti, and milk are encouraged after childbirth for their perceived properties in aiding recovery and breastmilk production. This adds to the findings of the literature review, where foods rich in protein, dairy, fruit, and nuts were recommended and foods to avoid included rice, fried foods, chickpeas, lentils, and spinach (Qureshi et al., 2016; Shahid et al., 2011). This finding offers an extension of existing knowledge by exploring how change of diet was experienced and understood by Pakistani-Muslim mothers in this study. Three out of four who took part in change of diet were born and raised in Britain. It is interesting

that more British born women took part in these practices, as opposed to migrant women.

Chilla

Another widespread cultural postnatal practice across Asian cultures is a resting period. In the Pakistani-Muslim culture this is known as *Chilla* and traditionally lasts for 40 days. Table eight reports participants who did and did not take part in *Chilla*. Slightly more women took part in *Chilla* (7 out of 14) compared to change of diet (4 out of 17). The study found two versions of *Chilla* to be implemented: traditional 40-day and an adapted version. Both versions will be explored in relation to how they were implemented and experienced.

Table 8: overview of participants observing *Chilla*

Participant	Participation in <i>Chilla</i>	Country of Upbringing
Ayesha	No	Britain
Aleena	No	Britain
Neelam	Yes	Pakistan (rural)
Maariya	No	Pakistan (rural)
Nadia	No	Pakistan (rural)
Isma	Yes	Pakistan (rural)
Asma	No	Britain
Mariam	Yes	Pakistan (rural)
Tayyba	No	Pakistan (rural)
Nazish	No	Pakistan (rural)
Alisha	No	Germany
Saifah	No	Britain
Sofia	Yes	Britain
Lubna	Yes	Britain
Arooj	Yes	Britain

Amaarah	Yes	Britain
Aaliyah	No	Pakistan (rural)

Amaarah is one of the mothers who participated in the traditional 40-day *Chilla*. One of the main reasons for observing this practice was spiritual protection, as suggested in extract 8. The postnatal period is viewed as a time where new mothers are vulnerable (mentally and physically) and in South Asian and Muslim cultures, new mothers are also considered spiritually vulnerable during this time also. Extract 8 pays attention to the spirituality aspect of *Chilla*. Amaarah insinuates that her grandmother did not participate in *Chilla* as one should and therefore, she was affected by evil spirits who have an influence over her to this day.

Extract 8

“Amaarah: 40 days you can’t go out because they [family members] say there are ghosts and stuff, they stick to you. It’s happened to my mum’s mum when she had her second baby in England. Mum’s mum it happened to her that she had something with her, that it’s not going away from that time so obviously” page 12

Amaarah’s knowledge of *Chilla* and its association with spiritual protection comes from her family, which can be categorised as received knowledge (Belenky et al., 1986). The addition of the grandmother’s experience makes this knowledge concrete and ‘true’ for Amaarah, who believes in the spiritual protections and benefits of observing *Chilla*. Hanley and Brown (2014) explored cultural variations and interpretations of postnatal illness in Muslim communities. The study focused on the lived experience of Jinn possession in mothers during the postnatal period. Women reported experiences of sadness, anxiety, and emotional pain after childbirth. These symptoms were

interpreted as Jinn possession by the Muslim women. Hanley and Brown (2014) drew comparison to symptoms of Jinn possession and that of the Western interpretation, postnatal depression. Affected mothers experienced a sense of self-guilt and blamed themselves for being possessed but feeling powerless once possession took place. Hanley and Brown (2014) also found women to express a family history of Jinn possession, which was compared to family history of common mental health disorders, including postnatal depression. Amaarah does not go into depth regarding her grandmothers change in behaviours but the association of being vulnerable to and affected by evil spirits after childbirth is something she is aware of.

From a spiritual focus of *Chilla*, we now move onto the physical and practical benefits as demonstrated in extract 9. Sofia gave birth via caesarean-section and observed *Chilla* for 40 days. The reason or motivation for taking part included cultural expectations, passed on by “they”. In this context, “they” could be referring to Sofia’s own mother and other women in the household who are involved in postnatal care. Sofia demonstrates received knowledge (Belenky et al., 1986) and a level of trust in “they” in relation to optimal perinatal health, and is therefore trusting of the 40-day *Chilla* period.

Extract 9

“Sofia: like well its cultural, isn’t it? And they [family] say you know you, what do you call it? You get better by staying inside and you know you need to eat properly as well, and you recover more quickly by staying inside that’s what they [family] said

Interviewer: so, do you think you benefitted from staying indoors?

Sofia: I think it did yeah because straight after the 40 days that’s when the new term started September, so it was really easy for me because I had recovered fully when I went back to school” page 22

Core components for successful (physical) recovery included rest achieved via staying indoors and minimising strenuous activity, along with the consumption of fortified foods, as discussed in the previous sub-theme. Sofia had her mother's support during *Chilla* such as cooking, allowing her to experience full benefits of *Chilla*. Trust in the practices, social support, rest, and fortified diet are suggested by extract 9 to have contributed towards experiencing the benefits of *Chilla*. In some cases, a 40-day *Chilla* is not feasible. Extract 10 demonstrates how Mariam had to resume her daily duties after a set time. This may have been due to lack of social support and traditional gender role expectations, preventing her from observing the full 40 days.

Extract 10

“Mariam: no, I rested for 15/20 days. Then I have children have to do obviously curry chapatti” page 8

This finding adds to the literature review, which found traditional gender roles and lack of social support (paid or family) can make it difficult for women to participate in *Chilla* (Edhborg et al., 2015; LeMasters et al., 2020). However, Mariam did not report this as a negative and suggests resting the necessary period to feel well enough to carry on with day-to-day duties. This was not reported to contribute towards psychological distress. This suggests that *Chilla* was adapted for practical purposes and the focus may have been on physical recovery. Extracts 11-13 represent the experiences and views of migrant Pakistani-Muslim women living in Britain who did not participate in *Chilla*.

Extract 11

“Maariya: in Pakistan a lot do it but not here, so I didn't do it I just went out” page 5

Extract 12

“Isma: some people say for 40 days don’t go outside or something. Sometimes like at Maghrib time [after sunset] I try not to and go out daytime instead. Person can’t stay at home for 40 days. Shopping, baby shopping have to do or home shopping, go Asda, Morrisons that’s fine” page 5

Extract 13

“Tayyba: happens in Pakistan, it happened before. No, I go out. She was born in June in the summer weather, was good I went out a lot” page 8

Maariya and Tayyba report *Chilla* as being context-specific and that it is only observed in Pakistan. Thus, indicating that it is not an important part of their postnatal period and transition to motherhood in the UK. This is an interesting finding and adds to the literature review, which found migrant women to report feelings distressed about missing out on cultural practices (Parvin et al., 2004; Khan et al., 2009; Lamba; 2015; Wittowski et al., 2017; Schmied et al., 2017). Living in the West may provide flexibility in relation to expectations after childbirth and the postnatal period, as the overall lifestyle is different. In extract 12, Isma expresses a general rule of avoiding going out after sunset, not specifically linked to *Chilla* or the postnatal period. The context of this statement indicates that Isma is referring to the cultural and Islamic belief that after sunset individuals are more vulnerable to being affected by evil spirit/Jinn. In extract 13, Tayyba mentions the additional factor of nice weather and wanting to be outside as a reason for not

participating in *Chilla*. This links to discussions in the literature review regarding differences in housing structure in the UK and Pakistan, and how this influences experience of motherhood and day-to-day living. For example, houses in rural Pakistan are generally on private land, which gives women the space to sit and relax outside. In the UK, houses are generally smaller with little garden space (inner-city Bradford) and are not designed for warmer climates. Thus, migrant women like Tayyba may feel cooped up on a hot summer's day and decide *Chilla* is not necessary in these conditions. The literature review also highlighted core components of resting periods, with the foundation being sufficient source of social support. Extract 14 provides insight into the potentially harmful nature of *Chilla* if not implemented in the traditional manner and is reflective of Lubna's own experience. Lubna emphasizes the importance of practical and emotional support for a new mother during the postnatal period, something which was lacking when she became a first-time mother and observed *Chilla*.

Extract 14

“Lubna: I think it would have helped if it was done properly. I mean I recently, I saw a document where Islamically where if they, a woman does have a baby 40 days is a time for her to heal because obviously she's having a baby. Is a big thing your body goes through a lot and healing in the sense that she's kept happy mentally. So, they showed you how that should be, so you should have your friends coming in together, cleaning your house for you, ironing for you, cooking for you, helping you out, just keeping you laughter, the laughter going. Giving you good advice, positive things. So, if it was done properly the 40-day thing is going to work for everyone and I think every woman should have that where she's just told to relax. Not on bed rest because that is just going to jam her up, so in the house she's walking around and you're helping her out so that she feels that she's not alone.

Because once you have a baby you do feel a bit alone because its,

can't explain why you feel alone so you may even be in a room full of people and you still feel lonely, can't say what makes you feel like that but there is that feeling. There and then if somebody's there to actually help you through that period where they come and they don't just drink your tea and go. They say, "right I'm going to go wash up this now, do you want anything else doing?" Or they bring little gifts with them like food, not expensive gifts, "I cooked this meal at home, do you want to have it? lets sit down together and share it" and knowing when it's their time to leave. So, a lot of people don't really know that, so then they be like when the baby's crying and they just sit and sitting there like "my baby's crying, can you leave now so I can breastfeed?" that type of thing. So, I think if it's done properly the cultural practices are very very good, but if not done properly they can be very very dangerous. So, it's, it's that sort of thing you just need people who can do it properly" page 33-34

In extract 14, Lubna refers to feeling alone in the transition to motherhood, thus emphasizing the importance of emotional support, particularly in the first 40 days. For contextual purposes, Lubna is now a mother of five and is referring to her earlier experiences of the postnatal period and *Chilla*. Lubna engages in a range of internal dialogues, which will be labelled and referred to as the 'idealised voice'. Lubna relays a range of ideal scenarios which she feels would have been helpful for her during the postnatal period. This included the provision of practical and emotional support, for someone to make food for you and offer social contact, and to overall feel supported during this transitional period. During the postnatal period it is common to have visitors, but in the South Asian culture this may a larger number of visitors from the wider community. These individuals may be known to the grandmother and not close friends or family of the new mother. This cultural practice is known as *Bhartan* and will be explored in the next sub-section. Lubna makes references to this in the context of *Chilla* as she felt trapped adhering to the needs of guests and not being able to attend to her infant. This is represented by the internal dialogue *"my baby's crying, can you leave*

now so I can breastfeed?”. This represents what Lubna wanted to say during interactions with guests but was unable to due to cultural norms and expectations. This is another example of cultural silence (Belenky et al., 1986). What Lubna is presenting in extract 14 is the ideal version of *Chilla* or a bid to go back to how it is traditionally intended to be observed. However, this may be challenging in urban Western societies whereby working and living arrangements differ vastly from rural South Asian contexts. The key areas which Lubna emphasizes include emotional and practical support, something which is important outside of the *Chilla* experience. Key relations and their role in social support is also an important aspect of *Chilla*. The wider importance of these relations will be discussed in the next master theme.

Participants in this study associated the resting period known as *Chilla* with being Muslim. However, the resting period is not necessarily part of the core Islamic traditions and rituals after childbirth. Hassan (2022) conducted a qualitative study exploring religious practices of Muslim women in the UK during maternity. Much of the practices reported were surrounding the newborn, such as reciting the call to pray and slaughtering an animal (Lamb/sheep). The importance and encouragement of breastfeeding was also reported. The 40-day period Islamically is significant and often refers to postnatal bleeding which prevents women from praying. Thus, there is no religious basis to stay indoors post-birth and thus this is a cultural practice (LeMasters et al., 2020).

The extracts presented in this chapter linked the practice of *Chilla* to being Muslim, with some women making links between staying in-doors for 40-days and protection for evil spirits or Jinns. This indicates an overlap between religious beliefs and cultural practices which can dictate how the postnatal period is experienced. The risk of combining religious and cultural practices, often due to lack of guidance, may lead to some new mothers experiencing psychological distress. This was demonstrated in the findings of this chapter, where in some cases *Chilla* was made to feel restrictive under the guise of religion.

Influx of guests (Bhartan)

In the Pakistani-Muslim culture the birth of a child is something which is celebrated by the whole community. This means that usually new parents will receive many visitors, consisting of their own family and friends but also guests from the wider community. The wider community represents the well-established networks and linkages across the older generations. As mentioned in the previous sub-theme, these visits are generally related to the cultural etiquette and 'returning the favour', known as *Bhartan*; and has ritualistic (giving/receiving in a near transactional manner) as well as more profound elements (maintaining ties/bonds/relationships). *Bhartan* is done in several contexts some of which include, weddings, funerals, and births. The community coming together to wish you well on the birth of your child can be seen as positive, as demonstrated in extract 15.

Extract 15

“Amaarah: yeah, I had a lot of people like my mum’s side, dad’s side and they come they give money that’s the main part. Literally [child name] made £500 out of all the people that came. They come and stuff, some bring mithai [traditional Asian sweet treat] and stuff, some bring clothes, the best one bring money” page 49

Amaarah expresses joy and excitement at visitors who gifted her traditional sweets, clothing, and money. Visitors are ranked as “the best” based on the item they gift, with a preference for money. This suggests that guests come with the expectation of bringing gifts, which is the purpose of *Bhartan*. It is important to note that Amaarah did not suffer any complications post-birth that may have pro-longed her postnatal recovery at home. Aaliyah on the other hand, did experience complications during and after birth which made her experience of visitors different, as demonstrated in extract 16.

Extract 16

“Aaliyah: you know in our culture once you come home, and people start coming straight away. There were loads of people coming and they, if would like to pick him up and I wouldn’t let go off him and that was that fear that if somebody goes near and is ill, can pass it onto my son. And I cannot afford to lose him, things like that and that created a lot of misunderstandings. And I think our families don’t have much of an understanding, that even if you don’t have a depression put that to one side, traumatic birth is, it takes you some time to recover. And thing they take it as you being a difficult person or you being nasty, or it’s a common thing that they say once a baby boy born, mothers change thinking they can do whatever, those things I’ve heard a lot of that” page 14-15

Aaliyah had experienced what is termed as a ‘perceived traumatic childbirth’ (pTCB) and after childbirth Aaliyah and her infant suffered from sepsis. In the following empirical chapters, I go deeper into Aaliyah’s background, but for contextual purposes she experienced many traumatic incidents throughout her life which shaped how she viewed situations. Past trauma coupled with pTCB led Aaliyah to be over-protective of her son. She mentions she does not want to lose him, perhaps these were earlier concerns during recovery from sepsis. There could also be underlying meaning to this statement. For example, Aaliyah felt vulnerable during various stages of her life (feeling abandoned by her mother) and developed a certain exterior, discussed in chapter seven. The ‘loss’ may not only indicate loss via death, but possibly loss via the fear of her child being taken away from her. The infant moving from guest to guest not only represents the very real risk of spreading germs and infection, but may also signify a sense of separation, which for Aaliyah is magnified.

Past and present trauma restricted Aaliyah from participating in *Bhartan* as culturally expected. This led to tensions between Aaliyah and her mother-in-law. Aaliyah reports feeling misunderstood and links this to lack of

understanding of the nuances and complexities involved in childbirth and motherhood. She refers to “*our families don’t have much of an understanding*” which could be directed at her own family or ‘our families’ in the context of the wider Pakistani-Muslim population. This links with her comment that childbirth and motherhood is not always an experience which is dichotomous as being good or depressed. Various factors such as pTCB and past traumas may impact how a new mother approaches motherhood and cultural traditions. Bay and Sayiner (2021) and Turkmen et al. (2021) found perceived traumatic childbirth to increase the risk of postnatal mental health, such as depression, anxiety, and stress. The current finding adds to the existing body of literature by paying attention to cultural and generational differences in the understanding and acknowledgement of pTCB. This chapter has found that lack of acknowledgement and understanding from family members of pTCB can lead to new mothers feeling misunderstood and thus, contributing towards psychological distress post-birth.

These misunderstandings also seem to be tied to the fact that Aaliyah has given birth to a male. Her comments indicate that giving birth to a male gives some women a certain status in which they feel a sense of superiority. The statement relating to this is interesting because it is society who creates and perpetuated gender inequalities and, particularly in South Asian cultures pushes for male infant preference. Women who bear male infant are often met with happiness and praise, whereas some women who bear female children are met with disappointment (Jiang et al., 2016; Khattak, 2014; Qadir et al., 2011). Over time a positive association is made with woman who bear male children. They are put on a pedestal, which Aaliyah reports can sometimes lead to behaviours of superiority which are viewed negatively by the family and/or community. A paradox of sorts. The present master theme has touched upon key relationships such as that of the mother-in-law and how different dynamics can influence how the postnatal period is experienced. The next master theme will explore these key relationships further.

5.4. Master Theme: The experience of social support during the postnatal period

The previous master theme touched upon family relations in the context of pressures and expectations of motherhood. This master theme delves deeper into the significant figures in women's lives. This included their partners, their own mother, and mother-in-law. The following sub-themes focus on each of these significant figures to explore social support during the postnatal period, and how this may shape early motherhood experiences and maternal mental health.

5.4.1. Sub-theme: The role of the partner

This sub-theme explores how partners responded to and understood psychological distress after childbirth. Extract 17 represents the experiences of Aaliyah, a mother of one who lives in a joint family consisting of her husband, child, and mother-in-law. Aaliyah expresses that her husband's ability to understand her psychological distress is capped, as he was able to understand how she felt but there was a limit to this. For contextual purposes, Aaliyah lives in her husband's familial home. Her father-in-law has passed away, making her husband the male head of the household and her mother-in-law is the matriarch. Aaliyah indicates that emotional support from her husband was limited due to a power struggle.

Extract 17

"Aaliyah: I think he understood me to certain point, but he had a lot of pressure where he was being understanding but things were not in his hands. I do think the men should take, they should stand up, say "if she doesn't want this thing to happen, it shouldn't be happening" page 22-23

Whilst Aaliyah's husband is now the man of the house, he may not have the power one may perceive. Patriarchal power and control may overrule the say of the son (Aaliyah's husband). From the context of the interview, Aaliyah's husband is stuck in a difficult position where he is simultaneously trying to be a good husband but also a good son. This is not easy to achieve as some acts may be seen as favouring one party over the other. In the current context, Aaliyah is feeling not fully supported, which may indirectly put her in a compromising and powerless position, as decisions made are in favor of others. This links back to the sub-theme '*Bhartan*' where Aaliyah was branded negatively if she spoke against wishes of the matriarch. Due to these reasons Aaliyah may feel it is the man's responsibility to be the voice of the woman in the context of conflicted family dynamics. This is supported by the 'idealized' internal dialogue presented in extract 17, where Aaliyah relays her ideal support scenario. This finding highlights how some Pakistani-Muslim men may find it difficult to navigate their respective roles of being a son versus husband. This may cause tensions amongst the mother-in-law and the wife, particularly in joint family settings. The postnatal period can be a vulnerable time for mothers anyway and the scenarios discussed may cause additional undue psychological distress.

Gendered understanding of reality

The limits of emotional support provided by male partners is reported in this study. Aleena expressed a gendered understanding of reality and preferred emotional support from other women, rather than her partner. This is demonstrated in extracts 18a-b, where Aleena states that men do not understand women's problems related to childbirth and motherhood and that issues are minimised as not mattering.

Extract 18a

"Aleena: men don't understand, men don't, they like doesn't matter"

page 10

Aleena goes onto suggest that she chooses not to confide in her partner, with a preference for female support. Reasons for not confiding in her partner include how busy he is, and feelings of low mood are constructed by Aleena as something negative, which will add pressure on the husband. The word pressure in association with low mood gives the impression that these types of feelings are perceived as burdensome for Aleena to share with her partner.

Extract 18b

“Aleena: I don’t tell him because it’s better to tell women than telling the man. That’s how I thingy it, he’s so busy himself so I don’t want to put pressure on him, so it’s mainly talk to my sis in law cause they women. Women like to talk to women, not bloody men. Who wants to talk to men? They help, they help in every way but it’s better to talk to women, girl to girl” page 11

Choosing what to share and what to hide from partners may be an attempt at preserving a certain image such as that of 'good motherhood', 'good wife' and femininity. The literature review found South Asian women preferred not to disclose psychological distress to their partners. Schmied et al. (2017) conducted a meta-ethnography exploring migrant women's experiences, meanings, and ways of dealing with postnatal depression. The review found that women were concerned that if they disclosed their feelings of distress, their husbands would be disappointed. Fears around being disowned by the family and bringing shame to the family due to having mental health issues were found to be prevalent. In the current finding, Aleena does not mention such concerns but there is an element of not wanting to burden her husband with her emotional distress. Furthermore, Aleena is not a migrant woman

which adds to results of Schmied et al. (2017) that such worries extend beyond the experiences of migrant women. The literature review found maternal mental health and stigma to be rife across women irrespective of ethnicity, but due to cultural norms and expectations South Asian women experienced stigma at multiple levels (Smith et al., 2019). In contrast to not sharing, extract 19a-b indicates that Asma chose to share her psychological distress with her partner but was very much aware of his capacity to understand her feelings. Asma relays her interactions during that time, in which she took a directive approach stating how she felt.

Extract 19a

“Asma: he didn’t obviously know. He didn’t know what was going on and then I told him I said, “I’m feeling low” and he said it himself “we’ll go out, I’ll take you, you’ll feel better” and left baby with my mum”
page 7

Extract 19b

“Asma: I’ve got friends, I’d speak to them. I’d speak to my husband. I guess women understand more better than men, which is true so yeah”
page 14

This may suggest that Asma did not expect her partner to know or realise that she was feeling low after birth, emphasised by the word “obviously”. Asma suggests women understand women, which adds to the re-playing of voices in extract 19a-b, emphasising that Asma *had* to tell her partner *how* she felt, indicating that this may otherwise have gone unnoticed/overlooked. Asma reports that she was feeling low, which does not indicate depression or a mental health issue. Thus, the suggestion of going out (solution) can be

seen as equal to the problem (low mood). Partner response to low mood/psychological distress will now be explored.

Partner response to low mood

To understand level of partner support provided, women were asked how their partners reacted when they disclosed feelings of sadness/low mood/psychological distress after childbirth. A common response and coping mechanism found in this study is the suggestion to take the new mother 'out'. This is demonstrated in extract 21, in which Maariya, a migrant woman explains that one of the reasons contributing towards low mood and anxiety is feeling cooped up in confined spaces.

Extract 21

“Maariya: yeah, when I’m sad or mood is a bit [low] then I tell my husband, he says “let’s go out”. Houses are closed, so person might feel a little anxious. So, then we go out and then everything is okay”
page 8

In this case, the chronotope of psychological distress is not only associated with the space of motherhood but also the physical space of where one is mothering. The value of the space has changed. Becoming a mother may mean spending extended periods of time in the home, which for Maariya contributes towards low mood. The value attached to temporarily being in a different space could be a change of scenery, which may act as a distraction technique and uplift mood. By being in a different space one may be attempting to bring back a sense of normality of the 'old' spaces attached to pre-motherhood. This highlights that restrictions of motherhood as well as differences in housing of urban inner-city Bradford housing compared to rural Pakistan and impact on mood. These differences and challenges may contribute towards distress in migrant women in general, but particularly in

new mothers who are considered vulnerable during this transitional period. The replaying of the partners voice indicates that when Maariya disclosed her low mood and anxiety, it was not questioned but instead attended to straight away via the suggestion of going out. This suggestion offers Maariya relief from being in a confined space, albeit temporarily but she reports this to be a positive suggestion. In cases like Maariya's, low mood is conveyed to partners in the 'everyday sense' which does not indicate a sense of seriousness or urgency to warrant a solution other than what was offered. In one case, the partner suggested seeking professional support, as demonstrated in extract 22.

Extract 22

"Tayyba: yeah yeah, we went [to the doctor] during morning it happened a lot, I was crying I didn't understand and then husband took me" page 5

In this case, psychological distress was difficult for Tayyba to understand and to convey to her partner. However, she was able to identify and voice to her husband that the feelings she was experiencing were not the norm for her. Uncertainty and confusion from both ends may have acted as a facilitator to seeking professional support. Tayyba's partner attended the doctor's appointment with her to explain her symptoms. The literature review found South Asian women's mental health to be stigmatised and women's help-seeking controlled by family members. Masood et al. (2015) found some South Asian women to attend group therapy for postnatal depression in secret, as their partners would not allow otherwise. The present finding indicates that Tayyba's husband wanted to support her during her time of need. The chronotope of distress in this context is difficult for Tayyba and her

husband to interpret and negotiate. The medical space acts as an outlet for support during this vague and frightening time. Given the context of migrant women being at increased risk of mental health issues and lower uptake of services, the level of support and encouragement of help-seeking from Tayyba's partner is important to note.

As well as emotional support, mothers described how their partners offered practical support. Extracts 23a-b outline Lubna's experience, a mother of five. During the birth of her fifth child her partner was out of work and thus spent a lot of time in the home. Across extracts 23a-b the negotiation of chronotope is present. For example, Lubna's partner prefers that she breastfeeds but to do so Lubna needs time. During the early postnatal period Lubna and her partner shared the same space, and thus negotiated and navigated their 'new' roles for this short space of time. In extract 23a, Lubna recalls her conversation with her partner, setting out expectations of support. The replayed voices indicate bargaining as Lubna expresses if there is an expectation to breastfeed then her partner must support her during this process. In extract 23a Lubna repeats that partner support was provided only for one month. This highlights traditional gender roles, where Lubna is the homemaker, and her partner is the breadwinner. It also highlights a circular chronotope where space and time, in particular the roles played during the early postnatal period, were temporarily changed but returned back to normal after one month.

Extract 23a

"Lubna: just one month he didn't have a job then luckily, he got a job because we needed that. But just that one month of having him in the house and me establishing breastfeeding, because with breastfeeding its constantly attaching the baby to yourself. So, if you've got little kids that are reliant on you to cook food for them, to change them, then you can't be doing that because you having to constantly take the

baby off. So, because I could just sit on that sofa and have that attached to me and my husband serve me. That was the only time he served me food, because I said, "if you want me to breastfeed your child, you're going to have to feed me and feed the kids and clean their poop whether you like it or not". So just that one month of having that support, then my milk flow started, and the baby managed to latch on, and it became easier. So yeah, just that one month period" page 8

Extract 23b provides further insight into traditional gender role dynamics and how they may influence expectations versus reality of support provided. Lubna emphasises that the bare minimum of practical support was provided to ensure she was able to breastfeed. The replaying of voices in extract 23b emphasises that basic cooking, feeding the children, and taking the children to the toilet were responsibilities of the partner. This suggests that these tasks were not the norm for the partner to perform and thus he needed guidance on performing them.

Extract 23b

"Lubna: he didn't do as much as I would've wanted him to do, but just being able to care basic needs. So, if a child wants sandwich or if they want food from outside or I'll cook the food and just feeding them. It wasn't like he was cooking for me, and I was just relaxing, so if I was able to cook the food at a specific time I would say "right okay the food's on, can you just keep an eye on it?" or "so and so needs the toilet so can you take them upstairs?" cause obviously the twins have been toilet trained as well so having to take them up and down for toilet trips that's a bit of a headache as well. So just that time, so if the baby is crying, I'm able to pick her up and give her milk whenever she wants it, rather than me leaving her to cry and become distressed and giving her bottle. So that was the, that was the whole trick to giving them breastmilk for me, just being relaxed" page 9

Lubna acknowledged the limitations of support her partner could provide, as she emphasised that she was in no way relaxing. Nevertheless, her partner did provide support to the best of his abilities. Reported barriers to breastfeeding included being a multiparous mother with little social support. Lubna reported poor social support could result in psychological distress, which would also prevent her from breastfeeding. Facilitators to breastfeeding included a calm and relaxing environment, maintained with the right level of social support. The literature review found low SES and traditional gender roles to contribute towards poor partner support in the South Asian population. In some communities' men were stigmatised for performing household chores or looking after the children, which were labelled as 'women's work' (Templeton et al., 2003; Parvin et al., 2004; Hanley, 2007; Lamba, 2015; Edhborg et al., 2015; Moghul, 2018; LeMasters et al., 2020; Rao et al., 2020). The current finding adds to the existing body of literature by offering a different insight into how partner support can be provided (even for a limited time) and navigated despite low SES and traditional gender roles.

5.4.2. Sub-theme: Role of own mother

This study found women's own mothers played an important role during the postnatal period. Own mothers were a good source of practical support for new mothers, demonstrated in extracts 24-26. We begin with extract 24, where Amaarah experienced first-time motherhood and the postnatal period living in her maternal home. This meant her mother was with her 24/7 and supported her practically by taking over maternal duties during the early postnatal period, apart from feeding as Amaarah was breastfeeding.

Extract 24

“Amaarah: to be honest because my mum was with me and she's still with me, life is really easy. If she wasn't with me it, would've been really hard. I was literally just laying down here 40 days you know like

in our Muslims they say 40 days you can't go out and stuff like that we still believe in them stuff. So, I was laying down here, baby was with me had to change her and stuff mum used to change her, sleeping with my mum looking after her at night. The first night when I came home I was totally obviously I didn't sleep in the hospital. Mum was looking after her all night and I fell asleep, for one full night I was asleep. I woke up in the morning and mum was sleeping with her, was sat down laying down sleeping with her 40 days and even after that mum been looking after most time. Obviously, I have to feed her I still do as well but other than that. I can't obviously if I was on my own, I would be able to tell you how hard it is, because mum was with me things are different" page 8

Common experiences which first-time mothers may face including lack of knowledge or experience of how to take care of a new-born, was something Amaarah did not need to worry about. Her mother was able to not only show her but also take over these duties until Amaarah felt comfortable to do so. General challenges for all new mothers such as lack of sleep can be a source of stress, this was avoided as Amaarah's mother took care of the infant so Amaarah could catch up on sleep. This level of support allowed Amaarah to participate in *Chilla* for the full 40 days. As discussed in the previous master theme social support is the main foundation to the effectiveness of *Chilla*. Practical support from the mother allowed Amaarah to rest her body (limited tasks) and mind (sleep/rest). For women whose mothers did not live with them but were close by, were also able to benefit from the provision of practical support. Extract 25 pays attention to Ayesha who became a mother again but encountered challenges during the early weeks due to stitches.

Extract 25

"Ayesha: it was quite bad but like I had my mum with me, and she

helped me a lot. She stayed with me for like first 10 days

Interviewer: yeah, and how did she help you when she was here for 10 days?

Ayesha: she just helped with the housework and with the children. After I think 2/3 weeks I was okay with the stitches” page 7-8

Ayesha’s mother played a role in looking after the other children and doing the housework. Ayesha suggests that this level of practical support aided her recovery. Absence of support may have caused additional physical and mental strain. For first-time mother Asma, practical support regarding night-time feeds was provided by her own mother, demonstrated in extract 26. This allowed Asma to ease into a routine, and ensured her body and mind were calibrated to this new schedule.

Extract 26

Asma: my mum stayed for a week. She did all the night feeds. I used to get up to get in a routine, I got a break for a few days then I got up to get into a routine you know, and not to go sleep all time” page 4

Extracts 24-26 demonstrate that support of women’s own mothers (grandmother) allowed the new mothers to ease into the role of motherhood at a comfortable pace, allowing for physical and mental recovery. This adds to the literature review which found the important role of grandmothers in providing knowledge during the postnatal period (Kandasamy et al., 2020) and Lamba (2015) which emphasised the role grandmothers played in the provision of practical support. In contrast to the above experiences, Aaliyah yearned for a mother’s love and presence during the postnatal period. She did not have a relationship with her mother and her relationship with her mother-in-law was conflicted at times. Thus, she felt she did not have a maternal figure to share her experience of childbirth and the postnatal period with. The absence of physical and emotional support from a maternal figure

is something Aaliyah yearns for, as she recalls her thought process at the time via internal dialogue. She uses the word “*desperately*” which highlights the intensity of her feelings at the time of birth, so much so that she mentions her father as an alternative source of support.

Extract 27

“Aaliyah: I was getting physically really tired and emotionally really down thinking “I desperately need my mother here” or I need my father because you probably know in our culture, there is that hayah [modesty] between you and your dad and you can’t really say things openly. And you would like your mother there. Like you can’t tell your father how rubbish you’re feeling or it’s hurting here or there” page 4

As soon as Aaliyah mentions her father, she reminds herself, as well as the interviewer of cultural and gendered barriers in support. Daughters in general may prefer not to discuss bodily issues or childbirth with their fathers, but women of Pakistani-Muslim origin may find it increasingly difficult due to the cultural concept of *Hayah*, which translates to modesty. *Hayah* covers many things such as what you wear, how you act and what you talk about. Aaliyah indicates in extract 27 that she cannot speak about issues relating to childbirth as they are constructed as coming under *Hayah*. Modesty and lack of trusted female figures means that Aaliyah is lacking social support, which may contribute towards feeling isolated and psychological distress after childbirth. The current finding adds to cultural codes of practice identified in the literature review, such as shame, *Izzat*, and honour. Cultural codes have demonstrated to prevent South Asian women from voicing their psychological distress and seeking help (Mafura and Charura, 2021; Guansinghe et al., 2019). Issues after childbirth and who this can be shared with is found to be gendered and controlled by the concept of modesty,

leaving Aaliyah in a silenced, vulnerable, and isolated position after childbirth.

5.4.3. Sub-theme: Re-producing culture

The literature review found migrant women to be at increased risk of psychological distress after childbirth, with one of the main reasons being lack of social support (Schmied et al., 2017). Extract 27 explores the experience of Maariya, a migrant Pakistani-Muslim woman and a first-time mother of twins. Maariya lives in a joint family. Extract 28 demonstrates the amount of support provided by the mother-in-law in looking after the twins.

Extract 28

“Maariya: I do miss them [parents] because I spent my whole life with them. So was thinking about them a lot, but I didn’t really feel that void because my auntie/mother-in-law is like a mother to me. She was doing everything, so I didn’t feel it as much. I have a lot of cousins here they were coming uncle and aunties all. So, they would help too, so I didn’t really feel that if mum was here would be better, didn’t feel like this but I do miss them a lot” page 9

In contrast to Aaliyah’s account, Maariya reports a good relationship with her mother-in-law and views the relation as equivalent to her own mother. A good relationship may facilitate the amount of practical support that is provided. Much of the literature around migrant women’s experiences of motherhood has cited loneliness and lack of social support (Lamba, 2015; Wittowski et al., 2011; Wittowski et al., 2017). The current finding adds to the literature by providing a different perspective, in which Maariya migrated into a well-established family in terms of migration and community development. Thus, when she migrated, she had parental figures and cousins in the UK which emulated the family feeling and environment that she left behind in

Pakistan. This is of course not the case for all migrant women and level of support also depends on the type of relationship with family members, regardless of migrant status. This is however, an interesting case where the social network was able to be re-produced in cross-cultural settings, which could be a protective factor for maternal mental health in migrant women.

5.5. Summary of results

This chapter has provided a detailed account of how Pakistani-Muslim women living in Britain, experience motherhood during the postnatal period. The first master theme explored how becoming a mother was experienced and how this influenced women's identities. Chronotope of time and space were relevant in the two contrasting accounts. The first account returned to the space of 'mother of a new-born' after being away from this space for several years. A difficult space to transition back into with the desire to stay in the current time and space, thus resulting in psychological resistance of becoming a mother again. This sub-theme challenged that narrative that motherhood is always innate and joyous by demonstrating the paradoxical nature of motherhood. This is a feeling not typically associated with the narrative of motherhood, especially amongst the Pakistani-Muslim culture. On the other hand, first-time motherhood represented a new life, in the literal sense of birthing a child and in the metaphorical sense as it is a new chapter of a mother's life. Motherhood was the centre of the mother's life, forming her main identity. Past identities such as work were let go of and motherhood was embraced. The two sub-themes demonstrate the very different experiences of women becoming mothers again and first-time mothers, and how this influences transition and negotiation of the motherhood identity.

The second master theme explored general and cultural expectations of motherhood. General expectations are something all mothers are likely to experience. This master theme found tensions related to generational

differences regarding infant care, in which some mothers due to lack of motherhood experience were made to feel like bad mothers. In other cases, generational differences clashed with cultural norms and expectations, in which mothers felt unable to speak up as they might be perceived as being rude. This led to some women positioned in a 'cultural silence'. Only a small number of participants were found to observe practices such as change in diet and the resting period known as *Chilla*. This was namely British born Pakistani-Muslim women. This also highlights that migrant Pakistani-Muslim women, and future generations may not feel these practices are important to observe in Western contexts. In cases where practices were observed, motherhood morality was used as a tool to regulate behaviours relating to practices. The potentially harmful nature of *Chilla* has been discussed when it is implemented in non-traditional manners and the influence of this on maternal mental health.

The final master theme explored social support and found women's own mothers to be an important source of practical support for new mothers. Women's own mothers were seen as someone who passed down knowledge and their role were embedded within the cultural framework of childbirth practices. For migrant women, emulating the support network originally available in their home country allowed them to receive the same social support and partake in any cultural postnatal practices and rituals. This was an important part of making the new mothers feel at ease, something which is not a reality for all migrant women. The impact of not having a mother to support you, further cemented the important role of a mother during the postnatal period. The findings demonstrated that women did confide in their husbands regarding low mood and/or psychological distress. The role of the husband varied in relation to social support and the way in which experiences of low mood were dealt with. Some husbands refrained from medicalising distress and instead offered support in ways which were in their power at the time, such as going for a walk. For others, the mysterious nature of feelings led to seeking professional support. The gendered nature of discussing issues after childbirth were highlighted, suggesting a

preference for female support. A core theme running across this chapter is generational differences which influenced various aspects of motherhood, such as the practical aspect of mothering, cultural practices, and social support. The next chapter of this thesis will explore generational differences in-depth, with regards to understanding of psychological distress after childbirth, in addition to how mothers themselves understood these experiences.

Chapter 6

Understanding Psychological Distress after Childbirth: The New Mother and the Absent Voices in Dialogue

6.0. Introduction

Chapter five explored experiences of motherhood during the postnatal period and identified generational differences across various aspects of motherhood. In some cases, generational differences were met with conflict and some women remained culturally silent as opposed to voicing their own concerns or beliefs. Generational differences in the understanding of psychological distress after childbirth and what this means for help-seeking, is one of the core areas of interest as discussed in the introductory chapter. Chapter five provided a broad understanding of various aspects of motherhood during the postnatal period. Chapter six aims to delve deeper by exploring how Pakistani-Muslim women understand their psychological distress after childbirth and to explore how family members react to disclosures of psychological distress. This will be explored via the perspective of the new mother, by paying attention to dialogical features such as the absent other, internal dialogue, and micro-dialogue.

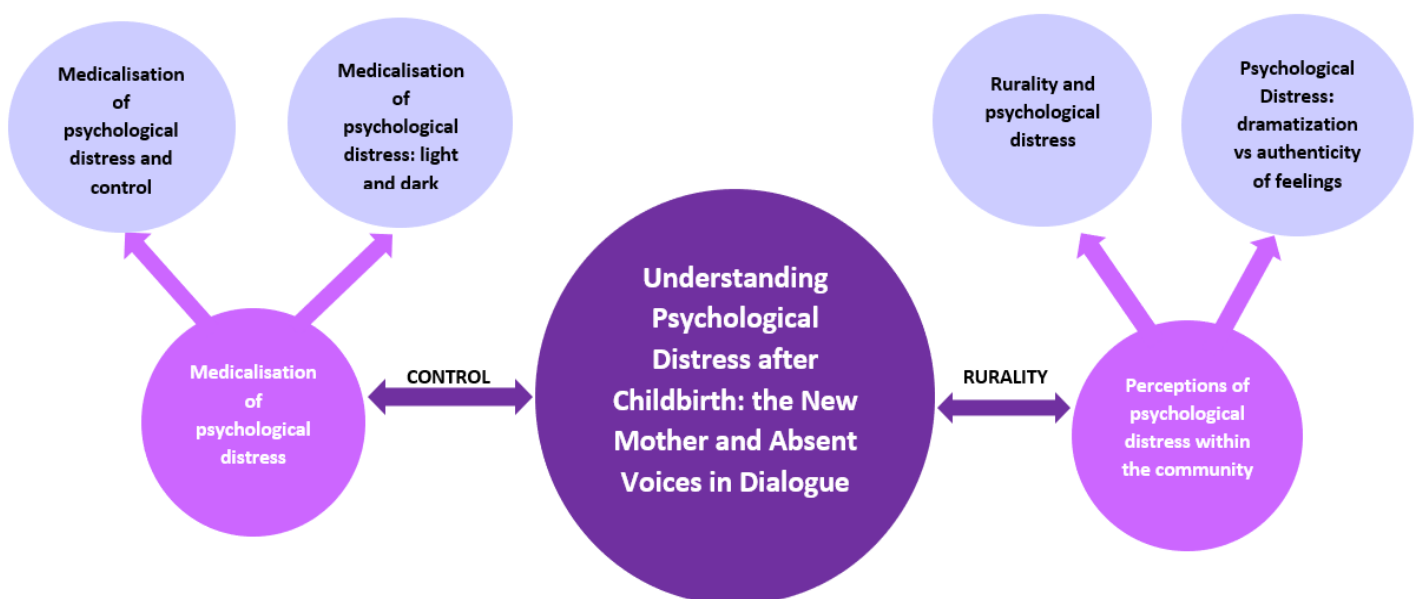
6.1. Thematic representation

The findings of this chapter are represented thematically in Figure 3.

Two master themes have been developed to explore this area. The first master theme 'Medicalisation of psychological distress' captures the experiences of mothers and how they understand their psychological distress. This includes two sub-themes, one which captures the role of

medicalisation and achieving a sense of control. The other sub-theme explores the role of medicalisation of distress and what this means for help-seeking. The term ‘control’ extends towards the first master theme, which represents control to be a core theme tying both sub-themes together. Control is explicitly explored in one sub-theme, but it is also implicitly present in the other sub-theme. The second master theme explores family reactions to psychological distress after childbirth, with a focus on generational differences and rurality. The first sub-theme captures the role of rurality and rural identity and how these influence understanding of psychological distress. All participants in this study had links to rural Pakistan. The second sub-theme delves deeper into how generational differences amongst other factors, influence how distress is responded to and interpreted amongst family members. The term ‘rurality’ extends towards the second master theme, which represents rurality to be a core theme tying both sub-themes together. The latter half of this chapter will provide a thematic summary of the following areas: knowledge of postnatal mental health issues, perceived causes of psychological distress post-birth and support preferences.

Figure 3: Thematic representation: Understanding Psychological Distress after Childbirth: The New Mother and Absent Voices in Dialogue



Findings

6.2. Master Theme: Medicalisation of psychological distress after childbirth

This master theme explores motivations behind medicalising psychological distress after childbirth. The first sub-theme pays attention to how medicalisation can be empowering for some women by giving them a sense of control over their lives. The second sub-theme presents varying accounts. In some accounts, medicalisation of psychological distress is understood as a positive step, aiding support and in other accounts it is viewed as negative and threatening.

6.2.1. Sub-theme: medicalisation of distress and control

This sub-theme explores how understanding psychological distress after childbirth as medical allows women to make sense of their experiences in a way which is empowering to them. Through medicalisation an element of control can be achieved, which will be explored across two accounts. Extracts 1a-c represent Lubna's experiences of early motherhood. She is a mother of 5 which allowed her to compare her experiences during the postnatal period and separate 'normal' feelings after childbirth from 'abnormal' feelings. In extract 1a, Lubna engages in an internal dialogue with herself in which she questions herself akin to an internal critic. Lubna received unsolicited advice, which made Lubna question her mothering abilities.

Extract 1a

“Lubna: the other problem is with Asian families they love to give advice, which you don't sometimes need. So, I was told my baby had clubbed feet because I sat in a weird position, and I hadn't been sitting properly. So, all that unsolicited advice that you're getting that annoys you more so and upsets you and kind of makes you think “well what

am I doing wrong?" But now with my fifth child, like I said I've realized that all them lot [family] don't matter, and get them out my life and if they give advice I have an answer back, I say "it's my child I'll do what I feel". Yes pressure, a lot pressure, a lot of expectation, a lot of the thing that I'm doing something wrong; I'm not a good enough mum. I think I must have had depression with my first one, although I didn't realise it was depression. I used to be anxious going place because I hadn't been out in so long, because of the whole idea you not allowed to go out" (page 27-29)

A reflexive chronotope is present in extract 1a, which represents changes in thoughts and behaviours across time and space through the act of reflection. Lubna's self-development can be seen from her first child to now fifth child. During her first child, Lubna was more susceptible to being impacted by the negative words of others (as seen in chapter 5 – navigating judgmental voices). At the time of her first child, she represented positions of silence and received knowledge (Belenky et al., 1986), as she was accepting of the words of others. Through experience gained after multiple births by the time of her fifth child Lubna had found her voice and was in the subjective knowledge position (Belenky et al., 1986). In extract 1a, the feature of sideward glance is present, as Lubna continues to anticipate judgement of her mothering abilities. Through internal dialogue, she has a response prepared for judgmental comments against the anticipated other. This demonstrates self-development through time and space, and greater mastering of control when it comes to your role as a mother. A reflexive chronotope is re-visited in the context of depression. The past chronotope was characterized by Lubna's lack of awareness of mental health terminology. Thus, at the time she was unable to attach labels to her feelings, which may have hindered the meaning-making and help-seeking process. This finding is in contrast to chapter 5, which found lack of mental health knowledge as a facilitator to help-seeking. Being stuck in the same space (due to *Chilla*) is reported as contributing towards psychological distress and anxiety. This finding adds to the findings of chapter 5, where

Lubna speaks of the harmful nature of *Chilla* if not implemented with appropriate social support. Through this circular and reflexive chronotope, Lubna is able to participate in a deeper sense of meaning-making, which was not paid attention to in the past.

Extracts 1b-c, highlight Lubna's interactions with other new mothers who had experienced similar feelings of psychological distress. This led Lubna to the missing piece to help make sense of her experience, the words anxiety and depression. In extract 1b, the past chronotope of psychological distress is revisited, in which the normality of feelings was emphasised during the time of distress.

Extract 1b

"Lubna: no one really picks up on it because it's so subtle that even you don't know its depression, so you think it's normal. You feeling isolated is normal, you having these feelings you're meant to have them because you're a mum now. So, you don't really realise its depression as such, it's only when somebody actually sits and talks to you. I've only now realised its depression when my friends gone and had a baby and she tells me about these things and I think "oh actually I had all that happen to me" and you know what? That isn't normal you know? Because I haven't had it with my fifth child, so I think it is depression" page 38-39

Interactions with other mothers allowed Lubna to listen and take in the lived experience of another, leading to appreciation and acceptance of another's understanding of psychological distress after childbirth. Through these interactions Lubna is demonstrating the position of procedural knowledge in the form of connected knowing (Belenky et al., 1986). Through a reflexive chronotope, her understanding of past feelings has evolved from what was perceived as a normal reaction to motherhood to medicalization of

psychological distress. A shift in her knowing is documented across extracts 1a-c, which suggests that Women's Ways of Knowing (Belenky et al., 1986) can change across time and space. As Lubna built her experience and confidence in motherhood, she began to recognize herself as an authority figure, someone who can make decisions and knows what is right for her. With this transformation in motherhood, Lubna's way of knowing also transformed. From a position of vulnerability and silence/received knowledge to a position of inner strength in the form of subjective/procedural knowledge. Extract 1c details Lubna's representation of her feelings/symptoms. The Common Sense model of self-Regulation (Leventhal et al., 1984) can be applied here to understand Lubna's interpretation of her feelings in the context of the past chronotope and how this influenced her help-seeking behaviors.

Extract 1c

"Lubna: I never really realised it was anxiety myself until I thought about it cause one of my friends recently had a baby, and she said, "I feel anxious going out" and you know that's the word I was looking for, anxious. I wasn't making sense of feelings as such. I had these feelings and they stopped me from going out, shopping and stuff. But I didn't really look for answers, and then when I spoke to my friend, she told me about her anxiety and I realized that's what I had, but by then I was better" page 31-32

In terms of identification, extract 1c suggests that at the time of psychological distress Lubna did not have the vocabulary to explain or label her distress. Without a label, Lubna lived with these feelings paying little attention to them. In terms of cause, she understood her feelings as a normal part of motherhood. Understanding feelings as normal as opposed to abnormal may have prevented Lubna from seeking support. The consequences of psychological distress included Lubna feeling limited in her ability to get out and about. Despite experiencing distressing feelings, the normalization of

anxiety in motherhood may have prevented Lubna from viewing these feelings as a threat. It is suggested that the severity of feelings did not increase and with time these distressing feelings passed. The subtlety of changes in mood after birth is emphasized by Lubna, which is indicated to be a barrier to help-seeking. For example, as a first-time mother Lubna found it challenging to differentiate normal feelings of motherhood from abnormal feelings of psychological distress. As a first-time mother, Lubna also accepted feelings of isolation as a normal part of motherhood, even when they prevented her from leaving her home due to anxiety. Now a mother of five, Lubna compares her experiences during the postnatal period and re-evaluates her 'normal' feelings as 'abnormal'.

It is not unusual to reflect on past feelings and experiences once they have passed, but it is interesting that Lubna chooses to understand her feelings under a medical framework. The literature review found the impact of maternal mental health stigma to affect South Asian women on multiple levels (Smith et al., 2019; Yasmin-Qureshi and Ledwith, 2020). However, for Lubna a label may offer a sense of validation for her past feelings and to counteract the 'bad mother' narrative, which is indicated in extract 1a. Through a reflexive chronotope, the medicalisation of psychological distress through a self-diagnosis indicates things are not in your complete control, so to an extent you are not to blame for your feelings or behaviors. By medicalizing past distress, Lubna may be attempting to understand her feelings in a safe space through interactions with trusted others. Medicalisation of psychological distress has also been associated with regaining control over the mind and body, as demonstrated by Alisha in extract 2a-c. In extract 2a Alisha reports that she gained knowledge about postnatal mental health via her midwife. Alisha referred to this knowledge to label her feelings as depression when she began experiencing distressing symptoms.

Extract 2a

"Interviewer: did the midwife or anyone ever mention that this is a

possibility, this can happen to women?

Alisha: they did. Afterwards I noticed these things myself then” page 19

Extract 2b details circumstances behind Alisha’s depression, which is the hostile home environment. In this extract, chronotope is split for example, family members behave and treat Alisha differently dependent upon the absence or presence of her husband. The relationship between chronotope and depression can be seen in extract 2b, as time progressed in the hostile environment symptoms of depression also increased in severity. Alisha also demonstrates her mental health literacy as she states being aware and noting changes in her mood.

Extract 2b

“Alisha: when he wasn’t home [husband] there was always fights and his brothers, they used to shout over small things. I was in the depression, was getting worse day by day, so I thought I have to go [to the doctors]” page 16-18

In extract 2c, Alisha details the severity of her symptoms, which includes frequent crying and self-harm. Alisha did not seek support until she began to self-harm, which can be viewed as a crisis point (Yasmin-Qureshi and Ledwith, 2020). With Alisha’s chronotopic relationship and experience of depression in mind, she may have seen value in seeking professional support, particularly as she began to self-harm. It is evident she required an outlet for support to share her feelings and understand how to manage them.

Extract 2c

“Alisha: I used to feel over small things. I used to cry a lot and I used

to harm myself. I used to get glass and do these things and used to eat tablets. But then I went doctors and he spoke to me, and he gave me tablets, but I didn't take the tablets. Because the doctor told me, he goes "you take tablets it will help for a while and if you stop them, it will get worse", but I tried to control my body myself, so I was okay then" page 14

Alisha's decision to seek support could suggest that she felt her symptoms could be controlled/managed. This finding adds to research by Baines et al. (2013) who conducted a systematic review exploring illness perceptions in mental health, utilizing the Common Sense model of self-regulation. The review found that when mental health issues were viewed as chronic, controllable and with negative consequences, individuals displayed more active coping strategies and help-seeking behaviors. In Alisha's case severity of psychological distress determined time of help-seeking. It was only when she began to self-harm and lose control over her mind and body that she decided to seek support from the doctor.

In extract 2c, Alisha replays the voice of her doctor in which he prescribes her medication. However, there is a disclaimer as Alisha did not take the medication, as the doctor made her aware of the risk of dependency. The decision to not take medication may have been associated with desire to have full control over the mind and body. Control was previously lost through self-harm and would have been gained back through medication, however this can be classed as passive or partial control. The literature suggests that it is not uncommon for some women to express reluctance and fear over taking medication for psychological distress after childbirth. Turner et al. (2008) found that women believed anti-depressants to mask feelings of psychological distress, and thus delay recovery. Further research by Patel et al. (2013) found stigma attached to taking anti-depressants as women perceived they would be viewed as weak and categorised as bad mothers. The present study adds to the literature around taking medication for

psychological distress, by paying attention to how dependency interlinks with a felt loss of control over the mind and body. As such, Alisha decided to opt for self-care methods to manage her psychological distress.

Understanding illness beliefs may contribute towards predicting how individuals are likely to respond and cope with psychological distress. However, as highlighted in Lubna's case illness beliefs are not stable over time and due to various exposures, have the potential to change. In such cases, it may be useful to merge the Common Sense model (Leventhal et al., 1984) with the Women's Ways of Knowing (WWK) model (Belenky et al., 1986), to develop a greater understanding of behaviors. In hindsight, Lubna medicalised her distress after childbirth, perhaps as a way of negotiating and resisting the dominant discourse around intensive mothering and codes of femininity within the Pakistani-Muslim culture. Alisha sought professional support for her psychological distress when she began to self-harm and lose control over her body and mind. Professional support was an outlet for support which helped her re-gain control, not through medical intervention but through self-care methods. These findings offer unique insights into how Pakistani-Muslim women may understand their psychological distress after childbirth under a medical framework.

6.2.2. Sub-theme: Medicalization of psychological distress: light and dark

This sub-theme explores two distinct ways in which medicalization of distress is responded to. In one case it is viewed as a negative, something which attacks the sense of motherhood and is therefore rejected. In another case medicalization of distress is viewed as a savior, an outlet for much needed support and intervention. Extracts 3a-b focus on Amaarah's experiences of disclosing feelings of psychological distress to her midwife and health visitor. For contextual purposes, Amaarah experienced her pregnancy and the early postnatal period without her husband, who was living in Pakistan as he did not have a UK visa at the time. This was a source of stress for Amaarah.

Across extracts 3a-b, when talking about her distress Amaarah uses the terms 'depression' and 'stress'. These are used on multiple occasions during interactions with health professionals, as a result she was referred to mental health services. In extract 3a Amaarah recalls her thought process during the referral visit

Extract 3a

“Amaarah: because I was thinking like I will end up going crazy. Like I thought I might go mental because they asked me so many weird questions, like actual mental people. Like obviously I wasn't mental, all that was that I was stressed and depressed and I always used to cry just for my husband. But they were taking it some other way around as if I'm mental or something” page 27

The dialogue in extract 3a is filled with sideward glances and after almost every sentence Amaarah throws in a disclaimer that she was not 'mental' but just 'stressed and depressed'. This indicates a level of perceived stigma and fear of being labelled as mentally ill. Although Amaarah was using medicalised language to describe her psychological distress, she did not identify as someone with a mental health issue. Medicalised language was used to describe what was considered by Amaarah, a normal or expected response to her husband's absence. Thus, for some individuals the term depression may not necessarily reflect what it does in the DSM-5. This may pose challenges for health professionals when attempting to interpret an individual's mental state based on descriptions given and the type of support to be provided. This indicates a shift in chronotope of medicalised language. What was once terminology held by psychiatrists and psychologists in diagnostic settings, is now part of everyday vernacular as an ordinary description of sadness and as an expert codification (Pilgrim, 2015). The impact and consequences of being labelled with a mental health issue is further unpicked in extract 3b.

Extract 3b

“Amaarah: well, some of them I could've been honest, but I wasn't because I was thinking like they might actually think that somethings wrong with me, and they might end up taking my baby off me cause I've heard a lot of stuff like that. If you're a bit not good in the head take your baby off you I've heard. So obviously I was worried that if I say stuff like, I obviously with me I've never thought of committing suicide like tauba [to ask for forgiveness from God] but like, just its obviously used to be depressed stressed used to cry and stuff. I couldn't be arsed with [child] like I couldn't be arsed picking her up if she crying and stuff, because I was that upset. But it's not like I wanted to hit her or something, just like I couldn't be arsed, like if she was crying I was like let her cry forget it” page 28-29

Amaarah recalls her thought process at the time, paying attention to the potential reaction of the other (mental health practitioner). Within this hidden dialogue exists reservations and hesitations of knowledge regarding what information to disclose and what information to hide from the mental health practitioner. Amaarah recognises a power imbalance between herself and the mental health practitioner, leading her to exhibit a form of strategic silencing (Belenky et al., 1986). Reasons for this include fear of her baby being taken away and/or Amaarah being labelled as mentally ill. Amaarah mentions that these are things she has heard from others, which is representative of received knowledge (Belenky et al., 1986). Being perceived as a bad mother and fear of child being taken away can be considered barriers to seeking professional support. Such factors continue to be common concerns, particular amongst ethnic minority women in the West (Ahmed et al., 2008; Dennis and Chung-Lee 2006; Wittowski et al., 2017). Through the use of sideward glance and disclaimers, Amaarah goes onto explain her interpretation of what mental illness looks like. Mental illness is depicted as outwardly extreme behaviors such as feeling suicidal and/or

thoughts/acts of harming your child. This may indicate that severity of feelings could be related to increased likelihood of help-seeking for Amaarah. Throughout the interview, the source of stress was emphasized to be her husband's absence. Thus, the solution was his presence, not psychological or medical intervention.

Through the lens of the Common Sense model of self-regulation, across extracts 3a-b Amaarah displays signs of someone who is trying to seek support for her psychological distress. She recognizes her symptoms as feeling down, frequent crying, and labels/identifies as depressed. She reports the cause of psychological distress as being away from her husband and in the next sub-theme, Amaarah goes on to demonstrate a coherent understanding of mood changes during the perinatal period. Baines et al. (2013) found individuals with a coherent understanding of mental health were more likely to seek professional support. In the current study, Amaarah was referred due to her consistent use of the term depression to describe her feelings. However, as extract 3b suggests, she did not want to be referred and did not view herself as ill. Therefore, although Amaarah seemingly looked like someone with positive self-regulating behaviors advocating for help-seeking and treatment uptake, this was not the case in reality. The present finding highlights limitations in the Common Sense model (Leventhal et al., 1984) for complex cases, such as that of Amaarah. This finding has highlighted a relevant issue in present times, the popularization of mental health terminology for describing 'everyday emotions'. This account has demonstrated the challenges this can cause for health professionals who are responsible for safeguarding patients. In this scenario, the mental health referral was perceived as negative, threatening, and unnecessary for Amaarah. The next account presents a contrasting experience of psychological distress, in which professional support was actively sought.

In extract 4, Aaliyah mentions past trauma where she was abused. For contextual purposes, she disclosed this abuse to her family members. Due to

various complexities, family members did not take this further and discouraged Aaliyah from speaking on the matter. The traumatic experience was therefore psychologically buried and not spoken of for many years. In Aaliyah's case, individuals that played a part in silencing her included her mother-in-law and immediate family. Cultural barriers, perceived shame, and not being believed also cast doubt in Aaliyah's mind, leading her to remain silent (Belenky et al., 1986). As suggested by Aaliyah in extract 4, it was the silence and concealment which she could no longer carry on with. Thus, reaching a breaking point which allowed her to seek support for her current feelings of distress.

Extract 4

“Aaliyah: to be honest I didn't have opportunity to speak to my health visitor that these are the symptoms because things were happening so fast that I just had to tell her. When she did that depression thing [screening questionnaire], that was the point she realized you do have depression. But they reckon I got more of a just a depression rather than being postnatal or prenatal depression. And I think if I got help at that point from counselling when I was abused, probably I wouldn't have gone through it. It's because I was hiding something inside me for so long and then you know the final kick was when all this happened, and you just couldn't take anymore” page 45

A cyclical chronotope is present in extract 4, in which Aaliyah must re-visit her past trauma to help the healing process of her current psychological distress. Past untreated trauma is reported by Aaliyah as a risk factor to psychological distress after childbirth. This adds to existing research by Hutchens and Kearney (2020) who found past or present trauma to increase the risk of psychological distress after childbirth. A shift in Aaliyah's epistemology can be seen based on her overall interview. For example, she began with hiding her feelings, representative of the silence category, which

according to Belenky et al. (1986) is common amongst individuals who have experienced abuse. Through the support of health professionals, she gained trust and transitioned into a subjective knower. This sub-theme has demonstrated two contrasting ways in which psychological distress is medicalised and what this means for clinical settings and for help-seeking. The first account was particularly nuanced, highlighting complexities between language use and what this represents in everyday settings compared to clinical settings. Medicalisation has shown to be both a blessing and a curse, in the sense that it is an outlet of support for those desperately in need, having reached a crisis point. For others it is a threatening prospect, which may deter them from such services in the future. A combined approach of the Common Sense model of self-regulation (Leventhal et al., 1984) and the WWK model (Belenky et al., 1986) may support researchers and clinicians in gaining a better understanding of women's feelings and support needs.

6.3. Master Theme: Understanding of distress after childbirth amongst the Pakistani-Muslim community

Chapter five reported on the role of family members providing social support during the postnatal period including the impact this had on new mothers. Through the perception of the participants, this master theme pays attention to how family members understood and reacted to psychological distress after childbirth, including implications for help-seeking. Key factors such as rurality, rural identity, and low SES will be unpicked.

6.3.1. Sub-theme: Rurality and psychological distress after childbirth

This sub-theme explores the role of rurality and generational differences in the understandings of psychological distress after childbirth. Extract 5 pays attention to Amaarah's experience of pregnancy, childbirth, and motherhood as well as her mother's reaction to her experience. Amaarah recalls a conversation with her mother where she discloses feeling low during and

after pregnancy. Her mother is represented by the absent voice, in which she responds to Amaarah's disclosure of distress in a dismissive manner. Extract 5 suggests that Amaarah's mother views the chronotope of pregnancy, childbirth, and motherhood as fixed, meaning that across time and space everyone experiences these life events the same. However, Amaarah is arguing against this, as she has a different experience which she is trying to convey.

Extract 5

“Amaarah: I don't know cause like when I gave birth, even now cause I'm pregnant as well when I had her as well, I used to feel a bit down. I explain to my mum obviously that I'm feeling a bit down, because obviously I'm pregnant. Used to be like, she used to be like “oh everyone gets pregnant it's a normal thing”. Because these lot don't know like because, I don't know, they know more obviously they're parents but obviously like we think that when you're pregnant you have a bit of ups and down. But our mothers and these old people, they think that obviously it's not real [psychological distress]. Obviously, mum goes “I've had three babies, I've looked after them myself, I've given birth myself, no one has come with me to hospital, but we look after them, I've never felt down”. Obviously with me because obviously I've read books and stuff. I know that when you're pregnant you do feel down, and I said to her “look you have ups and downs and its true it is real”” page 35-36

Disparity amongst the ontological status of psychological distress could be explained by differences in backgrounds of Amaarah and her mother. Whilst both share the same ethnic and religious background, they differ in their geographical background and upbringing. Amaarah's mother was born and raised in rural Pakistan and migrated to the UK after marriage. Amaarah's mother is of the older generation and via her re-presented voice in extract 5, it can be deduced that values and traits associated with motherhood in the

older generation of Pakistani-Muslim women is made up of stoicism, independence, and self-reliance. The repetition of “I’ve” emphasizes these traits and suggests that pregnancy and motherhood for Amaarah’s mother was a sole experience, as there is no mention of her partner or any other figure. For contextual purposes, Amaarah was feeling low due to her husband being away, in Pakistan. Thus, via the absent voice of the mother, it is being emphasized that the absence of a partner should not be an excuse for psychological distress.

Her mother’s solo experience of pregnancy and childbirth may also have extended to motherhood, falling under traditional gender roles. This is suggested in extract 5 as the absent voice of mother reports caring for children despite hardships and lack of support. This indicates a sense of responsibility as a mother and that the experience of low mood or psychological distress may threaten functionality, which may have an impact on other family members’ workload/running of the household. Thus, in rural communities it is possible that through stoic values, feelings of psychological distress are not given the opportunity to manifest. The literature review found rural identity to influence constructions of mental health and help-seeking. A review by Cheesmond et al. (2019) found traits such as stoicism, independence, and self-reliance to be valued within rural communities. Furthermore, rural communities constructed symptoms of depression as a normal response to everyday stressors, as opposed to an illness (Cheesmond et al., 2019). This sheds light onto the statement of the absent voice “*I’ve never felt down*”. The absent voice of the mother is narrated as unsympathetic, with little to no acknowledgment of distress on Amaarah’s part. Research around the development of the Liverpool Stoicism Scale found stoic individuals to demonstrate weaker emotional reactions to emotional stories and lack of emotional involvement and expression (Moore et al., 2013). This contrasts with Amaarah’s experience, who is British born and gave birth to her first born in the comfort of her childhood home with ample social support. As such, Amaarah’s mother exhibits a gap in

experiential understanding, as she is unable to empathise with Amaarah and her experience of psychological distress.

Extract 5 suggests that both Amaarah's experience of motherhood does not echo her mother's experience, as she seemingly lacks stoic traits. From an acculturation perspective, collectivist values are transmitted through generations. The literature review explored parental collectivism, which refers to parents working hard to instil collectivist values and traditions in their children (Triandis, 1995; Tse and Ng, 2014). Collectivist values of stoic nature are particularly valued by Amaarah's mother, which can be seen within extract 5. Amaarah demonstrates inner conflict, something which can be seen across the empirical chapters in various scenarios involving the older generation. A back-and-forth dialogical structure is present in extract 5, in which Amaarah's experience is presented and then her mothers, with a struggle in accepting one's lived experience, whilst being respectful of the knowledge held by the older generation. In this case, Amaarah is displaying signs of a subjective knower but in a resistive and conflicted manner. This is reflective of received knowledge which shifts to subjective knowledge (Belenky et al., 1986) as Amaarah evaluates her mothers' views compared to her own.

Amaarah expresses that her knowledge of psychological distress during the perinatal period has been informed by books. Words written in books about mood changes during the perinatal period cements the 'realness' of her feelings. The literature review found education and knowledge of perinatal mental health as a key factor in determining help-seeking behaviors (Smith et al., 2019). In contrast, Amaarah expresses that her mother and others of the older generation do not view these feelings as real. To conclude on Amaarah's experience, the extract has demonstrated generational differences in the understanding and chronotope of psychological distress after childbirth. The role of rurality and rural identity is likely to influence

understanding of mental health issues. Extract 6 expands on this further by paying attention to the rural-urban divide and how this shapes experiences of motherhood and subsequent views around psychological distress.

Extract 6 is made up of multiple absent voices representing Lubna's mother and other women of the older generation. For contextual purposes, Lubna is currently a mother of five and reported psychological distress as a first-time mother. Thus, extract 6 is referring to her earlier experiences of motherhood. Each of the three absent voices mention number of children and the ability to cope. Within the rural South Asian communities, it was much more common amongst the older generation to have larger families compared to present times. Larger families indicate greater responsibilities and mothers in rural communities especially, are expected to mother without complaint. This links with stoicism, a trait found to be desirable in females (Cheesemond et al., 2019). By displaying stoicism, women were living up to the culturally constructed ideals of a 'good woman'. Thus, minimisation and inability to understand psychological distress in first-time mothers comes through in extract 6, as the older generation use their own experience of motherhood as the benchmark for distress.

Extract 6

“Lubna: “it’s just one baby, we had seven and you can’t deal with one child?”. So, it’s all that “we were fine, we had eight babies and we still managed to milk a cow and do the rest, so I don’t know what she’s on about”. My mums like “I raised six of mine and I managed to stay intact”. So, a lot of the times they don’t realize the actual thing [psychological distress]” page 41

The reference of “*managed to milk a cow*” emphasizes the demands of rural life and that life does not stop after motherhood. Indirectly this reference suggests the ease of urban life, in which the older generation can use to question mothers' psychological distress. Rogers-Clark (2002) explored the

influence of rurality on suffering and resilience in women with breast cancer. The research was conducted in rural Australia and women reported rural life to be harder than city life. Reasons for this included being isolated and 'living in the bush', which meant women had to be independent and self-reliant. Due to this type of lifestyle women learnt to cope and live with stressors, including pain (emotional, mental, and physical). The present finding is of course not related to breast cancer. It does, however, demonstrate how rural identity consists of stoic traits and irrespective of ethnicity and culture, rural identity influences the response to and understanding of psychological distress after childbirth. The next sub-theme will go into further detail of how family members reacted to women's disclosures about psychological distress. This will be understood from the women's perspective by paying attention to voices in dialogue.

6.3.2. Sub-theme: Psychological Distress: dramatization vs authenticity of feelings

This sub-theme pays attention to ontological assumptions of psychological distress, with a focus on micro-dialogue. Across extracts 7-9 participants take part in an internal dialogue, in which family members' views on psychological distress is re-created (micro-dialogue). A running theme across extracts 7-9 is psychological distress being branded by family members as inauthentic and dramatised as suggested by the terms 'acting' and 'drama'. In extract 7 the terms 'acting' and 'drama' are associated with avoidance of domestic chores.

Extract 7

"Lubna: the older generation say "she's just acting" or "she's just doing drama because she doesn't want to do housework"" page 41

This type of thinking may be associated with joint families, where each member is expected to contribute to the household in some way. If someone is unable to contribute, then extra responsibilities may fall on other family members. This may cause conflict to the extent where psychological distress of the new mother is branded as inauthentic because it disrupts household dynamics for longer than planned. Crumb et al. (2019) explored mental health issues in rural, low-income populations in the United States. The findings indicated that sufferers of mental health issues were often discredited by their immediate family and/or their communities. Some sufferers were accused of using mental health issues as an excuse to avoid responsibilities. The present finding adds to this research by highlighting core components influencing understanding of mental illness to include rurality, rural identity, and low SES. Such factors may have a greater influence in shaping views around mental health compared to ethnicity alone. Extract 8 delves deeper into family dynamics by paying attention to how in-laws can contribute towards the dramatization of distress via role-play.

Extract 8

“Nazish: people don’t understand. You know what it is, people think the person is doing it themselves, they just pretending to do something, to get attention. To be honest, especially I think uneducated people like mother-in-law, sister-in-law make this issue worse, [they] do more role play” page 18-19

Through my knowledge and experiences within the Pakistani-Muslim community and culture, it can be deduced from extract 8 that Nazish is referring to efforts made by in-laws to paint the new mother in a bad light through the way they interpret her distress. These interactions between the in-laws and the new mother can indeed feel and look like a theater role play. Nazish associate’s ontological assumptions of psychological distress to level of education, suggesting that educated individuals may understand psychological distress as an illness or something requiring support. On the other hand, family members with lower levels of education may interpret

psychological distress in various ways. Lower levels of education have found to be associated with poorer mental health literacy. Furthermore, urban populations displayed greater recognition of depression than rural populations (Furnham and Swami, 2018). Extract 9 builds on Nazish's account by demonstrating interactions between Alisha and her mother-in-law and methods used to discredit Alisha's psychological distress and suffering. It is also possible that cultural expectations of maintaining your role in the family, coupled with lack of education or experience around mental health issues may lead younger family members, such as the sister-in-law in this context, to adopt a stoic understanding of psychological distress.

Extract 9

“Alisha: she [mother-in-law] used to say “oh she’s an angry one” and “she is acting. If I knew this before you are like this, I wouldn’t get you married to my son”. They never used to think what they do. And you know, when I got married my dad told them my daughter is like this because my dad never made me cry, and they begged my father for the rishta (proposal), then say things like this you know” page 20-21

Alisha's mother-in-law minimized her distress by branding her as 'angry' as evidenced by the absent voices presented in extract 9. Anger in women is stereotypically associated with being irrational, hostile, and negative despite the circumstances. It is associated with being unfeminine, undesirable, attitudinal and overbearing (Morgan and Benner, 2006; Ashley, 2014). These associations with women and anger are often depicted in the stereotype of the 'Angry Black Woman'. Similar patterns can be seen in this sub-theme, but in a very different context. Here, a Pakistani-Muslim woman is discrediting the feelings and experiences of another Pakistani-Muslim woman. As part of the 'Angry Pakistani-Muslim woman' narrative, Alisha is made to feel unwanted and undesirable. Her mother-in-law makes it clear that the marriage went ahead because she (mother-in-law) had decided so. This shows that she is the matriarch and has authority and control over

Alisha and her own son (Alisha's husband). At the same time, this comment may also suggest that the marriage can just as easily break if she (mother-in-law) wanted it to. This may be an attempt at controlling and silencing Alisha and for her to conform to standards of 'good mother' and 'good daughter-in-law'.

This sub-theme has highlighted the struggles of suffering women in receiving support and understanding from their family circles. There is tension and stigma of psychological distress after birth, across generations. In the current sample, the older generation push for a stoic approach. By doing so, they are deciding what is authentic distress and what is dramatized, as per cultural and societal norms and expectations. This puts the suffering woman in an even more vulnerable position as she may hold limited control over how her distress is understood, and the implications of this on help-seeking. As found in master theme one, poor support and delayed help-seeking can result in a worsened mental health state. The first half of this chapter has presented the findings of two master themes, which has explored the medicalisation of psychological distress and has paid attention to how family members reacted to disclosures of psychological distress. The second half of this chapter will explore participants' knowledge of postnatal mental health terminology, perceived causes of psychological distress after childbirth, and support preferences.

6.4. Knowledge of postnatal mental health

This section presents a thematic summary of findings underpinning knowledge of postnatal mental health. Knowledge of the term 'postnatal depression' is explored, in addition to perceived causes and support preferences.

6.4.1. Terminology: postnatal depression

The literature review found lack of knowledge of maternal mental health terminology to act as a barrier to help-seeking (Smith et al., 2019; Moghul, 2018). Therefore, it was deemed important to gain an understanding of how many women in this study had heard of the term 'postnatal depression'. The findings presented in Table nine indicate that 13 out of 17 mothers had heard of the term postnatal depression. In terms of language spoken, 3 out of 7 Potwari speakers had not heard of the term postnatal depression and 1 out of 10 English speakers. Whilst these are relatively small numbers for any definitive conclusions, the findings do suggest awareness of postnatal mental health terminology to be lacking in almost half of the women who did not speak English. However, the mothers who responded 'no' to knowledge of the term postnatal depression, when given a definition they were able to recollect similar experiences or stories that could represent postnatal depression.

Table 9: Knowledge of the term 'postnatal depression'

Name	Language spoken	Knowledge of terminology
Ayesha	English	Yes
Aleena	English	Yes
Neelam	Potwari	No
Maariya	Potwari	No
Nadia	Potwari	No
Isma	Potwari	Yes
Asma	English	Yes
Mariam	Potwari	Yes
Tayyba	Potwari	Yes
Naz	Potwari	Yes
Alisha	English	Yes

Saifah	English	Yes
Sofia	English	Yes
Lubna	English	Yes
Arooj	English	No
Amaarah	English	Yes
Aaliyah	English	Yes

Four extracts will now be presented to further understand how women defined postnatal depression or psychological distress after childbirth. Extracts 10 and 11 represent accounts of women who had heard of the term postnatal depression and extracts 12 and 13 represent women who had not heard of the term. In extract 10, Naz associates psychological distress as a natural response to becoming a mother. However, gradual decline is described, from feeling low, to helpless and so on, which may be indicative of something more serious.

Extract 10

“Naz: like when you have children feelings change after that. Person feels low, then slowly, slowly you feel helpless then like slowly, slowly get worse” page 14

Extract 11 gives insight into how mothers may gain knowledge of postnatal depression. Sofia suggests that she was given a leaflet which outlined this information, as she associates postnatal depression with a change in hormones after birth. Sofia refers to “they” which could be the health professionals who provided the leaflet to her.

Extract 11

“Sofia: yeah, they just give you a leaflet and they'll just give you a bit of information. Like if you do feel a bit low like your hormones are obviously all over the place” page 16

Mothers who responded 'no' they had not heard of the term postnatal depression demonstrated some understanding and knowledge of this phenomenon. In extract 13, Neelam describes postnatal depression as frequent sadness and difficulty sleeping. These descriptions are consistent with items in the Edinburgh Postnatal Depression Scale (EPDS), a screening tool for postnatal depression.

Extract 12

"Neelam: yeah, I've heard it can happen to women they sad all the time, they can't sleep" page 12-13

In contrast, Maariya describes feelings of postnatal depression through physical, bodily complaints of the heart.

Extract 13

"Maariya: when heart is troubled like that" page 10

The use of physical, somatic complaints to describe psychological distress is discussed in the literature review and may lead to misinterpretations of symptoms in health settings and may increase the risk of misdiagnosis. Existing literature in the last two decades has found terms such as 'sinking heart' 'dead heart' 'someone holding heart tightly' as characteristic of depression amongst individuals of South Asian origin (Anand and Cochrane, 2005; Akram-Pall and Moodley, 2016). This finding adds to cultural conceptions and language use of mental health by paying attention to the area of postnatal depression. In addition to popularization of mental health terminology, cultural idioms and somatization is a continuous challenge for health professionals. In terms of the women who had not heard of the term postnatal depression, the overall experience of distress post-birth was familiar but not the medicalization of this distress as postnatal depression.

This finding adds to the study by Oates et al. (2004) discussed in the literature review, which explored postnatal depression across countries and cultures. The current finding almost 20 years later demonstrates similar patterns of some women from different countries (Pakistan) and those who speak languages other than English (Potwari) are familiar with distress post-birth but do not necessarily label or understand this as postnatal depression.

6.4.2. Perceived causes

Women in this study were asked what they thought may cause psychological distress after childbirth. Five perceived causes were reported, four of which fell under social cause and one under biological, presented in Table 10.

Table 10: Perceived causes of psychological distress after childbirth

Perceived causes	Number of participants
Poor social support	11/17
Social isolation	8/17
Relational conflict	6/17
Cultural expectations	5/17
Biological causes	5/17

Lack of social support is one of the most reported causes for psychological distress in this study. As found in chapter five, women's own mothers played an important role in providing practical support. In extract 14, Ayesha reports how lack of social support can lead to feeling unsupported, a factor contributing towards psychological distress.

Extract 14

“Ayesha: cause she's not getting any help; she's doing everything that's why” page 16

The second most reported cause is social isolation. In extract 15, Nadia suggests that some women may be socially isolated due to restrictions placed by family members. She describes a scenario where the woman in question has limited authority and autonomy over what she does, leading to silencing. This may sound like a generic scenario, but one can see how such an environment may make the transition to motherhood more difficult if one is socially isolated. Lack of social interaction may limit meaning-making of experiences and contribute towards psychological distress, as indicated in extract 15.

Extract 15

“Nadia: staying at home, staying quiet can lead to depression too. Many people stay inside all time, family don’t like them going out for many years so that’s why I think women go into depression” page 12

The third reported cause is relational conflict. The content in extract 16 is an extension of the master theme which explored dramatization vs authenticity of distress. In extract 16, in-laws are mentioned as the carriers of relational conflict. The chronotope of psychological distress is shifted by in-laws to a context which removes responsibility from them, evidenced by the absent other. Lack of acknowledgement from individuals who might be responsible for causing distress can lead to relational conflict and may contribute towards psychological distress post-birth.

Extract 16

“Alisha: if somebody is depressed and worried first thing which will come from in laws, I’ve seen mostly they’ll say “oh we didn’t say anything” “oh she’s taking her tension about her brother, sister whatever and she bring the tension at home” this what they think. This is what I’ve seen in a lot of families. They [family] don’t think maybe its them they’re doing something wrong” page 25

In extract 17 Lubna reports the demands placed on her when meeting guests, which is explored in chapter five under '*Bhartan*'. In chapter five, '*Bhartan*' is seen as a burden when mothers came home from complex and traumatic births. The present finding adds to this by understanding day-to-day challenges of new mothers during the early postnatal period. For Lubna, an additional factor which made her feel low was physically not looking nice/presentable, which made the cultural expectation of '*Bhartan*' a not so enjoyable experience. Pressures to engage with guests whilst not feeling comfortable and having to think about breastfeeding can be overwhelming and may contribute towards psychological distress.

Extract 17

"Lubna: I can't excuse myself either because they'll [guests] find me to be rude. If there's all that scenario going on and not only that, the other thing that depresses you more so is because you can't really dress up as such. So not being able to dress up because I have to keep myself nice and warm so I'm wrapped up in all these cloths. Because my mum says "if you're nice and warm and if your chest is warm, you'll make more milk" page 26

Five women attributed feelings of psychological distress to changes in hormones during the perinatal period. This knowledge was gained via health professionals such as midwife, as indicated in extract 18.

Extract 18

"Tayyba: my midwife said it's because of hormones get disturbed a lot, so that's how it can start" page 10

The majority of causes reported pertain to external stressors (social), with the minority being internal (biological). This highlights the significance of socio-cultural conflict as a contributor towards psychological distress. These findings are consistent with previous qualitative research exploring causes of postnatal depression (Lamba, 2015; Moghul, 2018; Khan et al., 2019). The social context is also important to consider when developing and delivering interventions. For example, as discussed in the literature review Mir (2015:2019) adapted behavioral activation for depression in the Muslim community. The social context such as poverty, unemployment and discrimination were found to be important to participants to be recognised and incorporated into therapy. Mir (2015:2019) found a reduction in depressive symptoms via the adapted behavioral activation intervention. Similarly, interventions for psychological distress after childbirth may be beneficial when targeted at a socio-cultural level.

6.4.3. Support preferences

All women in this study were asked what type of support they preferred if they felt sad/low/psychologically distressed after childbirth. Table 11 outlines support preference for each woman and whether they experienced psychological distress after childbirth.

Table 11: Support preference for psychological distress after childbirth

Name	Support preference	Experience of distress
Ayesha	Self-care, break from caring responsibilities	No
Aleena	Family support and self-care, break from caring responsibilities	No
Neelam	Family support	No
Maariya	Family support	No
Nadia	Family support	No

Isma	Friends and family support. If severe, then seek professional support	No
Asma	Someone to talk to (non-family member)	No
Mariam	Family support	No
Tayyba	Professional support	Diagnosed postnatal depression
Naz	Family support	No
Alisha	Talk to someone, group support. If severe, then professional support	Subjective
Saifah	Family support	Subjective
Sofia	Family/friends, if severe then health visitor	Subjective
Lubna	Talking to other mothers: coffee morning	Subjective
Arooj	Self-care	Subjective
Amaarah	Confide in health visitor	Subjective
Aaliyah	Professional support after crisis point	Diagnosed postnatal depression

A limitation of this research is that questions around using religion as a coping resource were not directly integrated into the topic guide. Through the patient and public involvement exercise where British Pakistani-Muslim reviewed study materials, adding a question around religion was not raised. Religion can be a sensitive topic and personal journey, thus it was decided that conversations around religion would be probed if broached by participants. For women with experience of psychological distress, preferences for support included talking to others with similar experiences or seeking professional support. However, religion was used in subtle ways

which to some extent helped women seek support. For example, in extract 19 Alisha recalls her experience of resorting to self-harm during a period of psychological distress. Whilst self-harm could be a cry for help, it may also be an attempt at suicide, which is forbidden in Islam. Alisha reminds herself of this, and also thinks about the wider consequences such as leaving her children without a mother. These religious reminders helped Alisha in seeking professional support, as discussed earlier in this chapter.

Extract 19

“Alisha: I thought these things we do harm ourself when we are angry but really if something happens to me who's going to look after her [daughter] and other thing it is haraam [forbidden] in Islam anyway to harm your body and it's not good” page 19-20

The findings indicate three types of support preferences: 1. professional, 2. family/friends, and 3. Other, which includes self-care, a break from caring responsibilities and informal support such as coffee mornings. Women who did not report experience of psychological distress, hypothetically felt that they would confide in family first. This may seem like a first logical step if one experiences sadness or low mood. In addition to family support, women also considered self-care techniques to improve mood, such as taking a break from childcare, going out and relaxing. If symptoms persisted women reported that they would seek professional support. Women who reported experiences of psychological distress were more likely to prefer professional support, followed by self-care or attending coffee mornings to socialize with other mothers. Family support was least preferred. This ties in with the findings of the master theme discussed earlier in this chapter, which found older generation of family members to dismiss women's experience of psychological distress. These findings imply that women may initially decide to seek support from family members but may not always feel supported or heard. This resulted in some women's psychological distress increasing in severity. In some women like Aaliyah and Alisha, a crisis point was reached which facilitated seeking professional support. This finding indicates a need to raise awareness of psychological distress after childbirth amongst the

wider family networks. This point will be expanded on in the next chapter of this thesis.

6.5. Summary of results chapter

This chapter has provided a detailed narrative account of how Pakistani-Muslim mothers understand psychological distress after childbirth. The first master theme explored the role of medicalisation of distress and how this linked with the element of control. In the first sub-theme, two accounts demonstrated how medicalising psychological distress empowered women, giving them a sense of control. For one woman this control was over her narrative as a mother, giving her the opportunity to counteract the 'bad mother' discourse. A cyclical chronotope is present, where the mother revisits her previous childbirths and early motherhood experiences and compares them to current experiences and knowledge. In the second account, medicalisation was a way for the mother to understand her feelings and experiences and to then make an informed decision on treatment. The Common Sense model (Leventhal et al., 1984) and the Women's Ways of Knowing model (Belenky et al., 1986) combined, offered a greater insight into patterns of behaviours, but also the understanding behind why women may or may not seek support for psychological distress after childbirth.

The second sub-theme paid attention to accounts of women who received formal support for their distress, two distinct accounts were presented. In the first account a mental health referral was made, and this was seen as threatening and in the second account it was seen as a saviour. In the first account, the referral was partly due to frequent use of the term 'depression' by the participant to various health professionals. Thus, medicalised terminology was used to describe everyday sadness rather than a mental illness. This can be confusing for health professionals who have a duty of care, especially when an individual is verbally saying they are depressed. In the present case however, this shows a shift in chronotope of the medicalisation of distress, which was once terminology used by

professionals in psychiatry or psychology. It is now terminology used openly and sometimes loosely by the general public. In the second account, receiving professional support for psychological distress is seen as a saviour. Due to years of repressed trauma and current psychological distress, the participant to some extent could no longer hide her distress and felt compelled to seek support. A cyclical chronotope is present, where the new mother had to revisit past trauma to understand the present trauma, and to develop positive coping strategies for the present and future.

The second master theme explored how family members reacted to disclosures of psychological distress after childbirth. This is explored via the perspectives of new mothers, through dialogical analysis. Absent voices, micro-dialogue and sideward glance were some of the features paid attention to, in order to develop a deeper analysis. The first sub-theme focused on factors such as rurality and rural identity and how these shaped understandings of psychological distress in the older generation. Personality traits typically associated with individuals of a rural background such as stoicism, independence, self-reliance are found in this chapter. Thus, psychological distress after childbirth was not viewed as something serious or something that should be given attention to. An expectation to carry on regardless was found. The second sub-theme delved deeper into the type of reactions, by whom, and the impact of this. Majority of negative reactions were from other women, such as mother/mother-in-law/sister-in-law. Psychological distress was branded as pretence or being dramatized. Women were perceived as exaggerating their psychological distress to avoid housework for example. Knowledge of mental health and links to education level was explored, as well as power struggles between the mother-in-law and new mother. The chapter concluded with a thematic summary exploring knowledge of postnatal depression terminology, perceived causes of psychological distress and support preferences. The next chapter of this thesis explores the lived experience of psychological distress after childbirth, in a sub-sample of women.

Chapter 7

Lived experience of psychological distress after childbirth

7.0. Introduction

Thus far this thesis has explored experiences of motherhood during the postnatal period (chapter five) and understanding of psychological distress, including exploring the reactions of family members through paying attention to voices in dialogue (chapter six). Chapter five found three salient features of motherhood during the postnatal period, which were influential in shaping experiences. These included availability of social support, cultural and general expectations of motherhood, and negotiating identity and transition into motherhood. Overall, chapter five captured a broader understanding of how the postnatal period is typically experienced by this sample of women. Chapter six had a narrower focus, exploring the medicalisation of psychological distress and what this means for suffering women. Medicalisation of distress was found to be widespread across the sample, for varied purposes. It allowed women to have a greater understanding of their feelings and how to manage distress. Family member reactions were explored from the point of view of the women, through the analysis of voices in dialogue. In terms of family reactions, rurality and rural identity were found to shape understanding of distress. Family members understood distress as inauthentic and dramatized for effect. Medicalisation of distress and rural constructions had implications for help-seeking. Across chapters five and six, a sub-sample of women were identified as experiencing psychological distress after childbirth, including subjective experience, and diagnosed postnatal depression. The present and final empirical chapter aims to explore these lived experiences of psychological distress after childbirth. This chapter will focus on the experiences of eight women (out of a sample of 17).

7.1. Thematic Representation

Figure four is a thematic map representing the main themes and sub-themes capturing the lived experience of psychological distress after childbirth. Three master themes were developed, and this included the role of control during the onset of psychological distress after childbirth. Mothers went through the process of losing control (onset of distress) and gaining control (self-help/medical intervention). The second master theme, 'navigating through young motherhood' explores the paradoxical nature of motherhood and experiences of early marriage and early childbearing. The final master theme, 'the self as fluid' explores how psychological distress impacted women's sense of self. For example, how distress is manifested (the 'not my usual' self), situating distress in relation to the past and present (re-discovering the self) and inner struggles to acknowledge distress (postnatal depression: the self that cannot be hidden).

The core theme running through each of the master themes is inner rebellion/resistance/ambivalence. In the master theme 'psychological distress and control' the use of medication to control distress is resisted against, links are made to moral framework of consuming medication and motherhood. In 'navigating through young motherhood' mothers demonstrate inner resistance, rebellion, and ambivalence against the dominant discourse of 'good motherhood', demonstrating how such expectations can result in feelings of guilt, stress, and psychological distress. In 'the self as fluid' acknowledgment of one's distress was resisted and rebelled against, until eventual acceptance and growth.

Figure 4. Thematic Representation: Lived experience of psychological distress after childbirth



Findings

The literature review found experience of psychological distress after childbirth to differ cross-culturally (Oates et al., 2004; Karasz et al., 2019; Templeton et al., 2003; Parvin et al., 2004; Wittowski et al., 2011; Lamba, 2015; Khan et al., 2019). Thus, the findings section will begin by providing a description of symptoms of psychological distress experienced by this sample of women. Experiences will be mapped against the Edinburgh Postnatal Depression Scale (EPDS), as the literature review identified this to be a popular screening tool for psychological distress after childbirth, and it is a screening measure which is utilised internationally (Husain et al., 2013; Fuggle et al., 2002; Gausia et al., 2007a:2007b; Maity et al., 2015). Given the debates around the cultural relevance of the EPDS, including that of translated and adapted versions, it would be useful to map items against the EPDS to establish how well the items represent lived experience of this sample. Due to the nature of the study, limited inferences and conclusions can be drawn. However, the rationale behind mapping against the EPDS is to develop a preliminary understanding of how mothers interpret and verbalise their psychological distress. The chapter will then go on to present findings of the three master themes, as represented in Figure 4.

7.2. Description of psychological distress after childbirth

A sub-sample of women (8 out of 17) in this study reported the experience of psychological distress after childbirth. Table 11 presents demographic information of the eight mothers in this study. Two out of eight mothers were diagnosed with postnatal depression and the remaining six reported subjective experience of psychological distress after childbirth.

Table 11: Participant demographic information for lived experience

Participant	Age	Number of Children	Type of Family System	Country of Birth	Country of Upbringing	Language of Interview	Type of experience
Tayyba	31	2	Nuclear	Migrant	Pakistan (rural)	Urdu	Diagnosed
Alisha	Missing	4	Nuclear	Migrant	Germany	English	Subjective
Saifah	28	2	Nuclear	British born	Britain	English	Subjective
Sofia	33	3	Nuclear	British born	Britain	English	Subjective
Lubna	32	5	Nuclear	British born	Britain	English	Subjective
Arooj	21	4	Joint	British born	Britain	English	Subjective
Amaarah	20	1	Joint	British born	Britain	English	Subjective
Aaliyah	21	1	Joint	British born	Pakistan (rural)	English	Diagnosed

7.2.1. Core features of psychological distress

Following on from table 12, table ten outlines core feelings and experiences mothers associated with being psychologically distressed after childbirth. Symptoms that closely matched with the items of the EPDS have been noted in table two (see Appendix 1 for the original version of the EPDS 10-item questionnaire).

Table 12: Description of psychological distress after childbirth

Participant	Lived experience	Potential EPDS Items corresponding to the lived experience
Tayyba	Weird feelings Weird dreams Anxiety Feeling scared Feeling restless Crying for no apparent reason	4, 5, 9
Sofia	Feeling sad Feeling low	8
Alisha	Frequent crying Thoughts of self-harm	9, 10
Saifah	Frequently shouting, screaming, arguing	n/a
Lubna	Feeling anxious Feeling depressed	4, 8
Arooj	Stress Thinking too much Feeling moody	6, 8
Amaarah	Depressed	8, 9

	Stressed	
	Crying	
	Less motivated to attend to child's needs	
Aaliyah	Feeling low	3, 4, 8, 9, 10
	Hating myself	
	Loss of appetite	
	Frequent crying	
	Anxiety	
	Thoughts of self-harm	

Table ten highlights four items of the EPDS which correspond with the lived experience across this sample. This includes item eight *“I have felt sad or miserable”* with 5/8 mothers reporting this. Followed by 4/8 mothers reporting feelings matching item nine *“I have been so unhappy that I have been crying”*, 3/8 mothers reported feelings of anxiety, corresponding with item four *“I have been anxious or worried for no good reason”*. Thoughts or acts of self-harm were reported by 2/8 mothers, corresponding to item 10 *“the thought of harming myself has occurred to me”*. Table ten highlights that for each participant 50% or less items in the EPDS were representative of their lived experience. This may suggest that the EPDS for this sample of women did not fully capture their lived experience. However, as this study is exploratory and mothers in this study did not complete the EPDS for research purposes, it is difficult to know how mothers would interpret and complete the EPDS in real life settings. This links with the findings of chapter six, in which the popularisation of mental health terminology to describe every day emotions posed a challenge for health professionals. Terms such as depression were used loosely and were not interpreted as clinical, this may influence how the EPDS is completed.

Chapter six also identified barriers to disclosing low mood such as fear of consequences (child being taken away), this may also determine how

women choose to complete the EPDS. The literature review, as well as chapter six found somatisation of psychological distress. The EPDS does not capture somatic items, thus some women who vocalise their distress in somatic terms may not be flagged up as needing support. These findings highlight potential complexities involved in screening and broaching the topic of low mood after childbirth in this sample. It is also important to highlight that support or follow-up is not only for women who score high on the EPDS. If women tick items representing anxiety (item 3/4/5) they are followed-up, as well as women who tick item 10 which is flagged up as a safeguarding concern. For example, Tayyba's experience largely represented anxiety provoking feelings and she was one of the women with a diagnosis. Thus, the EPDS proved to be a useful measure for these women. The next part of this chapter will present the findings of the three master themes, which represent the lived experience of psychological distress after childbirth in this sample of women.

7.3. Master Theme: Psychological distress and control

Across chapters five to seven, control has been identified as a running theme. Chapter six explored medicalisation of psychological distress and the impact of this. For some women medicalisation allowed control over your narrative as a mother. Medicalisation offered legitimacy to feelings and thus counteracting the bad mother narrative. In other examples, medicalisation acted as an outlet for support and encouraged women to seek out treatment options. Thus, the findings of chapter six focused on how medicalisation of psychological distress supported women. The current master theme overlaps with that of chapter six in terms of the core theme of control but pays attention to the cyclical chronotope of control and psychological distress. This theme will present the accounts of two participants, one who seemingly had a linear journey to coping with psychological distress and one who's journey was more complex in terms of fluctuating levels of control over her psychological distress.

7.3.1. Sub-theme: loss of control

This sub-theme pays attention to how the onset of psychological distress can lead to feeling out of control. Extracts 1a-b represent Tayyba's experience of distress, in which chronotope, particularly time is reported as significant. Feelings of psychological distress such as restlessness were experienced at the start of her day, which may set the tone for the day if one does not know how to cope with these distressing feelings. This is suggested by Tayyba in extract 1a as she reports the severity of her feelings to increase day by day.

Extract 1a

"Tayyba: yeah, then it got a little worse [feelings]. When I'd wake up in the morning, I was restless. I didn't understand what is happening to me. Like there wasn't a reason and I still had these feelings" page 5

Tayyba indicates lack of a coherent understanding of her distress, as she is unable to identify the cause of such feelings. The literature review explored the impact of coherent understanding in the context of postnatal depression. Baines et al. (2013) explored illness perceptions in mothers with postnatal depression. Women with less coherent understanding of their postnatal depression were more likely to view their mental illness as chronic, with many symptoms. Similarly, Tayyba's experience is underpinned by the unknown and extract 1b suggests that Tayyba views her feelings as out of her control. From the lens of the Common Sense model (Leventhal et al., 1984) Tayyba is displaying negative representations of illness, which may prevent her from seeking support.

Extract 1b

"Tayyba: negative feelings came to my head. Strange, strange, negative and they are such that person can't even change yourself"
page 10

It is important to note that Tayyba is of migrant background. The literature review found lack of knowledge of mood changes during the perinatal period to be higher amongst South Asian women, particularly for migrant women (Wittowski et al., 2011; Smith et al., 2019). Typically, poor knowledge of mental health issues has shown to be a barrier to help-seeking (Shafiq, 2020; Mogul, 2018). However, in the current case despite a lack of coherent understanding of her feelings, it was clear to Tayyba that what she was experiencing was outside of the norm. This may have acted as a health threat cue which prompted her to confide in her husband, who suggested they seek professional support. The partner support element was explored in chapter five. In terms of WWK (Belenky et al., 1986), Tayyba was not necessarily in a position of silence in the way WWK understands silence, yet at this stage neither was she at the stage of received knowledge. She was on a journey to received knowledge, through the support of health professionals. This will be discussed in the next sub-theme exploring gaining control over psychological distress.

7.3.2. Sub-theme: gaining of control

This sub-theme explores how mothers managed their psychological distress to eventually gain control over their mind and body. Two women in this study reported experience of psychological therapies to manage their psychological distress. The previous sub-theme explored how Tayyba was unequipped to manage her psychological distress, leading to a loss of control. Extract two documents Tayyba's experience of psychological therapies, which gave her the tools to manage her psychological distress.

Extract 2

“Tayyba: she [therapist] used to say, I mean did some counselling she said do this do that. She used to help me, she helped a lot. So, like what [she] said I followed that’s how I became better. Like she said like “keep yourself busy, go out do this, share with good friends, then with time person starts to feel okay”. So, I just did that, kept myself busy and she said positive thinking that’s the most best thing to make yourself better. In mind or heart if negative things came then I stopped them immediately, like made myself busy. But thankfully, now that doesn’t happen a lot like before. She said “go for walks, drink more water” so she made me understand and I used to listen. So, thankfully I got better from that” page 6

Tayyba narrates her experience by bringing in the absent voice of the therapist. She relays advice given which was to take part in self-care techniques to manage symptoms of psychological distress. As Tayyba relays the absent voice of the therapist, she demonstrates a dialogical feature known as stylisation, as she agrees with the words of the therapist and experiences benefits of the given suggestions. In the previous sub-theme Tayyba was floating between knowledge positions, but during therapy she demonstrated characteristics of a received knower (Belenky et al., 1986). The therapist was the primary knowledge source who was able to turn her unknown and unmanageable feelings into manageable feelings. As such, it is possible that Tayyba experienced a shift in her illness representations, as now her symptoms were controllable, and she was making positive steps in therapy. Typical of received knowers, Tayyba recognised the therapist as an authority figure, someone who should be listened to.

Statements made by Tayyba in extract two indicate a positive and nurturing therapeutic relationship. This factor may have acted as a facilitator to recovery, alongside timely intervention. This study did not go into depth

regarding the experience of therapy. Therefore, it is difficult to know if any cultural adaptations were made to meet Tayyba's needs. However, as she is a migrant woman and non-English speaker it is possible that these needs were met via a therapist who spoke the language. Tayyba does not met use of interpreters during therapy. Previous research has demonstrated the benefits of culturally adapted models of therapy for reducing symptoms of psychological distress/depression (Anik et al., 2021; Mir et al., 2015:2019; Masood et al., 2015). Tayyba's case describes a linear experience of losing and gaining control after the onset of psychological distress. Extracts 3a-c explores a cyclical chronotope of distress, in which the complexities and fluidity of control is highlighted, particularly when psychological distress is treated in an untimely manner. In chapter six, Aaliyah reported repressed trauma and a stoic approach to dealing with psychological distress after childbirth, which eventually developed into a mental health crisis. To manage her distress, Aaliyah was offered both pharmaceutical and therapeutic options, she started with the latter.

Extract 3a

“Aaliyah: it was really good, it was. I think that someone that doesn't know you and whatever you tell them you know it's going to stay with them, so you can be 100%. But, you know when they tell you, that you know you're doing really well, you've got work, you've got family, you've got you know little baby, you've got education, its brilliant this and the other. You feel good about yourself, you think “actually I'm managing well than I think”. But then you know the session finishes, you just go out you know in your family doing as normal and, in our families, it's very common thing not to say things very directly but to say things indirectly. And I think that affects you more than direct things and sometimes you would just hear these things and stuff and you would just think “probably I'm not a very good mother, probably I'm not a very good human being”” page 25-26

Aaliyah begins by stating some reasons which may have contributed towards her decision to start and continue in therapy, such as discussing her issues in a confidential and trusted space, with a trusted individual. The chronotope of therapy provides Aaliyah with a positive and nurturing environment, allowing self-development. This is indicated by internal dialogue in extract 3a, in which Aaliyah demonstrates the dialogical feature of stylisation as she acknowledges progress made in therapy. At the same time, two contrasting spaces are described: the 'therapeutic world' and the 'everyday world'. The 'therapeutic world' is described as positive and nurturing. A safe space, confidential, anonymous, and free from judgement where Aaliyah can be open and vulnerable. The 'everyday world' is described as a toxic space filled with negativity, threatening to un-do progress made in the 'therapeutic world'. It is these negative comments which Aaliyah is vulnerable to, which permeate through to her sense of self and self-worth. This is represented by the re-playing of the internal self-critic voice *"probably I'm not a very good mother, probably I'm not very good human being"*.

This finding highlights the importance of considering family and interpersonal contexts in relation to psychological distress after childbirth. One way this has been addressed in previous research is through the inclusion of family members in therapeutic contexts. Cluxton-Keller and Bruce (2018) conducted a systematic review and meta-analysis examining the usefulness of family therapy interventions, in the prevention and treatment of perinatal depression. Women who took part in family therapy reported a reduction in depressive symptoms post-intervention. An improvement in overall family functioning was also found. The results of the meta-analysis are promising for the inclusion of family therapy when treating perinatal mental health issues. However, it is important to acknowledge that inclusion of family in therapy can be complex amongst some groups. For example, as part of an adaptation study for behavioural activation for Muslims with depression, Mir (2015) conducted a qualitative study which explored family inclusion. As highlighted in the literature review, service users reported concerns around being contradicted by family. This links to findings of chapter six, which found

family members to question the experience of psychological distress in women. Furthermore, Mir et al. (2015) also found some therapists to resist family involvement in Muslim patients due to lack of training and perceived patient disempowerment. However, the benefits of family inclusion were reported as raising awareness of depression and improving communication and support levels. Further research by Taylor et al. (2019) explored difficulties working with families of women of diverse ethnic backgrounds with perinatal mental health issues. Common causes of distress included family conflict and marital issues during the perinatal period, which made inclusion difficult. Taylor et al. (2019) found that involving family members was seen as complex and challenging, with some family members having an influence on support received and recovery rates. The findings of chapter six add to Taylor et al. (2019) by demonstrating how the sufferer and family members may understand psychological distress after childbirth in different ways. Groundwork such as that conducted as part of this thesis may help towards tackling these challenges.

Extract 3a suggests for a certain period Aaliyah was engaging in a cyclical chronotope of moving back and forth between the spaces of the 'everyday world' and 'therapeutic world'. Some control over her thoughts was gained thorough therapy but was compromised once she entered the 'everyday world'. Extracts 3b-c highlight the strain and impact of this on Aaliyah's mental health and subsequent treatment choices. In extract 3b, Aaliyah brings in the absent voice of a woman she met at a postnatal class who had lived experience of managing her psychological distress via anti-depressants.

Extract 3b

"Aaliyah: I used to take my son to this massage class and she said to me, that she actually go on to these anti-depressants whilst her daughter was born. Sorry when her daughter was born and she still on them and it's been 23 years and she said "when I try stopping them

I'm right here but when I don't take them I'm right there and you do not want to talk to me, I'm absolutely miserable". And that made me think I don't want to [take anti-depressants]. I decided not to take them, just have talking therapies but then it wasn't helping" page 25

The absent voice portrays anti-depressants as reducing symptoms of distress, but this came with dependency. Withdrawal of anti-depressants is linked with misery. This bleak picture of anti-depressant use was enough for Aaliyah to decide against this as a treatment option, instead opting for talking therapy. As discussed in extract 3a, the 'everyday world' had greater control over Aaliyah compared to the 'therapeutic world'. This meant therapy alone was no longer effective in managing her psychological distress. Mixed opinions on medication for mental health issues continue to permeate through the literature. Ridge et al. (2015) explored patient constructions of anti-depressants use and crisis legitimacy. Some participants expressed fears around psychological and physical dependency. The current finding of this thesis adds to this by demonstrating how such fears can lead to individuals deciding against medication, as seen in Aaliyah's case. Ridge et al. (2015) also found opposing views where taking anti-depressants was perceived as courageous and the only thing that worked. Aaliyah's account shows her journey from initial rejection of medication to eventual acceptance, as nothing else was helping, as demonstrated in extract 3b. The findings of the current study contribute to the moral framework of taking medication for psychological distress and how this can pose as a challenge for individuals who may benefit from taking medication. The decision to then take anti-depressants could represent procedural knowledge, in the form of separate knowing (Belenky et al., 1986). It is characteristic of separate knowers to critically analyse situations and exclude their personal feelings and beliefs about a certain issue. Thus, in Aaliyah's case she concluded that an alternate form of treatment was required for her to manage her distress. Following on from extract 3b, in extract 3c Aaliyah emphasizes that anti-depressants were the last resort. *Time* is mentioned at the beginning of extract 3c and at the end, indicating a source of significance.

Extract 3c

“Aaliyah: I truly feel if I was given my time, I probably wouldn’t have needed this medication. Now I’m on it and sometimes like without telling doctor if I say “I want to stop” I’m not taking it for a couple of days and I’m not myself you know. I would just get upset for no apparent reason. Sometimes I would feel like something really bad is going to happen. So, I would be just thinking about something that is not even there or worrying about just small worries if you know what I mean. You know, your head would come up with things that are not even there because you’re just stressed and it’s just making up the situations. Now that I am on medication, I found it a bit easier to get on with my day-to-day life and do things. But I think I could’ve been better without it as well, if I was given my time” page 33-34

Aaliyah engages in an internal dialogue in which she negotiates the continuation of her medication. There is an internal struggle of wanting to stop taking medication but the mind and body reject this through withdrawal symptoms. For Aaliyah, withdrawal effects included feelings related to anxiety. Cartwright et al. (2018) explored use of anti-depressants and personal agency in women’s recovery from depression. The study found that antidepressants promoted agency as it gave women the ability to manage their depressive symptoms and be proactive in recovery. This included being able to take part in exercise, gaining social support, and engaging in therapy. Some, however, had shifted to long-term anti-depressant use. Severe withdrawal symptoms and fear of a relapse created a sense of dependency on anti-depressants and thereby diminished personal agency in recovery. Without anti-depressants Aaliyah felt *“not myself”* in reference to the worries and anxiety. If she is not herself without anti-depressants, is she herself with anti-depressants? This indicates a level of dependency on medication, diminishing some sense of agency and control over the self. Questions of the self arise, such as does Aaliyah know *who* she is, given her past unresolved

traumas? On one hand, therapy may act as a tool to reach *the self*, as a way of tackling issues around self-doubt and low self-esteem. At the same time, anti-depressants may play a role to help Aaliyah managing practicalities of day-to-day life. It is suggested that anti-depressants alongside talking therapies is the optimum formula for Aaliyah to regain control over her psychological distress in the 'everyday world'. This master theme has demonstrated control as a core theme to be complex, something which fluctuates, must be negotiated, and is crucial to the management of psychological distress. The potential of pharmaceutical interventions and therapeutic interventions in contributing to the development of control has been demonstrated. Moral dilemmas and current issues regarding pharmaceutical interventions were highlighted and how this complicates and adds nuance to the definition and experience of control over psychological distress after childbirth.

7.4. Master Theme: Navigating through young motherhood

This master theme explores the experience of being a young mother and how this can contribute towards psychological distress. Young motherhood is represented as being an adolescent mother but also represents women out of this age bracket who identify as young mothers. The experiences explored in this master theme reflect the paradoxical nature of motherhood, underpinned by psychological resistance and ambivalence.

7.4.1. Sub-theme: Paradoxical motherhood: inner conflict

Within the current dataset, 12% of women reported struggles transitioning to motherhood as a cause of psychological distress. In chapter five, the process of becoming a mother and how this impacted women's identities were explored. To reiterate, not all mothers in this sample experienced psychological distress after childbirth. Therefore, the findings of chapter five relate to the broader area of identity and the transition to motherhood. The current sub-theme adds to the findings of chapter five, by exploring young motherhood through the lens of being psychologically distressed. The two

accounts presented pay attention to the paradoxical nature of motherhood. In extract 4, Saifah recalls important life transitions she experienced in her early 20s such as marriage and motherhood. Although she was not an adolescent at the time, she identified as young mother. Reasons for this included her social circle being at different, more carefree stage of their lives.

Extract 4

“Saifah: I felt like I was quite young. I got married at 20 then I had my daughter at 23 and out of all the people that are my age, I was the only one that was married and having a baby. And it just felt like “why am I going through all this” you know? “Why am I the only one that’s stuck at home” you know? To having to have timings for everything and having to just always you know, looking at the time. Even if I’ve gone somewhere, looking at the time “oh I’ve got a baby, I should be at home looking after the baby”. I’m not free anymore you know, to go do whatever I want” page 20-21

In extract 4, Saifah questions her experience of marriage and motherhood leading to a divided self. This is in the literal sense as Saifah now has to think about dividing her time for herself and her child, as well as being psychologically divided as Saifah tries to make sense of her new role and responsibilities. Saifah associates motherhood with the loss of freedom and feeling trapped. Entrapment could be related to the physical, such as spending more time in the home with limited social opportunities. It could also indicate emotional entrapment where Saifah feels stuck between being a young adult and a mother. Internal structures such as self-identity are conflicting against external structures such as the institute of motherhood. For example, in extract 4 Saifah replays internal voices stating that when she does have ‘me time’ she feels that *“I should be at home”*. This indicates Saifah’s feelings towards motherhood, that it should involve being caring and giving towards the child, but inner resistance and ambivalence is present

pulling her in opposite directions. Whilst Saifah's account focuses mainly on psychological, inner struggles to make space for a motherhood identity, the next extract offers deeper insight into community constructions of 'good motherhood' and what this means for new mothers. Extract 5 adds to the paradoxical nature of motherhood by exploring withdrawal of social support via the social network, post-motherhood. Arooj describes a social transformation after becoming a mother. Pre-motherhood is associated with greater social interaction, whereas motherhood is associated with lower levels of social interaction and social support.

Extract 5

"Arooj: when you don't have kids people [social network] are all sucked on you. Like they'll help you with everything, but when you have kids I've really noticed that the families, yeah they all like move far away. They'll like "oh they got kids now, that's it keep away, it's their life" or something like that. That really annoys me sometimes, like you've got so many kids. People be like "they're your kids, you do it". I just think the stressful part is, how are you going to bring them up when you've got no support. But now when you know, you've got support, you've got someone with you, then I think that's calmed down with me as well. Before I was stressed "I'm too young I've got so many kids I'm only 20 I'm only 19" them ages that I had my kids" page 41-42

Arooj engages in micro-dialogue as she relays the views of absent others in relation to motherhood. The statement *"oh they got kids now, that's it keep away, it's their life"* suggests motherhood is understood by her community as a natural, social, and moral identity, which Arooj must accept and practice. The second statement *"they're your kids, you do it"* further emphasizes that Arooj's community and social network in Pakistan understood motherhood to be her responsibility. These ideologies may have resulted in withdrawal of social support and social contact. It is worth noting that Arooj's support

network did not consist of immediate family members such as mother/mother-in-law/partner. It was made up of friends and relatives. Thus, it is possible that her social network naturally felt that they need to give her space during this transitional phase. For contextual purposes, Arooj's mother-in-law and partner suffered from what was described by Arooj as mental health issues. However, this was rarely acknowledged or understood as an illness by her community in Pakistan. Behaviours related to mental health are likely to be viewed as abnormal and deviant. The literature review found moral obligations for rural communities to protect their image by keeping 'unattractive' problems such as mental health issues hidden (Magnus and Advincula, 2021).

Furthermore, being a mother of four children can be overwhelming for any mother and more so for a young mother. This is emphasised by Arooj as her age and number of children dawns on her via internal dialogue "*I'm too young I've got so many kids I'm only 20 I'm only 19*". To some extent this displays internal criticism of being a young mother as well as showing a divided self who is displaying inner resistance to motherhood. Prabhakar et al. (2019) explored life transitions in low-income mothers and found that once women had become mothers, they experienced a loss of friendships. Reasons included no longer having enough time to maintain friendships. Low-income mothers were also less likely to have access to childcare, particularly paid childcare for reasons which may not be thought of as priority (social outings). The current finding adds to Prabhakar et al. (2019) by paying attention to constructions of good motherhood within social circles of Pakistani origin, which resulted in reduced social contact post-motherhood. The process of socialization into another self, a new social identity, a new role is described by Goffman (1961) as a re-birth. At the current stage, both Arooj and Saifah display feelings which are paradoxical. Changes in identity and role are psychologically resisted, as both women experienced motherhood in ways which are not typically portrayed in the literature, for Pakistani-Muslim women. The discourse of good motherhood and a paradoxical lived experience may have led to a mixture of feelings including

ambivalence and guilt of what a mother *should* be doing. These experiences of motherhood are not unique to one ethnic group or culture, but have been found in mainstream, Western women in the literature (Lucas et al., 2019; Liamputtong, 2006). However, the paradoxical nature of motherhood is something which is rarely voiced in ethnic minority groups, thus adding to the literature.

7.4.2. Sub-theme: Early marriage and Early childbearing

Early marriage and early childbearing are widespread amongst South Asian/non-Western cultures (Scott et al., 2021). From this data set, Arooj was the only woman who experienced early marriage and early childbearing, at the age of 16. The rest of the sample married and gave birth over the age of 20. By the time Arooj had turned 20, she was a mother of four children under the age of five. In general, this experience can be considered outside of the norm making it of interest to explore in this chapter. It must be noted that Arooj married young through her own choice, something which her parents were against. It is commonly understood in the literature that early marriages are arranged by the parents/elders within South Asian cultures (Kamal and Ulas, 2021). This makes Arooj's experience unique to unpick further as she had a choice in the matter.

Extract 6a

“Arooj: I was stressed, “I’m too young I’ve got so many kids, I’m only 20 I’m only 19” them ages that I had my kids. “Oh my God, I’ve got so many kids. What am I going to do with them? Why am I having so many kids?” It was like so stressful for me” page 41

As a young mother of four with little social support as indicated by the previous sub-theme, Arooj describes motherhood as stressful. She engages in an internal dialogue with herself, in which she questions her reproductive choices in a critical manner. Through this internal criticism, psychological

resistance to being a mother of four is present. Arooj reflects on her years in Pakistan, an emotional time. She replays voices to make sense of her experiences, which are centered around her life not turning out how she may have expected. She was a separated, young mother of four at the time of this interview.

Extract 6b

“Arooj: when I think about my past then I even get more emotional like “eh what was that time?”. Time flies thank God for that but really, it was really hard for me as a child, as a teenager. Like my other sisters they all saying now, like they’ve seen my life, now everyone’s changed their marriage line to 24 now” page 28

Arooj refers to herself as a child and teenager during that time, a factual statement. This may also indicate a sense of vulnerability, as well as role conflict between being an adolescent, wife, and a young mother. Mangeli et al. (2017) explored adolescent Iranian mothers experiences of motherhood, who were typically married to older men. The experience of motherhood was surrounded by emotional and mental distress such as fear, worry, regret, frustration, and depression. Insufficient support was reported from spouse, family, and health care providers. The current finding adds to the findings of Mangeli et al. (2017), as Arooj displays similar experiences. This suggests that adolescent married women participating in early childbearing, perhaps irrespective of ethnicity, are more likely to experience psychological distress, exacerbated by risk factors such as poor social support. In extract 6b Arooj mentions that her role of a young, now single mother is not something her sisters aspire to. This suggests that ‘good motherhood’ is now constructed by her family as being a slightly older first-time mother.

Whilst women such as Arooj who partake in early marriage and early childbearing can be classed under ‘teen pregnancy’ and ‘teen motherhood’,

the findings of the current study compared to existing literature suggest differences in the lived experience. For example, teen mothers who are unmarried are often stigmatized for their choices. Jones et al. (2019) explored the views of teen mothers in relation to other teen mothers. Moral judgments of becoming teen mothers were found, as teen mothers were stigmatized and critically judged by other teen mothers for getting pregnant. Jones et al. (2019) findings suggest that teen mothers themselves further perpetuated the negative discourse around teen pregnancies. In Pakistan, Arooj did not face such stigma as she was married, thus it is socially acceptable and sometimes encouraged to bear children during teenage years. However, the current finding and previous literature suggest some similarities amongst teen pregnancies and early marriage/early childbearing experiences, such as emotional and mental difficulties, as well as lost dreams and ambitions. This is because teen mothers are more likely to drop out of education (Erfini et al., 2019). This sub-theme adds to the literature around early marriage and early childbearing, by reflecting on a unique case. The experience of a young mother of four children under the age of five, paying attention to psychological resistance and ambivalence. Early marriage and early childbearing were part of Arooj's identity for a significant portion of her life. These experiences contributed to her subjective experience of psychological distress. In the next master theme, the sense of self during psychological distress is explored.

7.5. Master Theme: The Self as Fluid

This master theme explores the chronotope of the self, including how shifts in time and space (pre and post motherhood) can impact women's mood and behaviours and thus their sense of self. The sub-themes represent three key areas of the self, deemed meaningful to women in this study. The 'not my usual self' highlights how the onset of psychological distress can lead to the development of a temporary version of the self and is differentiated from the self pre-motherhood. The 'losing myself' explores the desire and process of finding the self which was 'lost' in the process of early marriage and early

childbearing. The 'postnatal depression: the self that cannot be hidden' offers an insight into how a diagnosis of postnatal depression can feel like an attack on perception of the self, which can lead to questioning of the self and eventual acceptance.

7.5.1. Sub-theme: The 'not my usual' self

This sub-theme demonstrates a shift in chronotope post-motherhood, which is defined as experiencing distressing emotions and displaying defensive behaviours. This shift in the self is viewed as different to the everyday or usual self (pre-motherhood). In extract 7, Saifah describes this change in the self which is categorised as 'shouting' 'screaming' 'arguing'. These feelings are described as occurring 'all the time' which emphasises the frequency and perhaps the potency of such emotions, that they overshadow any other experiences and emotions at the time.

Extract 7

“Saifah: how I went, I was shouting at everyone all the time. I was screaming arguing over little, little things with everyone. So, I was like that for quite a long time, for 1.5 years I was like that. I was just really, really, I mean I knew it myself sometimes that I've gone like that. Shouting and you know always arguing with everyone all the time. My mums there explaining to me and I used to just start crying at that time, you know when my mum used to tell me off or whilst arguing with my mum or getting into an argument with anybody. I used to start crying about it as well, that maybe I am wrong but then I don't know whether it was my heart or my mind telling me that “no, I'm not wrong, I'm not wrong”. You know “you lot are all wrong, everybody is wrong”. But I'm like, it was actually the worse experience ever to be honest. And then I don't know, it was just all of a sudden that I came back out of it again. I went back to normal again” page 19-20

Within extract 7, Saifah is displaying internal criticism and a divided self, as she battles against the legitimacy of her feelings. The absent other (Saifah's mother) reacts to Saifah's change in self in a confrontational, unsympathetic manner. The reaction of the absent other adds to the findings of chapter six, which found generational differences in how psychological distress after childbirth is viewed. The voice of the mother can be described as coming from the outside-in and may act as a sore-spot for Saifah, who then seems provoked and reacts in a defensive manner. Extract 7 suggests that Saifah feels unheard and perhaps misunderstood, as the absent others react without understanding why this change in the self has occurred. International literature has demonstrated 'feeling misunderstood' to be a common experience during psychological distress, during and after childbirth. Keefe et al. (2021) explored experiences of perinatal depression in low-income populations, from African American and Latina/Puerta Rican/Cuban background. Women reported feeling misunderstood by family and health professionals. Babatunde and Moreno-Leguizamon (2012) explored daily and cultural issues of postnatal depression in African immigrants in Southeast London. Women felt alone and experienced difficulties in sharing their feelings with family members. Wittowski et al. (2011) explored postnatal depression in South Asian women and found that women felt alone and judged for feeling psychologically distressed, by family members and health professionals. The current finding contributes to cross-cultural literature around feeling misunderstood by paying attention to voices within dialogue and what impact these have on women's processing of their psychological distress after childbirth.

Saifah engages in an internal, confrontational dialogue representing an exchange of ideas between two or more 'I' positions. In extract seven, interactions are between Saifah and 'you lot' 'everybody', which represents her family members. The function behind this internal dialogical activity could be Saifah making sense of her distress. By doing so, she might be attempting to validate her feelings and to re-assure herself that this is not the

norm for her. Extract seven begins with Saifah in a position of vulnerability, where she almost accepts the weaker position regarding the legitimacy of her distress. Through internal dialogue between herself and her 'imagined' family, she is able to obtain the advantage, as she concludes that she is right, and they are wrong. This also indicates that Saifah may view her feelings as being absolute, as either *right* or *wrong*. This black and white, absolutist nature of knowledge is reflective of received knowers (Belenky et al., 1986). This suggests that Saifah may have lacked confidence in her ability to voice her distress in the external world but is engaging in an internal dialogue, as demonstrated in extract 7. Saifah reports feelings of psychological distress to pass over time without any specific intervention, leading her to return to her 'normal self'. Thus, the chronotope of distress and motherhood shifts once more, demonstrating fluidity of the postnatal self.

7.5.2. Sub-theme: Re-discovering the self

This sub-theme explores a cyclical chronotope where the onset of psychological distress leads to a sense of loss of the self, with hopes to re-discover the 'old' self. In the previous master theme Arooj spoke about her marital issues, repeat teen pregnancies, and concerns around raising four young children. These contextual factors are important to highlight, as they appear to be meaningful to Arooj's experience of psychological distress pre- and post-motherhood and to her sense of self. The literature review found factors such as marital issues to contribute towards psychological distress after childbirth, in South Asian women (Atif et al., 2021; Munaf and Siddiqui, 2013; Husain et al., 2012; Wittowski et al., 2011). Extract 8a refers to Arooj's marital issues and early childbearing experiences, which shaped her into someone different, someone who she did not want to be as she wished to re-discover her past self.

Extract 8a

“Arooj: I was proper a chilling girl a laughing girl, making people laugh, laugh myself. I used to be them girls but since I’ve been married, I’ve changed a lot. I’ve been too moody and sometimes my sister goes to me “you’re always so moody, no point talking to you”. I don’t know life changes. But I’m trying to get back into my old me. Now, I think I have a bit because I go hyper again now, but I think I’m okay now. For the last month I’m fine, no tension, no nothing, I don’t take it anymore”
page 49

Chronotope of marriage is suggested to be the catalyst for change in the self. Prior to marriage, Arooj described herself in a positive manner, as a happy, relaxed individual who others enjoyed being around. Post marriage, she describes herself in a contrasting manner, as a moody individual. Arooj engages in micro-dialogue as she brings in the voice of her sister and reflects on her mood, and how changes have become evident and impact interactions with her siblings. In extract 8a, Arooj demonstrates self-awareness of change and states that she is trying to re-discover/find her old self. It is here where the cyclical chronotope can be seen, as glimpses of Arooj’s ‘past self’ begin to surface as indicated by *“I go hyper again now”* suggesting that the ‘past self’ is still present deep within and retrievable in the present. The ‘past self’ is narrated with restorative nostalgia (Boym, 2001), with marriage and childbirth presenting as catalysts for radical and disruptive constitution of the self. Arooj’s nostalgia is characterized as restorative because of her motivation to return to a past version of herself by participating in activities that promote self-growth, evidenced in extract 8b.

Extract 8b

“Arooj: my kids are all settled now in school and all that so I’m going to start my life again. I’m going to go back and do my GCSE’s, driving. I’m going to make my life good again, see if I can, but yeah that’s my plan for later in life. Yeah, I’m just thinking instead of being home all the time, the little one she’s always with my mum anyway. The other

three are going to start school this week, the other two. So, I've got time to myself, and my dad said "you do your driving and go back to your GCSEs in September" I go "okay" so just planning for all that, see if I can become something. Because I really wanted to become a dentist, it was my dream but then I don't know this Pakistani thing just came, and I just messed all my life up. But now I'm going to get back on track, forget everything and just go back on track and be happy again" page 12

Arooj is hopeful to re-set her life, as she describes her married years as bad and as something she felt de-railed by. She refers to *"this Pakistani thing just came"* which could be in reference to her visiting Pakistan and by chance getting married and starting a life there. It is common when talking about individuals to refer to their location, such as 'Pakistan is calling' if one receives a call from a family member in Pakistan. Choosing to marry and bear children early meant Arooj put her career ambitions on hold, with limited opportunities or support in Pakistan. Returning to education and learning to drive are activities which promote independence and self-development, important for Arooj to re-gain control over the self. As Arooj is living back with her parents, extract 8b states the important role they play in Arooj's journey to re-discovery of the self. The mother is providing practical support, allowing Arooj to have the time to focus on herself. The absent voice of the father provides encouragement for Arooj to pursue avenues which promote independence and self-growth. Arooj demonstrates the dialogical feature of stylisation after the absent voice of her father, as she agrees with his suggestions. Being pro-active in changing her life is one step closer to rediscovering the 'past self' and turning her restorative nostalgia into her reality.

7.5.3. Sub-theme: Postnatal Depression: the self that cannot be hidden

This sub-theme explores how the sense of self is understood before and after a diagnosis of postnatal depression. In extract 9, Aaliyah relays her feelings and perception of the self when her psychological distress began to manifest.

Extract 9

“Aaliyah: I did not think I would suffer from postnatal depression. To be honest, because I always known myself being a very strong person. No one knows what’s going on inside me, can pretend in a way, very well. I think after my son was born, I actually suffered from it and realized that when we say “prenatal depression” “postnatal depression” doesn’t sound much of a thing. It’s like something that you will you know, come over it but it was a very, very tough time”
page 33

Aaliyah describes who she thought she was prior to her psychological distress manifesting, a strong and stoic individual who actively hid her feelings of distress or pain. To show feelings of distress was constructed by Aaliyah as a sign of weakness. To hide one’s pain or to not let feelings manifest was thus, seen as a strength. In this context, Aaliyah holds the power as the knower and possesses a level of control, not only to keep distress at bay but to also have some control over how others perceive you and what they know about you. This shares cross-over with the findings of chapter six, demonstrating another varied experience where control is at the centre of the experience of psychological distress. Lamba (2015) explored changes in identity and experience of self, majority of which focused on the physical. One participant did, however, report similar feelings to Aaliyah, of viewing oneself as strong and stoic prior to the experience of psychological

distress after childbirth. The current finding adds to research by Lamba (2015), by exploring this sense of self deeper and what it means for help-seeking. For example, chapter five of this thesis found Aaliyah to have experienced un-resolved trauma which put her in a vulnerable state and a position of silence (Belenky et al., 1986). To mask this vulnerability and to cope with past and present trauma, it is possible that Aaliyah had created this strong, yet fragile persona. As mentioned in previous chapters, various traumatic events following birth were chipping away at this already fragile exterior. Research has shown that in some cases suppression of emotion can lead to psychological distress (Ranney et al., 2020). This was found in chapter six, as post-childbirth Aaliyah had reached a crisis point and suggested the trigger to be unresolved past trauma.

Aaliyah indicates that she “*can pretend in a very well way*” which suggests that in the past, she preferred not to talk about her feelings with family members or professionals. Chapters five and six found complex family dynamics, which made it difficult for Aaliyah to be vulnerable and open. Lucas et al. (2019) conducted a systematic review and meta-analysis exploring young mothers’ perceptions of their mental health and wellbeing during the perinatal period. Young mothers reported that they were less likely to seek help, as they perceived the label of mental health contradicted the narrative of ‘good motherhood’. They also reported that voicing their mental health concerns would mean being under surveillance from health professionals as well as family members. In the context of Aaliyah, past negative experiences of voicing her distress positioned her in an over-arching silence, which is transmitted through the pretence exterior she had created. Prior to reaching a crisis point, in extract 9 Aaliyah indicates an inner resistance in accepting her distress. To pretend is to present or live in a false reality, subsequently suppressing her distress until it was no longer possible to do so. To be diagnosed and labelled with postnatal depression had several meanings for Aaliyah. It meant she could no longer hide her distress, psychologically it was time for help. Giving birth to her son was a

turning point, in which Aaliyah may have realised that to be able to take care of her son, she needs to take care of herself also.

The inability to hide distress resulted in a diagnosis, which she associated with being psychologically weak. Psychological distress/postnatal depression and its association with weakness has been cited in the literature. Ransing et al. (2020) explored views around perinatal depression with women and nurse practitioners in India. Postnatal depression was constructed as a weakness because it was believed to not exist in previous generations and suffering women were labelled as 'choosing' to be ill with postnatal depression. Constructions of mental illness being a choice, may lead to sufferers feeling that they are psychologically weak, as demonstrated by Aaliyah. Similar views were found in chapter six, where some family members did not acknowledge or understand psychological distress as an illness or something which required support. Instead, the authenticity of distress was questioned. This finding adds to that of Ransing et al. (2020) and Lamba (2015) by highlighting generational differences in how psychological distress is viewed and the impact this can have on the suffers sense of self and help-seeking behaviours. Negative views around postnatal depression may have contributed towards Aaliyah's inner resistance in accepting that she was suffering and needed support.

The experience of postnatal depression meant Aaliyah could no longer pretend, she had no choice but to live as her 'postnatally depressed self'. This is something which Aaliyah eventually goes on to accept, as the master theme around control in this chapter detailed Aaliyah's treatment journey. The medical discourse in which Aaliyah's feelings were framed and discussed with her, is suggested to have little meaning in terms of the actual terminology used. The availability of terminology did however, act as an outlet for support. The feelings were viewed as controllable and curable with time, which could explain Aaliyah's uptake of treatment discussed earlier in this chapter. The findings of the three sub-themes are tied together by a

cyclical chronotope where the concept of the self is fluid and ever-changing. During the experience of psychological distress and/or postnatal depression, mothers may have to deal with versions of the self which can be frightening to understand and to explore. However, this master theme demonstrates that these versions of the self are not fixed and can change and developed over-time.

7.6. Summary

This chapter has provided a detailed narrative account of Pakistani-Muslim mother's lived experience of psychological distress after childbirth. The chapter began with a thematic summary of symptoms of psychological distress after childbirth experienced in this sample of women. Symptoms were mapped against the EPDS to understand whether the EPDS captured the experiences of this sample of women. Symptoms corresponding with items of the EPDS included feeling sad, frequently crying and thoughts of self-harm. Three master themes were then presented. The core theme tying together each of the master themes included inner rebellion/resistance/ambivalence surrounding what it meant to be a 'good mother'. The first master theme explored how the experience of psychological distress is tied to the loss and gain of control. Loss of control is associated with a lack of coherent understanding of psychological distress and symptoms experienced. This was understood using the Common Sense model of self-regulation, in which negative illness representations meant sufferers felt their symptoms were difficult to control and manage. This contributed to feeling out of control both mentally and perhaps physically. The second sub-theme explored gaining of control. One account presented a linear transition whereby therapy services were sought. The therapist was seen as a trusted figure who had answers to these unknown, frightening symptoms. In such accounts, the feature of stylisation was found which may have contributed towards uptake of therapy and towards management of symptoms. This led to a shift in illness representation from negative to

positive. A second account demonstrated a more complex journey. A cyclical chronotope where management of symptoms was determined by two contrasting worlds. The therapeutic world facilitating management of symptoms and the everyday world which hindered management and exacerbated distress.

The second master theme explored the paradoxical nature of motherhood, in which the self was divided. The transition to motherhood was seen to be psychologically resisted, where freedom, time and space are negotiated. Social support post-birth was explored by paying attention to micro-dialogue outlining the views of absent others. A reduction in social contact and social support was found post-motherhood, implying a shift in roles and responsibilities amongst the new mother and social network. This shift was initiated by the social network, leading the new mother to feel unsupported. Early marriage and early childbirth were also explored. Critical internal dialogue was present in which the mother questioned her reproductive choices and attempted to make sense of her repeat pregnancies during teenage years.

The final master theme explored the self after childbirth, with the onset of psychological distress experienced in various ways. The 'not my usual self' consisted of internal, critical dialogue in which the self was divided as the mother tried to make sense of this changing sense of self. Various 'I' positions were used to demonstrate the interactions of the mother and absent others in making sense of distress. In other narratives, the onset of psychological distress led to feelings of restorative nostalgia of life pre-distress and pre-marriage. A cyclical chronotope was present, in which the past self was believed to be buried psychologically deep but still retrievable through a journey of re-discovery. In other experiences, inner resistance was found in preventing the current version of the self to emerge into the 'postnatally depressed self'. To hide the emerging self led to further suffering, indicating the importance of recognising, exploring, and accepting each

version of the self. Centrality of this master theme was fluidity of the self, and how each of the three versions of the self eventually transitioned from a dark to light state. The empirical chapters five, six, and seven have presented the findings of this thesis. This included women's experience of motherhood during the postnatal period, understanding of psychological distress by paying attention to voices within dialogue, and the current chapter has explored lived experience of psychological distress in a smaller sub-sample. The next chapter will provide a discussion of the findings, including methodological discussions, and implications for future research.

Chapter 8

Discussion

8.1. Introduction

This chapter will discuss the findings in relation to the research questions, existing literature, and theory. There will also be a critical evaluation of methodological issues, reflection on the researcher's role, implications for future research and original contributions to knowledge will be discussed.

8.2. Outline research questions

The overall aim of this thesis was to explore psychological distress after childbirth in Pakistani-Muslim mothers. To address this, the following research questions were explored:

1. How do Pakistani-Muslim women experience motherhood during the postnatal period?
2. How do family members react to disclosures of psychological distress after childbirth?
3. How do Pakistani-Muslim women understand and experience psychological distress after childbirth?

A qualitative methodology was employed, and data was analysed via thematic-dialogical analysis, details of which are outlined in the methodology and method chapters. This chapter will commence with a discussion around findings related to experiences during the postnatal period, followed by constructions of psychological distress and lived experience of psychological distress after childbirth.

8.3. How do Pakistani-Muslim women experience motherhood during the postnatal period?

To understand why Pakistani-Muslim women experience psychological distress after childbirth, it is important to explore their experiences during the postnatal period. Three key areas demonstrated the potential to enhance or diminish the experience of motherhood during the postnatal period. These included social support, experiences of cultural postnatal practices, and identity.

8.3.1 Social support

Three key relationships for new mothers during the postnatal period were found and this included their partners, own mother, and mother-in-law. Each of these relations will be discussed in how they contributed towards women's experiences after birth. The findings of this thesis found the mother-in-law to play a central role in shaping experiences during the early postnatal period. In some cases where a positive relationship was formed between the mother-in-law and the new mother, this acted as an outlet for support with childcare duties. In cases of conflict, a triangular relationship was illuminated in joint families between the mother-in-law, new mother, and the husband. The husband was found to be at the centre of this conflict, simultaneously trying to manage the husband-son role. Women (Alisha, Aaliyah) relied on their partners to act as a vessel of communication to relay boundaries, expectations, wants and needs to the mother-in-law. For the daughter-in-law to relay this herself would go against the 'good woman' discourse, who are preferred to remain silent. Thus, voicing her own opinion may lead to further conflict. This led to some new mothers not feeling fully supported during the postnatal period, and thus contributing towards her psychological distress. In such cases the mother-in-law has expectations of how the postnatal period should be experienced and the new mother had her own ideas.

Some of these differences were based on culture and generation and some were based on universal experiences such as traumatic childbirth. This triangular and often conflicted relationship highlights the importance of understanding the dynamics of multiple relationships within households and how they are likely to influence the perinatal period. Furthermore, the finding adds to existing literature around partner support by paying attention to the identity and role of the partner in a joint family dynamic, by demonstrating inner conflict between partner status and son status. A qualitative study by Lamba (2015) reported findings on conflicted relationship with the mother-in-law and power dynamics, in migrant Pakistani-Muslim women. The findings of this thesis drew attention to the subordinate position of some women living in joint families, perpetuated by a triangular nature of conflicted power relations. To add to Lamba (2015) the current findings also demonstrate conflicted mother-in-law dynamics in joint families to be a somewhat universal issue within the Pakistani-Muslim community and perhaps wider, as opposed to being specific to migrant women.

A gendered gap in understanding struggles of motherhood and psychological distress was found in this study. In their own ways, partners offered support to suffering new mothers which offered temporary relief, but women did not always feel completely understood or supported. Wider literature exploring motherhood and psychological distress across cultures have reported a gendered gap in understanding (Taylor et al., 2021; Lee et al., 2019; Moghul, 2018). This indicates that the current finding is universal and not a culturally specific experience to Pakistani-Muslim women only. This finding has the potential to help develop interventions for increasing awareness amongst partners and wider family members of changes experienced after childbirth.

Despite a gendered gap in understanding, partners suggested to take the new mother outside to offer relief from their low mood/psychological distress. This suggestion was generally accepted by mothers in this study and reported to uplift mood. Research across various contexts including the impact of covid-19, motherhood, and common mental disorders have found that increased time spent in outdoor spaces reduces symptoms of

depression and anxiety (Hall et al., 2023; Stock et al., 2022). The association between nature and improved mental health wellbeing is thus universal and the findings of this thesis suggest the potential for nature-based interventions during the postnatal period. Further research is required to understanding barriers and facilitators in taking part in nature-based interventions during the postnatal period in Pakistani-Muslim women. Female support was two-fold, practical and emotional. Women reported their own mothers as offering optimal practical support, including general child-rearing support as well as culturally specific support (nutrition, *Chilla*). Common struggles new mothers may face such as lack of sleep, waking up for night feeds, and bathing a new-born were not experienced to the same extent as the grandmother supported with these duties. These findings reiterate research by Lamba (2015) and Kandasamy et al. (2020) which also highlighted the important role of the grandmother during the postnatal period. For women who did not have a mother figure, gendered and cultural limitations were highlighted in terms of discussing issues related to childbirth and motherhood.

Some mothers perceived physical issues post-birth were not appropriate to be relayed to their fathers, with a preference for own mothers. This was linked to cultural concepts such as *Hayah* (modesty) and what knowledge could and could not be shared with certain genders. The concept of *Izzat* linked with shame and honour was identified in the literature review as acting as a barrier to help-seeking for mental health (Guansinghe et al., 2019; Mafura and Charura, 2021). The concept of *Hayah* adds to the existing literature, as *Hayah* is demonstrated to be another concept which is gendered. Like *Izzat*, *Hayah* is emphasised in women, and may prevent women from sharing feelings and experiences in the absence of trusted female figures. The findings of thesis suggested that this can lead to feeling alone in the experience of childbirth and motherhood. These experiences have typically been highlighted for migrant populations, who do have mothers but are living in different countries. In such cases, migrant women still reported speaking to their mother/family over the phone (Wittowski et al., 2011; Wittowski et al., 2017; Lamba 2015). In the current finding, even such limited contact was not an option. This finding highlights the importance of

understanding all new mothers existing relationships and the quality of these, to ensure they feel supported, and their cultural needs are met. A preference for female support indicates a need for greater access to female support groups for new mothers. The findings of this research have demonstrated what role these relations played during the postnatal period and their influence on maternal mental health.

8.3.2 *The self (identity and motherhood)*

Social support in the transition to motherhood has shown to be vital, mothers who felt supported experienced a smoother transition. This transition of *becoming* with a focus on the self and identity were prominent across chapters five and seven. In this thesis, all women experienced the process of *becoming* a mother and a sub-sample also experienced *becoming* psychologically distressed after childbirth. Each of these processes of *becoming* will be discussed separately however, they do interlink. The findings demonstrated the sense of self to be existential and dynamic in nature, as opposed to a fixed entity and mothers negotiated and moved between dialects of time. The transition to becoming a mother and its paradoxical nature was found in this thesis. This was particularly the case for women who were becoming mothers again, as they went through a process of fracturing their identity multiple times to make space for motherhood again. Through this process various paradoxical feelings were experienced such as inner resistance and ambivalence. To process and move past these feelings, reflecting on temporality and dialects of time (past, present, future) in relation to the sense of self and motherhood was found to be key. For example, some first-time mothers found it difficult to accept that now their social life was not the same anymore. Women, however, did not change their identities completely, as they tried to maintain some self-distinction as new mothers, whilst incorporating their children into their new role and identity. This included still socialising but less frequently for example. This ties in with the concept of expanded consciousness, the ability to extend the sense of

self to incorporate the needs of your child. This concept has been cited in previous literature (Laney et al., 2015) which supports the idea that women's sense of self and identity expand when they become mothers.

The findings of this thesis demonstrate that expanding the sense of self is not always a linear process, but one which can be filled with ambivalence and inner resistance. For some mothers in this study (Aleena) it was a natural transition, which could be explained by preparedness for a change in role and identity. For others (Ayesha) being mentally unprepared for becoming a mother again of a new-born led to inner resistance, which delayed the transition to becoming a mother again. In other cases (Saifah) lack of social support and circumstances surrounding becoming a mother again led to a challenging transition. The findings of this thesis have contributed to the literature in understanding women's transition to motherhood. The transitions found in this thesis can be described as universal to all mothers, as opposed to being culturally specific. Whilst mothers in this study eventually went onto accepting and incorporating motherhood into their lives, further research is required to understand if women's transition to motherhood impact motherhood later in life or on child development.

8.3.3. Becoming psychologically distressed: existential process

As part of the transition to motherhood, some women were more vulnerable than others and reported experiences of psychological distress after childbirth. In some cases (Aaliyah & Alisha) feelings of psychological distress were suppressed for a longer time resulting in delayed help-seeking and increased severity of psychological distress. One of the reasons for this delay was the discrepancy between the ideal self (strong woman and mother) and the real self (struggling with the transition to motherhood). This discrepancy in expectations is long established in the literature as a trigger for psychological distress (Higgins et al., 1985; Staneva et al., 2015). The existential nature and fluidity of psychological distress was demonstrated

once a crisis point had been reached. In such cases, women realised that their current state would impact their ability to care for their infant, thus acting as a facilitator to voicing their needs and seeking support. In other cases (Arooj) greater awareness of how psychological distress has impacted the sense of self led to a pro-active stance to retrieve the desired sense of self. Change promoted greater control over one's life and emotions, such as being independent and removing individuals from one's life who contributed towards a negative sense of self. This adds to the existential view of the self, as past versions of the self which were evaluated as positive and beneficial (compared to the present self) were trying to be retrieved to aid the transformation of the self. In these cases, women are letting go of the 'good woman/mother' practices by attending to their own needs first (Lafrance and Stoppard, 2006).

In other cases (Saifah and Lubna) the onset of psychological distress was subtle and gradual but led to tensions within familial relationships. This led to feeling misunderstood and to some level led to self-silencing whilst mothers tried to make sense of their mood changes (Belenky et al., 1986; Jack and Ali, 2010). In these cases, psychological distress resolved itself without the need for intervention. However, it is important to consider the impact of this on sense of self later in motherhood or in future cases of psychological distress. The findings of this thesis contribute to a deeper understanding of the intricate and nuanced ways in which women transition to motherhood and how they negotiate, navigate and deal with psychological distress after childbirth. Thus far, universal aspects have been discussed such as the role of social support and the transition to motherhood as part of core experiences during the postnatal period. The final section under this research question is findings related to the experience of cultural postnatal practices and traditions.

8.3.4. Culturally specific experiences

Key culturally specific experiences noted in this thesis included the resting period referred to as *Chilla*, changes in diet and customary visits known as *Bhartan*. A generational shift in terms of how these practices are observed and experienced can be seen through the findings. With each new generation there is a shift in norms and values. In the current sample, knowledge around change of diet was internally questioned as some new mothers had wider access to knowledge and were not only reliant on generational and folk knowledge for motherhood and the postnatal period. Existing literature has reported migrant women to experience psychological distress after childbirth when unable to carry out their traditional practices after birth (Wittowski et al., 2011:2017). The current finding adds to the literature by suggesting that migrant women found these practices context specific to Pakistan and thus not important to practice in the UK. In fact, women who reported being pressured into conforming to these cultural expectations reported feelings of psychological distress. Whilst there have been reported benefits of cultural postnatal practices, it is important to continuously evaluate how these practices are observed in each generation and whether in its current form are acting as a protective or risk factor towards psychological distress after childbirth.

8.4. What are family member reactions to psychological distress after childbirth?

Family member reactions to psychological distress after childbirth were captured through the voices of new mothers. Women confided in their own mothers and thus they were the focus of family reactions. The general response to disclosing changes in mood or psychological distress were dismissed, not taken as anything serious or legitimate and were often questioned. These reactions were as a result of the older generation comparing their experience of motherhood to the new generations. New mothers reported that the older generation felt their experience of motherhood was much more challenging, yet they coped and did not complain of psychological distress. This reflects a stoic approach to

motherhood, a positive trait when expressed by the older generation but negative to new mothers as it led to feelings being dismissed and acted as a barrier to help-seeking. References to rurality were made to emphasise hardship, further minimising women's distress in urban contexts.

These differences indicate a change in expectations around motherhood and voicing of distress. Much of the literature around knowledge of mood changes and mental health in South Asian communities explains differences through wider generational or cultural explanations (Goel et al., 2022; Karasz et al., 2019). This sometimes runs the risk of exoticizing cultures or automatically assuming the cause of a behaviour is only due to being part a certain generation or ethnic background. Current literature on rurality and mental health help-seeking has focused on the rural Australian population. Cheesmond et al. (2019) found stoicism to be trait integral to rural life, which acted as a barrier to mental health help-seeking. The findings of this thesis suggest stoic traits were perceived as positive by the older generation, but as a barrier to help-seeking for new mothers. Cheesmond et al. (2019) also found silence in women as a desirable trait, in adherence with cultural constructions of a 'good woman'. This links with the current findings, as the older generation discouraged voicing of psychological distress through their dismissive and unsympathetic approach. Rurality as well as cultural expectations and gender roles may have contributed towards grandmothers' construction of psychological distress as not 'real' or not serious. The findings of this thesis have developed understanding of mental health in Pakistani-Muslim communities, by delving deeper into characteristics such as rurality. Whilst multiple factors ultimately shape our understanding and response to mental health, rurality as a factor is under-explored and overlooked in the South Asian community. Future interventions on mental health awareness and help-seeking could focus on rurality in addition to cultural and ethnic differences.

8.5. How do Pakistani-Muslim women understand and experience psychological distress after childbirth?

Psychological distress after childbirth was experienced by a sub-sample of women in this thesis. This included a total of eight women, two of whom were diagnosed with postnatal depression and six women reported subjective experiences of psychological distress. The type of experience (diagnosed versus subjective) is important to note as it may influence meaning making and experience of help-seeking pathways. Unique understandings of psychological distress will now be discussed, including a discussion around symptoms and help-seeking behaviours. Knowledge of perinatal mental health issues has shown to be an important predictor of help-seeking behaviours (Shafiq, 2020; Smith et al., 2019; Moghul, 2018; Templeton, 2003). Thus, one of the aims was to establish whether women had heard of the term postnatal depression and their understanding of this. The majority of women in this study had heard of the term 'postnatal depression' and could describe typical feelings associated with the condition. This included feeling low, helpless, changes in hormones and somatic descriptions such as a troubled heart. The sample consisted of English and non-English speaking women, of which half of the non-English speaking women had not heard of the term. This suggests linguistic barriers to mental health knowledge, something which continuously needs to be addressed during the perinatal period to ensure women are aware of mood changes and support services.

Prominent power figures found in this study to influence psychological wellbeing in Pakistani-Muslim mothers included family members, particularly women's own mothers or in-laws. Generational comparisons of motherhood and lack of acknowledgement regarding postnatal mental health, resulted in a negative impact on women's mental health. The wider literature indicates how health and social care professionals can also shape South Asian women's psychological wellbeing. Wittowski et al. (2011) found women to have negative experiences when seeking professional support for postnatal depression, often feeling dismissed. This thesis demonstrated how positive interactions with health and social care professionals can improve women's

psychological wellbeing. For example, women who sought therapy for postnatal depression reported feeling better about themselves and their ability to cope with motherhood and external stressors. These interactions enhanced women's psychological wellbeing.

Despite having knowledge of depression terminology, the way the term was used and understood varied. One of the main findings suggested that the term 'depression' was used in casual and loose ways, to depict non-clinical negative emotions. This represents the term 'depression' to be part of everyday vernacular contributing towards normalisation and popularisation of mental illness terminology. The impact of this will be discussed later in this chapter in the context of the Common Sense model (Leventhal et al., 1984). The impact of using the term 'depression' to describe everyday negative emotions can contribute towards misunderstandings between the new mother and health professionals. Thus, resulting in referrals made which are thought to be necessary but ultimately are wasted due to differing constructions and uses of the term 'depression'. The normalisation and popularisation of mental illness terminology can be seen as a good thing, as it can contribute towards a positive help-seeking environment, which was found in this thesis (Tayyba). However, the negative side includes blurred lines of what is and is not considered a mental illness. Various grey literature sources have highlighted this as a major issue which contributes towards the sufferer casting doubt on the evaluation of their feelings. This may lead to delayed help-seeking, further contributing towards under/overdiagnosis and wasted time and resources of already stretched mental health services. Published literature in academic journals around the impact of casual use of mental health terminology is scarce. This is an important and evolving area which requires further attention.

Pakistani-Muslim women in this study perceived psychological distress after childbirth to be caused by socio-cultural conflicts. This included lack of social support, social isolation, family conflict and pressures to adhere to cultural

expectations during the postnatal period. The belief that psychological distress including depression and postnatal depression has social origins has been consistently reported in the literature for South Asian women (Karasz et al., 2019; Khan et al., 2019; Moghul, 2018; Lamba, 2015). These current findings contribute to conceptual models of psychological distress after childbirth in Pakistani-Muslim women living in the UK. It is worth noting that none of the women in this study perceived religious or spiritual causes of psychological distress after childbirth and only one woman attributed biological causes. The way people understand their symptoms is likely to contribute towards their treatment expectations. As the majority of the South Asian population understand mental health as having socio-cultural origins, there has been a steady increase in culturally adapting existing therapies. These adaptations have targeted cultural, linguistic, as well as religious needs and have found to be successful in reducing symptoms of psychological distress, depression, and postnatal depression (Masood et al., 2015; Mir et al., 2015). The findings of this thesis can contribute towards culturally adapting therapies for British Pakistani-Muslim women during the postnatal period. An understanding has been developed of the key issues causing psychological distress during the postnatal period, which can be addressed in therapeutic contexts.

Pharmacological treatments for psychological distress have received mixed views amongst the literature (Ridge et al., 2015). Similar mixed views were found in this study. Medication was deemed a last resort for women and was tied with losing control over their mind and body, as they were reliant on something external to manage their mood. Women who had a good relationship (Alisha) with their doctor felt more supported in making an informed decision as they were made aware of the risks such as dependency and were offered alternative suggestions. In other cases (Aaliyah) women listened to the accounts of other women with depression who were taking medication, which shaped their views. In some cases, this deterred women from taking medication even if they were suffering, leading to a crisis point where eventually they had to take medication. The on-going use of

medication for psychological distress was evaluated to ensure how best to manage symptoms. Participants reported not feeling like themselves when off medication and that it gave them a sense of control as they were able to carry on with day-to-day life. These findings are not culturally specific but contribute to the wider literature around moral dilemmas and medication use for psychological distress.

Women who experienced therapy (Aaliyah and Tayyba) to manage their psychological distress reported positive experiences. The therapeutic relationship was viewed as important, especially for women who experienced relational conflict during the postnatal period. A good therapeutic relationship was described as having key values such as anonymity, confidentiality and being free from judgement. These factors encouraged women to stay in therapy and openly speak about their experiences. This resulted in women feeling more confident in managing their distress and reduced negative feelings they had about themselves or their abilities to mother. Barriers to recovery in therapy included poor family support outside of the therapeutic context. This demonstrates that family conflict is not only a perceived cause of psychological distress but also a barrier to recovery for some women. Previous reviews have demonstrated family inclusion in therapy to reduce symptoms of perinatal depression (Cluxton-Keller and Bruce, 2018). However, the current findings demonstrate the complex and sensitive nature of this when family may be the core root of psychological distress. Further research is required to understand Pakistani-Muslim women's views on including family in therapy for psychological distress after childbirth.

In this study some women made references to religion in ways of coping with mental health, but this was not a significant theme. All women were asked about their interactions with health and social care professionals during and after childbirth, including the postnatal period. At this point women could have mentioned such experiences. However, apart from not taking a liking to a certain health visitor, women did not report discrimination. Thus, it is

possible that women did not experience discrimination however, a limitation of this study is that issues surrounding religion and discrimination were not directly addressed during interviews, unless such issues were brought up by women themselves. It is possible that women did have such experiences but due to not being directly asked, they may have felt unable to speak about such issues. The potential power dynamics between the researcher and participant as discussed in the reflections section, chapter three, some participants may not feel safe to speak about sensitive issues or fear repercussions. Perceived discrimination from health professionals for example may act as a barrier to help-seeking as well as exacerbating existing mental health conditions (Mir et al., 2015; Wittowski et al., 2017). Thus, it is important for researchers to create a safe space for participants to discuss such issues.

A preliminary understanding was gained regarding the symptoms mothers experienced as part of their psychological distress post-birth. The literature review identified the Edinburgh Postnatal Depression Scale (EPDS) as a popular screening tool for postnatal depression across cultures. Therefore, women's experiences in this study were mapped against items of the EPDS. The purpose of this is to understand how much of the lived experience matched items of the EPDS. In the current sample, experiences of distress were underpinned by feelings of anxiety, low mood, depression, stress, and thoughts of self-harm. These symptoms matched with items 3/4/6/8/9/10 of the EPDS. As these findings were preliminary, limited conclusions can be ascertained. An in-depth study is required with a focus on symptom exploration in Pakistani-Muslim women suffering from psychological distress after childbirth.

Previous research examining the suitability of translated and adapted versions of the EPDS for cross-cultural use have consistently reported poor results (Downe et al., 2007; Shrestha et al., 2016). Currently, the EPDS is not validated in British South Asian samples. This would be a recommended first step. This would then establish whether further work is required to

develop new screening measures. In addition to screening measures, this thesis has drawn attention to the importance of understanding women's context and circumstances. By taking an intersectional approach and understanding how much of certain identities (gender, culture, religion, education etc.) impact women's constructions and help-seeking behaviours, health professionals may develop a more sensitive approach to broaching the topic of psychological distress after childbirth. This type of information is more time consuming to gather compared to quick completion of a questionnaire. However, information a questionnaire omits such as family views of mental health and barriers to help-seeking, can be captured through observations made by health professionals. Qualitative findings are not always designed to be generalisable, however this thesis raises some important points for health professionals in maternity care to consider. For example, key areas noted in this thesis include quality of family relationships, generational differences, and cultural expectations during the postnatal period. However, help-seeking behaviours and the mechanisms behind this have found to be complex in this sample of women, which can complicate care. The Common Sense model (Leventhal et al., 1984) helps unpick these behaviours whilst illuminating limitations of the model for this sample of women in the context of mental health.

8.5.1. Common Sense model of Self Regulation (Leventhal et al., 1984)

The Common Sense model of self-regulation (Leventhal et al., 1984) has successfully been used in mental health contexts to understand illness perceptions and help-seeking behaviours (Baines et al., 2013). The model was applied to the current research to establish suitability, but from a qualitative perspective as opposed to using illness perceptions questionnaires. This is because in Pakistani, and wider South Asian new mothers may have certain views and understanding of mental health and the older generation a different view, which can act as barriers to help-seeking (Smith et al., 2019). Women in this study demonstrated the complexity of

illness representations and what this meant for help-seeking. In some cases (Amaarah) positive illness representations were perceived, which suggested identification of illness, the desire to seek support, and a coherent understanding of the condition. According to the Common Sense Model this would imply that the individual is more likely to seek support and lead to better management of symptoms. However, through qualitative exploration a mismatch was found between seemingly positive illness representations but negative help-seeking behaviours. This complexity could be explained by the popularisation of mental health terminology. This can make it more difficult to understand the intent behind using labels and on help-seeking. Other women (Lubna, Amaarah) in this study demonstrated how illness representations can shift over time. Interactions with others who had similar experiences, but different illness representations contributed to some women re-evaluating their earlier illness representations which may have been negative.

Understanding how and why illness representations change over time may allow health professionals to better support women who experience familial and cultural barriers to help-seeking. These findings have added to a theoretical development of using the Common Sense model to understand illness representations and help-seeking behaviours in British Pakistani-Muslim women. The findings indicate that whilst women may demonstrate positive illness representations, cultural barriers may now allow for these to be observed in practice. This questions the suitability of the Common Sense model in this context but further work is required before concrete conclusions can be made. To understand these nuanced and complex behaviours, the Women's Ways of Knowing (WWK) model (Belenky et al., 1986) is applied in conjunction with the Common Sense model. Application of the WWK model allows for an in depth understanding of women's knowledge positions and how these influence help-seeking and illness representations.

8.6. Women's Ways of Knowing

The Women's Ways of Knowing (WWK) model (Belenky et al., 1986) is originally an educational framework, developed to understand knowledge positions of women. As discussed in the methodology chapter, the model has since been applied in diverse ways and beyond educational contexts, for example in applied health research (Iqbal, 2021). The model has been applied to this thesis in a novel manner, as a form of theoretical development of the WWK model (Belenky et al., 1986) to better understand the processes behind women's understanding of motherhood, psychological distress, and help-seeking behaviours. The most frequent knowledge positions found in this research included silence, received knowledge, subjective knowledge, and procedural knowledge: connected knowing. The unique ways in which Pakistani-Muslim women experienced these positions will now be discussed and how these findings add to the theoretical development of the WWK model.

Silence

In this study the knowledge position of silence was represented in three distinct ways: trauma filled silence, strategic silence, and cultural silence. Women who reflected the 'trauma filled silence' position had experienced previous failed attempts at voicing their distress and at help-seeking. They were met with unfavourable responses from authority figures (family members), which led to fears of not being believed in the future as well as increased vulnerability. To mask this vulnerability, in future cases of distress women hid these feelings by created a strong persona. These findings share similarities to the original position of silence in the WWK, such as women in this position having a fragile sense of self, a fear of authorities and a history of abuse. The current findings add to our understanding of this position by providing insight into how this can impact future help-seeking behaviours and the negative impact on mental health. Trauma filled silence meant that women felt unable to voice future distress, which led to repressed emotions and in some cases, this led to being diagnosed with postnatal depression.

This contrasts with 'strategic silencing', a position where women may have been experiencing some struggles in the transition to motherhood but perceived if they voiced these that they would be labelled as mentally unstable. Women in this position had pre-conceived ideas of the health system, which included fear of child being taken away if they voiced any struggles. This links with received knowledge as the pre-conceived ideas were based on conversations with others or stories they heard via the media. Similarly, to the original WWK position this indicates a fear of authorities (health professionals). This has been consistently cited as a barrier to help-seeking in the literature (Pinar et al., 2022; Khan et al., 2015).

The third form of silence was identified by this research as 'cultural silence'. In this position women were exposed to cultural knowledge regarding motherhood and childcare, which they did not always agree with. Generational and cultural expectations of respecting elders made it difficult to voice their own views. Clashing views and the influential role of the family made it difficult for some women to parent how they want or seek support for psychological distress. All three forms of silence identified have one thing in common which is fear of authority figures, as identified in the original WWK silence position. These findings add to the theoretical development of the WWK by developing an understanding of how women may tailor their behaviours because of trauma, and pre-conceived ideas and fears of talking about psychological distress after birth. The former two positions of silence may be relevant universally to all women. The latter position of cultural silence has added a unique understanding behind some women's lack of voice during motherhood and psychological distress in a cultural context.

Received knowledge

The position of received knowledge represented what knowledge new mothers were exposed to during the postnatal period and how this subsequently impacted meaning-making of distress. Two key knowledge sources were identified which included knowledge via health professionals

and knowledge via family members which is termed as folk knowledge. The findings of this thesis add to the position of received knowledge by demonstrating how Pakistani-Muslim women can be exposed to multiple knowledge sources (medical and cultural) and how this can sometimes be conflicting. Similar to the original model, women in this position displayed lack of confidence in voicing their own opinions and displayed vulnerabilities in their transition to motherhood. During this time women were susceptible to the information they received, indicating it to be a crucial time for timely and appropriate support.

Subjective knowledge

Women in this study demonstrated their journey to becoming subject knowers. This included transitioning through silence and received knowledge, which highlighted ambivalence, not feeling understood or satisfied with the level of meaning making provided by previous knowledge positions. Thus, as the original WWK models suggests women in this position were protesting their inner voice. The current findings add to this position by suggesting that subjective knowledge for Pakistani-Muslim women in this study was still fluid and not concrete. Women still battled with inner conflict between knowledge they perceived as their truth versus cultural knowledge provided by family members. Thus, depending on context women demonstrated shifting between positions of cultural silence and subjective knowers. Understanding women's knowledge positions and behaviours through this model emphasises that women may react differently in different situations. Thus, emphasising the importance of health professionals speaking to women about mood change or motherhood one-to-one without family members being present.

Procedural: connected knowing

In this position new mothers reflected on their past and present through interactions with others, to make sense of their feelings. Sharing experiences of distress acted as a vessel for women to evaluate information and accept or reject certain knowledge in relation to themselves. At this stage, there was an appreciation for knowing different experiences, without it being threatening to the individual. Commonalities in experiences were embraced and in some cases another's experience aided meaning-making and resulted in shifted illness representations. The findings of this thesis suggest the WWK model to be useful in understanding the processes behind Pakistani-Muslim women's behaviours including help-seeking for psychological distress. To reiterate, the WWK model was originally developed based on research with ethnically and socially diverse women. This is perhaps one of the key reasons for its usability and applicability in various contexts to this day. The general characteristics of each position was reflective of Pakistani-Muslim women in this study.

Using the WWK specifically to understand Pakistani-Muslim women's knowledge positions in the context of motherhood and psychological distress, has highlighted some underplayed areas within the model. Through a dialogical approach to understanding women's experiences, features such as inner conflict and ambivalence were illuminated as women sought in the voices of others. This demonstrates that for Pakistani-Muslim women in this study, transition between knowledge positions is not always linear, but a fluid and nuanced process. The addition of the dialogical has led to an enhanced understanding behind women's knowledge positions and has added to the theoretical development of the WWK model (Belenky et al., 1986). Considering the recent findings, this is a useful model to help health professionals and researchers to understand more about why women behave the way they do based on their knowledge positions. Through some basic questions to understand women's current situations, it can be ascertained what knowledge position they fall into and thus potentially predict their help-seeking behaviours and offer them tailored support. As noted, a dialogical approach to research and analysis was taken. Dialogical features

are present in qualitative research but their meaning and significance in understanding experiences is often neglected. The next section of this chapter will therefore discuss the use of double voices and their significance within meaning-making.

8.7. Double Voices

The thematic-dialogical analysis paid attention to dialogical features within extracts. The aim of this was to enhance depth of understanding behind women's meaning-making and internal processes during motherhood and psychological distress. Women interacted and negotiated voices in two distinct ways, which influenced the way they approached motherhood and help-seeking. The first voice can be described as the 'hierarchy of absent voices', which means that during meaning-making certain voices were narrated as more dominant than others (health professionals). By doing so suggests what voices are most valued by the new mother, which may influence help-seeking preferences. For example, if a health professional's voice is dominant and at the top of the hierarchy, it is likely that this type of knowledge and information is well regarded by the new mother. Paying attention to such hierarchies may develop understanding of which figures are trusted by new mothers. This may lead to a greater awareness of how health professionals and/or researchers should relay information. For example, if women are more likely to trust community figures, then this might be a more effective and appropriate method of communicating information.

I labelled the second voice as the 'generalised voice' which links in with perceived stigma and the good motherhood discourse. The 'generalised voice' represents how new mothers' perceive the public to think about them. This includes concerns around whether people will judge you as a mother based on how well you are coping, how clean your kids look etc. This generalised voice can be experienced by all new mothers as they navigate between the romanticized version of motherhood compared to the reality. However, the generalised voice can transition into a more concrete voice

when the new mother directly experiences judgment of her mothering abilities. What I term as the sub-voice of 'judgemental voices' was shown to be linked with generational differences in postnatal care, child rearing and understanding of psychological distress after childbirth. The generalised and judgemental voices together were found to contribute towards feelings of psychological distress and perpetuated the bad mother discourse. Women navigating the generalised and judgmental voices demonstrated a vulnerability of absorbing these voices, with little ability to critically evaluate the voices. This links in with the position of silence in the WWK model. A focus on voice has developed understanding of what may contribute to women's fragility and vulnerability during the early postnatal period. In the current case, it is pre-existing concerns of being a good enough mother, coupled with real judgement from close ones. Paying attention to these multi-layered voices has deepened understanding behind women's experiences of motherhood, meaning-making and psychological distress during the postnatal period.

8.8. Strength and Limitations

The main strength and limitations of this PhD will now be discussed. One of the strengths of this PhD is the diversity of the sample, which included Pakistani-Muslim women of a wide age-range, nulliparous and multi-parous women. This allowed the research to capture a range of experiences. Furthermore, both English and non-English speakers took part. Non-English speakers are often omitted from research due to language barriers (Squires et al., 2020). By including them in this research, their key experiences of motherhood and of psychological distress after childbirth have been captured. Qualitatively speaking there were little experiential differences between the English and non-English speaking women, thus findings are pooled together. Nevertheless, the inclusion of these women strengthens the findings for the British Pakistani-Muslim population of women. Generalisability of findings is not really an aim in qualitative research, but it must be noted that findings of this thesis may not be representative of all

Pakistani-Muslim women living in Britain. The experience of motherhood and psychological distress is influenced by a woman's intersecting identities. Therefore, the experience of a Pakistani-Muslim woman with rural roots, residing in deprived areas of Bradford, may differ from a Pakistani-Muslim woman with urban roots, residing in an affluent area of the UK. However, many of the key themes were supported by wider literature, adding to the transferability of findings. It could therefore be argued that findings of this thesis may be relevant to Pakistani-Muslim women, with rural roots, in other deprived areas of the UK. However, direct information regarding socio-economic status was not collected in this research. The sample is part of the Born in Bradford Better Start cohort, who only recruit participants from deprived inner-city areas of Bradford. This is determined via postcode only. This is a limitation for this research because within the Pakistani-Muslim community it is not unusual for families to reside in deprived areas because this is where previous generations had settled. Thus, it is possible that some participants were of a higher SES, despite residing in an area classified as deprived and of low SES. This could mean that experiences of participants of higher SES were captured, who's needs are different to those of lower SES. However, through thematic-dialogical analysis the themes presented in this thesis were representative of the experiences of the sample.

Another limitation is the interpretive approach to thematic-dialogical analysis applied in this research. An interpretative approach means going beyond participant words and putting them into a theoretical context to explore meaning making and experiences. This type of approach may make findings harder to verify as they move further away from being objectively measurable. However, throughout the analysis and write-up of findings, my supervisors reviewed interpretations and picked up on areas which moved too far away from participant extracts. Therefore, although an interpretive approach to analysis was taken, all efforts have been made to ensure interpretation stayed close to participant words and experiences.

It is worth noting how this PhD has developed throughout the years. Initially, the study of psychological distress after childbirth was to be explored through a mixed-methods design. A qualitative element exploring lived experience and a quantitative element focusing on screening measures. The term 'postnatal depression' was also going to be used. Through much reflection and discussions with supervisors, the term postnatal depression was replaced by psychological distress after childbirth. As discussed in the introductory chapter and literature review, this is because of the positivistic connotations of the term. Keeping in mind the philosophical underpinnings of this research, the mixed-methods design was re-thought. Based on what I wanted to achieve through this PhD (an understanding of how Pakistani-Muslim women experience motherhood and psychological distress after childbirth), an in-depth 'big qualitative' study was most appropriate to meet these aims. Utilising a relatively neutral term such as psychological distress, is a strength of this study. This is because when studying this phenomenon in cross-cultural populations it is important to not label experiences based on what we as researchers think they should be or under a Western understanding. This approach allows the participant to use their own words to ascertain understanding and meaning-making and contributes towards culturally sensitive research. The qualitative design is also a strength as limited 'big qualitative' studies exist exploring this area. This design has allowed a rich understanding of key experiences of motherhood during the postnatal period, including aspects which may contribute towards psychological distress after childbirth. The implications and recommendations of these findings will now be discussed.

8.9. Implications and Recommendations

The role of social support including key relationships (partner, own mother, mother-in-law) for British Pakistani-Muslim women during the postnatal period has been identified via this research. Women's own mothers/mother-in-law have been identified as a source of practical support but may lack emotional support. Women experiencing psychological distress after childbirth require a level of emotional support to ensure they can confide in

people and feel understood during this vulnerable and transitional period. One way women may receive emotional support is through female support groups, a preference women reported in this study. The findings of this research thus support the need for culturally adapted support groups for motherhood and psychological distress. Partners were also key in supporting women's transition to motherhood. A universal gap in partner's understanding of motherhood and psychological distress was found. Despite this, partners did offer solutions to help uplift mood. It is recommended that partners have access to information on mood changes in the transition to motherhood, including an awareness of perinatal mental health conditions.

The popularisation of the use of mental health terminology, such as depression to describe everyday emotions was found. This is a concern as the line may be blurred between those attempting to disclose feelings of depression, compared to those who are using the term loosely. It is recommended that health professionals are made aware of this phenomenon and to develop a plan of action on how to deal with this. Pakistani-Muslim women demonstrated different knowledge positions through the WWK model and the fluidity of this. This is an important finding for health professionals to be aware of, that in different settings Pakistani-Muslim women may respond in different ways, thus a sensitive approach is required. When broaching the topic of low mood after birth in British Pakistani-Muslim, it is recommended that health professionals gain an understanding of the position of the new mother, her family members and whether family members could potentially influence future help-seeking of psychological distress.

The main protective factor identified in this study is social support provided by family members and the husband. Thus, in this study women without family social support or with conflicted marital or family dynamics, were more likely to report experiences of psychological distress/postnatal depression.

Thus, it is recommended that when healthcare professionals visit Pakistani-Muslim women during the postnatal period, they enquire about the level of family social support available to them.

For women without appropriate family social support, it is recommended that they are referred to culturally adapted support groups for new mothers. This might include a peer support group as a preventive measure, or specific to the experience of psychological distress/postnatal depression. Despite religion not being at the forefront of women's experiences as a coping mechanism, religious beliefs such as it is a sin to self-harm, were used to help women seek support. Thus, it is important that service users are asked about their preference to incorporate religious teachings as part of their therapy. Whilst there is some work conducted in this area already (Mir et al., 2015; Mir et al., 2019), it is a significant service gap.

The findings of this thesis indicated that the older generation of Pakistani-Muslim mothers struggled to recognise and empathise with the newer generation of mothers, when they were experiencing psychological distress/postnatal depression. It is recommended that further research is conducted directly with the older generation of Pakistani-Muslim mothers to delve deeper into their understandings of postnatal depression, to develop a culturally adapted educational programme to raise awareness.

9.0. Summary of original contribution to knowledge

Throughout this chapter, I have demonstrated how my findings have either added something new to the literature and/or reiterated existing findings. In this section I will summarise my original contribution to knowledge.

9.0.1. Generational differences and rurality

I have paid attention to why Pakistani-Muslim women may feel less supported (emotionally) by their families by focusing on generational differences, underpinned by rural identity. Previously, generational differences and understanding of psychological distress has been explained largely by cultural and ethnic differences. Through my findings I have demonstrated that these differences are more nuanced, and that they can

also be influenced by rural identity. This is beneficial for future research with ethnic minority groups as it demonstrates that some behaviours may be explained beyond the cultural influence. For all researchers it may be tempting to label certain behaviours as part of the Pakistani culture or the South Asian culture. This may lead to generalisations or risk of stereotyping in some cases. Through an intersectional and social constructionist-critical realist approach, I have paid attention to factors which have always been present but underplayed in the literature. This includes rural identity of the older generation (relevant to the current sample) and how these shape understanding of psychological distress. This is relevant as in some Pakistani-Muslim household the older generation may have power, control, or influence over women's help-seeking behaviours.

9.0.2. Dialogical

Dialogical features in interview transcripts are not new, but very little research pays attention to the significance of these. Through thematic-dialogical analysis, I paid attention to various dialogical features such as internal dialogue, sideward glance, and the use of double voices where participants bring in the voices of others. This has allowed me to gain a deeper understanding of Pakistani-Muslim women's meaning-making during motherhood and psychological distress after childbirth. Paying attention dialogical features almost provide a key into the women's sub-conscious, but these are verbally stated. I mention the sub-conscious mind because through communication we all demonstrate a range of dialogical features but this something we might not be consciously aware of and rarely reflect on. Thus, a much deeper interpretation of Pakistani-Muslim women's experiences has been achieved through this hybrid-dialogical approach to analysis and research.

9.0.3. Theoretical Framework

Throughout this thesis the WWK model (Belenky et al., 1986) has been applied to the research process and the findings of this thesis. To my knowledge, the WWK model has not been previously applied to understand Pakistani-Muslim women's knowledge positions regarding motherhood and psychological distress. Across the years the WWK model has been used in various contexts demonstrating its applicability. The findings of this thesis have contributed to the theoretical development of the WWK model. It has been established that this model can be used in mental health contexts (psychological distress after childbirth), to understand and potentially predict Pakistani-Muslim women's help-seeking behaviours. The findings have added a certain level of depth to the WWK model when understood in the current context. This includes the way women can move fluidly between knowledge positions and the meanings of this. Emotional and psychological struggles attached to knowledge positions add to the existing WWK model. The findings of this thesis contribute to research influenced by the Women's Ways of Knowing model (Belenky et al., 1986).

In addition to the WWK, the Common Sense model of self-regulation (Leventhal et al., 1984) did not apply well in the current research study. This implies a weakness of the model when used in mental health contexts with Pakistani-Muslim women. This is because of the varying influential factors which can lead to discrepancy between what women think and feel about their psychological distress, versus family perceptions. The latter may influence help-seeking behaviours, despite positive illness representations. The unique ways in which illness representations have been captured, that is qualitatively as opposed through questionnaires has highlighted this overlooked area. A combination of the Common Sense model and Women's Ways of Knowing led to deeper understanding of these discrepancies.

9.0.4. Pre-liminary work on the EPDS

One of the issues highlighted in the background of this research has been that of screening measures for postnatal depression, namely the use of the EPDS in cross-cultural populations. To reiterate, the issue surrounds whether the items of the EPDS capture experiences of psychological distress in culturally diverse women. To date, much of the research surrounding adaptations of the EPDS for South Asian women do not consider qualitative work around the experience of psychological distress and what symptoms women experience. In many cases, the original items are translated into different languages which do not always capture lived experiences. The preliminary findings of this thesis have added to the rationale behind studying lived experience of psychological distress after childbirth in cross-cultural populations and cross-referencing experiences with existing screening measures. For English speaking and British born Pakistani women it is still best practice to validate measures such as the EPDS and it is still possible that some items may not capture their lived experiences, as demonstrated by the current findings. It is acknowledged that further work is required in this area to strengthen findings and conclusions, but this is a step in the right direction. A summary has been provided of the original contribution to knowledge. In addition to this, recommendations for future research will now be discussed.

9.1. Recommendations for future research

The views of new mothers and their perception of family views of psychological distress after childbirth were captured. This is because just the perception of something can influence how people respond and deal with situations. However, it would be beneficial to explore the views of family members including partners first-hand. This would allow for a more holistic understanding from all perspectives to establish further gaps in research and/or support. The current thesis has provided a pre-liminary understanding

of the symptoms British Pakistani-Muslim women reported as part of their psychological distress after childbirth. However, an in-depth qualitative study with a specific focus on symptoms is required. These findings may strengthen or complement screening tool validation studies. To tie into this, a validation study of the Edinburgh Postnatal Depression Scale (EPDS) is required in this sample. The EPDS has not been previously validated in this sample but continues to be used with ethnic minority women. The consequences of this have been discussed in the introduction and literature review chapters. Based on future findings, recommendations can be made regarding the use of the EPDS or a need for new measures. Due to the sole qualitative nature of the current research, a validation study whilst beneficial did not fit the overall scope of this thesis.

9.2. Conclusion

This chapter has provided a discussion of the key findings from the empirical chapters, including theoretical contributions to the field. The findings have been discussed in relation to their respective research questions, to demonstrate how each research question has been addressed. This chapter has highlighted universal as well as culturally specific and nuanced experiences of Pakistani-Muslim women in motherhood and psychological distress. An in-depth understanding has been gained of practical elements such as what happens during the postnatal period and how women navigate through meaning-making and help-seeking. As well as areas which have been neglected in this population such as paradoxical experiences of motherhood, filled with ambivalence and psychological resistance.

A qualitative approach has allowed British Pakistani-Muslim women's voices to be heard and amplified, in this thesis. The narrative presented in the introduction chapter, of a vulnerable new mother silenced and feeling trapped motivated me to study the topic of this thesis. To conduct academic research on Pakistani-Muslim women's experiences on motherhood and

psychological distress, and to have this in writing and hopefully published in the future, feels invaluable. This is because, as a Pakistani-Muslim researcher I often come across certain issues or experiences within the community which may be accepted or taken for granted. Even if these are negative experiences with consequences such as the ones highlighted in this thesis. My hope for the future is that through dissemination, the community recognise the issues presented and work towards making a positive change for new mothers.

On a final note, throughout this PhD journey I have come across research in this field which is progressive and innovative. At the same time, I have come across research highlighting the same issues across two decades, sometimes longer. I envision that some issues may continuously be present throughout space and time. However, it is also important to start addressing such issues and disseminating findings wider, to prevent research waste. My plans post-PhD are to remain in academia and be research active. I hope to disseminate the findings of my thesis through publications in academic journals, conference presentations, and community events. I hope my current research makes a difference to the lives of Pakistani-Muslim mothers, that their experiences of motherhood and psychological distress are better understood, and they receive the most appropriate support.

10.0. References

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11.0. Appendices

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me |
| <input type="checkbox"/> As much as I always could | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual |
| <input type="checkbox"/> Definitely not so much now | <input type="checkbox"/> No, most of the time I have coped quite well |
| <input type="checkbox"/> Not at all | <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things | *7. I have been so unhappy that I have had difficulty sleeping |
| <input type="checkbox"/> As much as I ever did | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Rather less than I used to | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Definitely less than I used to | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> Hardly at all | <input type="checkbox"/> No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Yes, some of the time | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Not very often | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> No, never | <input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason | *9. I have been so unhappy that I have been crying |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Hardly ever | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Only occasionally |
| <input type="checkbox"/> Yes, very often | <input type="checkbox"/> No, never |
| *5. I have felt scared or panicky for no very good reason | *10. The thought of harming myself has occurred to me |
| <input type="checkbox"/> Yes, quite a lot | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No, not much | <input type="checkbox"/> Hardly ever |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Never |

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

Appendix 1: Original Version of the Edinburgh Postnatal Depression Scale

Appendix 2: DSM-5 Criteria of Postnatal Depression

Table 1 DSM-5 Diagnostic Criteria for Major Depressive Disorder³

For a diagnosis of major depressive disorder, 5 or more of the following symptoms must be present nearly every day for at least a 2-week period (at least one of the symptoms is either depressed mood or anhedonia). Symptoms must impair functioning and cannot be secondary to another drug or illness.

- Depressed mood most of the time and on most days (e.g., feels sad, appears tearful)
- Anhedonia (e.g., decreased interest or pleasure in activities)
- Significant change in weight (e.g., weight loss, weight gain)
- Sleep disturbances (e.g., insomnia, hypersomnia)
- Psychomotor fluctuations (e.g., psychomotor agitation or retardation)
- Changes in energy levels (e.g., fatigue, loss of energy)
- Excessive guilt or feelings of worthlessness
- Difficulties concentrating
- Recurrent thoughts of death or suicidal thoughts (e.g., active or passive suicidal ideation with or without a plan)

Peripartum onset specifier: Onset of symptoms occurs during pregnancy or within 4 weeks after childbirth. Episodes can present with psychotic features.

Appendix 3: Invitation Letter



20 November 2025

Study Title: Your views on talking about mood changes after having a baby

Congratulations on the recent birth of your baby. When you were pregnant you kindly joined BiBBS (the Born in Bradford's Better Start study) and agreed to be contacted about future studies. If you are still interested in taking part in other studies, please see the information included about an important new study that we would like your help with. A member of the study team will contact you in the next two weeks to discuss the study. If you don't want us to call you, or if you have any questions, please contact Amirah Akhtar on 07526934011

Thank you for taking the time to read this letter.

Yours faithfully,

Amirah Akhtar

PhD student

Appendix 4: Participant Information Sheet

Introduction

We would like to invite you to take part in a study being conducted as part of a PhD project by Amirah Akhtar who is a team member on the Born in Bradford's Better Start (BiBBS) study. This leaflet tells you about the study. Please ask us if anything is not clear or if you would like more information.

What is the study about?

We would like to understand life after child-birth for Pakistani women. To explore this, we will focus on mood changes after having a baby and what makes it easy or difficult to discuss feelings of low mood after having a baby.

Why have I been asked to take part?

You have been asked to take part because you are a part of the BiBBS cohort study and consented to be contacted about future studies.

Do I have to take part?

No. It is up to you. Even if you do say yes now, you can change your mind at any time without giving any reason.

What will be involved if I agree to take part?

The PhD student researcher, Amirah Akhtar, will contact you to arrange a convenient time to ask you some questions about your experiences. This can take place in any convenient location of your choice, or in your home if you prefer. We can discuss this when we speak over the phone when arranging the interview. The interview will last about an hour and will be audio recorded however your details will remain confidential at all times.

The researcher will contact you by telephone in the next two weeks to see if you want to take part. If you don't want the researcher to call you, please let us know by phoning Amirah Akhtar, the PhD researcher on her work mobile 0752 693 4011.

What are the possible disadvantages and risks of taking part?

We do not anticipate that there will be any disadvantages or risks if you take part.

You may find some of the topics covered in the interview upsetting. You do not have to answer any questions you do not wish to and you may pause or stop the interview at any time.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study at anytime. If you withdraw, the information already collected from you will be included in the final study analysis. If you withdraw consent for your information to be used within three months of interview date, it will be confidentially destroyed.

What will happen to the results of the research study?

The results of the study will be written up into a thesis, for submission to the University of Bradford. We also hope to publish the results of this study in an academic journal. We will send all participants a summary of the findings unless they opt out.

It is also possible that the results and extracts from the interviews may be presented at conferences. You will not be identified in any report/publication.

What if I need more information or there is a problem?

If you need any more information please contact Amirah Akhtar, PhD researcher on 0752 693 4011 or a.akhtar34@student.bradford.ac.uk. Alternatively, you can contact the main supervisor at the University of Bradford, Professor Abigail Locke on a.locke@bradford.ac.uk OR co-supervisor at Born in Bradford, Nimarta Dharni on Nimarta.Dharni@bthft.nhs.uk.

Will my taking part in the study be kept confidential?

University of Bradford and the Bradford Institute of Health Research (BIHR) is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The actual recordings of the interview will be destroyed once the study is completed.

All your personal, identifiable information (name, address and telephone number) will be kept confidential and will be stored safely at the Better Start Bradford Innovation Hub and the University of Bradford for 5 years after the study has finished. When the interview is written down you will be given a false name so that only the researcher who saw you will know who you are. Your rights to access, change or move your information is limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

The Better Start Bradford Innovation Hub is a part of the Bradford Hospitals NHS Foundation Trust. If we have concerns that you, or someone else, is at risk of harm then we will have to break confidentiality and tell the relevant healthcare services, for example your midwife, health visitor or GP. All information will be treated in the strictest confidence in accordance with the relevant UK data protection regulations and used for research purposes only. You can find out more about how we use your information by contacting the PhD research Amirah Akhtar on a.akhtar34@student.bradford.ac.uk.

What are the possible benefits of taking part?

People often say that it was helpful to talk about their experiences. It is hoped that the information you provide during the interviews will help gain a deeper understanding of life after child birth for Pakistani Muslim women. This may help inform health professionals to improve support services by making them more culturally appropriate to the Pakistani Muslim community.



Bradford Teaching Hospitals NHS Foundation Trust



Study Title: Exploring Pakistani-Muslim women's experiences of motherhood and mood changes after having a baby

INFORMATION LEAFLET FOR MOTHERS



Appendix 5: Consent Form

Study Title: Exploring Pakistani-Muslim women's experiences of motherhood and mood changes after having a baby.

1. I confirm that I have read and understood the information sheet dated 19.09.18 V1.1 for the above study. I have had the opportunity to ask questions.	Yes <input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.	Yes <input type="checkbox"/>
3. I understand that even if I withdraw from the study, the data already collected from me will contribute to the study unless I specifically withdraw consent for this within three months from the date signed on this consent form.	Yes <input type="checkbox"/>
4. I understand that my data will be collected for this study and may be used to help develop new research. Data protection regulations will be observed. Confidentiality will be maintained unless there are concerns that I, or someone else, is at risk of harm.	Yes <input type="checkbox"/>
5. I understand that the interviews will be audio recorded, transcribed and stored safely.	Yes <input type="checkbox"/>
6. I understand that any information I give may be included in published documents but where direct	Yes <input type="checkbox"/>

quotes are used my identity will be protected by the use of pseudonyms.	
7. I understand that a copy of this consent form will be stored at the University of Bradford and Better Start Bradford Innovation Hub and one copy will be provided to you, the participant.	Yes <input type="checkbox"/>
8. I agree to take part in the interview.	Yes <input type="checkbox"/>
9. I wish to receive a summary of the findings.	Yes <input type="checkbox"/>

Participant's Name

Participant's Signature Date

Researcher's Name

Researcher's Signature Date

If you would like to talk to the researcher or leave the study from three months of date written on consent, you can contact via mobile: 0797 0802 030 or email at

Appendix 6: Sample Interview Schedule from Lamba (2015)

- 1) How did you experience the postnatal period?
Prompts: How were you feeling? What made you feel this way? How did you cope? What was helpful? How did this compare to how you were feeling in the first few days after childbirth? How were these initial feelings in the first few days different?
- 2) How did you know that you were feeling depressed?
Prompt: When do you think it started? What did you notice?
- 3) What do you think of the term postnatal depression?
Prompt: What did you think of it? How do you understand PND now?
- 4) How did you feel about yourself at the time?
Prompt: As a person? How do you feel about yourself now?
- 5) How did postnatal depression effect your relationships? With your husband?
Your family members? With other children (if any)?
- 6) Describe what a typical day was like for you as a mother during this period when you experienced postnatal depression?
- 7) During this time, how did your experience of PND affect you as a mother with your baby?
Prompts: Were you able to feed him/her? look after her? If it was difficult, what was difficult?
- 8) How do you think you would have felt if you were in Pakistan after the birth of your child?
Prompt: different? Not different? If so / if not then how or why not?

- 9) What did you think of the health visiting services during the postnatal period?
Prompts: Helpful / Unhelpful, how?
- 10) Generally during the postnatal period, what do you think you needed? What would have helped you during this time?
Prompt: From personal relationships? From health professionals?
- 11) What was your experience of support - if any - during the postnatal period?
Prompt: If so, what kind of support? What was this like? What was helpful, what wasn't helpful?
- 12) What kind of support do you think you needed?
Prompt: what could have helped and how?
- 13) How do you think you could be supported by services like the NHS?
Prompt: What are your feelings on counselling? No to counselling? If not, why not? If yes, how do you think it would help?

Appendix 7: Interview Schedule

Topic guide for mothers

Opening statement:

Thank you for agreeing to take part in this interview. Feeling down before and after having a baby is part of the experience of many new mums. However, not all mums are able to express this or seek/receive the care. We're interested in finding out about how we can make it easier for mums to express their feelings and get the help they need....

The interview may take up to an hour, but we can stop at any time if you need to. Just to remind you, your identity will remain anonymous, you do not need to answer all questions and there are no right or wrong answers. We just want to hear your views. I may ask you to explain something further in the interview. This is not because you are not being clear, but because when presenting this work we need to use your words rather than mine to explain things. Your name will never appear in any reports or publications arising from this work. Do you have any questions before we start?

SWITCH ON RECORDER

1. To begin with I'd like to ask you a few background questions about yourself.

PROMPT: how old is your little one? Is this your first baby or do you have other children?

How old are they? Were they all born in Bradford?

2. What has your experience been of being a new mum?

mothers with more than one child what has your experience been of being a mum again?

PROMPT: how was this experience similar or different to previous children you had?

Can you give me an example?

3. It is common for women to experience changes in mood before and after having their baby – how have you been feeling?

PROMPT: During pregnancy?

How did you feel after the birth of your baby?

Was this similar or different to how you felt after you had your other children

4. Thinking back to your pregnancy, when you saw your midwife, health visitor or GP did anyone ever ask you about your mood/feelings of depression?

PROMPT: who asked?

Can you remember what they asked?

Did they ask on more than one visit?

What did you think about being asked about your mood/feelings?

Were you able to be open in your response?

What would encourage you/women to be more open?

4. Since having your baby, has anyone ever asked you if you have been feeling down or depressed?

PROMPT: who asked?

Can you remember what they asked?

Did they ask on more than one visit?

What did you think about being asked about your mood/feelings?

Were you able to be open in your response?

What would encourage you/women to be more open?

5. Did you ever tell anyone else about how you were feeling (aside from a health professional) e.g. family member, friend?

PROMPT: were they supportive?

Did they understand?

for women asked how they were feeling through an interpreter

How was your experience of being asked if you had been feeling down or depressed via an interpreter?

PROMPT: were there any challenges?

6. Did you know that GP/HV/midwife could refer you for extra support?

7. Have you heard of the term postnatal depression?

PROMPT: Where did you hear about it?

What do you think when you hear it?

Could you tell me what you know about it?

What do you know about depression in general?

Is your family aware of mental health/PND?

What are their views?

8. How do you think mental health is seen in your community?

Prompt: cultural

religious

9. If you/other mums were feeling down what would stop them from telling midwife/GP/HV?

10. If you/other mums were feeling down what would make it easier to talk to midwife/GP/HV?

11. Do you think it is important to talk about feelings of low mood/depression?

PROMPT: why do you think this?

12. If you were feeling down, what support would you find helpful?

PROMPT: A group – community based?

GP – prescription

Other health professional

Other type of support – what would this be?

What are your expectations of help?

Thank you very much for taking part. I'll now switch off the recorder.

Appendix 8: REC Favourable Opinion Letter



Yorkshire & The Humber - Bradford Leeds Research Ethics Committee

NHSBT Newcastle Blood Donor Centre

Holland Drive

Newcastle upon Tyne

NE2 4NQ

Telephone: 0207 104 8081

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

08 November 2018

Miss Amirah Akhtar
University of Bradford
Richmond Rd
Bradford
BD7 1DP

Dear Miss Akhtar

Study title: **An exploration of barriers to detection and disclosure of low mood during the postnatal period in first and second-generation Pakistani-Muslim women.**

REC reference: **18/YH/0404**

Protocol number: **0**

IRAS project ID: **244725**

Thank you for your letter of 5th November 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no

earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The

expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover letter]	V1.0	10 August 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employers liability]	V1.0	

Interview schedules or topic guides for participants [topic guide fa]	V1.0	06 September 2018
Interview schedules or topic guides for participants [hv topic guide]	V1.0	06 September 2018
Interview schedules or topic guides for participants [topic guide mothers]	V1.0	06 September 2018
IRAS Application Form [IRAS_Form_02102018]		02 October 2018
IRAS Application Form [IRAS_Form_02112018]		02 November 2018
Letters of invitation to participant [mother invitation]	V1.0	06 September 2018
Letters of invitation to participant [HV invitation]	V1.0	06 September 2018
Letters of invitation to participant [PFA invitation]	V1.0	06 September 2018
Other [Professional indemnity]		12 June 2018
Other [Public liability insurance]		12 June 2018
Other [email for hv team leader]	V1.0	
Other [Ethics amendments]		01 November 2018
Participant consent form [consent fa]	V1.1	19 September 2018
Participant consent form [consent HV]	V1.1	19 September 2018
Participant consent form [Consent mother]	V1.1	19 September 2018

Participant information sheet (PIS) [FA PIS]	V1.0	06 September 2018
Participant information sheet (PIS) [HV info]	V1.0	06 September 2018
Participant information sheet (PIS) [Mothers PIS]	V1.2	30 October 2018
Referee's report or other scientific critique report [Reviewer 1 internal report]	V1.0	23 July 2018
Referee's report or other scientific critique report [Reviewer 2 internal report]	V1.0	20 July 2018
Research protocol or project proposal [Protocol]	V1.1	06 September 2018
Summary CV for Chief Investigator (CI) [Amirah CI CV]	V1.0	10 August 2018
Summary CV for student [Student CV]	V1.0	04 August 2018
Summary CV for supervisor (student research) [Nimarta Dharni CV]	V1.0	04 August 2018
Summary CV for supervisor (student research) [EB CV]	V1.0	24 August 2018
Summary CV for supervisor (student research) [AL CV]	V1.0	
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Lay summary of protocol]	V1.0	17 September 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments

Adding new sites and investigators

Notification of serious breaches of the protocol

Progress and safety reports

Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality><http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

18/YH/0404 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp



Dr Janet Holt Chair

Email: nrescommittee.yorkandhumber-bradfordleeds@nhs.net

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: *Professor Abigail Locke, University of Bradford*
Ms Jane Dennison, Bradford Teaching Hospitals Foundation Trust

Appendix 9: HRA Approval Letter



Miss Amirah Akhtar

PhD Student

University of Bradford

Richmond Rd

BD7 1DP

Email:

hra.approval@nhs.net

[Research-](mailto:Research-
permissions@wales.nhs.uk)

permissions@wales.nhs.uk

21 September 2018

Dear Miss Akhtar

HRA and Health and Care

Research Wales (HCRW)

Approval Letter

Study title: An exploration of barriers to detection and disclosure of low mood during the postnatal period in first and second generation Pakistani-Muslim women.

IRAS project ID: 244725

Protocol number: 0

REC reference: 18/YH/0404

Sponsor University of Bradford

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.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the “*summary of assessment*” section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a ‘green light’ email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

Page 1 of 7

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

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 the devolved administrations of 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 (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your nonNHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including: Registration of research

Notifying amendments

Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Professor Abigail Locke

Email: a.locke@bradford.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **244725**. Please quote this on all correspondence.

Yours sincerely

Thomas Fairman

HRA Assessor

Email: hra.approval@nhs.net

Copy to: *Professor Abigail Locke, Bradford University, (Sponsor Contact)*

Mrs Jane Dennison, Bradford Teaching Hospitals NHS Foundation Trust,

(Lead NHS R&D Contact)

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover letter]	V1.0	10 August 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employers liability]	V1.0	
HRA Schedule of Events		21 September 2018
HRA Statement of Activities		21 September 2018
Interview schedules or topic guides for participants [topic guide fa]	V1.0	06 September 2018
Interview schedules or topic guides for participants [hv topic guide]	V1.0	06 September 2018
Interview schedules or topic guides for participants [topic guide mothers]	V1.0	06 September 2018
IRAS Application Form [IRAS_Form_02102018]		02 October 2018

IRAS Application Form [IRAS_Form_02112018]		02 November 2018
Letters of invitation to participant [HV invitation]	V1.0	06 September 2018
Letters of invitation to participant [PFA invitation]	V1.0	06 September 2018
Letters of invitation to participant [mother invitation]	V1.0	06 September 2018
Other [Professional indemnity]		12 June 2018
Other [Public liability insurance]		12 June 2018
Other [email for hv team leader]	V1.0	
Other [Ethics amendments]		01 November 2018
Participant consent form [consent fa]	V1.1	19 September 2018
Participant consent form [consent HV]	V1.1	19 September 2018
Participant consent form [Consent mother]	V1.1	19 September 2018
Participant information sheet (PIS) [Mothers PIS]	V1.2	30 October 2018
Participant information sheet (PIS) [FA PIS]	V1.0	06 September 2018
Participant information sheet (PIS) [HV info]	V1.0	06 September 2018
Referee's report or other scientific critique report [Reviewer 1 internal report]	V1.0	23 July 2018
Referee's report or other scientific critique report [Reviewer 2 internal report]	V1.0	20 July 2018
Research protocol or project proposal [Protocol]	V1.1	06 September 2018
Summary CV for Chief Investigator (CI) [Amirah CI CV]	V1.0	10 August 2018
Summary CV for student [Student CV]	V1.0	04 August 2018
Summary CV for supervisor (student research) [Nimarta Dharni CV]	V1.0	04 August 2018
Summary CV for supervisor (student research) [EB CV]	V1.0	24 August 2018
Summary CV for supervisor (student research) [AL CV]	V1.0	
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Lay summary of protocol]	V1.0	17 September 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments

1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	<p>The sponsor has submitted the HRA Statement of Activities and intends for this to form the agreement between the sponsor and study sites.</p> <p>The sponsor is not requesting, and does not require additional contracts with study sites.</p>
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No application for external funding has been made
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for	Not Applicable	No comments
Section	Assessment Criteria	Compliant with Standards	Comments
	compliance with the Clinical Trials Regulations assessed		
5.3	Compliance with any applicable laws or regulations	Yes	No comments

6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

All participating NHS organisations will undertake the same study activities. There is therefore only one study site 'type' involved in the research.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS or on the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net, or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator should be appointed at study sites.

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

As a non-commercial study undertaken by local staff, it is unlikely that letters of access or honorary research contracts will be applicable.

Where arrangements are not already in place, researchers undertaking any of the research activities listed in A18 of the IRAS form will be expected to obtain a Letter of Access. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of preengagement checks letter (if NHS employed). These should confirm DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 10: Braun and Clarke's 20 List of Questions

20 questions to guide your evaluation of a TA paper

A resource editors and reviewers of TA papers, to facilitate quality in TA

The following list of questions appears as **Table 1: A tool for evaluating thematic analysis (TA) manuscripts for publication: Twenty questions to guide assessment of TA research quality** in: Braun, V. & Clarke, V. (2020) One size fits all? What counts as quality practice in (reflexive) thematic analysis?, *Qualitative Research in Psychology*, DOI: [10.1080/14780887.2020.1769238](https://doi.org/10.1080/14780887.2020.1769238)

These questions are designed to be used either independently, or alongside our methodological writing on TA, and especially the current paper, if further clarification is needed.

Adequate choice and explanation of methods and methodology

1. Do the authors explain why they are using thematic analysis (TA), even if only briefly?
2. Do the authors clearly specify and justify which *type* of TA they are using?
3. Is the use and justification of the specific type of TA consistent with the research questions or aims?
4. Is there a good 'fit' between the theoretical and conceptual underpinnings of the research and the specific type of TA (i.e. is there conceptual coherence)?
5. Is there a good 'fit' between the methods of data collection and the specific type of TA?
6. Is the specified type of TA consistently enacted throughout the paper?
7. Is there evidence of problematic assumptions about, and practices around, TA? These commonly include:
 - Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.
 - Combining philosophically and procedurally incompatible approaches to TA without any acknowledgement or explanation.
 - Confusing summaries of data topics with thematic patterns of shared meaning, underpinned by a core concept.
 - Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by-line coding) apply to TA without any explanation or justification.
 - Assuming TA is essentialist or realist, or atheoretical.
 - Assuming TA is only a data reduction or descriptive approach and therefore must be supplemented with other methods and procedures to achieve other ends.
8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been achieved simply by using TA more effectively?
9. Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)?
10. Do the researchers strive to 'own their perspectives' (even if only very briefly), their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the 'voices' of marginal and vulnerable groups, and groups to which the researcher does not belong.)
11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures?
12. Is there evidence of conceptual and procedural confusion? For example, reflexive TA (Braun & Clarke, 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability

measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development).

13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA?

A well-developed and justified analysis

14. Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map?

15. Are reported themes topic summaries, rather than 'fully realised themes' – patterns of shared meaning underpinned by a central organising concept?

- If so, are topic summaries appropriate to the purpose of the research?
 - If the authors are using reflexive TA, is this modification in the conceptualisation of themes explained and justified?
- Have the data collection questions been used as themes?
- Would the manuscript benefit from further analysis being undertaken, with the reporting of fully realised themes?
- Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)?

16. Is a non-thematic contextualising information presented as a theme? (e.g. the first theme is a topic summary providing contextualising information, but the rest of the themes reported are fully realised themes). If so, would the manuscript benefit from this being presented as non-thematic contextualising information?

17. In applied research, do the reported themes have the potential to give rise to actionable outcomes?

18. Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants' language as a transparent reflection of their experiences and behaviours)

19. Is there evidence of weak or unconvincing analysis such as:

- Too many or too few themes?
- Too many theme levels?
- Confusion between codes and themes?
- Mismatch between data extracts and analytic claims?
- Too few or too many data extracts?
- Overlap between themes?

20. Do authors make problematic statements about the lack of generalisability of their results, and or implicitly conceptualise generalisability as statistical probabilistic generalisability (see Smith, 2018)?

Reference

Smith, B. (2018). Generalizability in qualitative research: Misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qualitative Research in Sport, Exercise and Health*, 10(1), 137-149.

Appendix 11: Sample interview and thematic analysis

THEMES	ORIGINAL TRANSCRIPT	EXPLORATORY COMMENTS/CODES
<p>18 married from Pakistan</p> <p>Pregnant in UK but husband in Pakistan – tough experience</p> <p>Partner absence – support</p> <p>First child at 20</p> <p>Good pregnancy</p> <p>Absence of partner during pregnancy: a void which cannot be filled</p>	<p>24.05.19</p> <p>I: okay its recording now so why don't we start with you just telling me a little bit about yourself like some background information</p> <p>p: umm never really done an interview to be honest (.) umm just that like i got married from Pakistan when i was 18 then i came back and applied for my husbands visa (.) he got refused the first time but then obviously i wasn't pregnant then i got pregnant when we applied for 2nd time and then because he wasn't here with it was really hard because i was pregnant with baby</p> <p>i: this your first child?</p> <p>p: first child</p> <p>i: and how old were you when you got pregnant or had baby?</p> <p>p: i was 20 and because i was alone here (.) mum was here obviously its different with your</p>	<p>18 got married from Pakistan – decision to bring husband to the UK</p> <p>Refused visa and pregnancy- what does this indicate? Did participant get pregnant to make the visa process easier? Or is she stating that is one of the reasons that can aid the process as she was pregnant the second time round?</p> <p>Husband Pakistan during pregnancy – a tough experience for participant</p> <p>Pregnant at 20 – young age, participant did not feel the negative effects of</p>

<p>Own mothers support</p>	<p>husband and your mum being different things (.) so to be honest my pregnancy like my first time i was thinking like ive heard ladies say its really hard this that but because it was my first time i didnt even realise i was pregnant i was just normal (.) i was active walking about everything but its just that one thing was that that was like making me upset and that was that my husband wasn't with me</p> <p>i: yeah</p> <p>p: and other than that i was totally fine (.) i had no problems nothing like i did used to feel abit of sickness but just sickness noises that you make only that (.) but other than that i was normal had no problem and ...</p>	<p>pregnancy or much discomfort as she continued a fairly normal life as before</p> <p>The absence of husband – something which cannot be filled with someone else's presence – suggested own mothers support but this wasn't same as husband being present – does participant long for that sense of closeness with her partner especially during pregnancy?</p>
<p>Husbands visa granted: a sense of relief</p> <p>Labour: first child, the unknown</p>	<p>i: so when did you husband come over? so was that after you've given birth?</p> <p>p: that was (.) when i went to pakistan a few months ago and then i just went for a holiday to obviously go show the little one to my in laws and my husband but then alhamdullilah we got</p>	<p>Smooth pregnancy</p>

	<p>the visa then we all came back together</p> <p>i: so was that</p> <p>p: he's just been here for 3 months</p> <p>i: oh so quite recent</p> <p>p: yeah so she was about she's 9 months now so about 6 months</p> <p>i: hmm</p> <p>p: and he's come (.) and other than that i was normal but now my husbands here things are better now cause i have him now with me</p> <p>i: and how was your labour just talk me through that</p> <p>p: labour (.) well it was half 5 when i woke up i was sleeping actually and i was leaking but obviously i didnt know cause it was first time (.) i went toilet i thought i'll just go toilet and i went toilet i did urine and then (.) i thought obviously its normal i got up leaking again i went back i was in toilet for 2/3 minutes i was worried like whats happening like im going back its still coming out (.) obviously mum was sleeping</p>	<p>Trips to Pakistan to show husband and in laws the baby – difficult time bringing up baby without husband</p> <p>Husband got visa- arrived back to the UK together – suggested this was a nice feeling as participant went to Pakistan alone perhaps not knowing husbands fate but then they arrived back to the UK together</p> <p>6 months of no husband post birth of child – how were these 6 months?</p>
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<p>Childbirth: support of own mother and family</p>	<p>cause it was half 5 and she was sleeping and i knocked in the door cause she's a bit deaf from one ear she didn't know but obviously my dadhe got the point that something is wrong (.) so he called and she came out and she goes are you not getting any pains in the back or anywhere i go no its normal i wasn't getting any pains</p> <p>i: so your waters broke but no contractions?</p> <p>p: waters broke (.) no i was just normal so obviously i had the stuff all packed had it packed from before</p>	<p>In what way does participant value husbands presence?</p> <p>Labour: waters broke, unknown, first child, confusion</p>
<p>Childbirth: remembrance that husband is not here</p>	<p>i: so was this like sort of around your due date or was it?</p> <p>p: no my due date was 27 i had her on the 23rd so on 22nd (.) so it was on Eid day basically and then she i went to my room i got changed and i was still leaking i go i cant do anything now i put on a pad and stuff and then i (.) dad took me to hospital and they took me to the child um you know wheres theres pool and stuff theres one hospital area where</p>	<p>First time child birth – support from own mother to determine what exactly is going on with the body – was it time for baby to come?</p>

<p>Induced labour, vaginal birth</p>	<p>theres like kids normal birth dont have the epidural and stuff they took me to that area and like they checked the urine i think the sample and they said yeah your waters broken and then checked me to see if babys okay and stuff (.) they go i think they said in 24hrs we need the baby out or obviously they can get infection or something so i was just crying cause obviously i wanted my husband here (.) but there was no chance cause you cant get a visa in one day now quickly but obviously i was thinking i want him here now and she goes dont cry cause obviously its not good for your health but i couldnt stop myself then it was really hard cause i could hear ladies screaming next door and really hard i was thinking thats going to happen to me as well but they sent me home after i think 1 hour or something they said once you get the actual pains then ring us back (.) i had the actual pains but obviously it was i think (.) i don't know what time it was (.) i rung them and they</p>	<p>Prepared for birth</p> <p>Slightly early that her due date – did participant think maybe if it wasn't sudden, unexpected that maybe husband could have made it for the birth</p> <p>Suggested that participant finds this moment of childbirth very special and important for her husband to be present</p>
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<p>Childbirth: aided through forceps</p> <p>Coping with childbirth: reliance on God</p>	<p>said sorry we don't have no room yet for like a bed for you to come i was like fine (.) i didn't ring them after that (.) 8 o'clock they rang me they go you didn't ring us back i said i rung you but you said there wasn't room so I thought i'll just forget it haha (.) they said no you have to come now or its not good for the baby cause she's been in there and can get infection and stuff so i went (.) worse part was when they induced then they did</p> <p>i: so can you talk me through that process cause i don't know</p> <p>p: induce was basically like they ask me first obviously even if i said no they have to cause they have to make the the bottom part 10cm wide you have to have it the baby has to come out (.) she did it first like put one finger in and 2nd one it she did that and it was really painful then she said now i think its 1 or 2 cm (.) come back again after hour or something but then the good thing was 2nd and 3rd time i had epidural in and with that i</p>	<p>Hearing ladies scream – first time experience, fear, unknown, hearing the pain of others and thinking about your turn</p> <p>Mixed messages – rang but no beds then told should have rang it is not safe for baby</p> <p>“I thought I'll just forget it” – reflects that it is participants first time, does not see the risks of not delivering baby once waters have broken – was this feeling emphasised when from the hospital it did not seem urgent from their side for her to come in?</p>
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<p>First born: overwhelmed with joy, disbelief</p> <p>Mothers support during labour and childbirth</p>	<p>couldnt feel nothing (.) first time was too too cringe and then did that and then she said obviously like put epidural in and stuff and they said we're going to come back later and i think it was (.) i had her on 23rd it was 8.59 i had her i: at night?</p> <p>p: yeah (.) bang on 8.59 i had her but then they couldnt (.) because i was pushing they said its not coming out that baby they said we need to get her out (.) then obviously took me to operation room they told me sign papers what if we cant get it normal have to operation (.) i had no choice i signed the papers and i went took me to the operation room (.) and took her out with forceps but it was normal didnt have to go through operation alhamdulillah (.) took her out with forceps it called forceps took her out with that (.) they go they take her out but obviously with forceps you can get a mark anywhere on the head im like we'll leave it to Allah and then but when they took her out she had no marks on her forehead that</p>	<p>Induced labour</p> <p>Epidural for pain relief</p>
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<p>Sharing birthing experiences with own mother</p>	<p>was a good thing (.) but yeah once she was out i forgot all the pains (.) once she was out it was all i forgot about all the pains (.) they put her on me and stuff cause they had that skin to skin contact and then she was crying and i go to my birth partner she was a family friend like sister to me i said to her its a dream she goes no its real its not a dream (.) she goes (.) obviously i kissed her and stuff she was all dirty and stuff but i kissed her and everything (.) they had to clean her up and stuff (.) family came and everything (.) but the labour pains when i had them at home the contractions they were quite hard (.) mum was there she kept rubbing my back and stuff (.) but the way i was thinking about they going be painful i've heard (.) obviously its your own body isnt it but what i've heard its really painful (.) didnt have it that much (.) cause i think when you have the actual pains that time i got the epidural in (.) so that time i got that in which epidural is a good</p>	<p>Birth of child aided through forceps procedure – difficult birth, first time, baby not coming out, the unknown</p> <p>“no choice” “they told me to sign” – suggested lack of independent decision – was it between having this procedure or risk harm to the baby?</p> <p>Firm belief in God – anything good or bad happens its from God – did this ease participants fears and nerves regarding the procedure and associated risks?</p> <p>Suggested that seeing child for first time was such a special and overwhelming experience – almost like it was unreal – suggested that all pain that was previously felt had disappeared</p>
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<p>Post-birth recovery: effects of induced labour and epidural</p>	<p>thing for that time but afterwards it is a bit hard</p> <p>i: oh so did you experience any side effects with the epidural?</p> <p>p: i dont know but i do get pains sometimes in the back in my back i do get sometimes pain but mum says it cause she had it done she had it when i was born as well when my brothers were born she goes there are side effects but doctors go there are no side effects but it depends on your own self but i wouldnt say that its really bad (.) i would say epidural is the best aha because its better than going through the actual labour pains the actual pains are really bad</p>	<p>Mother support during labour and pains</p>
<p>Post-birth recovery: suffered with piles</p>	<p>i: oh i cant imagine aha (.) so when you were when you gave birth through forceps did you experience any discomfort afterwards? did you have any stitches or anything like that?</p>	<p>Potential side effect of back pain with epidural</p>
<p>Knowledge of post-birth care: gained from own mother</p>	<p>p: oh yeah i got i think they said i got 3 or 4 stitches cant remember but obviously they were dissolvable they jus dissolve dont they so i got those stitches and other than</p>	<p>Sharing of stories with own mother regarding epidural experience</p>

<p>Post-birth recovery: bed-ridden</p>	<p>that i was normal (.) then after that they just dissolve i think after a few weeks (.) but i stayed there for one night the next day i went i came back home (.) they had a tube thing for my urine to come out and blood was coming out of that aswell i think (.) but yeah other than that it was all normal (.) i couldn't get up properly because i think of all that pain and stuff (.) i went to toilet its something funny aswell i went to toilet my birth partner my sister family friend said to me oh i'll come with you (.) i go no i'll be fine (.) i don't know what happened i just felt a bit dizzy or something and i just fell right on my bum</p>	<p>Suggested a little back pain post-birth is better than experiencing labour pain without pain relief</p>
<p>Epidural side effects: post-birth recovery</p>	<p>i: oh no!</p>	<p>Stiches post-birth, with urine and blood tube – what was this for?</p>
<p>Family and friends support: childbirth</p>	<p>p: and it was so bad like my family friend thought obviously something fell down and i go no it wasnt something it was me who fell down haha but it was really like painful cause obviously i just gave birth and obviously it was so hard (.) and after that it was a bit more hard cause i felt a bit bruised but i didnt tell anybody doctors over</p>	

<p>Physical pain: expecting the worst</p> <p>Joint family: living with own parents</p> <p>Important role of own mother: support and transition into motherhood</p> <p>Chilla period observed</p> <p>Chilla: generational practice</p> <p>Recovery: physical and emotional from mothers support</p> <p>Own mother: primary caregiver during chilla</p>	<p>there and when i came home when midwife came i told her later she was like are you okay and stuff i said im okay now (.) then down below i got whats it called (.) in our language they see bowaseer (.) in english they say (.) piles piles</p> <p>i: piles yeah</p> <p>p: piles (.) i got that then then obviously mum was like it happens after pregnancy (.) obviously for me it was something different i didnt know then you have to keep clean obviously after you've had birth you bleed a lot have to keep changing pads so doesnt get worse (.) obviously i thought it was going to stay forever i couldnt even initially get up from the bed thats how hard it was (.) to sit down i used to think like 10x should i get up or should i just stay here it was so hard i just couldnt get up (.) obviously i thought im going to stay like that but then after a weeks i think it was 3 weeks i went normal</p> <p>i: hmm so this was when you were at home?</p>	<p>Post birth – dizziness, what could have caused this?</p> <p>Participant still at hospital at this point</p> <p>Did not share this fall with the doctors why? Told friends and family</p> <p>Shared with the community team</p> <p>Piles post-birth – how did this impact participant in the post-birth period?</p> <p>Gaining knowledge of post-birth effects from own mother</p>
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<p>Own mothers support: comfort, safety, guidance first time mum</p>	<p>p: yeah (.) even when i was in hospital i forgot to tell you when i had the epidural my left leg totally went numb (.) it kept falling down off the bed then my birth partner kept picking it up it was funny she kept picking it up (.) it was like a hammer basically she kept picking it up putting it on the bed and it kept like whenever it fell down i couldnt feel anything all i could feel that something fallen down (.) and i thought my legs gone numb i thought i've gone now one leg has gone</p> <p>i: oh noo</p>	<p>Lack of knowledge of what to do post-birth related to hygiene</p> <p>Suggested that post-birth recovery was tough – almost bed ridden</p> <p>Three weeks can be a long time to suffer like this -the length of time and how this felt in participants head emphasised as she expresses she though she would never get better – that this would be her reality</p>
<p>Brest-feeding: positive experience</p>	<p>p: put after that after everything after [child name] it went normal but once you had that feeling you be thinking thats it now im going to stay like that forever but yeah i wanted the baby to come out quickly and quickly because it wasn't i wouldn't say it was hard but then again labour pain it is hard (.) its not easy to give birth</p>	<p>Did participant have support during this time?</p>
<p>Benefits of breast-feeding: practical, weight loss</p>	<p></p>	<p>Epidural side effects- numb leg, participant recalls this story in a comical manner</p>

<p>Cultural expectations after giving birth: to look weak in front of others to avoid the evil eye</p> <p>The evil eye during the perinatal period</p> <p>Strict following of chilla</p>	<p>i: so when you came home how was life with the new baby?</p> <p>p: to be honest because my mum was with me and shes still with me life is really easy (.) if she wasnt with me it wouldve been really hard (.) i was literally just laying down here 40 days you know like in our muslims they say 40 days you cant go out and stuff like that we still believe in them stuff (.) so i was laying down here baby was with me had to change her and stuff mum used to change her (.) sleeping with my mum looking after her at night (.) the first night when i came home i was totally obviously i didn't sleep in the hospital mum was looking after her all night and i fell asleep (.) for one full night i was asleep i woke up in the morning and mum was sleeping with her (.) was sat down laying down sleeping with her (.) 40 days and even after that mum been looking after most time (.) obviously i have to feed her (.) i still do as well (.) but other than that (.) i can't obviously if i</p>	<p>In the absence of partner, participant had the support of her friends and family during child birth</p> <p>Suggested participant tends to expect the worst in situations – is this only linked to physical pain and conditions?</p> <p>Living with own parents – suggested that own mothers support was integral for participant as a first time mother – eased the transition into motherhood</p> <p>40 day chill period</p> <p>“we still believe in them stuff” – suggested that it is an ancient postpartum</p>
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<p>Differring constructions of etiquette post-birth: looking weak vs active</p>	<p>was on my own i would be able to tell you how hard it is because mum was with me things are different</p> <p>i: so you breastfeeding at the moment?</p> <p>p: breast feeding</p> <p>i: so how's that been has been easy for you or?</p>	<p>practice – suggested that perhaps some people no longer partake but it is important in participants household and family – here it is associated with Muslims – the religion – not necessarily Pakistani culture?</p>
<p>Post-birth: quick recovery</p>	<p>p: breast feeding was really easy like then again i don't know why its you're own body isn't it i heard you get pain or something the first time you feed (.) i was normal like even until now (.) now she got teeth obviously she bites sometimes but other than that i've been perfect in breastfeeding (.) i think breastfeeding is that best</p> <p>i: yeah yeah definitely</p> <p>p: its easy aswell in the night time if you want to wakeup to breastfeed you don't have to go down or you know make the milk and bottles thats all hard i prefer breastfeeding (.) its good for yourself you lose a lot of weight ahah</p>	<p>Mothers support allowed participant to get a full nights sleep after coming home with baby – often rare as new mother – big advantage</p> <p>Own mother took lead as primary caregiver during the 40 days – suggested this was seen as helpful rather than own mother taking over?</p>
<p>Cultural expectations post-birth: different views but unable to speak out</p>	<p>i: oh ahah okay (.) so you mentioned the 40 days so do</p>	<p>Suggested participant breastfeeding – how was this experience</p>
<p>Cultural postnatal practices: to stay insulated</p>	<p>i: oh ahah okay (.) so you mentioned the 40 days so do</p>	<p>What mothers support means to participant emphasised suggested the</p>

<p>Cultural postnatal practices: focus on the somatic (wrapping up warm)</p> <p>Cultural postnatal practices: focus on the spiritual (not going out at certain times)</p> <p>Cultural postnatal practices: generational difference in understanding of protective effects</p> <p>Mothers support: cooking, cleaning, looking after child</p> <p>Change in diet: related to the somatic</p>	<p>you think the 40 days were beneficial for you? sitting indoors resting what did you do for the 40 days?</p> <p>p: well with me i used to lie down i used to get up and move about but obviously in our families they say when family comes over to see you you're supposed to be lying down cause then they do this thing they say oh my god look she just gave birth now and she's already up and everything and they give you this evil eye thing (.) so my mum just tell me whenever somebody comes in just lye down</p> <p>i: so like laying down not even just sitting up?</p> <p>p: no no laying down even sitting down they said its not good cause i had piles said you shouldn't be sitting down its not good so i had to lay down (.) i used to walk up and down stuff like that but because the first few weeks first one or two weeks i couldn't even walk (.) i used to feel scared that i might end up</p>	<p>support was greatly valued, a sense of comfort and safety present as first time mum, having someone to guide you and not feeling overwhelmed with tiredness or the unknown of looking after child</p> <p>Positive experience of breastfeeding – suggested that this is the best method – if you are able to do this without pain or struggles then it is first choice</p> <p>Breastfeeding is practical – don't need to sanitise or prepare bottle feeds</p> <p>Breastfeeding: personal benefits related to weight loss</p>
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<p>Cultural postnatal practices: are they out of touch with younger generation in Britain?</p>	<p>slipping because my one leg was still numb (.) but only i went once i went out because i went for her name you know to register her name other than that i didnt go out anywhere</p>	<p>Suggested that participant largely rested during the chilla period – as its intended purpose</p>
<p>Cultural myths: size of the bite and breastmilk</p>	<p>i: oh yeah (.) so can you tell me more about like a bit more about the cultural side of it (.) how you mentioned other people would give you evil eye can you tell me a bit more about that?</p> <p>p: its just like you know if i was up and about active and stuff they going to be like look she just given birth and she's not even like you cant even tell shes given birth like when you give birth you be all like lazy and stuff laying down (.) maybe because i was young i was only 20 i think cause the doctors were telling me when i was going to give birth they go (.) i go to her its going to be really hard to give birth she goes no trust me this age is the best (.) 20/21/22 is the best cause you're young yet once you get older and you give birth its hard then cause you cant you can't (.) its different</p>	<p>Laying down to give the impression that you have literally just given birth</p> <p>Giving birth associated with body weakness, seen as a bad thing if you are doing normal daily activities post- birth</p> <p>The evil eye – is this a sense of envy or jealousy that you have so much energy post-birth? Or are people stuck in the mindset that this is the experience post-birth and this is what to do for recovery?</p>
<p>The importance of maintain family bond and relations: staying silent</p>	<p>(.) i go to her its going to be really hard to give birth she goes no trust me this age is the best (.) 20/21/22 is the best cause you're young yet once you get older and you give birth its hard then cause you cant you can't (.) its different</p>	<p>Suggested when have piles best to lay not sit – is this a</p>
<p>Following cultural postnatal practices: to keep the peace</p>	<p>(.) i go to her its going to be really hard to give birth she goes no trust me this age is the best (.) 20/21/22 is the best cause you're young yet once you get older and you give birth its hard then cause you cant you can't (.) its different</p>	<p>Suggested when have piles best to lay not sit – is this a</p>

<p>within family, maintenance of self image</p> <p>40 day period: vulnerable to evil spirits (spiritual and psychological)</p>	<p>inside isnt it now im young everything is different inside (.) she said to me its the best age to give birth (.) and obviously then my family are going to be like look she's given birth and she's not even bothered even with the first baby aswell its different for me but..</p> <p>i: why do you think they think that its a bad thing that you should be laying down (.) is it not a good thing that you are out up and about</p> <p>p: exactly but i don't know its just asian people our families we think that and even one thing after you have to have a scarf on your head because if not then like the wind comes to you or something and its not good for you and everything you have to have slippers on your feet or else</p> <p>i: even when you're inside?</p> <p>p: yeah you have to have slippers on your feet or else if not then the like they say like its not good because you cant feel it now but once you get a bit older you'll feel it now (.) you put on weight or something</p>	<p>cultural thing or something which is advised wider?</p> <p>Suggested followed 40 day chilla strictly apart from absolutely necessary – registering of baby's name</p> <p>Suggested the Pakistani-Muslim family view giving birth in a different way to participant</p> <p>Construction of birth: you have given birth and you must be weak, you must rest, seen as negative and stigmatised if you carry on with daily life – not seen as</p>
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<p>Chilla: difficult to do, isolation, boredom, but important</p>	<p>(.) i don't know haha that's how they say it but to be honest i had the socks on ahah the first day obviously i was like you know what i'll put socks on (.) I'm a person who likes walking around without shoes and socks (.) I'm like you know what i can't stay with this I'm going to do whatever i do ahah so i was (.) but when somebody came to the house quickly i lay down but my mum used to do all the cooking and everything (.) you know in our like family they say when you have a baby you have to have parantha and stuff you have to have healthy stuff like halwa stuff like that but obviously I'm not into these stuff (.) and i wanted a burger straight away i was like give me a burger or something cause im not into these roti and stuff but obviously mum used to make me it i used to just have a little bit like choori little little thing pieces i used to have only a little bit and then they say you cant have even big you have to have tiny (.) obviously i used to feed her they say because</p>	<p>positive – to some extent is it seen as careless, perhaps even reckless behaviour? Is it also associated with regardless of how well you feel you should still partake in cultural practices? Is it seen as rude if you do not?</p> <p>Suggested participants young age aided in her quick recovery post birth</p> <p>Suggested that participant disagrees with the cultural views and comments “its different for me but..” but she is unable to go against them – is this to maintain familial relationships?</p> <p>Other postnatal cultural practices – have to stay wrapped up to prevent wind</p>
<p>Pregnancy and post-birth: fear of the evil eye (good health)</p>		
<p>Respecting beliefs of husband and family: observing chilla</p>		

<p>Chilla and Jinns: a social construction</p> <p>40 day chilla: important role of mother/mil</p>	<p>whenever she used to cry they said she's crying because you have eaten a bigger piece of chappatti and its going to hurt her inside (.) that doesn't make sense because when she drinks my milk its comes out as pure liquid (.) liquid isnt it its not coming out as lumps (.) my family they say if you eat more thicker food its going to come out as (.) its going to make her have stomach ache because its going to come in her milk as lumps (.) but when i always seen i always expressed a lot milk cause alhamdullilah i've had a lot of milk and i've expressed it out a lot and its always been liquid i could never see lump inside it (.) then again its family (.) they used to make me bite and bite and bite the food</p> <p>i: oh god aha (.) so was this mainly your mums views or was it?</p> <p>p: my mums views and mum was like you know my mums mums mum they used to say all this (.) so because we've always heard this (.) i don't know like i used to try what</p>	<p>from affecting you, or the cold – this all links to the somatic, the physical properties and benefits – what about the psychological? Is it linked?</p> <p>Cultural postnatal practices: wrapping up, keeping the feet covered – participant is partaking in these but does not really know the purpose of such practices – a sense of unclarity is present as she struggles to articulate what it is and why it is practiced</p> <p>It is suggested that participant herself does not really believe in this particular practice, especially as she felt good post-birth after the initial couple of weeks of recovery – “I'm going to do whatever I do” – some kind of autonomy but this has to be hidden in front of members who do not live in the household</p>
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<p>Role of own mother/mil: female orientated support, transition into motherhood</p>	<p>they say but i can't always bite my food i need to hurry up and eat it haha</p> <p>i: ahha yeah (.) so you went along with most of these practices?</p> <p>p: i did go a long with most of them yeah the 40 days obviously my husband was in Pakistan he's come now he's at work but he's more Islamic alhamdulillah and he's like he believes in (.) he doesn't believe it in but obviously he's like its 40 days you can't go out cause they say there are ghosts and stuff they stick to you (.) its happened to my mums mum when she had her 2nd baby in England mums mum it happened to her that she had something with her (.) that its not going away from that time so obviously</p> <p>i: she still has it?</p> <p>p: yeah obviously if someone had it in your family you feel a lot more scared but i was like you know even though I'm a person who can't sit at home (.) when i was going to have [child name] i was literally out</p>	<p>Mothers support: cooking, cleaning, looking after child</p> <p>Change of diet – heavy, buttery foods</p> <p>“but obviously I’m not into these foods” – why is this obvious? Is it because participant is more used to other foods which are available in the UK, more variety, less into South Asian food and sweet foods?</p> <p>Suggested participants mother encouraged her to eat more South Asian and specific foods for postnatal period – is this related to the somatic?</p> <p>Quite a lot of restrictions and specifics to how you carry out the practices – this seemed overwhelming/draining for participant</p>
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<p>Experience of attending services: Sure Start during pregnancy, source of support</p>	<p>even the end days i was out (.) these next door auties used to say to me sit at home now you might end up having the baby on the way (.) i go i don't care i can't sit at home like i had a belly up to her but i was walking normal i didn't walk with my legs open like everyone say to me how come you walking straight i go i don't know things are different with me like alhamdullilah my pregnancy went really good like even when my midwife came to me she goes you're walking normal (.) normally ladies walk with their legs open you can't walk properly cause of the belly but alhamdullilah alhamdullilah it went really good and like couldn't sit at home but then i had to sit at home</p>	<p>The belief that large bites of food are uncomfortable and that these large lumps will be transferred to baby during breast feeding – reason for child crying and being uncomfortable</p> <p>Participant does not see this as logic – refutes the cultural claim/myth – milk always liquid not lumpy due to eating large bites</p>
<p>Husbands absence: a constant emotional struggle</p> <p>Husbands absence and effects: concerns over participants wellbeing SureStart</p>	<p>i: yeah (.) so did you find it difficult staying at home or?</p> <p>p: i did find it really difficult i used to try standing in the garden my mum used to say no don't stand in the garden i used to be like at least let me put the little ones clothes out at least (.) she was like no what's</p>	<p>“then again its family” – suggested that participant is fine to do as family say to maintain the relationship? Would it cause friction if she refused or expressed her own views? Did participant directly question any of these practices?</p> <p>Suggested these postnatal practices have been observed in participants family for many generations – would it then be considered bad if</p>

<p>Husbands absence: source of stress and depression</p> <p>Checking foetus for conditions: not part of belief system</p> <p>No male gender preference for participant & husband</p>	<p>it called you cant stand outside people are going to look at you they going to say look she's had a baby and she's already standing outside</p> <p>i: yeah so you wanted to get out</p> <p>p: yeah i wanted to get out but i just couldn't (.) my husband was like don't go out cause if anything happens then we're going to be worried then so don't go out so i didn't go out then</p> <p>i: so do you (.) did you find any benefits to any of the practices that you did?</p> <p>p: erm the midwives and stuff?</p> <p>i: no did you any of the cultural rituals and practices did you yourself find any benefits to</p> <p>p: ummm the one that I'm saying about don't go out i think that was a good idea cause in our religion we do think that you can get something stuck to you in the 40 days jinn or something or a ghost whatever so that was a good thing i didn't go out and one that they say in our like</p>	<p>participant did not continue – the benefits to taking smaller bites of food is not evident to participant – can this add frustration compared to protective effects? Somatic related to baby</p> <p>Suggested that participant went along with practices as it would be considered rude and perhaps reckless from the point of view of family if she did not partake</p> <p>Husband – described as religious which comes with certain beliefs about the 40 days – suggested this is a vulnerable time for women as they are more likely to attract evil spirits – is this belief more linked to the psychological? Or perhaps psychological and physical depending on its presentation?</p>
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<p>Childbirth: fears of epidural being unsuccessful</p>	<p>religion in our like culture we say for 40 days you can't get up like stay laying down like obviously your mother-in-law is in Pakistan she can't do anything so mum does it for me (.) so i think that's a good idea cause you don't have to get up for 40 days haha so that was a good one as well</p> <p>i: do you think that helped you recover faster or (.) better?</p> <p>p: yeah because i couldn't get up properly cause you know once the 40 days were out i was feeling more fresher cause like obviously still with me i wasn't like i don't want to get out now (.) i wanted to get out then cause like i didn't get out for 40 days but it was better like after the 40 days i actually went out and stuff (.) and like in our culture its a good thing they say 40 days stay inside just relax cause my mum her daughter in law she was in Pakistan and she had a baby and she did the same for her as well the mother in law did the same 40 days she didn't let her get up (.) she goes obviously if i can do it for my</p>	<p>This particular belief seems to resonate with participant as she has seen the effect on her grandmother</p> <p>Whilst this frightened participant she still went out during pregnancy – is it all relevant for pregnant women?</p> <p>Participant emphasises how well the pregnancy went – did this make it harder to sit at home? When you feel fine or well you want to be doing this? Even whilst heavily pregnant participant coped well physically</p> <p>“couldn't sit at home but then I had to sit at home” – did participant feel isolated at home?</p>
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<p>Post-birth: physical side effects</p>	<p>daughter in law your my daughter I'm supposed to be doing it for you (.) and still now as well like you can see she's feeding her like she does a lot for her so i don't find it hard and she's more attached to her dad now even though she was born i was there her dad wasn't there was he but still like she's more attached to him now she doesn't really care about me even if i am around or not</p> <p>i: oh haha aww (.) so when you were at the hospital did a nurse doctor or midwife ever ask you how are you feeling or..</p> <p>p: erm when i used to go to surestart clinic they used to always ask me cause they knew that my husband isnt here and i used to start crying when they talk to me i used to start crying</p> <p>i: ohh surestart was that after you'd given birth?</p> <p>p: no no that was before when i was during pregnancy yeah</p> <p>i: so what was that?</p> <p>p: that was i used to go like say after every 2/3 weeks cause i</p>	<p>Own mothers fear of judgement or perhaps evil eye of others – even being out within your own property was frowned upon – concern of others and how they will view your family – maintenance of family image seems important here – could it also be due to belief in the evil eye? “she’s already standing outside” this may indicate good health and strength? Is this something to be desired and could bring about the evil eye?</p> <p>Suggested participant respected husband and families wishes and observed chilla properly – suggested husband was in Pakistan and was worried about participants health and wellbeing – to take</p>
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<p>Birth of child: a dream, did not feel real</p>	<p>think it was the first baby i think they give you more priority cause you don't know anything about it (.) so they used to call me a lot to the sure start health Centre (.) and i used to go there and they used to like check my belly like check her is she's okay and stuff everything they check her height they said to me like used to talk to me like obviously i used to tell them that totally im fine my health and everything is perfect im walking im active (.) one thing is hurting me and killing me is my husbands not with me (.) and only because of that i had problems they used to be worried like obviously cause you're crying and stuff its not good for the baby cause you're always depressed and stressed and stuff (.) obviously i couldn't i used to try to be happy but i used to think that when i'm going to be in the hospital giving birth i wont have anyone with me no matter who's going to be there mum dad my whole family's going to be there but husbands not</p>	<p>precaution during this vulnerable and transitional time period – respected their beliefs – suggested participant also believes in the evil spirits, but it is still difficult to implement</p> <p>Suggested whilst chilla was difficult participant did see the benefits – better to stay safe than sorry regarding jinns – reference made to religious beliefs, “in our religion we do think...” – social construction</p> <p>40 day rest period – suggested usually mother in law or mother whoever you are staying with takes on the role of carer in charge of cooking,</p>
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<p>Relating to the research: same cultural, ethnic, and religious background</p>	<p>going to be there i don't care who else is going to be there cause my husband is something else (.) but other than that like used to talk about they ask me for i think its downs syndrome or something do you want to get that i said no because obviously in our culture we don't believe in that because we know Allah tallah is going to give us a healthy baby inshaAllah we don't believe in like any disab (.) obviously you can have a disabled baby but we don't want to get it checked so i said no i don't want to get that checked and other than that the scans i used to go to BRI i think you have two scans and the first scan i went they just checked if babys okay and stuff and the baby was good mashaAllah (.) 2nd time i think i found what its going to be gender and that obviously i wanted a girl Alhamdullilah i got a girl (.) and in the hospital i dont think they asked me how my pregnancy went but they were really nice (.) the lady who was with us she was really</p>	<p>cleaning, perhaps even taking some care of the baby whilst mother is able to recover fully – physically, emotionally and mentally</p>
<p>Happy at giving birth to a daughter: no cultural gender preferences for male</p> <p>Male doctors present at birth: necessary, exceptional circumstance</p>	<p>who was with us she was really</p>	<p>Culturally the role of the mother or mother-in-law important post-birth as it provides new mother with a foundation and support system – does this ease transition into motherhood? Does it feel less overwhelming when you know you have support system around you, particularly female</p>

	<p>nice like she was like oh don't worry even i had a baby but she said obviously she was telling us about hers she was like i got the epidural done but because epidural didn't like work on her she felt the pain so i was like oh my god what if it doesn't work on me but then good thing was that it did work on me (.) but yeah when they did epidural so many doctors came in there was female and (.) male and female so obviously it was scary (.) i was a bit like bad with the doctors cause you know when (.) they layed me down to take me to the operation room they took the pillow from under my head and with me i like 2 pillows under my head (.) if i get one pillow i start feeling irritated and i said put the pillow back (.) obviously i was in pain aswell and i was like hurry up take the baby out and that time we don't realize what you saying to people haha so i said to the doctors give the pillow back (.) he was like no you have to calm down you have to have the pillow cause we can't</p>	<p>orientated (own mother) as they have gone through raising children so can guide you and support you?</p> <p>Attended SureStart centre during pregnancy – was participants needs recognised for example a pregnant woman who's husband was in Pakistan – she did not have him as a physical support?</p>
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<p>Male doctors in team: not discussed, issues of cultural sensitivity/appropriateness?</p> <p>Good relationship with health visitor</p>	<p>put two pillows obviously to take the baby out with the forceps some whatever they do it don't they so i said no and i was really bad (.) afterwards my birth partner she said to me you were being really bad to them (.) you did their insult and stuff (.) i go i don't know what i was doing but the thing is that they took the pillow out and i was feeling irritated haha but yeah it was a doctor and after that he was (.) he wasn't giving me dirties obviously they know its hard as well but doctors were looking at me like this lady's very bad (.) i go well it is my first baby and even if it was my 2nd baby aswell i its hard cause like you just you cause i prefer being high up i dont like getting low down cause i start getting headache and stuff and after they took the baby out with the forceps i was totally out of my mind like i start i was shaking yeah i was shaking it was really bad my full body was shaking i was just like this (.) obviously that time same as leg that got numb i thought i was going to stay like that (.)</p>	<p>Sure start – support for new mothers, physical health checks</p> <p>Suggested participant and baby physically health throughout pregnancy</p> <p>Recurring theme – husbands absence and how this was an emotional struggle for participant “hurting me and killing me” – emphasis on what his presence would mean for participant – suggested she wanted him in the UK to share this journey with her</p> <p>Suggested emotionally burdensome – frequent crying, concern for health and baby – did health professionals think this may lead to some sort of mental</p>
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<p>Health visitor: supporting visa application</p> <p>Facilitator to disclosure: good relationship with HV</p> <p>Continuity of HV important for disclosure</p>	<p>when i was shaking i thought that's it I'm going to stay like this now what's happened to me (.) and i go to the doctor look im shaking i don't know what's happening they go dont worry its because they put something i dont know what gel they put on that makes obviously for the forceps to take the little one out so i dont feel no pain (.) i go no its not stopping though im just shaking and shaking (.) once they took me out of the room operation room took me to normal room the ward then i was fine i was like ahh im actually going back to normal (.) but it was too scary when i was shaking (.) my birth partner goes whats happened to you i was like this my full body was just shaking (.) too scary</p> <p>i: hmm yeah sounds it (.) so the male doctor what was his role in your pregnancy?</p> <p>p: one male doctor that i remember was that he put the epidural in and then when i took me to the operation room there were so many doctors</p>	<p>health issues such as perinatal depression?</p> <p>Trying to stay positive but difficult</p> <p>The importance of husbands presence is emphasised during childbirth – his place cannot be replaced by other family members – definitely a source of stress and unhappiness for participant</p> <p>Views on checking foetus for conditions – suggested for cultural and religious reasons participant declined this as it is believed that however the baby is born is from God – not right to intervene?</p>
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<p>Barrier to disclosure: poor rapport</p>	<p>around me (.) like i all and they were like giving each other like how do you say it they were giving each other messages like do like oh you do this and do that (.) obviously it was scary like they were talking think they were whispering or something so they were in operation room i was laying down obviously i was looking at everybody they were like oh yeah they were asking each other whatever they needed tools and stuff so they go whichever tools he goes check and it was so scary like you know when you watch dramas and stuff like when they have operation and stuff it was like that (.) he was like scissor the doctor goes check or they say forcep whatever he goes check and they kept doing that like to see if they got all the tools over there and then obviously they go okay then whatever after that (.) i was literally watching everything when they were taking out but couldn't see how it was coming out cause obviously my legs are there (.) i was watching everything and</p>	<p>Gender reveal: girl, participant expressed happiness at this as she wanted a girl</p> <p>Friendly staff at the hospital – suggested good experience during pregnancy</p> <p>Participant expresses her irritability during labour – as expected for someone who is in pain about to give birth</p> <p>Fears of epidural not working though listening to others experiences</p>
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<p>Facilitator to openness: a kind and nice health professional</p>	<p>when it came out they go oh the baby's out and stuff it was just soo like (.) it was like a dream to be honest</p> <p>i: aww yeah (.) so did you have any preference of whether it was male or female or where you not bothered at that point?</p> <p>p: noo me and my husband cause in Islam should be first daughter (.) us Muslims we say first boy I'm sure you know about it our mother in laws and in laws they more like should have a son first cause obviously that's the baby that brings on more generations isnt it? but my husband whos totally Islamic cause [Prophet] had daughter first so we said we wanted a daughter first so alhamdulillah we got a daughter first and i really wanted a daughter (.) to be honest i didn't mind if it was a girl or a boy but cause i've never had a sister (.) never had a girl in our house and i've always wanted a girl cause you have those dresses you can put on them and little ponies and hair bands and stuff i've</p>	<p>In comical fashion participant recalls story where she was being a difficult patient</p> <p>Post-birth body reacting unusually – shaking, numbness, scary experience but due to medication for forceps</p>
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<p>Facilitator to disclosure: feeling comfortable, safe space</p>	<p>always wanted to do that so i couldn't have a sister</p>	
<p>Facilitator to openness: personal gain, visa application</p>	<p>i: I'm the same i don't have a sister</p> <p>p: yeah i've always wanted a sister (.) and people who have sisters they like ohh take my sister im like yeah i wish i could but now i've got a daughter its im happy</p>	
<p>Role of good team: getting you through pregnancy</p>	<p>i: ahha (.) and in terms of doctors that were there (.) how did you feel about male doctors being present?</p>	
<p>Facilitator to disclosure: -friendly and respectful staff – encouraged participant to be open</p>	<p>p: i used to feel a bit uncomfortable to be honest (.) like cause (.) i was when i was like obviously but when doctors came in that time i had like cloth over me (.) when they took me operation room for forceps to take her out that time the doctors were there and obviously they were looking at me and i found it obviously we dont find it right do we for a non-mahram to look at us (.) but i was finding it a bit bad but then again i was thinking i don't think its gunnah cause like you have to (.) doctor has to come to get the</p>	<p>Big team of doctors – participant seems to be passive here, whilst she is the patient, doctors talking and discussing amongst themselves – participant is</p>

<p>Factors to good relationship with health professionals: first impression, demeanour</p> <p>Barriers to disclosure:</p>	<p>baby out but i think it was female who was taking it out i think it wasn't a male (.) but there were doctors around who obviously they did see me you know what i mean (.) i was feeling it a bit but then again you cant its better to have doctors cause they know more don't they the doctors (.) cause every doctor nurse they have their own place dont they so obviously so i didnt mind about that i just wanted the baby out to be honest but then again it was like a bit uncomfortable when i seen those male doctors there (.) it was so bad there was this man i dont know i think he came to the wrong room and he just opened the door and he goes and i was there you know open legs it was so bad and then he goes oh sorry sorry and we were like no sorry just run out</p> <p>i: oh haha</p> <p>p: dont need sorry just go out i didnt know who that guy was i think he was looking for his wife or something he came to</p>	<p>present but not present during doctor/medical jargon</p> <p>Procedure and doctors compared to medical dramas</p> <p>The moment the baby was out felt like a dream – not real, out happiness participant could not believe the baby she had carried was now out and with her physically in the world – I think these type of narratives even of joy are not discussed enough in the community – in the Pakistani-Muslim community is having a baby seen as kind of robotic to the outside world? With lack of emotion</p>
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<p>- domestic violence, fear of husband finding out if disclosed</p> <p>- preference to avoid sharing with health professional – preference for family?</p> <p>Sharing is important: for non-mental health related issues (health professionals)</p>	<p>the wrong room but it was so bad</p> <p>i: and did you get asked whether you were okay with males doctors coming in or anything like that</p> <p>p: i (.) dont think they asked me that</p> <p>i: would you have preferred to be asked?</p> <p>p: umm yeah</p> <p>i: yeah (.) so then when you came home you had health visitor appointments umm visits am assuming (.) did the health visitor ever ask how you have been feeling in regards to your mood?</p> <p>p: yeah my health visitor she's literally the best [name] maybe you know her [name] (.) she's always coming to me and its like she comes after every 2/3 weeks she just come a few weeks ago (.) she's ending it now cause she said she's going to put someone else cause her jobs changed to something else now (.) she's really been nice to me she's done so much for my like for</p>	<p>– even when these are positive? stoicism?</p> <p>No male gender preference from participant and husband – opposite, wanted to follow religious path where girls are valued not seen as burden</p> <p>Participant relates to researcher “you know about it”</p> <p>Suggested participant and husband and over joyed that they have a baby girl – but no real gender preferences present here</p> <p>Suggested within Muslim culture male gender preference still prevalent</p>
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<p>Sharing low mood with health professionals: not preferred</p> <p>Sharing low mood with health professionals: fear of consequences, referred to support when don't want, stigma, label of mental health</p> <p>Use of the term depression by participant: loosely/ social construction?</p>	<p>my husband cause obviously we writing to do the home office tell them that we want the visa to be quick (.) she literally wrote one big form of like she wrote that obviously [mothers name] is really upset and its not good for the baby (.) then its like (..) then its like (.) what was i saying?</p> <p>i: so she wrote (.) did she write a letter?</p> <p>p: yeah she wrote a really good letter for me and it was like she put her signature as well like look I'm from the BRI and stuff (.) still that didn't (.) obviously she did do she did like put her efforts in and stuff but she did a lot for me (.) it was just that (.) then obviously she used to like i think she wrote that for me and she even said to me if you need my help again i'll try something else but that wasn't making any effort like they were not really bothered about the letters cause they were going to give the visa when they wanted to give it so then i said to her just forget we'll get it when Allah Tallah wants us to (.) and then what happened</p>	<p>Male doctors being present during childbirth – suggested that participant was a little uncomfortable for cultural and religious reasons not permitted for other males to see you in such a manner – however this was exceptional circumstances so participant accepted the situation – did she feel she had less control, for example to suggest a change of team? Would this have been impractical? In this situation participant justifies male doctors being present within religious sphere such as it is for health reasons so it is not a sin etc</p>
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<p>I am not mental: conscious decision not to seek help</p> <p>Referral to MH services: stigma, fear of being branded as mental</p> <p>Referral to mental health services: declined, stigma, perceived as not relevant</p>	<p>was she was really good always asking how are you feeling and everything she even comes now and she asks me and i said to her im feeling fine you know i was feeling i used to feel down then because of my husband because he's here now alhamdulillah im totally fine and then i when i came home i think they day after one health visitor came it was a nurse i think she was a bit of a like she wasnt nice (.) she came and i was upstairs cause i think it was my first day back or secound first day back i think from hospital (.) i couldnt even walk properly like i was telling you (.) i said to my mum like can you tell her to come upstairs (.) and she was like oh noo i can't come upstairs you have to come downstairs (.) obviously i felt actually i felt bad cause i was really ill i couldn't even walk i just woke up aswell and then i came down (.) i couldn't walk properly then i layed down here and then obviously she asking me questions and stuff</p>	<p>Perhaps preference for all female team however this did not seem to bother participant to the extent where she would request a change in team – priority was to give birth to healthy child</p>
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<p>Referral to MH services: it won't help the visa application?</p> <p>Barrier to attending mh support: too many long questions/questionnaires</p>	<p>how you feeling and obviously i got put off because of the way she spoke to me and she was telling me how to breastfeed her and stuff cause i was finding it a bit hard cause i didn't know how to hold her cause she was too tiny then as well (.) so then she goes to like you can breastfeed her by laying down or sitting up she was telling me over here how to breastfeed her laying down (.) then after (.) she only came once only came once then i think after 1/3 days other nurse came she was really nice (.) these two nurses only came once (.) only came once each after that it was my normal health visitor she used to come (.) had this other one aswell from sure start she used to come aswell she was really nice as well (.) hmm health visitor are literally i think they're the best cause they give so much support (.) before when i (.) i was pregnant they gave me so much information like how the labour pains are going to be like she gave me one big book to like use she goes once</p>	<p>Suggested that it was not discussed with participant that the team would include male doctors – participant expresses she would have preferred to be asked or at least told about this beforehand? Is this related to cultural sensitivity?</p> <p>Good relationship with health visitor</p>
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<p>Barrier to attending mh support: fear of consequences, branded as mental, unstable, unfit mother</p> <p>Experience of depression: medical or socially constructed definition?</p> <p>Social construction of mental health: the term mental</p> <p>Social construction of depression</p>	<p>you have the baby i'll take it off you (.) i had read it obviously but obviously the main main parts like the labour pains and stuff so i knew how its going to be what's going to happen</p> <p>i: yeah yeah (.) so when you were at sure start and the health visitor as well so were you able to be like quite open in how you're feeling what's going</p> <p>p: yeah cause the midwife she was really nice to me (.) some people they're a bit stuck up but with that midwife she was really nice and she was literally making me feel like as if im sat with one of my close family members (.) i told her everything like look im feeling down i've even got a job i work and obviously my husband is not with me and she used to be like ohh look we cant do anything but obviously they used to give me a lot of support they'd be like dont worry he'll be there with you when you have when you give birth even though i knew he's not going to be there with me but obviously just to give</p>	<p>HV supported participant with husband's visa application</p> <p>Suggested HV did a lot for participant to try and help her husband's visa – asked about participant in general too, participant seemed to have developed a good rapport – able to be open</p>
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<p>I'm just depressed and stressed: what support is needed?</p> <p>Is depression the right word?</p> <p>Barrier to mh support: uncomfortable questions, fear of repercussions, fear of being honest</p>	<p>myself a bit of relaxation i was like okay that's fine but they did a lot for me though they were too nice (.) even after when I've given birth now like i bought them presents and stuff and my health visitor my midwife (.) i was just too happy cause if they wasn't with me i don't know i think i wouldn't have she wouldn't have been here today cause something would've happened to me because i would've been that much stressed (.) they gave me a lot of love and care and everything</p> <p>i: so what helped you be like really open and honest with them?</p> <p>p: i don't know i think because when i went there and they were talking to me and stuff really friendly (.) really friendly and they have that respect in them they are kind and stuff they know how to talk to somebody like cause obviously i was a first mum wasn't i so there was more like sweet to me (.) and i was open to them like she asked me like do you ever feel down in pregnancy i</p>	<p>how husbands absence is affecting her</p> <p>Facilitator to disclosure: good relationship with HV</p> <p>Change in HV – not as good of a relationship, did this affect how much participant shared with the new HV?</p> <p>Why was this HV described as not nice?</p> <p>Suggested that the new HV did not know participant and her needs – came</p>
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<p>Barrier to mh support:</p> <ul style="list-style-type: none"> - fear of being labelled with a mental health issue - fear of baby being taken away from you <p>Participants depression:</p> <ul style="list-style-type: none"> - frequent crying over husbands' absence - no energy to attend to crying child <p>Coping with low mood:</p> <p>reliance of God and religion, praying</p>	<p>said other than that im fine only my husbands now with me (.) she asked me like why is he there why is he not here (.) obviously i told her everything im married there and stuff and all this that and (.) that's it like she was very nice to me if someone is kind to me i literally i get open with them cause its that thing isn't it (.) if someone is grumpy with you its like you know what i don't even want to talk to this person</p> <p>i: yeah yeah (.) and other women that may find it difficult to share their feelings or what's happening around them (.) what do you think (.) why do you think they are not able to share their feelings with health professionals?</p> <p>p: can you say that again?</p> <p>i: other women who may not be as open (.) why do you think they struggle to open up to people or they don't want to share their feelings with a health professional?</p> <p>p: maybe its like some women like say if (.) in pregnancy i've had a lot of that some</p>	<p>across as inpatient and rude</p> <p>"I got put off because of the way she spoke to me" – poor rapport seems like a barrier to interaction and disclosure – unclear whether participant talking about HV or nurse</p> <p>Overall role of HV/nurses during and after pregnancy was valued – especially as new mother being provided with relevant information helped</p>
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<p>Partner support from Pakistan: emotional</p> <p>Coping with low mood: trying to stay positive, looking to the future</p> <p>Support for mental health: unintentional disclosure, outlet of support available</p>	<p>husbands like men they hit their wives and stuff some they beat them up and stuff whilst they pregnant some women might be like say if they want to share that like with the midwife they're scared that what if their husbands find out then obviously things would get bad (.) might come to an end and stuff but other than that some women they more like keeping things to themselves but once they've kept to themselves if something bad happens then they regret it like why wasn't i open in the first place</p> <p>i: so how important do you think it is to share your feelings with anyone?</p> <p>p: i think its you should share your feelings 100% whatever you're feeling just say it out cause if like say if im feeling if i have something like i can't take tablets i can only take liquid things (.) but if i can't take tablets and if i don't tell my midwife and if i went to the doctor they would've given me tablets for pain and stuff obviously when you're in pain you cant explain things you're</p>	<p>Facilitator to openness: a kind and nice health professional</p> <p>Suggested that midwife made participant feel really comfortable which allowed her to feel in a safe space – described similar to the feeling of being around family, suggested safe space, without judgement</p> <p>Suggested in participants case being open about her circumstances was beneficial as she received</p>
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<p>Emotional support: midwives</p> <p>Risk of perinatal depression?</p>	<p>like nobody talk to me because im in pain (.) if i already explain to my midwife and health visitor they will know let the doctors know thats it people know that she can't take tablets so obviously if something you ahead tell your doctors first about how you feel they'll let the hospital people know like this is how this girl feels so be abit kind to her be abit soft to her stuff like that (.) when i went to doctor when i was going to give birth they obviously said to me do you want a paracetamol i said look (.) they knew i have the dissolvable ones they said yeah we read it on the paper that you don't take tablets so they gave me the dissolvable ones (.) you put the water in they just dissolve (.) even though i took my own but they said no you can't have your own (.) cause i had the strawberry paracetamol dissolvable ones they taste much better (.) but yeah i think you should say it all out whatever you feel shouldn't keep it in</p>	<p>support – emotional support throughout husbands absence</p> <p>Suggested good care from the health team was pivotal in participants journey and mental health – to the extent where participant believes maybe her health and the child's may have deteriorated if this support wasn't available – what about the role of family?</p> <p>Did participant need to hear the advice of others?</p> <p>Love and care from health team: good experience</p> <p>Facilitator to disclosure:</p>
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<p>Relationship with HV: good rapport, knowing how they operate, how they will respond to things</p>	<p>i: yeah (.) so if someone's feelings a little upset or down or maybe a little bit depressed do you think its important for them to share those feelings with someone?</p> <p>p: i think it is good but then there are some things you can't really share say if you are feeling depressed cause of your (.) i dont know cause sometimes if you share a bit too much then the midwives they sometimes take it a bit too much over (.) then obviously they get other people involved like mental people like when i told them about my husband and stuff they got involved mental people and stuff then they thought obviously im being mental or something cause my husbands not with me (.) then i got calls from one of the people in [postcode] somewhere and they obviously call me and i went it was like 1 hour interview thing</p> <p>i: hmmm</p> <p>p: and they were asking me about stuff and obviously i said to them look I'm not mental or</p>	<p>-friendly and respectful staff – encouraged participant to be open</p> <p>Demeanour of health professional or anyone is important – how they conduct themselves can be the difference to whether or not someone discloses</p>
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<p>Talking about mental health is not easy: stigma, fear of consequences</p> <p>Health visitor: friendly, good listener, helpful – facilitator to openness</p> <p>Importance of continuity of HV for disclosures</p>	<p>anything and i will not go mental but obviously I'm only upset cause my husbands not with me (.) then obviously they take it a bit too much over cause my midwife got a bit worried she was like ohh shall we send you to somewhere like where theres a bit more care and stuff (.) i go no no im fine like that (.) cause i can't be bothered to go every day or once a week to go somewhere</p> <p>i: hmmm (.) so at that clinic what sort of questions were they asking you?</p> <p>p: they gave me like (.) it was like a really thick question like a lot of questions and they told me to answer them but obviously they gave me the booklet through the post and i thought obviously its a normal booklet i didn't even initially look at it (.) and when i went in there they go wheres the booklet i go i don't i didn't i thought i was supposed to leave it at home not bring it here (.) she goes well you were suppose to bring it here and we going to help you answer the questions and stuff (.)</p>	<p>Barriers to disclosure:</p> <ul style="list-style-type: none"> - domestic violence, fear of husband finding out if disclosed - preference to avoid sharing with health professional – would they share with family instead? <p>Participant suggests she knows people who have been in such situations who then regret not being open</p> <p>Participant believes it is important to share feelings: in this case she has given an example of her medical preferences – what about sharing feelings regarding low mood? In directly can</p>
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<p>Participant expecting another baby</p> <p>HV: knowing what you mean by certain terms – feeling safe and secure</p> <p>Preference to share low mood with husband</p>	<p>obviously she goes it doesn't matter i've got one here so we'll just use that (.) it was questions like saying ummm it was questions like asking me about like how i feel and do i ever feel like committing suicide and stuff cause obviously im upset and everything (.) i said i said to them look im totally fine im totally fine i have no other problems at home my family's kind to me like i have loving parents loving brothers other than that all i want that my husband is there and i know nobody can bring him me except the person involved they going to give the decision then he's going to come then he cant come before that (.) obviously they said to me stay with us for 1 or 2 weeks then we will whats it called (.) we will like write a letter to them and i was thinking if i keep coming here for one or two more weeks im going to go crazy (.) i thought you know what just over a letter im not going to come here because they asked me so much like</p>	<p>be seen as important as she has expressed/disclosed low mood to health professionals in the past</p> <p>Benefits of sharing to health professionals: not linked to low mood but medical preferences suggested then all teams on same page and aware of needs</p> <p>What are the consequences of keeping feeling in from participants perspective?</p> <p>Sharing low mood and depressive feelings with health professionals:</p> <p>- medical preferences suggested fine to share as it does not exactly affect</p>
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<p>Husband, midwife, and health visitor: shared feelings with all both with different dimensions</p> <p>Husband: share low mood (safe space)</p> <p>Midwife: shared low mood but not safe space</p> <p>HV: shared about visa concerns</p> <p>HV: sharing for own gain (visa)</p> <p>Benefits of sharing:</p>	<p>questions about mental people that i will literally go mental aha so i said you know what (.) they called me for an appointment to be honest i didn't even go to it because i thought you know what i don't even know how to ring them and say to them i don't want to come because then they're going to ask me questions like why is everything okay and i cant be arsed to answer the questions so i was already depressed (.) and stressed out that i cant answer so many questions (.) i stopped going then</p> <p>i: so what was the main reason that you didn't want to continue with that?</p> <p>p: because i was thinking like i will end up going crazy haha like i thought i might go mental cause they asked me so many weird questions like actual mental people (.) like obviously i wasnt mental all that was that i was stressed and depressed and i always used to cry just for my husband but they were taking it some other way</p>	<p>your care or life much in general</p> <p>- sharing mental health: suggested that if you tell health professional you are experiencing low mood or depression they will "take it a bit too much over" – indicating that they will take action, as participant mentions getting other services involved – what does this mean in wider context in terms of depression? Does this indicate stigma – you don't want others to know you are depressed</p> <p>Is the term depression used but loosely not in clinical sense?</p> <p>Did participant ever mention the word depression to health professional regarding husband's absence?</p>
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<p>Participant had heard of the term PND</p> <p>Cause of depression: husbands absence</p> <p>Depression post-birth not linked to the child</p> <p>The stigma around PND: is it assumed to be due to child?</p>	<p>i: yeah yeah okay (.) what was the thing you didn't like too much about it?</p> <p>p: like they asked too many questions about like how do you feel have you ever like tried to do something to yourself and stuff like that (.) i found those questions a bit you know dumb</p> <p>i: so when they were asking you them questions did you feel that you could be honest with them?</p> <p>p: well some of them i could've been honest but i wasn't because i was thinking like they might actually think that something's wrong with me and they might end up taking my baby off me cause i've heard a lot of stuff like that if you're a bit not good in the head take your baby off you i've heard (.) so obviously i was worried that if i say stuff like (.) i (.) obviously with me i've never thought of committing suicide like tauba but like just it's obviously used to be depressed stressed used to cry and stuff i couldn't be arsed</p>	<p>perspective of midwife but participant perceives it as she is being branded as mentally unstable?</p> <p>Suggested that health team did not see participant as high risk otherwise she would have received immediate mental health support?</p> <p>Participant lack of involvement in the mental health support apparent as she discards any documents sent to her</p> <p>Did participant always emphasise how upset she was without her husband and how this was impacting her, thus the referral?</p> <p>Participant now seems to be expressing that she is only upset that her husband is not present but does feel severe about this?</p>
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<p>Views on PND:</p> <ul style="list-style-type: none"> - hormone fluctuations - physical changes: takes time to recover - mood fluctuations - wanting to be alone <p>PND: neglected concept in Pakistani-Muslim community, not discussed</p>	<p>with [child] like i couldn't be arsed picking her up if she crying and stuff cause i was that upset (.) but its not like i wanted to hit her or something just like i couldn't be arsed like if she was crying i was like let her cry forget it</p> <p>i: so how long did these feelings last where you didn't really want to pick her up or you were feeling sad?</p> <p>p: its not like every day its like you know later in namaaz and stuff i used to be normal and stuff but when I'm not on the massalla and stuff i used to be i used to like cry and stuff but then my husband used to give me like a lot of support even though he was far he support me a lot from there as well (.) but then obviously he used to say to be don't worry i'll call you over and obviously thinking about oh I'm going to go Pakistan now my mind used to go to that place then (.) obviously then we did go pakistan when she was 6 months (.) when she was 5 months actually (.) and then obviously i was prepared i was</p>	<p>Questions around suicidal ideation – participant feels this is not relevant to her</p> <p>Participant expresses herself rationally – she is not presenting herself in a manner which may indicate mental health issues such as demanding husband be here or threats of self-harm if he is not here</p> <p>Participant did not see any benefits to attending mental health appointments – her main priority and source of stress seems to be absent husband</p> <p>Nature of appointments – did participant find this intrusive as well in her perspective irrelevant? Suggested she knows herself well enough to</p>
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<p>Own mothers' response to low mood during perinatal period:</p> <ul style="list-style-type: none"> - normalisation of feelings - feelings not validated by older generation – different perception <p>Construction feeling low perinatal period: its not real (older gen construction)</p> <p>Generational difference of motherhood experiences: cannot relate to new gen</p>	<p>like you know what forget everything now im going to Pakistan to my husband so there's no point being upset so it wasn't like everyday thing (.) when i had (.) when i was pregnant it was more worse then i used to feel (.) obviously then they worried that she may end up doing something to the baby (.) obviously when you're stressed and depressed they say if you cry and stuff its not good for the baby (.) like its not good isnt it so because of that they said they were a bit worried about the baby and stuff</p> <p>i: so who was worried about the baby was it the people at surestart?</p> <p>p: the midwife (.) the midwife was worried obviously but they couldn't do anything all they used to say was don't worry he'll be here with you (.) cause you have to feel happy happy cause if you feel happy its better for the baby cause the baby's more happy as well then (.) and then them people they called me once i had the</p>	<p>know when to seek support?</p> <p>Missed appointment on purpose – suggested that participant does not like to delve into personal life or personal reasons for not attending with health professionals – does she feel it is not their business to know? Does she feel that this will cause more misinterpretation?</p> <p>“I was already depressed” in what context? Is depression in this context depression as it is known in West or is a word to replace being sad?</p> <p>Whilst according to West depression is a mental health condition – does participant not view it like this? She is taking the term 'mental' as it is used in a derogatory fashion – this</p>
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<p>Changing experiences of motherhood</p> <p>Knowledge of changes vs not understanding/keeping inside</p> <p>Role of men older gen: less support, women had to accept</p> <p>The act of childbirth: robotic vs personal</p> <p>Shift of traditional gender roles: role of husband</p> <p>Own mother lacked social support</p> <p>Own mothers response to low mood: generational difference in understanding</p>	<p>baby they didn't call me when i was pregnant</p> <p>i: so when you were pregnant and you were and they were getting a bit concerned did they refer you to anywhere or give you any support?</p> <p>p: they just referred me to that clinic thing that i was telling you about</p> <p>i: so that was during the pregnancy?</p> <p>p: no that was after pregnancy (.) during pregnancy i think she asked me about something but i think i said no cant remember other than that only that was health visitor there was the sure start thats all i went to but then after when i had [child] then i think i was i think 2 months then they called me to clinic (.) cause then they were more worried about the baby cause i might end up harming the baby but obviously i wouldn't cause she's my daughter (.) obviously they think about it a lot obviously i've heard a lot of things that they take your baby away so i didn't want anything like that to</p>	<p>term seems negative, attached with stigma – is mental seen as someone who is totally out of control? Were the questions being asked related to the type of 'mental' participant envisions? How does participant view her depression?</p> <p>Participant acknowledges that she was referred for her benefit</p> <p>Suggested the long process and many questions, some uncomfortable questions put participant off from pursuing the support</p>
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<p>Older gen: low mood during PNP not accepted to talk about</p> <p>Shift in traditional gender roles: Pakistani men more attentive to women's feelings</p> <p>Husband support: emotional, changing dynamics with generations</p> <p>Husband attitude towards pregnancy: aware & attentive</p>	<p>happen cause obviously i was stressed and depressed they might have taken the baby away so i thought you know forget this</p> <p>i: so you know like yourself other women might fear that if i tell a doctor how i really feel they may take baby away (.) or something negative might happen (.) so in them situations what do you think the best way is for someone (.) who do you think the best person is to talk to or what do you think the best support is so that woman is still getting support and she's not (.) her symptoms wont worsen as a result of not sharing?</p> <p>p: i don't know like</p> <p>i: or like what helped you?</p> <p>p: health visitor thing is the best to talk to cause my health visitor she just too nice like she like when i used to talk to her she used to be so friendly like she's really nice even now like my [child] is 9 months she's still like whenever i ring her she's really nice (.) its that thing whenever she comes to my</p>	<p>"I'm just depressed and stressed" – if participant was repeating these terms – this may have been reason for referral</p> <p>Did participant depression match for example DSM criteria?</p> <p>OR is this a different kind of depression – is depression even the right word? Has it been used too loosely for western context? Or is participant in denial or does not want a depression diagnosis but does not mind telling people she is depressed?</p> <p>Uncomfortable or questions which were not relevant – did participant feel she could not connect with the support service? Did she feel she is not severe so it is not the right fit for her?</p>
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<p>Husband present at birth via video call: wasn't common in older gen</p>	<p>house she's always asking me about my health child's health like how's things going stuff like that and i was telling her look I'm going to get a house now and she was like where how she's really into the stuff like even though what's it got to do with her but still its that love isn't it (.) i think health visitor is the best person to talk about cause i used to tell her everything (.) the person i spoke to a lot about my thing was health visitor cause even she did a lot as well (.) she wrote a letter and stuff</p>	<p>Participant suggests that she was not open about her mental health with the support team:</p> <ul style="list-style-type: none"> - fear of being labelled with a mental health issue - fear of baby being taken away from you
<p>Husband present at birth: seeing the reality of child-birth:</p>	<p>i: yeah yeah (.) so did you have the same health visitor pretty much?</p> <p>p: yeah she's always been that but now she's 9 months she came the other day she said cause obviously i've moved like she got a different job now so other one going to come now other health visitor (.) i said i don't need no health visitor now cause obviously i know how to look after she said no we need to until she's one year</p>	<p>Participants depression:</p> <ul style="list-style-type: none"> - frequent crying over husbands' absence - no energy to attend to crying child
<p>Becoming a mother of 2: own mothers support makes the transition easier</p>	<p>(This cell is empty in the original image)</p>	<p>Suggested that when participant prayed she did not feel sad or depressed for that short moment –</p>

<p>Joint vs nuclear family: more support in joint family</p>	<p>old (.) because i am expecting again</p> <p>i: oh are you! congratulations</p> <p>p: yeah thank you and then she said now obviously i don't think she might come i don't know for her but i am expecting again i've got my next appointment next month now first appointment next month (.) but</p> <p>i: so did it make a difference having the same health visitor throughout? like a long period of time</p> <p>p: ye.. what do you mean?</p> <p>i: like were you able to build a better bond compared to if it was a different lady every</p> <p>p: no if it was a different it would've been hard cause its not easy to find good health visitors to be honest cause after that one nurse that came to my house straight after my pregnancy after that i feel like you know what every ones like that (.) the health visitor cause i've had her from the start she knows how i feel (.) like if you say something to me she'll</p>	<p>faith and reliance on God as coping mechanism?</p> <p>Emotional support provided by husband who was in Pakistan</p> <p>Coping with low mood: looking to the future, planning ways to see husband even if visa was not possible so soon</p> <p>Suggested that plans of going Pakistan to see husband put participant in good spirits</p> <p>Suggested that through pregnancy participant was seen as more of risk for mental health issues? –</p>
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<p>Construction of childbirth and motherhood: normal vs medicalised</p>	<p>know how i feel how to make me happy so i think its best to have one health visitor throughout</p> <p>i: yeah (.) so lets just say hypothetically if you were feeling sad or if you just had a down day (.) how do you feel about talking about these feelings and who would you share these feelings with?</p> <p>p: when i used to feel down and stuff i used to ring my husband i used to tell him everything like look I'm upset this and that just tell him everything (.) the first person was my husband tell him everything like I'm feeling down this that he used to say don't worry inshaAllah i'll be there with you everything (.) nobody else to be honest (.) i used to tell my midwife but my midwifes something else (.) my husband used to tell him more like look I'm feeling down and i want you here this and that but midwife used to tell her but not like sometimes (.) cause telling her is different like (.) they couldn't do anything (.) with my health visitor used to tell her (.)</p>	<p>how did participant feel about this?</p> <p>Although – it can be seen as a positive that she did not slip through the net and was offered support even if she did not accept it – outlet of support was available</p> <p>Midwives reassure participant regarding husbands absence during pregnancy</p>
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<p>Husband: openly loving and caring, change in attitudes</p> <p>Social support of own mother: made the motherhood transition easier</p> <p>My child is my companion</p> <p>Having a daughter: comfort, relatable</p>	<p>she used to be like ohh look I'm going to come next time and i'll bring this thing and I'll send it off this and that (.) with my midwife she did a lot for me but obviously she didn't help me with visa stuff (.) my health visitor did (.) shared it with her shared it with my husband (.) that's it to be honest</p> <p>i: and how did you feel once you shared your feelings with your health visitor</p> <p>p: i used to feel more like (.) like more like calm and more fresh and i used to feel like okay somethings going to change now he might be here with me now soon (.) cause i used to always think one thing in my mind he will be with me by when im going to give birth he'll be with my by then i used to think that (.) even though obviously its not going to happen but i used to make myself happy and say he's going to come he's going to be here by the birth (.) but obviously he wasn't</p> <p>i: and you mentioned when you were feeling a little bit down</p>	<p>Participant again expresses that she was stressed and depressed – did she feel that support from services was not going to help her in anyway unless they could bring her husband over to the UK?</p> <p>Did health professionals think participant might be suffering from perinatal depression and therefore kept an eye on her?</p> <p>Suggested participant declined mental health support due to the fear of branded as mentally unwell and fears around baby being taken away</p> <p>“but obviously I wouldn't” – suggested that health professionals would not know this and it is very subjective – it is their job to</p>
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<p>The enjoyment of motherhood</p> <p>Generational differences in caring for child</p> <p>Concealment of feelings: maintenance of self-image, respect to elders (generational differences)</p>	<p>and depressed that when you prayed you felt better (.) did you do anything else that made you feel better or forget about things??</p> <p>p: no because like when i was pregnant i hardly listened to songs and stuff because i wanted her to be like more on the deen and stuff (.) i used to like read quran majeed i used to prefer that (.) and then i used to read namaaz cause i wanted to like keep my mind that was cause when i used to do dua and stuff i used to feel more calm(.) and i used to feel like as if someone will listen to me cause Allah tallah is like listening to me i used to feel more calmer so because only that's the only way would make me feel more calm and you know more fresh there was no other way</p> <p>i: hmm okay (.) so did you ever hear the term postnatal depression?</p> <p>p: yeah i have heard obviously when i had i think that i think you get that after your birth yeah?</p>	<p>offer support and intervene where they see fit?</p> <p>Suggested that participant had a good health visitor so this was her go to person to share with – because participant had the visa issues did she feel that sharing this with external people would aid the process? Does participant</p>
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<p>Unable to voice opinions: respect to elders, maintenance of self-image</p>	<p>i: yeah</p> <p>p: cause i heard (.) cause i said well i heard of when somebody said they think the doctors (.) they said it happens something after you've given birth (.) i don't think it happened to me (.) i did cry the first day after i came back (.) yeah [child] was crying and i thought how was she going to get quiet on the first day back when i came home (.) she was crying i started to cry with her (.) we were both crying (.) i think that time i felt a bit like how am i supposed to look after her how is she going to get quiet cause it was the first time ever holding a baby and looking after her so other than that i was fine (.) i had no i was normal (.) the only depression i had was because of my husband there was no other depression cause of pregnancy cause of [child] there was nothing like that</p>	<p>know how this health visitor operate so is open to sharing her mood also? Or is participant able to say she is feeling low but nothing severe so things wont escalate?</p> <p>Suggested easier to talk about other things not related to mental health – is this due to fear of consequences and stigma?</p> <p>Health visitor: friendly, good listener, helpful – facilitator to openness</p>
<p>Concealing true thoughts and feelings amongst elders</p>	<p>i: yeah (.) umm so what are your thoughts on postnatal depression like what do you</p>	<p>Continuity of HV: participant had good rapport but hv being replaced by someone else – participant does not seem keen on the idea as she suggests she doesn't need further support if current HV leaving</p>

<p>Concealment of negative emotions: anger, silence to maintain relations</p>	<p>ever think that they would say that you've got postnatal depression?</p> <p>p: no (.) i don't think they've said that</p> <p>i: no? umm so how do you think postnatal depression is viewed in Pakistani community? do you think people know what it is? do you think people understand what it is?</p>	<p>HV: knowing what you mean by certain terms – feeling safe and secure</p>
<p>Concealment of emotions and inter-dependent culture</p>	<p>p: i don't know (.) cause like when i gave birth (.) even now cause i'm pregnant as well when i had her as well i used to feel abit down (.) i explain to my mum obviously that im feeling a bit down cause obviously im pregnant (.) used to be like (.) she used to be like</p>	<p>Sharing feelings with husband – this was first and main person of contact for participant to share her feelings with – suggested her reassured her as he was in Pakistan couldn't do anything physically</p>
<p>Concealment of feelings and conforming attitudes</p>	<p>oh everyone gets pregnant its a normal thing (.) cause these lot don't know like cause i don't know they know more</p>	
<p>Coping with conflicting attitudes: getting own mother to intervene</p>	<p>obviously they're parents but obviously like we think that when you're pregnant you have a bit of ups and down but our mothers and these old people</p>	<p>Husband, midwife, and health visitor: shared feelings with all both with different dimensions</p>
<p>Lack of experience of hearing about PND in community</p>	<p>they think that obviously its not real (.) obviously mum goes</p>	<p>It is suggested with husband: shared more</p>

<p>Depression post-birth: is it depression or PND?</p> <p>Experience of depression label vs PND</p> <p>Running away from mental health label: missed app at clinic</p>	<p>i've had three babies i've looked after them myself i've given birth myself no one has come with me to hospital but we look after them (.) i've never felt down (.) obviously with me cause obviously i've read books and stuff i know that when you're pregnant you do feel down and i said to her look you have ups and downs and its true it is real (.) even now im pregnant im 5 weeks 6 weeks alhamdulillah and its like i do feel a bit up and down i feel a bit like nobody talk to me like just leave me alone cause its that thing like when i get headache or when i get a bit of back pain im like leave me alone (.) mum thinks say if she asks to help me with the work i'll be like i'm not feeling well (.) she'll be like you're the one who's always only having a baby no one else has ever had a baby have they (.) cause for her its something different i don't know cause maybe in her time nobody like you know helped out a lot cause them days our dad and these past people dads and uncles and</p>	<p>about low mood – it is a safe space he is not going to call social services and he understands where this sadness is coming from – also knows her family is living with her and this acts as a safety net</p> <p>Suggested with midwife: MW referred participant to mental health services which may have put off participant from sharing – did she no longer see this as a safe place, did the relationship turn more clinical and less friendly as such?</p> <p>Suggested with health visitor: shared more about visa concerns as HV was able to do some things to support visa application</p> <p>With health professionals suggested that participant is sharing for own gain – the visa application</p>
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<p>Mh clinic: scary space, stigma of labels</p> <p>Participant able to be open with HV – good and close relationship</p>	<p>stuff they don't really care helping out with wife they think oh its something wrong helping out with wifes (.) but with my husband he helps me out a lot like say if im in the kitchen and stuff he helps me out .) but for her its something different so she thinks like (.) she always says to me you're not the only one giving birth theres like so many ladies giving birth for her its something like normal (.) but obviously when you having a baby when you're pregnant it is hard its not like an easy thing (.) especially for me like i feel I'm still young yet cause I'm only 21 soo (.) but for her she thinks it's like you're not young now cause you've already had one baby (.) for me I still feel young yet haha</p> <p>i: ahah yeah (.) so when your mum says its normal or its part of birth so how does that make you feel when you're telling you feel down but she's telling you..</p> <p>p: yeah i start crying i sit down and like I can't explain to her (.) i can't explain to her cause she doesn't understand it's hard to explain to her cause she's</p>	<p>Benefits of sharing:</p> <ul style="list-style-type: none"> - feelings positive and optimistic - feeling relaxed and calm - feeling happy <p>Coping with sadness through religion:</p> <ul style="list-style-type: none"> - praying and reciting Quran gave participant peace - reliance of God allowed participant to feel a sense of hope that prayers will be answered
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<p>Mum and baby groups: not preference</p>	<p>never (.) maybe she has felt that way whilst she was pregnant but she didn't have anyone to share it out with (.) cause now whenever she feels down she shares it out with me but at that time i wasn't there to</p>	<p>- Doing more religious activities and staying away from music which is disliked/not allowed in Islam</p>
<p>Mum and baby groups: shy and introvert</p>	<p>like share it out with me so (.) cause like its different (.) with us lot cause we're now now people like every obviously it changes in it (.) like with me i</p>	<p>Participant had heard of the term PND</p>
<p>Cultural beliefs during perinatal period: evil eye, evil spirits</p>	<p>share things with my husband and obviously he like gives me a bit of support (.) with my mum like my dad doesn't really care what's going on in life what's not going on (.) so its different with her and its different with me (.) i don't</p>	<p>Does participant think she experienced this?</p>
<p>Cultural beliefs during perinatal period: compelled to observe as instructed by elders</p>	<p>blame her (.) obviously i do feel upset that minute but afterwards i be like you know what its not her fault i: yeah yeah (.) so with your husband does he have an understanding of postnatal depression or even just changes in mood pregnancy after birth?</p>	<p>Participant recalls her depression and the root cause: husband being in Pakistan</p>
	<p>p: i don't think he knows (.) i don't really no about that but obviously he does know that</p>	<p>Participant recalls that depression was not linked to the child – would medics still class this as postnatal</p>

<p>Pregnancy and post-birth: vulnerable to evil spirits</p> <p>Evil eye and losing unborn child</p> <p>Medical vs cultural explanations for birth related issues</p>	<p>obviously when you're pregnant you do feel down and stuff (.) since he found out im pregnant he's been looking after me more (.) he's been giving me more love and care stuff so he does look after me more and he knows that giving birth is not easy cause when i had the first baby and he seen me in pain cause he kept video calling me when i was in hospital (.) and he seen me on video call and i couldn't (.) initially i went so so dark cause of the blood i was loosing a lot of blood (.) i lost a lot of blood whilst i was giving birth cause when they told me to push my blood was coming out (.) i don't know so much even my birth partner she was like (.) she never told me that time cause obviously im going to be upset then (.) she told me afterwards after when i came home she goes you lost a lot of blood (.) like your blood was like soo like she goes normal person i've never seen this much blood come out when you gave birth (.) and when he's seen me so dark my face all yellow</p>	<p>depression because the depression falls within that period? Does the term PND automatically insinuate that you are unhappy with child? Does this lead to stigma and judgement?</p> <p>Views on PND:</p> <ul style="list-style-type: none"> - hormone fluctuations - physical changes: takes time to recover - mood fluctuations - wanting to eb alone
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<p>The link between evil eye, being around women who have aborted and own foetus</p>	<p>and stuff he goes this is the first and last pregnancy (.) even that time i said it as well first and last pregnancy and even until now i've been saying it but you know what i just want another baby like its that thing you want a boy and a girl (.) this time inshaAllah i want a boy cause like i want one of each (.) its hard to give birth like obviously when i think about her it is really hard (.) then again you just want to go through it (.) you want that little baby again cause she's growing up now want that tiny baby again</p> <p>i: aww yeah (.) so how do you feel like having two babies so close together?</p> <p>p: to be honest my baby she's like i don't mind (.) if you get pregnant i'm here for you now i'll look after them for you like i'll help you look after them (.) so because of that obviously i have a bit more like you know what i'll just give birth cause mum will be there for me cause i'm living with her at the moment so she'll help me out a lot and if i was alone i think</p>	<p>Suggested that participant was never diagnosed or suggested to have PND – is this what the clinic which participant left was trying to figure out?</p> <p>Participant unsure how PND viewed in wider Pakistani community – is this because PND is not widely discussed? Do people see this as PND?</p>
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<p>HV: signposted to relevant organisations</p>	<p>would wait until she's one or two cause she is quite naughty (.) so other than that with me (.) my husbands like obviously he wanted me to get pregnant once she's 1 or 2 cause it is quite hard (.) but then again we think about mum she's going to help us out so why not (.) say if i had my own house it would've been hard then</p> <p>i: are you going to move out soon or?</p> <p>p: we are planning to move out then i don't want to move out yet</p> <p>i: yeah its nice having mum there to help you out (.) so like you mentioned your mum has a different view of postnatal depression maybe (.) so when women are experiencing symptoms and maybe people around them don't know what's going on (.) what do you think people of your mums generation or other people would think why is this woman behaving like this or why is she feeling like this?</p> <p>p: i don't know but mum like (.) obviously with her i like i would</p>	<p>Own mothers' response to low mood during perinatal period:</p> <ul style="list-style-type: none"> - normalisation of feelings - feelings not validated by older generation – different perception <p>“its not real” – what does participant mean by this?</p> <p>Does older generation feel that the younger are not good at handling such situations?</p> <p>Mothers own experiences are different – done things alone but has not felt down about it (motherhood) – getting on with it attitude</p> <p>Participant read up change in pregnancy – because participant has this knowledge does it change her experience of</p>
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<p>Giving birth and being mum isn't easy: being open about the reality</p>	<p>say like whenever i say I'm a bit moody and stuff she'll just be like oh everybody gets pregnant its a normal thing you're not the first lady who's getting pregnant in this world like the way you're acting and stuff (.) then i don't know its hard to explain like (.) its like mum cause she's obviously had 3 babies with operation with c-section (.) so it was more hard for her and she looked after them herself she thinks its normal for everybody (.) then again c-section is more hard than normal birth (.) and then still like i don't know (.) don't know to be honest how to explain to like these kind of people it is quite hard (.) with me cause I'm young as well and my husband cause he's more loving and stuff i do be in pain say im feeling a bit down then i start acting a bit more upset to get his attention and stuff aha to be honest thats what i do (.) other than that like i do feel down sometimes like he's at work now i don't really act much (.) when he's home i act a bit more like I'm feeling</p>	<p>pregnancy and childbirth? For older gen were same feelings present but it was constructed as normal so you just got on with it?</p> <p>Suggested older gen are used to doing everything on their own – suggested older gen of men helped less with what is considered female roles – so the same is expected for younger generation – suggested child birth back then was somewhat of a robotic act, something normal, was this due to men viewing such acts as normal, nothing important, just what women are made to do? – whereas now it seems different for this generation, more aware of the physical, of the psychological – more awareness of own needs – more willing to speak up about these things</p> <p>Suggested that participant husband helps with household duties – shift in</p>
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<p>Desire for small family: 2 children</p>	<p>down and stuff (.) he does more stuff for me he helps me out more like i just sit down and he goes and gets stuff jmfor me to eat and everything (.) yeah i don't fast (.) soo</p> <p>i: yeah (.) that's nice (.) so when you became a mum did you feel like any expectations of you as a mother?</p> <p>p: i don't know i used to think obviously its a bit its quite hard really hard being a mum (.) it is hard but like then again mum she does a lot for me soo (.) once i get my own then obviously i'll know how hard it is (.) right now she does a lot for me (.) but like its been a few months like say one month or two month that obviously she's more close to her mum now (.) when she was small she was more close to my mum but now whenever i go out i have to take her with me cause now she doesn't like staying at home with my mum she prefers it with me (.) i dont i think i find it fun with her to be honest i dont find it hard (.) like whenever i go out i used to normally go out on my own</p>	<p>attitude of traditional gender roles</p> <p>Suggested own mother did not have this social support available</p> <p>Response of own mother to low mood during perinatal period:</p> <ul style="list-style-type: none"> - generation difference in understanding of low mood and challenges during perinatal period - suggested that mother may have experienced this but culturally wasn't accepted for women to voice such concerns or issues - suggested a shift in the role of men/husbands – suggested older gen men and women relationship was different – less willing
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<p>Husbands presence during pregnancy: happy, safe</p> <p>Guests post-birth: community feeling, cared for</p>	<p>cause obviously i don't have a sister do i? so i used to always go out on my own but now cause i have her i feel like she's my sister my friend my daughter like i feel everything inside her (.) so its actually good like to have a daughter cause then you don't feel alone (.) like now my husbands at work if i want to go out i take her with me in the pram and i just feel like theres somebody with me i feel like theres somebody more older than me with me i feel more secure with her so yeah (.) i think its not hard (.) then again obviously it is hard when she's say if she's feeling ill and stuff then obviously i get upset even today she's got a little bit of flu nose leaking and stuff (.) i start feeling upset like when is she going to get better (.) not because she's annoying she's not annoying even if she's poorly (.) she doesn't be annoying just normal but obviously when i see her in pain i feel upset (.) im like i don't mind if i get that illness but i don't want her to be ill</p>	<p>to share such issues with each other – suggested that this is changing with time</p> <p>Participant comfortable to share feelings with husband and he is willing to listen and offer support – changing dynamics</p> <p>Suggested husband is sensitive to the needs of pregnancy – offering more support and care – does this help participants pregnancy journey? Suggested that he values participant and does not take being pregnant for granted – in the past was it seen as something normal,</p>
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<p>Post-birth beliefs: cannot shower immediately, uncomfortable, have to observe</p>	<p>cause i don't want to see her in pain (.) but other than that i think being a mother is good</p> <p>i: yeah (.) did you feel any pressure to be a mum in a certain way or do things from family or wider people?</p> <p>p: no its like (.) what do you mean like?</p> <p>i: so for example you know when you mentioned when you came home if you wernt laying down they'd be like why are you not laying down (..) things like that?</p> <p>p: oh yeah yeah one of my family members came to my house my dads close relative (.) she came and she was sat here and obviously i've never wrapped my daughter (.) you know wrap a baby around</p> <p>i: swaddle?</p> <p>p: swaddling (.) i didn't ever do that obviously i used to feel irritated looking at that and you know what im not doing to my daughter cause i want her to feel more free and i used to put the mittens so she doesn't scratch her face and stuff used</p>	<p>nothing spectacular or much of an achievement?</p> <p>Suggested husband has seen the realities of giving birth through video call – the loss of blood and some gory details – in the past not important for men to be present at birth or even at hospital – seen as a women thing – is this also changing? Do Pakistani women now prefer their husbands to be present at birth?</p> <p>Suggested he was shocked – and did not want participant to go through another pregnancy again at the time</p>
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<p>Enjoy being a young mother</p> <p>Arranged marriage by family: good choice</p>	<p>to put the mittens on her hand and i didnt like put her in a swaddle and stuff but that auntie came and she goes you've got the baby wrong i go why she goes you're supposed to tighten her up with the blanket and stuff (.) i was like i couldn't say no to her cause she older she's an auntie and i go okay (.) she picked her up out of the cot and she goes look im going to tie her up dont open her now cause she has to be totally like wrapped up in a blanket (.) i was like what can i say now (.) straight away she went out the door the door closed i literally opened her quickly cause i was feeling irritated (.) she goes no no you're still its your first baby you don't know much about it yet (.) you're supposed to have a hat on her blanket on as well (.) i used to hate putting hat on as well cause it was warm in the room heating was on its not like she was sat outside (.) i used to let her feel more free and more full like she's been in the belly for 9 months i want her to feel more free now (.)</p>	<p>Whilst giving birth difficult participant want another baby to look after especially now that husband is able to see the whole journey</p> <p>Suggested that participant does not have many concerns around having two children close together in age as social support from own mother is available – makes the transition easier, less overwhelming</p>
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	<p>that was the one thing that one auntie came and obviously i was like leave it i know im a first mum obviously i don't like that cause i've heard cause when i was pregnant i used to go to surestart and then one i had one appointment that nurses they (.) there were more other mums there first mums and they taught us how to like you know give a baby a bath how to wrap the baby up and they even said it that our old generation used to wrap their babies up and stuff but we don't have to obviously cause its not a must (.) so obviously i remember that as well you know what if nowadays people don't do it (.) i didn't blame the auntie when she had kids she was the olden days one so in her time did like wrap the baby up but now we don't wrap them up because we like babies to be more free like move the hands about arms about (.) but yeah and obviously giving her a bath in the start mum gave her a bath but they taught me how to give her a bath the easy way like so obviously its not</p>	<p>Suggested if living in nuclear family would've been harder and may have delayed decision for second child so soon</p>
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<p>Participant used to work in London</p>	<p>hard but she was too tiny i didn't want to hold her was too scared so mum used to give her a bath till now (.) still she gives her a bath (.) i think i've never given her a bath mum always gives her a bath (.) i still feel scared cause she doesn't like having a bath starts crying so its more hard when she cries and stuff</p>	<p>Own mother comparing her experience to participants – suggesting that birth and motherhood are natural phenomena's that shouldn't be medicalised? It is the norm</p>
<p>Worked as event planner in London</p>	<p>i: so how did you feel that auntie was telling you this is what you need to do this is what you're doing right you know (.) how did you feel when she saying these things?</p> <p>p: to be honest i used to feel angry but i couldn't say anything cause she's my auntie (.) so i used to be like okay auntie she used to wrap her up and put her in cot and be like don't open (.) but [child] wanted to get out herself cause obviously she's not used to that thing herself from the start (.) so obviously i was like you know what when's this auntie going to get up i'm going to open her so once the auntie was out and obviously i opened her and go mum this</p>	<p>Participant struggles to convey this phenomena of generational difference in motherhood and birth culture</p> <p>Suggested participant husband is loving and shows this openly by getting things for her around the house – simple gestures but in older gen even this was not common to be seen – participant seems to enjoy this and</p>

	<p>auntie if she comes to our house next time tell her off not to interfere with my daughter</p> <p>i: haha (.) so do you know anyone who's had postnatal depression or has suffered from depression after childbirth?</p> <p>p: i don't know umm (.) i don't know to be honest like my friends nobody's married yet I'm the first one out of all of them (.) who's got a baby as well so (.) sis in law i don't know about her hardly go to her house so (.) other than that i don't know to be honest (.) never heard of any i don't even have any friends who are (.) who have been pregnant and stuff</p> <p>i: so when you heard about postnatal depression did you ever think like this is a possibility that i could go through this?</p> <p>p: yeah yeah i used to think i used to be like maybe its going to happen like obviously you've given birth and you might feel depressed (.) i wasn't (.) i used to think obviously I'm going to</p>	<p>emphasises her care needs – suggested this positive response leads participant to be open with husband regarding low mood</p> <p>Expectations of motherhood: participant does not express experiencing any kind of motherhood expectations</p> <p>Social support of own mother emphasised how it made the motherhood transition easier</p> <p>Participant feels close bond with child, a relief to her loneliness when husband is</p>
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	<p>be all depressed i won't want to be doing anything just sitting down don't want to move and stuff but i wasn't like that</p> <p>i: so you know when you went to that clinic (.) did they mention that we are doing this depression screening for postnatal depression or was it just depression? what exactly were they looking for?</p> <p>p: no i go and they just said for i think health and stuff mental i dont know (.) mental was mentioned once</p> <p>i: hmm like your mental health?</p> <p>p: yeah mental health or something but yeah that's it then a lot of questions to be honest i cant remember now (.) had to tick the boxes and stuff and then i don't know (.) but obviously i think it was for half and hour to an hour or something and i was like you know what i need to get out of this place (.) they let me go after the time was done (.) i don't know but obviously after that they gave me appointment i didn't even go to it</p>	<p>away – is this because baby is part of them both? Baby is more than just a child – she is a companion</p> <p>Daughter – participant feels a sense of comfort and can relate even though she is just a baby – there is something in the fact that they share the same gender</p> <p>Participant enjoys motherhood with the ups and the downs</p>
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	<p>i: so if you were feeling like down what type of support would you find helpful?</p> <p>p: i would tell my health visitor (.) speak to her about it if im feeling down and stuff to be honest (.) thats the only person im really close to out of like nurses and midwives and stuff (.) health visitor cause she's known me from the start now (.) even though like she's saying to me im going to leave this job now but still if you ever want to call me when you feel down and stuff i'll be there for you and stuff (.) so that's the only person</p> <p>i: and if the health visitor recommended that you attend like a support group with other women who've got similar backgrounds similar stories do you feel you would sort of trust your health visitor that she's saying the right thing and you would give that a go or? how do you feel about</p> <p>p: to be honest with me I'm more like a shy person like going out with somebody say if like there's mums and stuff that</p>	<p>Generational difference on motherhood advice: taking care of child and swaddling – was this advice now out of date and not recommended? Whilst participant holds here own views as in previous example she cannot really openly voice her difference of opinion or even state that this is now not the recommended advice – if participant does this would she come across rude? Disobedient? Will others</p>
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	<p>are there i wouldn't be able to talk to be honest i am a bit shy (.) i think there was once when i was pregnant and i think they said to be there's a day come into surestart there's a day like all the families parents come and stuff and like you talk and stuff (.) i didn't want to go to that place (.) cause i just don't feel comfortable with so many people (.) like even with my little one i think they said once she's born and stuff like now now ish you can bring her and play with kids and stuff (.) i think she's too young once she's one and like one over then i would take her (.) cause in our don't know if you believe in it or not but in our culture they say when your pregnant you shouldn't go out much as well like (.) like cause there's some people who have had abortions and stuff and then that disease thing or whatever its called that thing can come to you and even your baby can die or something (.) so when i had my daughter they when i was pregnant my in laws they believe in it a lot my mother in</p>	<p>think she knows more than them and this is wrong because she is younger and they are older?</p> <p>"I couldn't say no to her"</p> <p>Level of respect maintained as it was an elder and a relative – desire to maintain relationships and avoid friction by not voicing her true opinions and thoughts</p> <p>Elders seem to assume don't know what you are doing with baby – overly critical? However at the same time participant does not demonstrate that she does know what she is doing etc – even if participant said swaddling is not recommended would elders discard these new recommendations?</p>
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	<p>law cause it happened to her once as well with her baby (.) and she said like obviously don't go out much and even if you do go out once you come home have a shower</p> <p>i: so how did she know that was the reason?</p> <p>p: because she said she went out after Isha i think and she had her 5th baby or 6th baby and she goes she went (.) aha thats a lot (.) she's had about 10 and only 6 survived the rest past away and she went out and i think she was end months she was end time to give birth (.) she went out with her husband and i don't know she goes she went past some lady who had abortion or something she came home</p> <p>i: so how (.) but did they know that lady</p> <p>p: no</p> <p>i: how did they know she had an abortion?</p> <p>p: i don't know they just believe in this thing and she came home and she goes like i was in pain or something and then</p>	<p>Participant expresses whilst she is a first time mum she is not totally clueless as she went to classes during her pregnancy where she was taught some basics – however she is not comfortable voicing this in front of family or elders – cultural element</p> <p>Suggested generational difference on how to care for new-borns – does it add to the gap when participant is unable to voice her opinion on these old methods?</p>
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	<p>period don't tend to go out or a bit of a vulnerable period (..) so when you spoke to your health visitor does health visitor recommend different services as well refer you to different services if you needed or does she just help with herself</p> <p>p: she helps herself but sometimes (..) when i gave birth after [child] came home obviously i was here and i spoke to her about contraception you know and she said to me right now my husbands not even here anyway (..) but if i go Pakistan she goes obviously she gave me a contact number for center where they give you free contraceptions and then she gave me that number just to refer there and that's the only thing (..) she goes to me look obviously I've been feeding [child] my own breadth feeding she gave me like this contact number she goes if you ever find it hard to breastfeed like you know ring this number they'll tell you (..) my health visitor my midwife mostly my health visitor she's given me so</p>	<p>“so I used to be like okay auntie” – conforming attitudes?</p> <p>Method of coping with conflicting advice from family members: listening to them when they are present – getting own mother to intervene – is this more acceptable as it won't be coming from participant but another elder?</p> <p>Suggested that participant does not have a circle of friends or people that she knows who are mothers – it seems she hasn't really heard of anyone who has experienced PND – is this because no one has in her circle or that such issues are taboo to discuss even if they did occur?</p>
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	<p>much like papers and booklets and CD of breastfeeding and i think i've still got that yeah to watch it (.) i didn't watch it to be honest cause i didn't think breast feeding was hard (.) so she gave me CD she gave me books reading books and then obviously she told me to apply signing or something i don't know like you get free books or something</p> <p>i: oh yeah for the baby</p> <p>p: i got free books</p> <p>i: better start imagine that one</p> <p>p: yeah every month i get a free book</p> <p>i: yeah i like that project</p> <p>p: one just came a swell today so i've got so many books now</p> <p>i: that's nice build a collection for baby</p> <p>p: thats only in this area to be honest cause i've got a sister in law in BD8 she was living in BD5 or somewhere and she goes i was getting in then and she moved to BD8 and there's nothing there (.) i think cause BD3 they need more help i think its more not a clean area</p>	<p>Earlier participant mentioned that she was depressed – does she view this as general depression and not postnatal depression – can this cloud judgement of health professionals or even of the self when seeking help? Would participant have been diagnosed with PND if she continued to go to the clinic apps? Whilst at the same time participant did not disclose such feelings due to fear of consequences baby being taken away</p>
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	<p>for kids and they give a lot more support to be honest but in BD8 i think they don't give much support to kids over there</p> <p>i: yeah i work on a few projects for Better Start as well so its only a couple of areas but it would be nice if it was for everyone</p> <p>p: exactly</p> <p>i: i think they might do that in the future (.) i think we're coming to the end of the interview now (.) do you have any questions for me or do you have anything else interesting to share?</p> <p>p: ummm i don't know obviously when you have a baby you be thinking like its your first and last now that's what i thought as well (.) my nurse goes to me (.) you're saying it now I'm going to see you here again in 2 years or 1/2/3 years i go don't worry you won't haha (.) then again i am pregnant again but it's not easy giving birth but once you have a girl or a boy you want the other gender as well so</p>	<p>Suggested the purpose of the clinic was to assess participants mental health – suggested as she repeatedly mentioned that she was feeling depressed this was reason for referral – did participant regret mentioning this?</p> <p>“I need to get out of this space” suggested that participant did not feel safe in the sense that she felt she would be labelled as being mental – complex situation, suggested that in participants case cure to depression was for husbands visa to get accepted – did she feel mental health support would not help her? What about helping her to cope better whilst husband was away? Did participant not think about this side? Was she simply thinking I am not depressed as such only because my husband is not here? Is this still depression though?</p>
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	<p>obviously I've got a girl now I want a boy as well (.)</p> <p>inshaAllah if I get a boy then inshaAllah inshaAllah that's it then two are enough</p> <p>i: so like your husbands here now (.) do you feel different that now</p> <p>p: yeah I feel more better now I feel normal cause he's here with me now like feels so good now (.) like last pregnancy was really different and everything (.) but now cause he's here with me alhamdulillah its really good (.) inshaAllah this pregnancy will be good (.) I can't even feel anything yet I think I'm 6 weeks pregnant now and what's it called I don't feel no sickness nothing I'm just normal (.) when I had [child] the way I found out I was pregnant obviously I was feeling a bit I had a bit of headache I used to feel a bit sickness obviously I checked and I was pregnant (.) this time I just checked out of the blue my period date went over 5 days I thought lets just check and I was pregnant (.) this time I checked cause of my period</p>	<p>Participant able to be open with HV – good and close relationship</p> <p>Mum and baby groups: not participants preference: - suggested she is an introvert and does not feel comfortable in a group of people, prevent from attending</p>
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	<p>date not because of my feelings this time I'm normal and i don't feel anything</p> <p>i: so when you came home when you were recovering so did a lot of people come to your house?</p> <p>p: yeah i had a lot of people like my mums side dads side and they come they give money that's the main part hahah literally [child] made £500 (.) out of all the people that came (.) they come and stuff some bring mithai and stuff some bring clothes the best one bring money hahaha</p> <p>i: how early did they start coming cause some people come as soon as you come home?</p> <p>p: soon as i came home there was one family already sat here haha</p> <p>i: haha before you came?</p> <p>p: yeah and then after that like say few days some people came and some people who not that close to them they came when [child] was 5 months</p>	<p>Cultural beliefs:</p> <p>- avoid going out when pregnant – suggested that some kind of evil eye, suggested if women who have had abortions or even wanting to get pregnant see you pregnant something bad may happen</p> <p>What is the purpose of the shower? Is this to maintain a pure state in terms of cleanliness and hygiene as recommended in Islam for example during prayers or after intercourse or after menstruation?</p> <p>Cultural beliefs on in-laws imposed onto participant – again does she feel compelled to observe this</p>
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	<p>i: oh okay</p> <p>p: then they remembered then they came and a lot of people came though</p> <p>i: how did you feel when a lot of people came quite suddenly like?</p> <p>p: yeah i don't know i used to feel uncomfortable cause i wasn't all fresh cause obviously i didn't have a bath yet cause in our thingy they say shouldn't have a bath (.) in hospital they say you should have a bath straight away don't they but i didn't have a bath there straight away i came home i think i had about after like a week cause they say same as your on periods cause we shouldn't be having a bath cause they say like you get fat and stuff so they didn't let me have bath so obviously i wasn't feeling fresh (.) i wasn't feeling fresh inside outside nowhere so i wanted like my family members more like once i felt fresh (.) but obviously they weren't going to wait for me they were like dying to see the baby and obviously when</p>	<p>as it is within the beliefs of her family members – does she also believe in this?</p> <p>Religious belief going out after sunset more vulnerable to evil spirits especially during certain times such as pregnancy, post-birth or menstruation</p> <p>Suggested this belief was inferred – lady went out at time when vulnerable and lost her unborn baby – cultural belief?</p> <p>Apparently death of unborn baby unexplained in medical terms – only explanation was in the form</p>
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	<p>everybody see's me now as well I'm only 21 i was 20 then wasn't i they see me and they like we can't believe it you're actually a mum (.) you don't even look like one anyway next thing is we remember when you were tiny playing outside and now we're going to see your daughter playing outside (.) the other day i was outside in the garden there was this little boy he was like 10/11 years old he said to me ohh are you playing with your sister (.) i go no she's my daughter he goes huh are you married i go no I'm not married but i've got a daughter haha he goes to his other friend oh my god this girl doesn't look married and she's got a baby as well (.) i go no its my daughter not my sister i haven't even got a sister (.) i get that a lot outside as well she's your sister i go no my daughter (.) but its good like if you're young and you have a baby get married i think its a good thing (.) i think its good age to get married when you're 18 to be honest cause you're young and then you (.)</p>	<p>of folk beliefs, cultural beliefs of evil eye etc</p> <p>Suggested that medical professionals do not believe in such cultural views – is relating to Pakistani-Muslim doctors too? Is this because they are trained from a medical perspective and not from cultural folk views on illness? Gap between the cultural and medical perspectives</p> <p>Participants mum also believes the same view and advised participant to avoid</p>
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	<p>now my daughters 9 months when she's going to be 20 or something I'm going to be 40 i think like we're all going to be young so i think that's a good age</p> <p>i: so was it your mum who suggested you get married young or was it mutual?</p> <p>p: my mum they seen this rishta and stuff like it was out of family totally and it was in Pakistan and they go he's a good guy</p> <p>i: and where do they live in Pakistan?</p> <p>p: we live in a village area they live in a city about 20/30 minute away from our house</p> <p>i: what city?</p> <p>p: Chakwaar near Islamabad</p> <p>i: yeah</p> <p>p: so what happened was my said there's this rishta in Pakistan and do you want to get married (.) i go i don't mind cause i said to my mum and dad that I'm going to get married wherever you lot say to me cause they know more better for me cause I'm one of</p>	<p>going out in crowded place as this may increase risk of something bad happening to mother and foetus</p> <p>Suggested that English people more open to having abortions – does this mean you are more likely to come across someone who has had an abortion even if you do not know it? Does this increase your perceived risk of harm?</p> <p>HV provided support for participant and signposted to relevant organisations</p>
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	<p>those people who can't go out and find somebody myself cause I'm a bit of those shy ones (.) cause if used to go to college and stuff there were guys with me i used to be so shy there were other girls who were talking to them i just couldn't talk to them (.) they used to all make fun of me like oh my god she doesn't even talk to us i go i don't mind if you don't make fun of me but i just can't talk to you guys like I'm a bit different (.) and then when i umm they told me about rishta and stuff and obviously my husband they told me about the guy and stuff they showed me pictures and he was quite tall and i go bloody hell he's so tall and im so short he's 6'2 and im 5'3 or something or 4 maybe not even 5'4 and he goes my dad goes look he's a good guy and obviously look he's got facebook and obviously us girls we do the full detective don't we literally fbi i went through all his facebook it was good clean no girls i was like you know what this guy is good (.) i go to</p>	<p>Participant part of Better Start Bradford area so eligible for free book scheme for child</p>
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	<p>my dad okay i go to him he goes to him i'll give you 1/2 weeks you can decide whatever like then i said okay that's fine (.) then we spoke 6 months on call and stuff got to know each other (.) was happy and stuff and got married after 6 months of knowing each other (.) i was 18 the when i got married then i came back after (.) obviously i had job in London i was working</p> <p>i: oh in London (.) oh wow what did you do there?</p> <p>p: it was like you know like when you do functions and parties and stuff doing all those you know sorting out everything like (.) if there's a function in someone's house or hall</p> <p>i: ohhh like event planner</p> <p>p: yeah event planning yeah (.) then obviously then i now I've stopped (.) when i was pregnant i stopped half way cause i literally couldn't be arsed cause i was already upset and stuff i was like you know what i can't do this</p>	<p>Participant suggests the area she is living in is considered deprived as it is part of Better Start – finds the schemes really helpful</p> <p>Participant emphasises how hard it is to be pregnant and give birth – to the extent where you naturally might feel 'never again' – but a desire to have a girl and boy led to another pregnancy</p> <p>Suggested 2 children are more than enough – smaller families for new gen more common</p> <p>Current pregnancy – husband present this time</p> <p>"now I feel normal" – suggested without husband participant did not feel 'normal' – in her words she</p>
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	<p>i: so were you alone in London or?</p> <p>p: no my dads cousin i used to live with him (.) but obviously i used to come here as well holidays and stuff saturday sunday but other than that (.) yeah then got married and stuff</p> <p>i: and is he a little older or same age?</p> <p>p: no he's 25 and im 21 now so only like 4/5 years difference (.) but he looks a bit more older cause he's got height mashaAllah he's really tall and I'm really short so umm (.) in Pakistan i used to always wear heels with him so i look a bit taller but here i can't be arsed to wear heels you know what forget heels (.) if I'm going to live with him forever inshaAllah i can't always wear heel now can i (.) you know what i prefer plain i don't care if i look shorter with him (.) when we are with our daughter outside we look more like a family when like im with him alone we don't look like husband and wife we look like something else cause I'm too short (.)</p>	<p>felt stressed and depressed first time round – a different experience this time round</p> <p>Suggested husband's presence makes participant feel she is not going through this pregnancy alone – it is part of both of them, suggests husbands more likely to understand her feelings such as low mood or pains</p> <p>A lot of guests post-birth, suggested this was nice as participant got a lot of money and gifts – shows love and care for mother</p>
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	<p>obviously we prefer going out with [child] cause we look more like a family (.) but yeah my mum and dad they made a good decision to be honest im happy they got me married there cause you can't find good guys here to be honest (.) its not easy to find especially in this area Bradford you can't find good guys (.) but yeah its a good thing i got married there it took 2 years for him to get visa (.) first time got refused 2nd time got it (.) he's just been here for 4 months recently he come (.) so we got his visa after 2 years</p> <p>i: wow (.) and how is he finding it here?</p> <p>p: he's finding it okay only think he misses in Pakistan is his mum and dad (.) other than that he likes it here (.) who doesn't like it here haha</p> <p>i: hahah (.) so thank you so much for participating its been really really interesting talking to you (.) do you have any questions for me?</p> <p>p: no its just the question about the recording are you going to</p>	<p>and child, community feeling</p> <p>Suggested close family and friends came as soon as baby was born – some even before mum had arrived home – how did participant feel with this sudden influx of guests?</p>
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	<p>delete the recording cause I'm a bit of a person I don't want it to go wide</p> <p>i: yeah no no no (.) it does get deleted but it's all stored confidential and in a secure place so where i store it it's all in the hospital servers so it's all protected it's not stored on any personal laptops so it won't get hacked or anything like that and then it will get deleted and then when i type it up i won't include any names it'll just be all anonymous</p> <p>p: yeah that's fine</p> <p>i: that okay?</p> <p>p: that's fine (.) cause with me I don't want anyone to know its me</p> <p>i: yeah nonono (.) so again with so when i put it in my work its not like it'll have the whole interview</p> <p>p: yeah main main points</p> <p>i: cause I'm interviewing quite a few women so it'll just be like a sentence and even then it won't be identifiable</p> <p>p: right right (.) like I've seen it on those magazines theres</p>	<p>Cultural practice: now allowed to bathe straight after having baby "they didn't let me" – again something which was imposed onto participant unclear whether she believes in these things and perceived protective effects</p> <p>No shower – uncomfortable, not really in a state to see guests but no choice</p> <p>Suggested that participant enjoys the idea of being a young mother – to grow up with your child when you are young mum seen as a good thing</p>
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	<p>somebody saying one thing but some people have their names there so will my name be written in there?</p> <p>i: no no no no usually those are magazine articles (.) no in research its totally anonymous and I'll also give you a false name so if i do put names it will be a fake name it won't be (.) so everyone will get a pesudonym and then i can send you the results as well i think you ticked you'd like the results</p> <p>p: yeah yeah yeah</p> <p>i: okay thank you so much</p> <p>*END OF RECORDING*</p>	<p>Arranged marriage by family – with someone who is outside of the family, not related to participant or her family in any way</p>
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		<p>Suggested participant wanted an arranged marriage as she felt she was unable to find her own partner due to her shyness</p> <p>Got to know each for 6 months then got married</p>
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		<p>Participant used to work in London</p> <p>Worked as event planner in London</p> <p>Suggested participant could not concentrate on work during pregnancy and husband being away – took its toll – left work</p>
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		<p>Suggested participant is happy in her marriage</p> <p>Participant trusts parents' judgement</p> <p>Suggested husband likes it in England</p>
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		<p>Participant enquires about recording and confidentiality</p> <p>Participant expresses concerns around anonymity</p>
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Appendix 12: Sample dialogical analysis

Transcript	Dialogical analysis
<p>Extract 7</p> <p><i>“Saifah: how I went, I was shouting at everyone all the time. I was screaming arguing over little, little</i></p>	<p>Internal criticism, internal confrontation based on experiencing mood changes</p>

<p><i>things with everyone. So, I was like that for quite a long time, for 1.5 years I was like that. I was just really, really, I mean I knew it myself sometimes that I've gone like that. Shouting and you know always arguing with everyone all the time. My mums there explaining to me and I used to just start crying at that time, you know when my mum used to tell me off or whilst arguing with my mum or getting into an argument with anybody. I used to start crying about it as well, that maybe I am wrong but then I don't know whether it was my heart or my mind telling me that "no, I'm not wrong, I'm not wrong". You know "you lot are all wrong, everybody is wrong". But I'm like, it was actually the worse experience ever to be honest. And then I don't know, it was just all of a sudden that I came back out of it again. I went back to normal again"</i></p> <p>page 19-20</p>	<p>Engaging in various I-positions (internal dialogue) to make sense of experiences</p> <p>Absent others, imagined others (family members)</p> <p>Voice of own mother coming from the outside-in : acts as a sore-spot</p>
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