A Qualitative Study Exploring Migrant Pakistani-Muslim Women's Lived Experiences and Understanding of Postnatal Depression

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ABSTRACT

An array of literature suggests that "postnatal depression" is particularly high among Black and Minority Ethnicities, migrant women, those from non-English-speaking backgrounds, and South Asian women.

Studies which have been conducted in this field, tend to be from a quantitative stance, not taking much account for individual experiences. Qualitative research which has been conducted tends to place women from South Asian communities into one group which ignores the existing diversities within South Asian communities. As a result, the experiences of migrant Pakistani-Muslim women within the context of maternal distress have been largely overlooked.

This research tries to address this gap by attempting to gain a rich understanding of migrant Pakistani-Muslim women's experiences of postnatal depression within motherhood. The research hopes to inform clinical practice and suggests ways of improving supportive services for this group of migrant women.

A qualitative approach was used to interview four migrant Pakistani-Muslim women in London aged: 27-39 who subjectively experienced depression during the postnatal period in motherhood. The interview transcripts were analysed based on the principles of interpretative phenomenological analysis.

Six main themes emerged from the data: 'experiencing transitions', 'the experience of significant relationships', 'the body and motherhood', living with postnatal distress', the experience and perception of Pakistani culture' and 'patchy provision of "good" healthcare'.

The research findings illustrate that migrant Pakistani-Muslim women's experiences of postnatal depression maybe complex and seem to be a combined product of psychosocial, cultural and physiological issues and stressors.

This study highlights the importance of support for migrant Pakistani-Muslim women and how healthcare services could improve to meet their needs, which may ultimately reduce or prevent experiences of maternal distress.

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Table of Abbreviations

BME	Black and Minority Ethnicity
CGT	Constructivist Grounded Theory
CLS	Centre for Longitudinal Studies
CVD	Cardio Vascular Diseases
DA	Discourse Analysis
DH	Department of Health
DSM-V	5th edition of the Diagnostic & Statistical Manual
EPDS	Edinburgh Postnatal Depression Scale
GT	Grounded Theory
HV	Health Visitor(s)
IOE	Institute of Education
IPA	Interpretative Phenomenological Analysis

ICD-10	10th revision of the International Statistical Classification of Diseases and Related Health Problems
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NICU	Neonatal Intensive Care Unit
ONS	Office for National Statistics
PND	Postnatal Depression
PTSD	Post-traumatic Stress Disorder
RCPSYCH	The Royal College of Psychiatrists
TUC	Trade Unions Congress
WHO	World Health Organisation

Glossary of Terms

Caesarean-Section: Major surgery where a surgeon makes a cut through a woman's stomach and uterus to help the baby be born. Elective means the operation is planned in advance so the woman does not experience labour. Emergency means an unplanned caesarean which may be decided just before or during labour when natural delivery may not be possible due to health reasons.

Doula: A woman who provides physical and emotional support to a woman and her family before, during and after childbirth

Infant's Adaptive Behaviour: Ability of an infant to learn, adapt and manage their surroundings and function effectively

Lactogenesis: The onset of milk secretion in females

Multi-parous/parity: Having birthed more than one child

Perinatal death: Death of a foetus

Perinatal period: The time-period immediately before and after childbirth

Pre-eclampsia: A condition during pregnancy where a woman develops high blood pressure

CHAPTER ONE

INTRODUCTION

1.1 Origins of this Study

My personal interest in this research resulted from various factors. My first clinical supervisor headed a unique service in London which provided psychological support to parents. Hearing about her service inspired a natural interest in the topic of motherhood. Reading around the topic served to fuel my interest and I began to be absorbed by many of the ideas. However, as I reflected during the years of conducting this research I realised that motherhood has always fascinated me, be it the nature of pregnancy, the notion of holding a child through one's body or with one's arms. In addition the diversity of this experience, the immense changes, the many challenges, difficulties and often sacrifices that some women make as part of fulfilling their role of motherhood served to fascinate me. Thus it seemed fitting to study this intriguing subject further.

1.2 Objective of this Research

The objective of this research was to explore migrant Pakistani-Muslim women's lived experiences and understanding of depressed feelings in the postnatal period. In carrying out interviews with women and asking them about their lived experiences of the phenomenon, the aim was to understand how women who subjectively expressed encountering depression, experienced and interpreted the postnatal period. For this reason, the aim was to conduct research using IPA methodology, which consisted of research questions that aimed to elicit rich exploratory data. It was hoped that such a qualitative study would ascertain an understanding of how the postnatal period was experienced by women with maternal depression. Being from Pakistan-Muslim women's personal accounts, it was hoped the research would highlight new insights and perspectives valuable not only to counselling psychology but also to other disciplines and professionals interested in maternal health.

1.3 Research Rationale

This research topic is critical to the discipline of counselling psychology as well as other professions interested in maternal psychological health, as there is a paucity of research specifically exploring migrant Pakistani-Muslim women's experiences of distress and depression in the postnatal period. The discussion presented below aims to highlight some of the issues within the Pakistani female community (including migrants), as well as the wider South Asian community.

1.4 Statistics on Migration

Britain is immersed in an international community and counselling psychologists have a duty to "be able to draw upon sociological insights relating to the social characteristics of clients and to develop a detailed knowledge about client populations" (Strawbridge and Woolfe, 1996; p.605).

Over 12% of UK residents are born abroad (ONS, 2013) and Pakistan seems to be one of the main countries of birth (Rienzo and Vargas-Silva, 2013), reflecting the steady growth of the Pakistani population in the UK. However, like the rest of the female migrant population (Rienzo and Vargas-Silva, 2013) the migrant Pakistani female population is continually growing, most probably due to Pakistani men often choosing to marry from "back home" (Dale, 2008).

1.5 Statistics on Maternal Depression

Cumulative research in the UK as well as internationally has demonstrated that PND is considered to effect 10-15% of women within the general population (National Mental Health Development Unit, 2011; 4Children, 2011; Chew-Graham et al., 2009; Patel, Rodrigues and DeSouza, 2002; Chandran et al., 2002; Jomeen, 2004; Green, Broome and Mirabella, 2006; O'Hara and Swain, 1996). However, Pakistani women in the UK have been identified with a higher prevalence of PND (22.6%) than their White

counterparts (Husain et al., 2012), which echoes the soaring rates of PND identified in Pakistan (63.3%), compared to all other Asian countries (Klainin and Arthur, 2009).

Generally, national and international research statistics suggest that migrant women demonstrate an increased risk for PND (Stewart et al., 2008; Zelkowitz et al., 2004; Zelkowitz et al., 2008), especially those from non-English speaking backgrounds (NESB) and from South Asian backgrounds (Onozawa et al., 2003). Common mental health problems, such as depression, have been found at high levels not just in the migrant population within the UK (Nazroo, 1997; cited in Hussain and Cochrane, 2002), but specifically within the Pakistani female community (Gater et al., 2009[1]; Weich et al., 2004; Cochrane and Stopes-Roe, 1981, cited in Hussain and Cochrane, 2002).

1.6 Psychosocial and Socioeconomic Issues within South Asian and Muslim Communities

Research in England has shown reports of Muslim, and particularly Pakistani women, facing high socio-economic disadvantages[2], lack of education, high contact with maternity wards due to one of the highest childbirth rates, no antenatal care[3], increased perinatal and infant mortality risks, institutional racism within the NHS (The Maternity Alliance[4], 2004; The Change Institute, 2009; ONS, 2014; Dale, 2008; Schott and Henley, 1996; Squire, 2003, Jayaweera, 2011; Cross-Sudworth, Williams and Herron-Marx, 2011) and high suicide rates as part of the wider South Asian female population (Bhugra, 2002; Hicks and Bhugra, 2003; Tuck et al., 2011; Merril and Owens 1986[5]).

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[1] majority of this sample were migrants

[2] The Pakistani community has high unemployment rates, high economic inactivity, low education and low economic activity among women (The Change Institute, 2009; *TUC.org.uk, 2006; CLS: IOE, 2010; The UK Poverty Site, 2011)*

[3] A risk factor for maternal mortality (Lewis, 2007)

[4] Now known as Maternity Action

[5] The research sample contained UK born as well as women born in the Indian subcontinent, which dilutes cultural differences

1.7 PND, Suicide and South Asian Women

PND is considered a risk for suicide and suicide, in turn, has been identified as the leading cause of maternal deaths (Lewis, 2007; Oates, 2003). Suicide rates are found to be high among South Asian women, especially in India (Patel et al., 2012) and whilst it is underreported, suicide is viewed as a growing concern in Pakistan too (Khan, Ahmed and Khan, 2009; Khan and Reza, 2000[6]). UK statistics show that rates of suicide are two to three times higher in South Asian women than their White counterparts (Bhugra, 2002; Hicks and Bhugra, 2003; Tuck et al., 2011; Merril and Owens 1986).

If suicide has been identified as a concern within the maternal, as well as the female South Asian population, counselling psychologists would do well to attribute attention and focus onto the psychological wellbeing of migrant Pakistani-Muslim women in the postnatal period. Especially in light of evidence showing low-uptake of mental health services by the Pakistani community (Rethink, 2007), there is a need to understand those women who subjectively encounter postnatal misery and may/may not approach healthcare services.

1.8 Key Differences Between the South Asian Communities

Whilst people from South Asian cultures do have overlapping similarities and often get pooled together and studied, there are marked differences between the cultures that originate from South Asian countries and specifically the Indian Subcontinent. These differences cannot and should not be ignored. Language, dialect, cuisine, diet, attire, physical appearance, religious beliefs and practice can all vary enormously between people of Indian, Pakistani, Bangladeshi and Sri Lankan ethnicities. In addition, the level of political democracy, freedom of speech (or lack of), civil rights, civil unrest, human rights, independence, education, employment opportunities, economy and gender attitudes are all issues deeply entangled in the lifestyle and culture of each of the

[6] In the absence of accurate data and information, the researchers utilised 2-years worth of newspaper reports where incidents of suicide are - rather interestingly - frequently reported

South Asian countries, which all have an impact on individual lives of people from these nations. The issue of suicide will be considered as an example of this. The high suicide rates found among women of Indian ethnicity, seems to be a result of powerlessness and depression (Thompson and Bhugra, 2000). However, questions have been raised as to whether the psychology behind suicide attempts among Indian women may be enmeshed in religious factors, especially when we consider the excessive rates of suicide by burning among Indian women. In Hinduism (the predominant religion in India), self-immolation [*sati* practice as known in the Hindu religion], where a widowed woman kills herself by placing her body on the funeral pyre of her dead husband was common practice in India until 1861, when the practice was banned by Queen Victoria during the British Raj. Bhugra (2005) denotes that this was a type of ritual suicide developed and is embedded within the religion and culture of Hindu people of India and specifically for the women of the culture. The *Sati* act was considered a mark of a "good wife" (Bhugra, 2005; p.26). Bhugra states that rather than suicide being purely due to "mental illness", the act of self-immolation practice even in modern times may be rooted in historical and cultural contexts for Indian women.

In contrast, the Islamic religion prohibits any form of suicide, which may be why it is underreported in Pakistan. However rates of suicide are rising and a cause for concern (Khan and Reza, 2000). Ineichen (2008) reported that lower rates of suicide among Muslim people compared with Hindu people could be due to the religious differences, which may go unseen. He goes on to say that the different rates of suicide between the two religious groups could reflect the different attitudes to suicide in the two religions. The issue of suicide discussed here in regards to the different South Asian communities is an example of the deep seated differences that manifest in certain behaviours, choices and actions.

Jejeebhoy and Sathar (2001) discussed the influence of religion and region on the autonomy of Pakistani and Indian women. They found that rather than the religious background, it was the regions which women come from that had an impact on the level of freedom autonomy that women of South Asian origin had. This epitomises the importance of studying South Asian women from within their distinctive country and area of origin rather than being studied as part of the South Asian continent. For

example, Jejeebhoy and Sathar (2001) found that women from Southern part of India (Tamil Nadu) had significantly more decision-making power, "mobility and access to and control over resources than women from" the northern province of the country (Uttar Pradesh) and Punjab in Pakistan. It is possible then that the culture and lifestyle of certain regions can influence women's actions, behaviour, thoughts, emotions, decision-making abilities and choices. Thus a South Indian woman, Punjabi woman and/or a Pakistani woman who migrates to the UK will ultimately be psychologically influenced by the cultural, social and political forces of a country and region that she has grown up in. In addition, the family who she moves in with after marriage (husband, or also in-laws), will also be psychologically influenced by their own cultural background and country of origin background. In terms of education, Pakistan demonstrates a much lower adult literacy rate than India and Bangladesh, and women in Pakistan particularly have a lower literacy rate than the other neighbouring countries (Nationmaster.com, 2012; UNICEF, 2013; Latif, n.d.). This is important to think about as access to education, and educational achievements has been linked to psychological well-being, positive social identity, better health, higher social trust, increased political interest and lower political cynicism (Economic and Social Research Council, 2014). Education also has implications for employment opportunities and economic stability, so this is an important issue to consider. The lower literacy levels found among women in Pakistan (and the wider population generally) may explain the persistent PND identified among mothers in Pakistan, where poverty and education were implicated as factors in PND (Rahman and Creed, 2007). If we were to think more specifically in terms of motherhood, then clear differences in culture and society pervade through South Asian women's lives. Firstly, sex-selection during pregnancy is extensive in India and women are often forced or persuaded to abort a female foetus or worst - a newborn baby girl is killed (Niaz and Hassan, 2006). In Pakistan, such practices are considered less common, but women are plagued with pregnancy after pregnancy in the hope of producing a boy who can continue the blood lineage of the family. This pressure to keep reproducing is often from family and particularly mother-in-law's (Niaz and Hassan, 2006). This may explain the high childbirth rate among Pakistani women in the UK too.

1.9 The Need to Study Migrant Women and Motherhood

The Health Protection Agency (HPA, 2011), states that the healthcare needs of the migrant population might demonstrate more complexities than UK-born residents. These complexities can be influenced by "the burden of disease and living conditions in their country of origin, experiences during migration, their circumstances in the UK, as well as factors relating to ethnicity and cultural practices" (p.4). The agency highlight that meeting the healthcare needs of migrant populations residing in the UK is imperative for individual as well as public health reasons. These needs cannot be met of a continually flowing migrant group such as Pakistani-Muslim women, unless there is an exploration of their circumstances during times like the postnatal period; where a high prevalence of maternal misery (PND) maybe concerned (Husain et al., 2012).

Barclay and Kent (1998) have argued that migrant women, especially those from non-English speaking backgrounds (like Pakistani women) are often faced with two major transitions migration and motherhood, which produces an array of difficult psychological issues individually, let alone simultaneously. This is a complex issue which has generated interest amongst scholars (Helman, 2003; Kitzinger, 2000) yet has received mainly quantitative research attention both worldwide in relation to migrant mothers (Stewart et al., 2008; Zelkowitz et al., 2008) and in the UK (Onozawa et al., 2003). In addition where quantitative and/or qualitative research has been conducted nationally or internationally in regards to PND, the specific psychosocial issues for Pakistani women[7] have been diluted as women from South Asian or Muslim communities are often pooled together and studied as one group, discounting cultural differences between the women's individual cultures within those communities (Onozawa et al., 2003; Wittkowski et al., 2011; Nahas, Hillege & Amasheh, 1999). This lack of focus on differences even extends to generations; for example, there is only one quantitative study examining PND rates amongst Pakistani-Muslim women in the UK

[7] As well as Bangladeshi and Indian women

(Husain et al., 2012), which is distorted to some degree due to the samples inclusion of first and second generation Pakistani-Muslim women, which have large differences.

This particular topic merits focus from an IPA perspective, which would provide health professionals with understanding of [solely] migrant Pakistani-Muslim women's individual lived experience of distress in the postnatal period, of which there is a paucity of research. Ashworth (2008) says that the most valuable way to attain this is to "return to the things themselves, as experienced" (p.11) by making sense of other people's perceptions of that phenomenon (PND), in effect being "hermeneutic" – "a process of interpretative activity" (Smith and Osborn, 2008; p.53). Such a research approach is imperative within this topic as it aims to provide psychological understanding of the women's experiences and their own understanding of that experience. Such a qualitative approach will not only provide fresh insights, but it is also embedded in the day-to-day therapeutic practice of a counselling psychologist.

1.10 The Wider Impact of PND

There is a general consensus that PND has a vast impact on a woman's health and wellbeing, the child's development and the wider family as a whole (Tsivos et al., 2011). Research has identified that husbands can suffer with PND too (Davey, Dziurawiec and O'Brien-Malone, 2006; Deater-Deckard et al., 1998) and maternal depression can place a huge strain on a couple's relationship. This latter issue was identified in a single-case study with a migrant Pakistani woman in Malaysia (Khan et al., 2009).

Maternal depression can impair the maternal-infant attachment and thus impact upon the baby's wellbeing (Herrera, Reissland & Shepherd, 2004; Meredith and Noller 2003). Cross-cultural research illustrates that damaged maternal-infant attachment is linked to developmental, physiological and psychological difficulties for the child in early years as well as later life (Cornish et al., 2005; Hay, 2005; McMahon et al., 2005; Manning and Gregoire, 2006; Adewuya et al., 2008; Milgrom, Westley & Gemmill, 2004; Patel,

DeSouza & Rodrigues, 2003). Amongst, first and second-generation Pakistani women in the UK, perinatal depression has been associated with parent-reported problems in the infant's adaptive behaviour (Husain et al., 2012). Such a study highlights the impact that maternal depression, specifically within the Pakistani community, can have on the wider development (not just physiological) of infants, who are ultimately part of the future generation of the UK.

McLaren et al., (2007) conducted a longitudinal study and found that women who received the lowest level of maternal care in their early childhood from their mothers who were experiencing PND, and who had been separated from them beyond 3.5 days, had more than double the risk of PND in their adult years. This shows that by focussing on maternal depression as an important area of research, psychologists may overthrow potential future psychological problems in generations to come, making maternal depression a case of critical early intervention.

1.11 Impact of PND on the Woman

Aside from the intense emotional anguish and risk of suicide, similar to general depression, PND can effect a woman's physical health, (PANDA.org.au, 2014). Depression can lead to changes in diet, sleeping patterns and amount of activity, which is normally expected as part of caring for a baby, but these things can also occur through the experience of maternal misery (PANDA.org.au, 2014).

The consequences of depression can include heightened stress-hormones in the body which can weaken the immune system (Webmd.com, 2014), bodily aches and pains[8], breathing difficulties, longer-term mental health issues (PANDA.org.au, 2014) and major illnesses such as cardio vascular diseases (CVD). Postpartum depressed women have shown elevated cholesterol levels (a risk for CVD), which implicates PND as a risk factor for heart issues (Prairie et al., 2012).

[8] Pain diseases are known to be of high levels within the South Asian female community and specifically also within the Pakistani community (Hameed and Gibson, 1997)

This is important as the risk of CVD is particularly high for Pakistani women (Jafar et al., 2005), reflecting the general high mortality risk of heart diseases in the Pakistani as well as the wider South Asian community (Bhf.org.uk, n.d.).

The impact of maternal misery on a woman's physical health creates a further burden of disease on the woman, her family and for the healthcare system; therefore, illustrating the need for early intervention in managing PND by learning about women's needs. Such intervention begins with this kind of research.

1.12 Migrant Pakistani-Muslim Women: "A Hard-to-Reach Group"

The lack of research in this topic area, may be due to the fact that being part of a Black and Minority Ethnicity (BME) community and not having English as a first language makes migrant Pakistani women a "hard-to-reach" group (DH, 2012). Language, the inexistence of words such as "depression" in various South Asian languages (Central Office of Information, 2009) and even family members can act as barriers to disclosure of problems and accessing help (Almond, 2013). Based on such issues, it seemed that migrant Pakistani women may not readily access service support (Rethink, 2007), which in turn suggested difficulties in engaging this client group for research purposes too. However, these hard-to-reach groups are the ones that health professionals need to target, especially where numerous psychosocial issues may be of concern. A lack of understanding of migrant Pakistani-Muslim women's maternal psychological health may allow devastating effects to unfold on the mother, the baby, the family and thus the wider society.

1.13 The Importance of Subjective Experience

This study is exploring the subjective lived experience of PND. It is distinct, as whilst other qualitative approaches have explored PND by carrying out interviews, the thread of subjectivity has not been sown through their research as objective screening tools (e.g. EPDS) have been used to screen for PND and only those indicating "clinical depression" through such instruments have been included to participate. This includes research related to South Asian women (Wittkowski et al., 2011; Templeton et al.,

2003). This brings into question: is misery, distress, or sadness only acknowledged and real, if it is objectively measured and/or observed? What about women, of say, Pakistani origin, who do not seek help, access services or disclose their misery openly? We are forced to question, what their experiences are and how they may be slipping – in effect - through the net. By examining women who express subjective experience of PND, rather than researching women who are measured objectively for PND (through screening tools), the research is honouring the underpinnings of qualitative research which holds subjective experience and subjectivity as a central feature in generating knowledge of a particular phenomena.

1.14 Problem with the Reification of Clinical Disorders - "Postnatal Depression"

Viewing female human experience in the context of clinical disorders can be reductionist and fails to take into account the individual's subjective meaning (Ussher, 2010; De Souza, 2004). This reductionist approach is based on medical naturalism, which would treat PND "as a real entity that exists independent of perception, language or culture" (Ussher, 2010; p.10). This can be problematic and many feminists' have argued that clinical disorders, such as PND, are socially constructed[9] (Burr and Chapman, 2004; Lewis and Nicolson, 1998; Nicolson, 1998; De Souza, 2004; Ussher, 2010). Therefore, when exploring the experiences of mothers, (which often involves utilisation of a clinical sample in research), the postnatal period is often defined through clinical lenses, which suggests reification of a pathologised concept. Yet, through the array and infinite facets of one's personal and socio-cultural background and history and through one's own perceptive qualities, a woman can give voice to what she feels and thinks she is experiencing and this is something that research needs to return to investigating. This may especially be important for mothers' from migrant backgrounds and cultures that are distinct from Western society. For such women, the term PND could be alien, damaging or stigmatising (Gask et al., 2011). However, it could just as easily be valuable – a helpful and knowledgeable description which explains what they

[9] See Appendix 1

are going through. In line with this, Nicolson (1998) voiced the need for more of a discussion on "understanding women's experience" (p.45). There can be no denial that social forces, language, powerful discourses and often patriarchal societies mediate women's experiences and can position women to belong to an illness narrative; however, one must not negate the reality of experiences, which may well encompass challenges, unhappiness and misery. It is hoped that this research will provide a focus on migrant Pakistani women's interpretation of reality and their psychological meaning of the lived experience of PND, which may then aid health professionals in providing support.

1.15 Rationale for a Critical Realist Position

Pilgrim and Bentall (1999) show that between the fierce and opposing camps of positivism and social constructionism, the middle position of critical realism is situated usefully as it values reality of experiences without falling into one end known as positivism, rooted in naive realism or the polar opposite end of social constructionism or relativism. This latter position particularly, questions the existence of any reality, due to the notion that whatever people think they feel is ultimately shaped and influenced by their cultural environment, social forces and powerful discourses. This position would implicate that PND is culturally sanctioned and circulated through Western medicalised discourses. However, in other cultures women are unlikely to attribute psychological distress to biological, hormonal or emotional disorders and consequently do not position the normally occurring, transitional difficulties and challenging experiences after childbirth as a pathological entity (Ussher, 2010).

It seems that issues of distress are either positioned as a discursive construct or positioned as a medico-psychological pathology resting in the individual. A critical realist epistemological position on the other hand allows one to acknowledge the realness of women's experiences, which may involve distress and misery and it also takes on board its social, psychological and biological facets. At the same time, as

Ussher (2010) describes, critical realism takes on board "the socio-cultural context within which women's misery is constructed and experienced as depression" (p. 16).
If this research was to be conducted from a full social constructionist perspective, it would beg the challenging question of how empowering or beneficial this research would be to women, if the reality of their experiences (of misery) are negated and attributed to wider socio-cultural issues and powerful discourses.

1.16 Contribution to Counselling Psychology

Although very little research has been conducted from a phenomenological perspective, that which has been carried out, has been conducted in other nations and/or minority ethnic groups (Nahas, Hillege and Amasheh, 1999; Rolls and Chamberlain, 2004; both studies conducted in Australia).
That being said, previous research findings must not be negated as they have provided valuable insights from which this research has raised questions. However, PND may helpfully be understood from an interpretative-phenomenological account of migrant Pakistani-Muslim women, by listening to their lived experiences. Listening to lived experiences is in itself part of the day-to-day practice of counselling psychologists. By conducting the research in this way, not only may it make an original methodological contribution in terms of the way maternal psychological health is studied, but it follows the basic principles of counselling psychology by promoting human experience, values and beliefs as most significant (the Division of Counselling Psychology, n.d).

Eleftheriadou (2010) contends that the cross-cultural counselling psychology field as a whole seems to have generated less research than other areas of psychology, which shows it is in need of attention. Eleftheriadou (2010) extends the earlier views of Strawbridge and Woolfe (1996) by stating that in this day and age, we are part of a diverse culture and immersed in an "international community" (p.197). Therefore cross-cultural issues will almost always permeate our lives and be a critical part of our therapeutic work. It is hoped that the outcome of this research will facilitate counselling

psychologists' professional duties and responsibilities by informing their therapeutic practice of working with female clients who are migrant Pakistani-Muslims.

1.17 Statement of Research Questions

The following central research questions were formulated through engagement with literature in the field of motherhood, how do migrant Pakistani-Muslim women experience depression during the postnatal period? How do the women with a subjective account of PND experience motherhood in the postnatal period? And, how do these women perceive their experience of support in motherhood during the postnatal period?

1.18 Reflexivity

It is impossible to remain outside of one's subject matter whilst carrying out research, which may ultimately influence the psychological knowledge produced (Willig, 2001).

Whilst the objective of this particular research was to explore migrant Pakistani-Muslim women's lived experiences and understanding of PND, I am aware that my pre-existing views, beliefs and understanding of this subject would have undoubtedly impacted the research, including its philosophical foundations, analysis, findings and conclusions.

As part of remaining reflexive, it was important for me to explicitly reflect on my background here.

I am a 31-year-old, married, British-Indian female. I was raised in a large Indian family in a southern county of England. For the last 5-years my professional experience has been mainly within psychology services in the NHS. My theoretical position was informed by my training in counselling psychology and my professional experience in my day-to-day work as a therapist. My clinical practice encompasses an integrative psychotherapy approach utilising a psychodynamic base with cognitive-behavioural techniques.

As a therapist, I have felt clients being active social, emotive and cognitive agents consciously and/or unconsciously interpreting their [often painful] life experiences, which have been valued as "real" by me. This in turn creates real empathy in the therapeutic engagement between the client and myself as their therapist. This background of personal and professional experiences have moved me to favour a thick critical realist ontological base underpinning hermeneutic phenomenology, with a thin social constructionist perspective.

Being from a South Asian ethnicity, I am aware of being from a similar - although not identical - cultural background as the women who have participated in this research. My cultural background may have provided me with certain ideas, beliefs and assumptions that naturally informed my research practice.

CHAPTER TWO

LITERATURE REVIEW

The literature review selected for this study is based on the most relevant research, which is embedded in the wider context of maternal psychological health.

2.1 Overview of Postnatal Depression

Postnatal depression (PND) is considered to be a form of non-psychotic maternal depression which occurs after childbirth. The Royal College of Psychiatrists (RCPSYCH) say: "PND is a depressive illness which affects between 10-15 in every 100 women having a baby. The symptoms are similar to those in depression at other times. These include low mood and other symptoms lasting at least two weeks. Depending on the severity, you may struggle to look after yourself and your baby. You may find simple tasks difficult to manage" (Rcpsych.ac.uk, 2014).

The diagnosis tends to be characterised by a host of symptoms, including: sadness, hopelessness, low self-esteem, guilt, feeling overwhelmed, changes in sleep and appetite, inability to be comforted, exhaustion, emptiness, loss of pleasure in activities, being socially withdrawn, lacking energy, becoming easily frustrated, feeling inadequate in taking care of the baby, impaired speech and writing, angry outbursts towards others, increased anxiety or panic attacks and a decrease in libido (Rcpsych.ac.uk, 2014; NHS.uk, 2012; Willacy 2014).

2.2 Diagnostic Criterion and Discrepancies in the Classification of PND

The ICD-10 suggests that PND is one of a group of maternal mental disorders and tends to occur 6-weeks after childbirth. Whereas the DSM-V considers PND to be a major depressive disorder that can occur during pregnancy or in the 4-weeks after delivery (Postpartum.net, 2014). Still some health professionals and clinicians state that PND can occur at 3 months, up to 6 months, anytime in the first year, or even persist for up to

four-years following childbirth (National Mental Health Development Unit, 2011, Schott and Henley, 1996; Kumar and Robson, 1984). There are discrepancies regarding the onset of this "mental health disorder", which raises questions about the whole diagnostic criteria that the medical system utilises. One could argue that this personal human experience is decided as normal/abnormal or pathological by the powerful medical healthcare system and yet the "objective" guidelines they draw on are themselves lacking in clarity and consensus. In addition these manuals are formulated and located within a Western culture. Based on such realisations, this study's participation criteria focussed on women voicing that they themselves felt depressed after having a baby, rather than including participants objectively perceived and measured to have PND according to a diagnostic-criteria utilised within the healthcare system.

In the UK, NICE (2007)[10] state that PND should be detected during the woman's first contact with primary care, at her booking visit and during the postnatal period, which can be 4-6 weeks and 3-4 months. Clinical assessment for PND tends to be done by a Health visitor (HV) who will usually utilise a screening tool such as the EPDS (Hill, 2010), which has been validated for use amongst women of Pakistani origin living in Britain (Husain et al., 2014).

Robertson, Celasun and Stewart (2003) state (and many clinicians follow this as a general practice) that PND usually occurs somewhere between 1-12 months following childbirth. As this seems to be a general consensus in practice, it seemed appropriate for this particular research to focus on women who experienced depression within the first-year following delivery.

2.3 The Postnatal Period

[10] Updated in 2014

Be it the first child or one of many, childbirth and the postnatal period involves major transitions physically, emotionally, relationally, socially and overall in life.

NICE[11] (2012) state that a woman who has experienced a normal vaginal delivery is likely to stay on the postnatal ward for an average of 1-2 days. However, in practice women may be sent home within 6-24 hours after delivery unless there are health or birth-related complications (uclh.nhs.uk, n.d.; Dufficy, 2014). Alternatively, with a caesarean, NICE guidelines (2012) state that the hospital stay may be 3-4 days (Dufficy, 2014). Schott and Henley, (1996) state that a period of rest and recuperation following the gruelling demands of childbirth seems to have become something of the past in Western society, as an increasing number of women are encouraged to be up and about and caring for their baby.

Eberhard-Gran et al., (2010) suggest that across cultures, the various practices of postnatal care may be influenced by early religious thinking in Christianity, Islam and Judaism. Within Islam, the postnatal woman is regarded as polluted and unclean. She abstains from: normal household activity, preparing food, religious practice (such as formal prayers or fasting) and sexual activity for 40-days after childbirth or whilst experiencing menstruation (Schott and Henley, 1996; Fonte and Horton-Deutsch, 2005). Generally, the mother is encouraged to rest; the baby, and all other household chores are taken care of by female relatives. The idea behind the 40-days is that the mother needs to recuperate from childbirth. During this time, the other female relatives cook special foods, help her regain physical strength through massages and manage all other day-to-day care (Fonte and Horton-Deutsch, 2005). Such salient practices are also found in other non-Western cultures, such as China, Japan and India (Eberhard-Gran et al., 2010; Yoshida et al., 2001; Kendall-Tackett, 2010). South Asian women interviewed in the UK have stated that whilst mother and baby bonding is important, rest and recuperation after childbirth is of primary significance so they could regain their strength and be able to care of their baby (Woollett and Dosanjh-Matwala, 1990). The researchers identified

[11] NICE Clinical Guideline 132

that the women's conflict with healthcare staff whilst receiving postnatal care could have been due to staff holding Western ideologies of "normal maternal behaviour". The South Asian women also reported how they were neglected if they could not speak proper English.

A report by The Maternity Alliance[12] (2004) explored Muslim women's experiences of maternity services in the UK and found they struggled with language barriers, experienced lack of privacy and difficulty with not having enough female staff to liaise with. They also reported that salient Islamic practices were not understood by NHS staff, which impacted upon their experience of maternity care. The women described experiencing at best - insensitivity and discriminatory attitudes, and at worst outward racist comments during their time in maternity care.

The above studies raise questions about the impact that institutional insensitivity and/or racism can have on women from BME communities who are in the hands of the healthcare system at a critical juncture in their life, that of becoming mothers.

2.4 Biological Theory

After childbirth there tends to be a prompt decline in reproductive hormones, which is thought to increase the likelihood of PND in women (Wisner, Parry and Piontek, 2002). Progesterone and oestrogen tend to fall after childbirth and return to pre-pregnancy level within 3 days. Prolactin tends to rise during pregnancy and is unblocked after birth when oestrogen has fallen. Although these hormones have been associated with PND, findings remain weak and inconsistent (Robertson, Celasun and Stewart, 2003) for the biological theory.

There seems to be a general consensus that psycho-social risk factors tend to hold more weight for the increased likelihood of developing PND (National Mental Health Development Unit, 2011).

[12] Now known as Maternity Action

2.5 Childbirth Complications and Postnatal Distress

Childbirth can include complications and cause significant distress to women and they can experience posttraumatic stress along with PND after delivery (White et al., 2006). Emergency and elective caesarean sections (Yang et al., 2011), severe pre-eclampsia leading to admission into a NICU, and perinatal death can increase a woman's risk of developing PND (Hoedjes et al., 2011). Yet, a study in Norway found no association between mode of delivery and postnatal emotional distress (Adams et al., 2012). Similarly, no association between childbirth complications and PND was found amongst their population of migrant Pakistani women (Bjerke et al., 2008). However, research in Pakistan has found that PND was more frequent with women who encountered childbirth complications during delivery (Emmanuel, Mazhar & Shahid, 2011), demonstrating a significant association between the two factors.

2.6 Antenatal and Postnatal Depression

Studies in Canada have shown the significance of the antenatal period for migrant women. Zelkowitz et al., (2008) found that many migrant mothers with PND experience depression during pregnancy too. Women who do not receive adequate antenatal care have been identified as having higher EPDS scores in their postnatal period (Stewart et al., 2008). Such findings demonstrate the importance of antenatal psychological health in postnatal psychological health.

Interestingly, Imran and Haider (2010) assessed women in Pakistan and found that a previous history of psychological issues (including PND) and obstetric factors were associated with antenatal depression. This is important as depression in pregnancy has been associated with depression after childbirth too (Milgrom et al., 2008), which has been documented across cultures, including India, Japan, Lebanon, Pakistan (Chandran et al., 2002; Rodrigues et al., 2003; Kitamura et al., 2006; Chaaya et al., 2002; Husain et al., 2006; Rahman and Creed, 2007), Singapore, Nepal and Israel (Chen et al., 2004; Ho-Yen et al., 2007; Glasser et al., 1998, all cited in Klainin and Arthur, 2009).

Furthermore, the researchers found that women with antenatal depression experienced more obstetric complications during the delivery of their baby. Such findings highlight the role that obstetric factors play, but more importantly, suggest that maternal depression and various obstetric complications can spiral into a cyclical process in which a history of PND seems to place the mother at future risk of depression in pregnancy, which is yet further linked to depression after childbirth and amalgamated with childbirth complications.

2.7 Unplanned Pregnancies

Unplanned and/or unwanted pregnancy has been documented as a risk factor for PND in Jordan, Iran, Pakistan (Mohammad, Gamble and Creedy, 2011; Iranfar et al., 2005; Ali, Ali and Azam, 2009. Kalyani et al., 2001 cited in Klainin and Arthur, 2009) and Indonesia and Turkey (Andajani-Sutjahjo and Manderson et al., 2007; Ege and Timur et al., 2008, all cited in Klainin and Arthur, 2009).

Dhillon and MacArthur (2010) found that along with other factors, an unplanned pregnancy was associated with an increased likelihood of antenatal depression amongst a sample of 300 South Asian women in the UK[13], over half of whom were migrants. This finding is important as antenatal depression often progresses into PND, following childbirth (as stated above).

2.8 Breastfeeding and Distress

UNICEF (2013) state that breastfeeding has immense nutritional value to an infant's health and wellbeing (see Appendix 2).

Mothers who exclusively breastfeed are said to have more sleep and energy, better physical health and lower depression than mixed or formula-feeding mothers (Kendall-

[13] Including: Bangladeshi, Indian and Pakistani women

Tackett, Cong and Hale, 2011). It has been argued that breastfeeding can be protective against postnatal distress (Watkins et al., 2011). However, distressing feelings can effect and/or inhibit lactation (Lau, 2001; see Appendix 3). Furthermore, women who find themselves unable to breastfeed as planned, may have an increased risk for PND (Borra, Iacovou and Sevilla, 2014).

Studies show an association between breastfeeding problems and PND (Green, Broome & Mirabella, 2006). Women with PND are at a higher-risk of discontinuing breastfeeding than non-depressed women (Henderson et al., 2003; Dennis and McQueen, 2009). It has been suggested that incidents of breastfeeding in the UK are highest among South Asian women (Hscic.gov.uk, 2012). However, Choudhry and Wallace (2012) unveiled an unpublished breastfeeding audit, which suggested that Pakistani women showed low-rates of breastfeeding initiation[14], which decreased further[15] once they were discharged from hospital.

Whilst a UK cross-sectional survey showed that Bangladeshi and Pakistani women had a significantly "happier" mood when solely breastfeeding (Noor and Rousham, 2008), a thematic analysis with South Asian women[16] in the UK (Choudhry and Wallace, 2012) revealed that women opted for bottle-feeding as they experienced mixed-messages about the best feeding-method. In addition, when assessing feeding choices, they experienced a conflict between their roles as a mother and a daughter-in-law to the family.

2.9 Gender Preference of Baby

In contrast to Western-European cultures (De Tychey et al., 2008), gender preference of boys over girls has been identified in cultures from the Indian sub-continent and the Orient (Patel, Rodrigues and DeSouza, 2002; Leung, Arthur and Martinson, 2005).

[14] 43%
[15] 35%
[16] Majority were Pakistani women and migrants from Pakistan

Husain et al., (2006) found little evidence of an association between birth of a girl and PND in Pakistan. However, Winkvist and Akhtar (2000) conducted a grounded theory (GT) study aimed at exploring the childbearing attitudes of forty-two mothers in Pakistan. The women from low socio-economic backgrounds described experiencing verbal and physical abuse from their husbands for bearing daughters. There was a general consensus amongst the women, regardless of their socio-economic status, that the birth of a boy was preferred over a girl. Many women reported feeling sad at the birth of a girl. The researchers also discovered that women from villages found it difficult to exercise their reproductive rights to use contraception, even though approximately half of them did not want further children.

Bhopal (1998) examined the social support system amongst UK-born South Asian mothers. The emergent themes from the interviews revealed that having a baby boy enhanced the woman's status in the female family hierarchy, where mainly the husband's mother possessed the power. Once a wife produced a son to carry on the family lineage, her honour[17] and worth would increase and her marriage would be secured. Such findings demonstrate how much of the female security and worth rests on the birth of a preferred gender.

2.10 PND within the Indian Subcontinent

Anthropological views and qualitative research suggest that loss of traditional cultural practices related to childbirth and the postnatal period constitute to the development of perinatal problems (Kitzinger, 2000; Helman, 2003; Nahas, Hillege and Amasheh,1999).

In India, Rodrigues et al., (2003), utilised a mixed-methods approach and found no quantitatively based significant difference in the childbearing and postnatal practices between PND mothers and non-PND mothers (based on EPDS scores). Poverty, marital

[17] often called: "*Izzat*"

difficulties and the need for more emotional and social support were the main causes of PND. However, during interviews, many of the PND mothers did reveal the importance of postnatal practices. Such as, special nutritious diets, which aids production of breast-milk and body massages and also help reduce body-aches, whilst increasing strength. In addition, lack of postnatal rest, postponing customary visits to ones parent's home after childbirth and having little or no practical help after childbirth were all voiced as causing them physical and emotional problems.

The researchers concluded that rapid socio-cultural changes have resulted in the demise of salient and culturally sanctioned practices, which are traditionally seen to support childbearing women. With the growth of nuclear family structures, the burden of child-care seems to rest mainly on women, which - the researchers state - could account for the higher rates of PND documented in the Indian sub-continent.

Furthermore, Husain et al., (2006) showed support for this, by stating that rapid urbanisation and socio-cultural change was impacting upon countries like Pakistan, also rooted in traditional values. This meant that large family structures were slowly diminishing, in turn removing women from protective factors against psychological problems, such as PND. These studies are important as Pakistani women migrating to the UK where nuclear family structures are the norm, may also experience feeling burdened.

Rahman and Creed (2007) assessed mothers in Pakistan, prenatally and then up to one-year in the postnatal period. The researchers found a significant association between persistent depression and poverty, having five or more children, an uneducated husband and lack of an important friendship, showing support for Brown and Harris' study (1978). The need for a confidant, signified the issue of support being imperative for mothers in the postnatal period. From these findings, one may conclude that having more children already might mean that a woman has more to manage, as a result there could be more stress and increased possibility of maternal distress. However, Green, Broome and Mirabella (2006) assessed Muslim mothers in Abu Dhabi and identified

high PND scores in relation to the birth of the first child, so findings may vary in different populations.

2.11 Migrant Mothers and PND

National and international research has identified that PND rates are high in BME communities (Segre, O'Hara and Losch, 2006)[18], amongst migrants (Stewart et al., 2008; Zelkowitz et al., 2008[19]), non-English speaking backgrounds (McMahon et al., (2005)[20] and especially [South] Asian mothers (Onozawa et al., 2003[21]). Interestingly, migrant Pakistani women in Norway demonstrate low rates of PND (Bjerke et al., 2008). Of the 197 migrant Pakistani women who participated, 46% spoke Norwegian. The remaining Urdu-speaking women were questioned by interpreters or the family members and husbands were often present at interviews. Whilst the researchers found little significance of depressive symptoms between those interviewed alone and those with family, they did suggest that the presence of family members during interviews may have led participants to conceal their true feelings.

Nahas, Hillege and Amasheh, (1999) conducted a phenomenological inquiry into the lived experiences of PND amongst Middle-Eastern migrant women in Australia. Their analysis revealed themes of loneliness (caused by feeling isolated and lacking social support), helplessness ("due to inability to cope with overwhelming task of fulfilling traditional gender roles as mother and wife"), "fear of failure and being labelled a bad mother" and the fourth theme - having "insufficient knowledge of PND and existing support services" (p.69-70).

Loneliness and isolation during motherhood has also been identified in other migrant populations within Australia, such as Thai women (Liamputtong and Naksook, 2003) and mothers of Turkish, Filipino and Vietnamese origins (Small, Lumley and Yelland,

[18] USA study
[19] Canadian studies
[20] Australian study
[21] UK study

2003). This latter study also found that marital issues were significantly associated with maternal depression, followed by issues such as - poor physical health, exhaustion, family issues and baby-related problems.

The aforementioned British study on breastfeeding within the Bangladeshi and Pakistani community (Noor and Rousham, 2008) also highlighted that women, who spoke excellent English and were educated to the age of 18 or more, displayed a happier mood. Although not stated clearly by the researchers, one may question whether language abilities provide individuals with the power of speech and communication, which may alleviate a sense of loneliness and any consequent distress. It is possible that one issue, such as speaking the language of a country that a person has migrated to, could have a domino-effect on many avenues of their life. Thus demonstrating the role of social stressors, which has been identified as a producer of postnatal emotional distress in a British focus group study of Bangladeshi women (Parvin, Jones and Hull, 2004). Whilst this study revealed important findings, with a focus group, one can lose sense of the individual (Wilkinson, 2008), in contrast this is exactly what the underpinnings of IPA provide - in-depth individual focus.

Khan et al., (2009) conducted a mixed-methods study in Malaysia, researching the role of the husband's knowledge and behaviour in PND, which involved a single case-study (n=1) of a migrant Pakistani-Muslim woman. The interview revealed that the participant was a medical doctor in Pakistan whose role had changed since moving to Malaysia where she was a housewife. She reported experiencing exhaustion, isolation, lack of independence and support, and lack of understanding from her husband. She also missed Pakistani postnatal cultural practices and support that a woman traditionally receives after childbirth. In relation to her baby she described feeling irritated when he cried and sometimes felt like slapping him. The husband's interview showed that he had poor knowledge of PND and also experienced tiredness. He described feeling as though he could not understand his wife and that she was constantly complaining. Couples therapy and a psycho-education session for the husband appeared beneficial in helping them understand each other. The woman also reported a positive change in the way her

husband behaved. The couple reported feeling happy and the woman showed a "complete remission of [PND] symptoms" (p.199). Whilst this research was limited to a single-case-study, it did illuminate a migrant Pakistani woman's personal account of what contributed to her feeling depressed after childbirth. It also gave value to the husband's role and emphasised the woman's need for her husband's understanding. Furthermore, the research showed the importance of psycho-education counselling in helping this couple develop a better understanding and therefore a happier relationship with one another. Finally, this study also highlighted that "depression" was not a psychopathology growing from within the female participant, but more an emotional response to the psycho-social stressors in her life. Whilst such findings were useful, the researcher's journal-article fails to clarify the specific method utilised to analyse the interview data; consequently, methodological issues and potential limitations are called into question.

A more recent, UK study was conducted by Wittkowski et al., (2011) using a grounded theory approach to explore ten South Asian women's experiences of PND. Their experiences included cultural: clash, shock and suppression; and also panic, somatisation, isolation, lack of understanding of their experience, inadequate support and lack of understanding from healthcare professionals.

This research generated interesting - rich exploratory - findings which illuminated South Asian women's experiences as important to understand. The study also adds to the breadth of research on culture, motherhood and maternal depression. However, 8/10 participants were UK-born and only two had migrated to England at some point (one from Pakistan and the other from India). Consequently this research was not based on the experiences of *migrant* South Asian women, as UK-born South Asian women made up the majority of the sample.

Generally, the study by Wittkowski et al., assumes that all South Asian women (whether UK-born or not) are homogeneous. Whilst South Asian communities have similarities, there are just as equally as many distinctions and variations between individuals from these specific backgrounds and when women from the Indian

subcontinent are placed under one group these diversities become masked. This forces the question of what might have been revealed if researchers gave light to these distinctions by studying a group of women belonging to one particular ethnicity. Moreover, whilst being a qualitative study, which involves polar opposite underpinnings to quantitative research, the research still demonstrated undertones of quantitative principles. Similar to the IPA study conducted by Hall (2006), rather than interviewing women who provided subjective accounts of feelings depressed Wittkowski and colleagues utilised a quantitative tool to measure the objective reality of that PND. In contrast this research on migrant Pakistani-Muslim women aims to interview women who state from their own subjective accounts that they experienced depressive feelings after childbirth. This follows the underpinnings of qualitative research, which values subjectivity threaded throughout the research.

2.12 Gaps in Research

Much of the quantitative research that has been conducted rests on positivist foundations, which may fail to take into account individuals' subjective meaning. This subjective meaning is critical to deepening psychologists understanding of how individuals may experience reality.

There is a substantial amount of qualitative research in the field of maternal depression (generally, not necessarily specific to ethnic groups), which is promising as it highlights that maternal psychological health is a virile topic, thus demonstrating its importance.

However, when it comes to women of ethnicity, the picture becomes a little more complex. Psychological research with South Asian communities needs to be explored in the context of their specific ethnicity and religious background. Within the South Asian community there are strong similarities between cultures from the Indian sub-continent; however, diversities do exist and the majority of studies concerning maternal

psychological wellbeing[22] have failed to consider this issue and placed Indian, Pakistani and Bangladeshi participants under the same category of Asian, South Asian or BME (Wittkowski et al., 2011; Woollett and Dosanjh-Matwala, 1990; Woollett et al, 1995; Templeton et al., 2003; Nahas, Hillege and Amasheh,1999[23]). Certainly cultural relativists would stress that "cultures are unique... [and] they must be evaluated according to their own values and standards" (Squire, 2003; p.81). Pakistani-Muslim women especially need to be explored as an individual group due to the particularly high PND rates identified in their own country of origin[24], due to quantitative research suggesting that being an Asian and/or migrant in the UK (as well as other Western countries) poses a risk for PND and due to the knowledge that socio-economic disadvantages place women at increased risk for PND. The impact of poverty in relation to PND has been identified as a problem for this particular BME group (Husain et al., 2006; Husain et al., 2004; Rahman and Creed, 2007; Dale, 2008; The Change Institute, 2009).

In the UK, to date, there is a lack of definitive research which explores migrant Pakistani-Muslim women's lived experiences and understanding of PND from their own subjective context.

[22] This means in regards to PND, postnatal care, and the postnatal period
[23] In this study, similar to how women from South Asian countries tend to be placed under one category, here, Middle-Eastern women were placed under one category and considered homogeneous
[24] as well as in the UK (Husain et al., 2012)

CHAPTER THREE

METHODOLOGY

3.1 Rationale for Qualitative Research

There is a paucity of research in the UK, exploring migrant Pakistani-Muslim women's subjectively lived experiences of depression in the postnatal period. Most UK-based research has placed Pakistani women under the BME and/or South Asian category (Wittkowski et al., 2011; Woollett and Dosanjh-Matwala, 1990; Woollett et al., 1995; Templeton et al., 2003). Studying this wider collective group fails to acknowledge diversities within the South Asian community. In addition, much of the research has been conducted from a quantitative angle (Onozawa et al., 2003; Husain et al., 2012); which may fail to shed light on the personal lived experience and psychological meaning of a phenomena. Therefore, our knowledge of maternal psychological health in migrant populations, specifically with regards to Pakistani-Muslim women is based on research that methodologically, has not always produced findings grounded in personal, human experience.

3.2 Rationale for Research Paradigm

How we see the world and behave in it, is fundamentally shaped by a net of principles. We are naturally entwined in this net of principles which we form, that contains epistemological (nature, scope and theory of knowledge), ontological (nature of reality and being) and methodological premises. This means a "basic set of beliefs..... guides [our] action" (Guba, 1990; as cited in Denzin and Lincoln, 2008; p.31), this is known as a paradigm.

The main research paradigms are positivism, post-positivism, interpretivism-constructivism and critical-ideological (Ponterotto, 2005; Morrow, 2007).

Ponterotto (2005) suggests that situating a study within a paradigmatic context can be complex, as research does not necessarily "fit" neatly in a paradigm. Research questions

should shape and establish the methods we select, rather than holding fixed ideals on paradigmatic choices relating to methodological segregation (Morgan, 2007).

This research falls between the paradigms interpretivism-constructivism and post-positivism, with a hermeneutic-phenomenological underpinning. As the research is based on a critical realist ontology, there is a foot in post-positivism which suggests that reality does exist, but we can only capture it imperfectly (Ponterotto, 2005). This latter position diverges slightly from the wholly positivist position which contends that a real reality does exist 'out there' in the world driven by fixed laws, which can be accessed through a detached and objective approach to research (Willig, 2001).

At the other extreme end of realism, sits relativism, which is the ontological position within the interpretivist-constructivist paradigm. Relativism argues that there are multiple and socially constructed realities that can be captured (Morrow, 2007; Ponterotto, 2005). This positions states that reality is constructed in the mind of a person rather than it being an external unit. This is why the research is not entirely interpretivist-constructivist as a relativist ontology does not fit with the natural world-view of the researcher.

Whilst engaging with previous literature in this topic, natural questions emerged requiring an understanding of how migrant Pakistani-Muslim women experience the phenomena of sadness, distress and depression during the postnatal period. Questions were oriented around discovering and understanding the meaning that mothers attach to their experiences of depression in the postnatal period, which illustrated the study's subjectivist epistemology, resonating with the interpretivist-constructivist paradigm (Ponterotto, 2005; Morrow, 2007; Willis, 2007).

If the aim of the study was to generate theories and seek universal laws in terms of causal variables of PND, then the study would have been conducted from a positivist or wholly post-positivist stance, using experimental settings or distributing questionnaires – answers to which would be measured statistically (Ponterotto, 2005). However, none

of these features fall within the aims of this research. Furthermore, recent feminist critiques especially in the field of motherhood suggest that a quantified approach to studying motherhood frequently depicts female experiences as 'meaningless' (Parratt and Fahy, 2010).

Consequently, the aim of this study was not to engage in a reductive, but a more inductive process, of understanding and acquiring knowledge. Within the interepretivist-constructivist paradigm, knowledge is something that is interpreted rather than objectively observed in a direct manner (Haverkamp and Young, 2007). The research process is usually influenced by the researchers' values, yet s/he is also expected to understand how ones belief system and characteristics may have shaped or influenced the co-construction of meaning (Morrow, 2007; Ponterotto, 2005). This research is qualitative, as there is a wish to "present a detailed and in-depth view of a phenomenon" (Morrow, 2007; p.211).

3.3 Theoretical Underpinnings of IPA

As a methodology, IPA (Smith, 1999), of which phenomenology was developed by Husserl (1936; cited in Smith and Osborn, 2008) and the theory was later extended by Heidegger to include hermeneutics, suggests that human beings' experiences cannot be merely described and they are not passive agents. People are also cognitive, emotional and physical beings who try to understand the phenomena they experience (Smith and Osborn, 2008).

IPA was the most appropriate method for studying migrant Pakistani-Muslim women's experiences and understanding of depression in the postnatal period, due to the combined theoretical underpinning of phenomenology and hermeneutics, which allows exploration of participant's sense-making process in relation to their experiences and there is primary focus on the "individual's particular account of reality rather than an objective reality itself" (Smith,1999; p.282). This illuminates IPA's critical realist roots *(*Reid, Flowers & Larkin, 2005*).*

IPA allows a "dynamic interaction between researcher and participant" in order to encapsulate and describe the individuals' "lived experience" (Ponterotto, 2005; p. 131).

Smith (1999) suggests that a co-constructive approach is adopted in which the investigator and the participant are actively involved in the sense-making process; therefore an engagement with participants accounts of their experience in the form of textual data is required within this sense-making process. This approach seemed most suitable as not only is there a focus on individual's interpretation of their lived experiences but the methodology implicates cognition theories as there is the understanding that human beings are active agents in interpreting and perceiving their lives and experiences (Smith and Osborn, 2008); which fits the researchers natural view of people in their social world. This approach also resonates with current mainstream approach of cognition theory in social, clinical and counselling psychology practice. However, where a mainstream approach to studying mental processes would value quantitative research methods, IPA employs a qualitative and in-depth approach to studying how individuals experience a particular phenomena (Smith and Osborn, 2008; Smith, Flowers and Larkin, 2009). For further philosophical underpinnings of IPA and the rejection of other qualitative approaches, see Appendix 4 and 5 respectively.

3.4 Research Design

Four, one-to-one, semi-structured interviews were conducted with women who voiced subjective experience of distress and/or depression during the postnatal period. Interviews generally lasted between 50-90 minutes. The researcher conducted all the interviews, which were audio-recorded and then transcribed verbatim.

3.5 Data Collection

This research employed a semi-structured interview design to gather data from participants. An interview schedule was drafted based on previous literature, discussion with research supervisors and IPA guidelines (Smith and Osborn, 2008; Smith, Flowers and Larkin, 2009). This schedule was used as a guide (See Appendix 6) to learn about participants' lived experiences and psychological meaning of PND. Semi-structured interviews allow researchers to maintain some control on the line of questioning in

interviews and ensure that specific research questions are answered (Creswell, 2003). Furthermore, semi-structured interviews “allow the researcher and participant to engage in a dialogue whereby initial questions are modified in light of the participants’ responses... [and I will be]... able to probe interesting and important areas which arise” (Smith and Osborn, 2008; p.57). This method is not simple, but as a practitioner in counselling psychology, this "style of inquiry" and data collection method requires “empathy, genuineness and acceptance” in developing rapport and relationships with participants. Therefore, allowing an added advantage in the ability to collect data in this way (McLeod, 2003; p.89).

Some baseline descriptive demographic data was also collected (see Appendix 7, for Table 1).

3.6 Participants

3.6.1 Recruitment

The initial plan of this study was to recruit participants from an NHS Trust in Berkshire and Birmingham. However, due to recruitment difficulties, alternative avenues were sought. In the end, Deanery Road Children's Centre in East London provided the support for this study and three participants were recruited from there. A fourth participant was recruited through a snow-balling technique, where one of the research participants knew someone who had experienced the phenomena in question. In order to try and generate more participants, Islamic services, Islamic website forums, social networking sites and personal and professional contacts were also requested to keep a lookout for anyone they may have known that fitted the research criteria.

A further five women were interested in the research, however on further communication, the following reasons were identified for their inability to participate: personal plans hindered possibilities to meet for an interview (e.g. holiday plans and weddings), recent bereavement, husband/families refusal to allow participation, change

of mind about participating and fear of repercussions if anyone was to discover their participation.

The issues with recruitment highlighted the problematic wider personal and socio-cultural circumstances that migrant Pakistani-Muslim women seem to find themselves in. This further indicates why research in this field seems scarce as women from this community seem apprehensive about coming forward and speaking about the difficulties and distress they face. It is possible that these issues demonstrate the community's potential fears and mistrust of Western help and psychological services. Living in such circumstances may thus hinder Pakistani women (especially those who have migrated) from accessing support, which creates a further complex picture of the women, the community they belong to and the NHS psychological services that try to support them.

3.6.2 Sampling

Purposive sampling method was used in this research. As the aim was to explore and examine "lived experiences", the participants recruited in the research must have subjective experience of a particular phenomenon (in this case PND), in order to articulate and share their reality verbally, and thus allow the researcher to gain insight into the particular phenomenon (Smith, Flowers and Larkin, 2009). Based on the objectives and foundations of this research, migrant Pakistani-Muslim women who had subjective experiences of PND, were recruited. This was achieved through referrals from organisational services, known as "gatekeepers" (Smith, Flowers and Larkin, 2009; p.49), and through personal and professional contacts.

3.6.3 Inclusion and Exclusion Criteria

Smith, Flowers and Larkin (2009) state that individuals are "selected on the basis that they can grant us access to a particular perspective on the phenomenon under study. That is they 'represent' a perspective rather than a population" (p.49) In order to fulfil

the objective of this cross-cultural counselling psychology research, participant selection criteria was based on meeting the following requirements:

A. Female

   Whilst there is evidence for depression occurring in the postnatal period for men too, this particular research is concerned with female experiences.

B. Born or raised in Pakistan

C. Muslim religion

D. Residing in England.

   As there is a paucity of research in the UK exploring female migrant Pakistani-Muslim's experiences of PND, specificity of criteria based on ethnicity and religion, seemed fitting.

   Homogeneity is also important; whilst the aim of IPA research is not to draw findings which can be representative of the population, it does need to provide insight about a particular cultural frame and if the sample consists of different ethnicities or genders, then ethnic diversities become masked or diluted in which we are unable to know if particular findings are representative of a particular perspective or cultural frame. As more IPA studies are conducted and as the field grows, then slowly general claims can be raised. But they need to be based "on the detailed examination of a set of case studies" (Smith, Flowers and Larkin, 2009; p.51)

E. Aged between: 18-40 years-old

   Pakistani-Muslim women over 18-years are most likely to have migrated to England for marriage to a British Pakistani-Muslim spouse (Dale, 2008). They are also likely to have a high childbirth rate with women often being multi-parous and most fertile/reproductive between 18-40 years-old (Rahman and Creed, 2007).

F. Experience of giving birth to at least one child

G. Subjective experience of depression during the postnatal period (PND) – up to one-year post-birth.

Previous findings illustrate that women can be susceptible to PND up to one-year after childbirth (Rahman and Creed, 2007). By selecting women who subjectively felt that they experienced depression after childbirth the research is following the IPA principle of "lived experience" rather than a phenomenon determined by objective measures (e.g. selecting participants by firstly determining PND through EPDS measures and then including their participation).

H. English-speaking

Participants needed to speak English in order to convey their experiences and understanding of the phenomenon. Without this, the aims of the research would have been compromised. Interpreters could have been used to translate participants' accounts in their first-languages, but this would have negated the interpretative ability as a researcher, in terms of interpreting the experiences and attached meanings of the "totality of the person" (Smith and Osborn, 2008; p.54) The IPA researcher acknowledges the "person as a cognitive, linguistic, affective and physical being". This is a "chain of connection", which can be complex as people encounter difficulties with expressing their thoughts and feelings. The researcher facing these issues in turn has to interpret the individuals' emotional and psychological state from "what they say" (Smith and Osborn, 2008; p.54). Therefore, if interpreters were included, fundamental concepts of IPA could have been negated and the researcher would have been unable to grasp the objectives of the research methodology, which was to interpret experiences as first-person accounts.

3.7 Sample-size

This study selected four participants who are migrant Pakistan-Muslim women that had experienced distress and/or depression during their first-year of delivering a baby.
Smith, Flowers and Larkin (2009) express that whilst there is “no right answer” (p.51), when it comes to the sample size, quality rather than quantity should be considered. They state that when deciding on a sample-size: dedication to in-depth analysis, data richness and organisational constraints must be factored in.

IPA is primarily concerned with an in-depth and detailed account of individual experience (Smith, Flowers and Larkin, 2009). As human phenomena is viewed as vast and complex according to IPA, studies usually fair better from “a concentrated focus on a small number of cases”. Smith, Flowers and Larkin (2009) state that meeting the commitments of IPA can become problematic when a sample size is “too large” rather than “too small” (p.51). They advise that professional doctorates typically have 4-10 interviews, but caution that quality analysis requires considerable deliberation, which is difficult to achieve with large data, especially as a first-time qualitative researcher. The overall consensus here is that bigger numbers is not necessarily better work (Reid, Flowers and Larkin, 2005). Hefferon and Gil-Rodriguez (2011) argue that IPA researchers should work with fewer participants, but examine the cases at greater depth rather than going for larger numbers, which would risk providing "shallow and... descriptive analysis of many individuals" (p. 756).

This fits with the general thinking in the qualitative research field. For example, Willig (2013) stated that qualitative data collection and analysis is "labour-intensive" and the aim of this type of research is not to be concerned with representative samples (p.25). Indeed qualitative research is not averse to using just one participant in case study type research. Willig (2013) also argues that whilst representativeness is not the aim of small-scale research, it is thought that any human experience is potentially representative of the universal. Even if it is not possible to know how many people share a particular experience, once it is identified through qualitative research, Willig (2013) states "we do know that it is available within a culture or society" (p,25). Miller and Willig (2012) have put such research ideas into practice by studying HIV-positive

clients' experiences of the process of pluralistic therapy. The study revealed the importance of shared understanding between therapist and clients with a HIV positive diagnosis. The researchers utilised a grounded theory approach to explore the experiences of three HIV-positive participants. Whilst the sample was small, the study produced highly relevant research findings by highlighting the type of therapeutic practice that may be needed with HIV positive clients, which has implications for HIV services in the NHS. Such research demonstrates the importance, impact and value of small-scale qualitative research. Furthering this argument in the context of IPA research, Allport (1940, cited in Eatough and Smith, 2008) emphasised that by ignoring the idiographic perspective and failing to attend to individual cases and human experiences, psychology was becoming limited. Being engrossed in "actuarial predictions" was making psychology a victim of an insular and one-dimensional approach to studying human life (cited in Eatough and Smith, 2008; p.182). Allport argued that it was imperative to understand phenomena from the participant's point of view, which acknowledges the importance of an idiographic perspective and even gives precedence to the single-person case study. This contrasts fiercely with traditional empirical approaches to research, as idiographic research like IPA focuses "on the particular rather than the universal" (Eatough and Smith, 2008; p.183). This means that rather than looking at causal laws, the idiographic researcher is more concerned with "understanding meaning in the individual life" (p.183). Such a shift in perspective has allowed research scholars like Smith (1999) to produce IPA research in the field of motherhood, with just three participants. Knudson and Coyle (2002) used only two participants in their IPA study on the experiences of hearing voices. Such published studies show the practical application of the concept that the particular is the universal and epitomizes the need for small-scale IPA research.

In support of the importance of small-scale research, this particular study selected four participants, who were migrant Pakistan-Muslim women that had experienced distress and/or depression during their first-year of delivering a baby.

3.8 Procedure

3.8.1 Recruitment Process

Participants were recruited from the Deanery Road Children's Centre, where I liaised with an outreach worker. She identified 30 migrant Pakistani-Muslim women, who met the research criteria and sent them an invitation letter (Appendix 8a) and an information sheet (Appendix 8b). The outreach worker also placed an advert (Appendix 8c) about the research in the centre and communicated with women who dropped-in who may have fit the criteria. Potential participants responded with interest to the outreach worker and provided their contact details to be passed on to me. I contacted each participant by telephone to discuss the research details and sent them the consent form (Appendix 8d). Once the participant provided consent to be interviewed, we arranged a meeting at a convenient time and date.

3.8.2 Interview Procedure

Participants were informed that the study involved a face-to-face, semi-structured interview, which would be audio-recorded and transcribed by the researcher and that their personal identity would remain confidential. The interview questions focussed on their experiences and understanding of depression in the postnatal period and how they experienced motherhood and support during that time. An interview-schedule was utilised to guide rather than direct the entire interview process. This was important as it was necessary for participants to be able to express their stories in their own words. The duration of each interview was between 50-90 minutes. Following the interviews, participants were debriefed and asked how they felt about the interview. They were reminded about the information sheet having the researcher’s details in case they had any questions. After each interview, notes were made detailing thoughts and feelings about the interview, which could have affected the process.

Each interview was then transcribed verbatim before engaging with analysis.

3.9 Data Analysis

Analysis was conducted according to the principles of IPA as described by Smith, Flowers and Larkin, (2009) and Smith and Osborn (2008).

The IPA method is not prescriptive and there is no specific way of carrying it out.

The analytic process was supported through supervision with an experienced qualitative researcher and psychologist who had ample knowledge of issues related to migration and mental health. This enabled adherence to the *quality* of conducting qualitative research, which was also facilitated through guiding papers (Yardley, 2008).

FIRST STAGE:

All transcripts were analysed individually. The process began with listening to each participant's interview whilst reading and then re-reading the transcript as a way of familiarising myself with the participant's text and acquiring an understanding of their thoughts, feelings, experiences and ideas.

Exploratory notes were made on the right-margin of the transcript. This aimed to capture anything interesting or salient for the participant in relation to the objectives of the research. The initial notes were kept close to the participant's individual viewpoint (see Appendix 9).

SECOND STAGE

The analysis moved on from the main transcript, to focusing more on the initial notes, which in turn was closely linked to the main transcript. Initial notes were explored and transformed into emergent themes. This entailed constructing a succinct phrase which captured the salient aspects of the notes attached to a chunk of transcript. The 'I' in IPA becomes more alive at this stage where there is more of an interpretative focus. The emergent themes aimed to capture an understanding of the participants' experiences, thoughts and emotions (see Appendix 10).

THIRD STAGE

The emergent themes were typed, listed in a chronological order and then printed. Each phrase was cut-up, and placed on a cork board (see Appendix 11 for spatial representation). Themes echoing similar concepts were grouped together, forming clusters and thus creating superordinate themes (Smith, Flowers and Larkin, 2009; (see Appendix 12). Throughout the process, superordinate themes were verified by going back to the transcript and ensuring that higher level themes reflected the participants' accounts.

A table was drawn up with superordinate themes, underscored by subthemes and supportive transcript extracts which provided evidence for the generated themes (see Appendix 13). This process was carried out for all four participants. Whilst not entirely possible, attempts were made to bracket ideas from the previous interview by taking a physical-break from analysis before beginning analysis of the next interview. Whilst shared themes were identified, attention was given to new issues surfacing in each transcript, therefore noticing similarities and differences between participant's stories (Smith and Osborn, 2008).

FOURTH STAGE

Once all four transcripts were individually analysed, connections across cases were examined. Each superordinate theme from each individual case was listed and whilst these were important, emergent themes echoed in different cases, were then upgraded to a subordinate level as part of cross-analysis. Overall, when one theme in a case helped illuminate other cases, it was considered strong, and through this a subordinate theme was formed. During the cross-analysis, it was discovered that many themes were theoretically related, but were labelled differently. These themes were then grouped under one subordinate theme and relabelled (see Appendix 14: Audit Trail).

FINAL STAGE

The aim was to organise the subordinate themes identified through cross-analysis and generate a structure on how they correspond with one another, all the while remaining

mindful of the research questions. Whilst convergences were important, divergences were also noted (e.g. experiencing difficulties in marital relationship but also experiencing supportiveness and strength within a marriage). Drawing themes together helped to formulate a higher-order of themes, known as superordinate or master themes (see Appendix 15). Support for the themes is evident in the quotes from each participant's account (Appendix 16).

3.10 Validity and Quality of IPA Research

Examining the validity of research means to judge how its conducted and whether the results are trustworthy and valuable (Yardley, 2008). Evaluating qualitative research according to quantitative principles (e.g. objectivity, reliability and statistical generalisability) remains inapt as quantitative studies are based on different epistemological foundations (Yardley, 2008).

Whilst consensus on this topic seems difficult, some form of criteria for assessing validity is necessary in order for researchers to demonstrate that their studies are rigorous and valuable (Yardley, 2000, 2008). This study used guidelines by Yardley (2008) for assessing the validity and quality of this research, which is recommended by Smith, Flowers and Larkin (2009) as the criteria is broad-ranging and applicable to many qualitative approaches. However, Yardley (2000) cautions that in keeping with the philosophies of qualitative research, these criteria's should not be construed as "rigid rules", and the way in which specific investigations try to satisfy these criteria, will vary as it ultimately it depends on the method utilised (p.219).

The four main principles for assessing quality according to Yardley (2000, 2008) are :

SENSITIVITY TO CONTEXT:

This can be achieved in the following ways:

1. Consider "relevant theoretical and empirical literature" (Yardley, 2008; p.243), which is evidenced in the first two chapters of the thesis. Considerable attention

was given to the socio-cultural issues faced by the Pakistani community in general, thus highlighting the social setting of migrant Pakistani-Muslim women too. Reflection on previous literature helped identify gaps in our psychological understanding of this topic and facilitated development of appropriate research questions.

2. Quality IPA research demonstrates sensitivity to the raw data of participants (Yardley, 2000, 2008; Smith, Flowers and Larkin, 2009). In order to support this principle, the research has a substantial number of transcript quotations, to evidence the themes and interpretations presented. This in turn gives voice to the participants in the study.
3. Relating findings to relevant literature within the discussion.

COMMITMENT AND RIGOUR

Data was collected and analysed with sufficient breadth and depth in order to extract meaningful and rich data. It was hoped that through "in-depth micro-analysis of dialogue" (Yardley, 2008; p.248), about how the participants experienced PND in motherhood, insightful findings were generated.

COHERENCE AND TRANSPARENCY

This refers to how the research fits well together as a whole, in terms of the research questions, the theoretical approach and the methods utilised. A thorough rationale for this study is provided in the introduction and the theoretical underpinnings of IPA is provided in this chapter (as well as within Appendix 4 and 5). This provides clarity and power for the argument of this study and the way it has been conducted, thus optimising coherency of the research.

Transparency is achieved by providing a clear description of the research process and methods carried out; This research aimed for transparency so readers can grasp what was done, by providing a thorough audit trail in the appendices to underscore the steps taken during analysis.

IMPACT AND IMPORTANCE

For research to be valid, it must show something important, interesting and useful (Yardley, 2000; 2008; Smith, Flowers and Larkin 2009). The necessity of this research has been highlighted in the introduction and literature review. The findings also facilitate our understanding of migrant Pakistani-Muslim women's maternal experiences and the way various clinicians can work with them or reach out to them more.

3.11 Ethical Considerations

Ethical approval for this research was obtained from UEL and NHS Surrey Research Ethics Committee (Appendix 17a,b,c,d).

Potential ethical dilemmas that could have impacted upon the study were addressed through supervision. Firstly it was decided that the women who participated would need to be describing PND experience which occurred in the past and was not current at the time of the interview. This was so participants could clearly reflect their issues in retrospect as current experience of PND could have clouded their thought processes and ability to articulate their feelings.

Participants were informed that whilst every effort would be made to maintain their confidentiality, there were limits to this if they revealed any risk of harm to themselves or others. Each participant was clearly informed about the purpose and procedure of the study and how the data would be used. Interviews only began after receiving their verbal and written consent. Each participant was informed and reminded during the interview that their participation was voluntary and they could withdraw at anytime, which would lead to their data being destroyed. They were also informed that they were within their rights to refuse to answer any questions at any point. No participant refused to answer any questions and neither did anyone choose to withdraw from the study.

Following the end of every interview, participants were debriefed and given information about supportive services they could contact should it have felt necessary. There was a concern that by recalling and discussing difficult experiences, participants may

experience distress. Through supervision it was considered that being in the role of a therapist would have helped the researcher manage participant's distress and provide initial support. Participants were also provided with information on accessing counselling agencies should they have required it.
A follow-up call was made to each participant after the interview and everyone reported feeling fine and declined the need for further support.

Recordings and transcripts were kept on the researcher's personal computer, which was secured with a password and kept in a lockable room in the researcher's home. Hard copies of transcripts were filed in a lockable cabinet which only the researcher had access to.

Anonymity of participants was assured by removing all personally identifiable information and using pseudonyms.

CHAPTER FOUR

RESULTS

This chapter provides the results of the Interpretative Phenomenological Analysis (IPA) of four migrant Pakistani-Muslim women's lived experiences and understanding of PND in motherhood. Through the analysis, six master themes emerged:

1. Experiencing transitions
2. The experience of significant relationships
3. The body and motherhood
4. Living with postnatal distress
5. The experience and perception of Pakistani culture
6. Patchy provision of "good" healthcare

The themes were generated through close "interpretative engagement" with the participants expressed words. This followed the double-hermeneutic principle of IPA, in which the researcher is attempting to make sense of the participant, who is making sense of their experience [of PND] (Smith, Flowers and Larkin, 2009).

The analytic process is two-fold in IPA, initially, one is taking an "insider's perspective" in which the participants' stories are heard and their world-view takes precedence. The researcher then attempts to understand the participants' experiences and perceptions and tries to interpret these in relation to the proposed research questions (Reid, Flowers and Larkin, 2005). The double hermeneutic means that it is possible that other researchers may have interpreted different meanings to this same phenomenon. The master themes do not shed light on every facet of the women's experiences, but they were selected based on their significance to the collective participants and their importance to the research questions.

In order to respect the principles of confidentiality, the participants were given pseudonyms and all personal and identifiable information was edited/removed.

Wherever necessary, if words have been implied but not clearly stated they have been included into square brackets.

See table 4, in Appendix 18 for further information on participants profile.

Table 5 below summarises the six master themes and related subordinate themes. Each of these themes will be explored and supported with transcript extracts.

Table 5: Master and sub-themes

Master (or Superordinate) Themes	Subordinate Themes
1. Experiencing transitions	Lacking knowledge and experience of motherhood
	The toll of migration and motherhood
	Change in identity and experience of self
2. The experience of significant relationships	The important role of a woman's own mother
	Matriarchal power struggle
	Experiencing difficulties in a marital relationship
	Experiencing supportiveness and strength within a marriage
3. The body and motherhood	Difficulties and distress with breastfeeding
	Post-birth immobility
	Experiencing an unplanned pregnancy
4. Living with postnatal distress	The experience and meaning of distress
	Feeling burdened and unable to cope
	Isolation and loneliness
5. Experience and perception of Pakistani culture	Pakistani culture's negative gender attitudes and issues with female autonomy
	Supportive system within Pakistani culture
6. Patchy provision of "good" healthcare	Poor experience of healthcare staff and services
	"Healthy" healthcare and services

Each master theme is explored individually in order to examine its detail, depth and richness. However, these themes are inter-related to each other and it was noticed that the psychological experience of distress is interwoven within every theme. Therefore it was observed that a core theme is evident and linked with the other master theme and that theme is "living with postnatal distress" (see Appendix 19 for a radial diagram). This core theme is the centre of the lived experiences of these women and to follow their story in a chronological order (i.e. first comes the transition of moving, having a baby and distress starts appearing within and after the fact), the master theme: "living with postnatal distress" has been kept in the middle of the analytic process. This also represents its position as a core, central theme visually and conceptually holding the other themes together.

4.1 Overview of Master Theme One: Experiencing Transitions

This master theme captures the transitional process that migrant Pakistani-Muslim women experience as part of migration to the UK and [often quickly] becoming a mother. In both aspects, the women describe a process of learning and adapting to a new world - whether it be motherhood and/or country, in which lack of knowledge plays a powerful role in their experience. As part of their engagement with motherhood and migration, they also experience a transition in their identity. Their experience is encapsulated through three subordinate themes: lacking knowledge and experience of motherhood, the toll of migration and motherhood and change in identity and experience of self.

4.1.1. Lacking knowledge and experience of motherhood

All of the migrant Pakistani-Muslim women described a sense of newness with becoming a mother and how lack of knowledge about the meaning of motherhood and dealing with the challenge of the day-to-day care of a baby played a central feature in their lived experience of motherhood during the postnatal period.

For Rahana the inexperience of being a mother and the fact that it was the first time seemed particularly significant to her. Her account shows how she was entering a new world where she lacked understanding of children and motherhood and in the same breath learnt about the difficulties that came with this challenging role:

> *"I think it was the first time and I didn't know anything at all. I just thought babies just cry, sleep and eat and that's it but I didn't know that actually having a child was actually quite a difficult thing....."*

Shabana echoes some of Rahana's experience:

> *"The thing is that a new baby - first baby, is your first time ..... how you are going to make up things, how you are going to keep it together"*

Shabana additionally shows how this "*new*" world of experiences for the "*first* [time]" is related to the manageability aspects of motherhood, which was something she perhaps had to adapt to.

Shaheena further elaborates how lack of knowledge plays a central role:

> *"Before giving - before the child, I didn't know anything about the baby. So I was very scared to how to give a bath, h-how I become a mum, so it was very difficult to give him bath and after giving him a bath, I just call my mum in Pakistan and my sister, I was crying that I can't give him bath..."*

Shazia reports:

> *"Its a hard duty to take care of a baby if you don't [have] experience before"*

> *"I didn't give him milk until 6, 6 hours and that was, that was easy for me because he was sleeping, sleeping and I was happy the baby is sleeping and I don't know that I had to wake him."*

Both Shaheena and Shazia's words illustrate that they experienced a lack of knowledge regarding the practical tasks required in caring for a newborn and yet the knowledge of these tasks seemed critical to fulfilling their role as a mother. Lacking understanding of

these practical "*duties*" (as exemplified by Shazia) can be connected to the distress that these women experience. For Shaheena this involved experience of anxiety (*scared*), distress (*crying*), and a sense of inadequacy (*I can't give him bath).*

For Shazia, along with the newness of motherhood, the lack of knowledge of basic infant-care led to danger [to some degree] to the newborns physical-wellbeing in which he was left unfed for hours purely due to the mother's innocent lack of knowledge:

> *"he lost too much weight, because it was totally new experience for me and I don't know that you have to give the milk maybe after two hours and I didn't give him almost the whole day because he was sleeping. So, it was new, ... I didn't give him till the six and seven hours and he gonna be sick"*

> *"They said... 'you have to go in emergency'. That was make me shock, how they are sending me in emergency, that what the emergency?..... Literally I was crying"*

For Shazia, the lack of knowledge on her role to fulfil a newborn's needs, led to ill-health of the baby, which in turn led to the A & E admission, which the mother clearly found to be a shocking experience.

4.1.2. The toll of migration and motherhood

This subordinate theme identified through analysis shows how the combined experience of migration and motherhood took some *toll* on all the migrant Pakistani-Muslim women.

Rahana describes encountering culture shock as part of her migration experience to the UK:

> *"Coming here was a complete shock to the system where you're left to be independent; you're allowed to do whatever you want. For me it was a big shock*

thinking 'Oh my God, I can do anything I want myself' and 'Will I get into trouble for doing something?' Just thoughts like that in my head."

The shock seemed in response to the thought of having complete freedom to "*do whatever*", which seemed quite alien to her. Rahana perceived the British culture as one which valued individual autonomy and this sense of *"Doing anything I want myself"* seemed to be a salient feature of being individualistic. Having freedom all of a sudden invited anxiety-provoking thoughts where she questioned the possibility of danger (*"will I get into trouble")* .

She also reports:

"It was a very difficult time, I wasn't - and I didn't expect to get pregnant that quickly. If I had known, I would have waited a year and then it's just missing home and missing my family life and friends. All that just took its toll on me".

Rahana shows that getting pregnant as a new migrant woman was perhaps regretful and something she should have *"waited"* on. She also reports the yearning of all that is familiar - "*family*", "*friends*" and what she had known her whole life as her *"home"* - a place where she belonged and had removed herself from due to marriage. This entire experience of these major transitions *"took its toll"*.

For others, the toll of migration and motherhood related more so with practical circumstances that have to be coped with, as shown by Shabana:

" I, we used to live at, with two other families…. So I had only one room. So, erm... you know, since its migrating women, so it's not always that you are going to get straight away a very nice and beautiful house, so things were not like that. So..... being within that one room and I used to probably analyse things too much, way too much than normal because I was alone."

Shabana's circumstances of living in over-crowded housing represents a double-edged sword of being around lots of people (*two other families*) and yet feeling isolated. The psychological process of isolation is explored further in detail later in the master theme: living with postnatal distress, subtheme: "isolation and loneliness". But this narrative account by Shabana shows the circumstances in which isolation can develop and

cement itself. Shabana's description of belonging to the group of "*migrating women*" implies that this kind of living situation is assumed and expected for a person who is new to the country. Her experience of lacking space in an entire home meant that she perhaps felt confined in a small inadequate space. She also feels this kind of environment combined with loneliness gave rise to a ruminative behaviour.

Shaheena also reports practical issues:

> *"I didn't know about the shopping, about everything, the nappies, the milk, what milk should I give him, and no-one is here to help me at that time. I was also new here... at that time"*

Being "*new here*" highlights the reason why Shaheena may have lacked knowledge on practical aspects of mothering (nappies/milk), it seems she was still adapting and learning about a new country and culture. To then have to quickly learn and know about everything to do with babies and motherhood seemed extremely difficult. Such an account illuminates the process of the previous sub-theme: lacking knowledge and experience of motherhood. It shows how the process of migration is interlinked and influential on the process of mothering and/or becoming a mother and the knowledge required in this transitional phase.

Shazia also emphasised the overwhelming experience of being in a new country. She describes dealing with costs of housing and then taking on motherhood within a short time frame. This shows the overwhelming experience of having to adapt to so many new "*duties*" and experiences:

> *"Sometimes happen if you came here the main problems less, house rents, you know house rents, all these things, and the same next year, came your baby, lots of duties."*

Shazia also illustrates the experience of language difficulties at a time when she was having to access services as a new migrant woman embarking on the first-time journey of motherhood, whilst already processing a new and unfamiliar country:

It's new here, everything was new, I just came two years - two months before, that's why, might be the lady [children's centre staff] she know that I don't know English even,

she, and yeah. At that time I know English but you know just because of shyness of something I can't speak properly.

4.1.3. Change in identity and experience of self

All the women described experiencing some form of change in their self-concept whilst exercising their role of motherhood during the postnatal period (and sometimes even beyond this period).

Rahana reported her body image experience as part of taking on motherhood:

> *"I didn't have time to look after myself, I put on so much weight; the pregnancy weight took ages for even a stone to go off. I was hungry all the time and I completely lost it I think."*

When asked what she thought she had lost, she responded:

> *"I thought.... I wasn't able to look after myself, I was letting go of myself and became like a complete fat slob."*

It seemed that Rahana had developed a negative self-concept of her body and weight, to the point where she even refers to herself critically: *"fat slob"*. She described feeling hindered in looking after herself, which can now be explored further:

> *"I always kept dreaming of moving back to Pakistan thinking that if I had more help with the kids then I wouldn't be depressed. But here it's like I didn't get time to do anything, I was sort of losing myself. There would be times in the day when I would realise 'Oh my God, I haven't even changed yet, I'm still in my night suit' you know?"*

Being in the UK and lacking support, help and time, meant Rahana felt unable to look after herself and therefore gained weight. This in turn created further psychological distress as she developed a negative self/body-image. Rahana seemed to experience a loss of self through this experience because ultimately her body was changing and she felt she no longer recognised herself. Consequently, there was a sense of ruminating on

the "what if" - she was in Pakistan where proper help would have given her time to work on her pregnancy weight and therefore, she would have her "self".

Rahana's negative self-concept even extended to her sense of her psychological self:

> *"I just went completely loopy."*

Shabana also described a change in how she viewed herself as a woman in regards to the personality traits she had applied to herself before and after experiencing childbirth:

> "*I never thought that I would be faced with that* [difficult and traumatic childbirth]. *I used to think about myself as a brave woman – I will do it, I would do that, I would do it, but unfortunately I couldn't."*

As can be seen from the above excerpt, Shabana's account illustrates that the traumatic childbirth experience was profound enough to create a shift in how she perceived herself.

Shaheena also illustrates that her self-concept changed after adopting the role of motherhood. She especially notes the change it inspired in her personality, behaviour and way of relating with her husband:

> *"I was very shy person before marriage or after marriage but after giving birth and after two months, ... I saw many changes in me. You know, I can say anything to my husband now but after marriage, I couldn't say anything to my husband."*
>
> *"But after delivery, after two months, I felt very changes in me that I can say now anything to my husband because of the understanding, because we know each other now."*

Childbirth and motherhood brought Shaheena the confidence to share her thoughts, desires and feelings with ease to her husband. She used to regard herself as a "*shy person*", a self-concept which changed after having a child. Her initial shy persona left her unable to speak out, and after taking on the role of motherhood she described feeling able to voice her thoughts and feelings. Her account illustrates that the husband and wife relationship grew through understanding and getting to know one another, which in

turn, aided her ability to share her feelings; resulting in a change in how Shaheena sees herself - no longer a shy person.

Shazia also described her view of herself:

> *"...to take care of the baby, to change the baby's clothes, to feed the baby, to make home meal, food for my own self, my husband, and cleaning, all these things, whatever else I'm doing at home."*

> *"I feel that's my duty, because I'm the and err, you know, the member…, [laughs slightly] have a family to support, holding the whole home."*

The above excerpts show how Shazia views her role of being a mother, caring for her baby and fulfilling her duty as a wife by looking after her husband, and supporting the family is part of her identity.

This master theme illustrates the numerous transitions that the migrant Pakistani women encountered. The experience of motherhood and caring for a baby seems to be a new and unfamiliar territory. Psychological distress appears to be part of this process as ultimately a small life is depending on the women to quickly learn a role which they have never known before. This is challenging enough, but then to also be a new migrant woman in a country that is vastly different from their own country of origin, brings further challenges. Culture shock, difficult living circumstances, financial challenges and lack of basic knowledge about the country amalgamated with a dependent life - a newborn baby, brings enormous psychosocial pressures for these women. Through these life-transitions, the women also encounter a change in their self-concept, in which they experience a difference in their self-concept before, and after motherhood. Motherhood can bring a negative body-image, an alteration in one's core belief of the self, and it can also bring a positive personality change where a woman develops assertiveness and believes that she has a wider and significant role to play in her family life. Within this master theme, it was interesting to see that whilst each subtheme showed a meaningful lived experience in its own right, each of them also helped illuminate the psychological processes of other subthemes. For example, the toll of

migration and motherhood in Shaheena's account was interlinked to her lack of knowledge and experience of motherhood. The issue of everything being "new here" coincided with the newness of the motherhood role and how lacking experience and knowledge of this new role was central to the mother's experience.

4.2 Overview of Master Theme Two: The Experience of Significant Relationships

This theme captures the importance of migrant Pakistani women's relational experiences and the impact these relationships had on their psychological wellbeing whilst on the journey of motherhood. The woman's own mother, her husband and the relationship with the mother-in-law appeared most significant in the migrant Pakistani woman's experience and all these relationships played a significant role in the postnatal period. These relationships played a mixture of positive and negative parts in the woman's wellbeing. This theme encompasses four subordinate themes which will now be discussed further: the important role of a woman's own mother, matriarchal power struggle, experiencing difficulties in the marital relationship and experiencing supportiveness and strength within marriage.

4.2.1 The important role of a woman's own mother

All of the migrant Pakistani women described how their own mother's support was necessary after the birth of their child[ren]. The women voice how the postnatal period could be or was eased by having their mother present, whilst others reported intense yearning for their mother if their mothers were not around during the postnatal period.

Rahana expresses that her own mother's role of being involved after childbirth is culturally sanctioned and perhaps put in place to aid the daughter who has now become a mother herself:

"It's a bit of a tradition as well that when your daughter has her first baby, well usually with every baby really, the mum usually comes and helps out and everything."

Rahana reported that during the second baby, her mother stayed for an extended period to help her, which she valued:

"My mother was there for about six months with me... with the second one. .... That helped me because Mum was there to sort of help me out a bit."

She also described how she experienced her mother's departure:

"I remember the day when my mum had to leave, I suddenly felt as if the world had come crashing down on me and I thought 'Oh my God, how am I going to cope? and what if the kids get ill or something?" (Rahana)

The above excerpt shows that Rahana immensely valued her mother's help and support, so much so, that when it came to her departure, the whole experience was construed as catastrophic. Almost as though something had ended for her - the comforting support and being looked after by her own mother whilst she found her way to become a mother for the second time. This support seemed so crucial to her existence, that the thought of it ending seemed unbearable to Rahana, hence the noisy and colossal image of the "*world" "crashing down"*. That catastrophe also led Rahana to think of future catastrophes or difficult circumstances (*kids get ill)* where she questioned her ability to cope. There seemed to be undertones of fear in this entire experience.

Shaheena, shows how having her mother around seemed to be powerful enough to prohibit any emotional difficulties rising after the birth of her second son:

"*The second child I didn't feel anything more because the second time my mum also come here"*

For Shaheena, her mother's role was critical as she provided practical help and support:

"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."

Shabana describes how she felt her mother's absence during the postnatal period and how she yearned for her:

"Well in my first postnatal period I needed my mother. I would not hesitate to say that. I really needed her."

Shabana also shows how she believes there is a naturally strong attachment and bond between a mother and daughter which is reinforced during pregnancy, hence the yearning that takes place for the daughter towards her mother:

"You know, every daughter is really close to the mother throughout, especially after, not after marriage, especially during pregnancy. That is what I think."

Shazia also stresses the importance of the family and especially the mother's role being central and necessary during her postnatal period:

"....Where I was living there was another girl [Pakistani], she was pregnant with me, we have the same time, ... and her family was here and they are, they are taking care a lot to that lady. I... just met her in the park and ...I asked her, a little bit.

..... Her mum do care her a lot and after, after the baby she was again, she, her mother do care a lot and that's why I'm feeling that if the mother will be here it's better for the person. The family does matter a lot"

One senses from how Shazia describes the vast level of care this other woman receives (repeated emphasis on receiving "*care a lot"*), that she was perhaps reminded of her mother's absence during this critical time of the postnatal period. When she states: if the mother is around "*it's better for the person*" one senses that she is talking about herself - that her experience after birth would have been better had her own mother been around providing care and support similar to this other woman. Further evidence for this comes from Shazia's explicit statement of feeling that nobody was around to care for her:

"I don't have anybody to look after me, that's the elders one, you know your mother or your family members, no one was there with me to share with me, only it was my husband, but he was also not experienced."

Shazia shows that whilst her husband was there, his lack of experience and knowledge about the wife's postnatal care made his presence not as important as her own mother's. Her mother would have fulfilled Shazia's need for practical care and emotional support. Interestingly, the husband's lack of knowledge and inexperience echoes Shazia's own inexperience of lack of knowledge as a mother as shown by the subtheme in the previous master theme. This demonstrates that similar experiences could have disseminated in the relational dynamics of Shazia's home.

4.2.2. Matriarchal power struggle

In contrast to the relationship with their own mothers (which was characterised as a necessary and supportive relationship), some of the women described difficult relationships with their mother-in-law's, which centred around power struggles based on the daughter-in-law playing the subordinate role and the mother-in-law playing the more superior, dominant role.

Rahana described how she experienced her mother-in-law as very critical:

"She just used to criticise me all the time for my weight and I said 'I can't help it, I'm pregnant'."

There is a sense that Rahana was desperately seeking understanding and emotional support; however, not getting this from her mother-in-law seemed to impact her emotional wellbeing and created space for deeper depression in the postnatal period:

"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."

Rahana describes how her mother-in-law appeared to play a more superior role to any other member within her family:

> *"When my mum came, she had actually booked my ticket to go with her and I thought that's great, at least when I go there [Pakistan] I'll be able to have a rest. But then my mother-in-law started saying that the baby is still too young and we're not going to send him there because he might get ill there or something. So then my parents said to me 'look, don't worry, just extend your ticket and we'll book it for some time in February once he's had his three month injections'. So I was very upset then to my mum, I said 'it doesn't matter, we have women in Pakistan whose kids are born on the streets and look at how healthy they are, there is nothing wrong with them'. We over protect our kids and that's why they're like that but she [mum] said 'we can't argue now because your mother-in-law has said this so we can't say anything'.*
>
> *.... It means that because they've got the upper hand.*
>
> *.... Because actually in a way, although it's my child and I gave birth, technically its there's, it belongs to them really.*
>
> *... So she [mum] said 'we can't argue in that respect, if they say no'. I said 'it's not fair, I want to go back; I don't want to stay here, I want to go back for 3-4 months and stay there'. But she said 'no, if your mother-in-law said stay then you have* to'."

One can hear the desperate plight in Rahana's report of wanting the freedom to make her own decisions, but she seems helplessly forced to obey the final words of the more dominant family member - the mother-in-law. We can see from the excerpt that Rahana experiences her own mother as someone who views her daughter's mother-in-law as the superior one. Rahana's description shows her mother's awareness that the mother-in-law is the one who makes final decisions as she heeds her words and encourages her daughter (the participant; *no if your mother-in-law said then you have to*) to change her decision and go to Pakistan at a later period once the baby has received all his injections; all to the mother-in-law's satisfaction. One is forced to question, where Rahana's needs and wellbeing were concerned? Perhaps this matriarchal power struggle

rendered her in the powerless position resulting in her emotional difficulties (*they've got the upper hand).*

Similar to Rahana, Shaheena also shares an experience of power struggle. In her experience the mother-in-law also seems to play the dominant role by being the person who makes decisions:

> *"At that time I know that in labour room my husband will go with me. I, I really feel like that but my mother-in-law didn't give him permission to go ..... with second baby because I knew that it was a caesarean. So I said to my mum, mother-in-law, that my husband will go, can go with me? She said no, I will go with you.*
>
> *.... And the first baby was also my mother-in-law was with me. She didn't, didn't give permission to my husband to come with me. .... At that time I feel very, you know, depression. Depression of like feeling really you know lonely. ..... That it's like when I went for the caesarean, there was two more patients and they're both you know Asian women and their husbands with them. But me with... I was only the one who had her mother[-in-law]*. "

The above excerpt shows how Shaheena plays the subordinate role in her lived experience by seeking permission for her husband to be around during the delivery of her child. The story above tells us that the mother-in-law has the power of decision-making, in which she rejects the participant's requests. Such dynamics lead Shaheena to feel *depression* stemming from the loneliness of missing her husband which was made all the more real when she saw other "*Asian women*" birthing with their husband's by their side.

Shaheena even describes how basic actions can be controlled and decided by her mother-in-law:

> *"You know, she will not react good for me or like - she will not react very bad for me but she will stop me. Don't do this. And if she will say me don't do this, I can't do anything."*

The above accounts by the women illustrate that mother in laws seem to hold a more dominant position and decision-making power over the women, compared to the power held by the daughter-in-laws. It seems that this relational dynamic maybe culturally sanctioned and it may be the norm to follow the command of the mother-in-law. This was certainly evident in Rahana's account when her mother advised her that she will have to listen to her mother-in-law. This sheds light on a subtheme that will be discussed later: Pakistani culture's negative gender attitudes and issues with female autonomy (within master theme: experience and perception of Pakistani culture). Freedom to make one's own decisions and the issue of female autonomy is prohibited and controlled by a hierarchal order where an older woman, the mother-in-law holds the dominant position. Whilst gender attitudes to female autonomy may be conservative and restrictive in the Pakistani culture (as will be seen in this later theme), it seems to be allowed to older women who make the decisions for the younger females in the family. This order and dynamic is clearly sanctioned and considered the norm within the culture as shown by Rahana's mother.

4.2.3. Experiencing difficulties in a marital relationship

Majority of the migrant Pakistani women described experiencing some form of difficulty in their marital relationship. This subordinate theme features conflict and disagreement with the husband and perceiving the marital relationship as lacking in support.

Rahana reported:

> *"I think he* [husband] *knew* [what I was going through] *but like I said, there wasn't any emotional or physical sort of support. It would be nice if you get that kind of… But he's never actually been that kind of person you know, to comfort you or… You know what I mean? If my son fell over or cut his hand or something I'd go and comfort him for example. ..... You need that sort of reassurance and comfort saying 'oh no, it will be fine, you can just put a plaster on it and…' you know? 'It will be okay, don't worry.' Just something like that. I*

never got any of that. Plus being tired all of the time. Everyone else, for example when I used to live with my mother-in-law, because obviously my mother-in-law used to go to sleep in her room, my husband used to sleep because he had to go to work the next day, my brother in law was in his room so I used to be the only one up and looking after him [the baby].*"*

Rahana's excerpt shows how she needed emotional support in the form of reassurance and comfort from her husband. The example she chooses to give is rather interesting of how she would comfort her son if he *fell over* and *cut* himself. One imagines she has many stories she could use but she opts for this. The narrative of falling over and being "*cut*" may actually represent the inner psychological process of how she felt. Perhaps the story was not so much an example about her son, but more the unconscious reality of herself, that she was falling and cut deeply on an emotional level. Perhaps she was wounded, and needed to be comforted and cared for, by her husband.

Rahana also describes how she received little practical support, but the narrative once again shows how her needs were left unmet. The last line illustrates how she felt completely isolated in dealing with the demands of a baby, an issue that was developed as a subtheme in its own right (feeling burdened and unable to cope, within master theme: living with postnatal distress) which will be illustrated further later. However, this particular theme involving the relationship with the husband does show the important role a husband plays according to Rahana's account. It is possible based on Rahana's account that if the husband was more involved in the childcare duties and the job of parenting was equally shared, then she may not have felt so overwhelmed and burdened - as the later subtheme will suggest. Such narrative accounts illuminate how the relationship with the husband and the level of support a woman may have can naturally effect her coping abilities and how burdened she may feel.

Shaheena reports how through her depression she felt immense anger towards her husband and rejected his affectionate advances:

"You also feel very anger to your husband as well. You doesn't like… him coming to you"

Shaheena also expresses the magnitude of the husband's role and its power to mediate a wife's emotional wellbeing:

> *"You know, if your husband support you, you will not feel lonely. You will not feel any, you know, depression. If your husband is good with you ...."*

> *"If your husband is loving or caring you do – I, I, I believe on this - you doesn't feel any depression."*

Shaheena also shows how her husband's role is all powerful and surpasses the need of any other relationship:

> *"If your husband will be caring, you doesn't feel - you doesn't need anyone. You doesn't need your mum, you doesn't need your friends, you doesn't need your sisters. If your husband is supportive to you, if your husband loves you, if he's a caring, he's a caring person."*

Shabana also reports how her experience of PND affected her relationship:

> *"I used to fight with my husband.... On petty things yeah it did, to, to some extent ...."*
>
> *"You know your relationship is badly affected".*

It seems the interview, provides a space for reflection on the past and Shabana felt that she used to be fighting with her husband about insignificant issues. Nonetheless, it seems that she views her state of being in depression during the postnatal period as something which *badly affected* her marital relationship.

Interestingly though, Shabana also reported positive aspects of her relationship with her husband which helped in providing her with physical and emotional strength as seen below with the final subordinate theme.

4.2.4. Experiencing supportiveness and strength within a marriage

Some of the migrant Pakistani-Muslim women described how their husband's support eased their postnatal experiences and provided emotional strength and positive feelings within the relationship.

Shabana reported:

> *"That one month period* [after birth] *got quite difficult for me to cope with as I.... was not really used to this .... I really salute my husband. He has - had always been with me at all times. He didn't let me climb the stairs. He used to be caring wherever he could. He did that and that is what I really appreciate,"*

Shabana describes valuing her husband for being by her side *"at all times"*. It seems like she feels grateful to him for helping her physically manage things after birth and this seems evident in her choice of words: *I salute my husband.* This attitude of care and respect seemed to aid a positive engagement in their relationship (*that is what I really appreciate).*

Shazia also describes how she valued her husband for providing care and support however he could, and she shows her appreciation for the sacrifices he makes for her and the baby:

> *"He's doing.... most of....he... he's working in footlocker, but he, one, one week off he, he... he take, just for me and my baby."*

When asked, how she found her husband supportive, Shazia reported:

> *"He, he do help me, you know, breakfast and dinner, and though baby's all their things, the duties, he don't know, he can't do that, and all others he was helping me with everything, but he himself don't know these things because he also was, don't have experience such kinds of things,"*

Overall the master theme of the experience of significant relationships show the powerful impact that supportive and unsupportive relationships can play in the postnatal period for these migrant Pakistani women. If there is a lack of support then the demands of an infant's care ends up resting solely on the migrant Pakistani-Muslim woman,

which may bring in issues of coping or feeling burdened. Such a subtheme helped to shed light on the link between difficulties in a marriage (the sometimes unsupportive aspect of the relationship) and how these women may end up feeling burdened and unable to cope (a subtheme within the master theme: living with postnatal distress). In addition one woman's report of how a loving and caring relationship could have been powerful enough to protect her against feelings of isolation and loneliness (Shaheena), illustrates a connection between the themes experiencing difficulties in a marital relationship and isolation and loneliness (a subordinate theme under living with postnatal distress). It shows how isolation as an experience of postnatal distress can be protected against, by ensuring a supportive and loving marital relationship.

This master theme also shows how supportive relationships foster a sense of feeling cared for and emotional wellbeing. But emotional support is not the only significant support, as the migrant Pakistani woman needs practical and physical support too in regards to chores within the home and care of other children (where applicable). The women's account shows that their own mothers are able to provide this all-rounded care, which amplifies the need of a woman's own mothers support. Equally, relationships where there appears to be a sense of power struggle, such as with the mother-in-law, a negative dynamic ensues. Here, the migrant Pakistani woman plays a subordinate role to the superior and dominant force of the mother-in-law, which creates a sense of helplessness, powerlessness and thus depressive feelings. Whilst, such relational dynamics maybe culturally sanctioned, it may be ever more difficult during the postnatal period when the migrant Pakistani woman desperately needs support and care and is left without these fundamental qualities.

4.3 Overview of Master Theme Three: The Body and Motherhood

The theme tries to capture how the migrant Pakistani-Muslim women experienced their body as part of motherhood after birth. The theme illustrates how the body impacts each woman and the distress that is felt in response to how the body is behaving, reacting and generally being. There is almost a sense that these women experience their body as an independent entity that does only what it is able to do and perhaps the women hope or

expect more from their body than it can provide. Three subordinate themes were found to represent this master theme, which are discussed further.

4.3.1 Difficulties and distress with breastfeeding

Most of the women described experiencing difficulties with feeding their baby. Some felt that the task of breastfeeding and the fact that it was not happening caused a deepening of their 'depression', whilst others described feeling that their own emotional state and distress affected their feeding supply to the baby.

Rahana reported:

> *"I tried to breastfeed him and he just wouldn't take it and it was all these things depressing me as well because he wasn't able to... he just wouldn't latch on and at the hospital the midwife when he was born she said 'just give him a bottle then because he needs to have something'. So I started that but then I used to get all these sarcastic remarks from my mother-in-law saying that the mother's milk is the best and I said 'I know it's the best'. And that made me depressed too that I couldn't give him... breastfeed him because you know children get more immunity and everything and it's better for them to have breast milk. But I said 'I can't do it; if he's not taking it what can I do then?' I did try and express it a bit but then obviously if he won't take it, it stopped coming so that made me really depressed as well; thinking that I couldn't breastfeed him. .....*
>
> *..... It felt really bad; I thought I was failing him as a mother you know, thinking that I couldn't...."*

One can see from Rahana's description, the disheartenment she seemed to feel with trying hard in providing the baby's nutritional need and finding that it was not happening. Rahana reports how she perceived her mother-in-law's voiced opinion about breastfeeding vs. bottle-feeding as disapproving (*sarcastic).* But it sounds as though she was not just contending with people within her personal life, but also the wider world and the message 'out there' that: *the mother's milk is the best ..... because.... children get more immunity and everything and it's better for them to have breast milk.* Such

messages from the wider world about what is best for the infant, may have served to frustrate and distress Rahana, or rendered her helpless as she found something she so desperately tried to do, did not occur. The finality of this postnatal experience seemed to be the lactation ceasing altogether due to the baby's non-latching behaviour. Rahana describes how she viewed herself as failing in fulfilling the motherhood role. Thus the occurrence of the depressive experience.

Shaheena also described how her depressive experience was interlinked with the feeding problems:

> *"The main thing was - depression was the how to breastfeed him.*
>
> *Because actually... I had a caesarean and after the caesarean, the milk doesn't come ou-out as normal delivery. So it was very difficult to breastfeed him and he didn't sleep and he didn't you know sleep the whole two hours. Every one-one hour he'd wake up and he cry, he – and you know I don't know how to give him anything, how to feed him."*

Shaheena illustrates that she holds the caesarean responsible for the non-lactation, therefore the unsuccessful breastfeeding. She also shares that she did not know how to feed him, showing once again that lack of knowledge - about breastfeeding in this case - as a new mother was playing a role. The issue with breastfeeding here and the not knowing aspect ("*I don't know how to give him anything, how to feed him"*) sheds light on the subordinate theme lacking knowledge and experience of motherhood (within the previous master theme: experiencing transitions) and Shaheena's account here shows how knowledge related to practical aspects of taking care of an infant is imperative as after all an infant's survival depends on nourishment.

Similar to Rahana's experience, Shaheena also demonstrates how she had to balance the conflict between the personal opinions of individuals in her life and her own experience:

> *"Because you know my mother-in-law she said do breast-feeding, don't do, don't give him bottle milk, you know the formula milk, don't give him. And you know at that time I don't - because I had a caesarean, the milk doesn't come, didn't come out at that time."*

It seems that on one hand the mother-in-law was directing Shaheena on the feeding-method. On the other hand, Shaheena was struggling to feed in this manner due to bio-physical reasons, which seemed outside of her control.

Shabana's account shows that there was an experience of symbiotic distress between mother and child as part of the breastfeeding encounter:

> *"...I used to be distressed and..... I used to analyse what is, what is actually happening. .....Obviously I opted for breast feeding a hundred percent - so ..... when I used to be too distressed I used to think he, I used to see him crying, not bonding with me more and not having enough feed and… because I did not have it, you know, you do know that you have it, isn't it? It's biological, it's, it's is something that you can feel"*

In the above excerpt, Shabana also shows that breastfeeding was the "*obvious[ly]"* choice, suggesting that she perceived this as the superior feeding method to any other. She also describes how through the symbiotic distress between mother and son, the baby was not getting enough nutrition through this kind of breastfeeding encounter and also because she as a mother was not lactating.

> *"I couldn't concentrate on my baby. The feed is affected, you know, I think… not, no I don't think, this is - this 100 per cent sure – when you are distressed i-it does affect your supply of feed for the - for the baby."*

Shabana also shows that she perceives the distress that she experienced in the postnatal period was affecting her feeding supply to the baby. Here we have an example of the impact that postnatal distress can have on caring for the infant, but specifically in terms of providing nourishment to the infant.

4.3.2 Post-birth immobility

Some of the migrant Pakistani women described feeling physically incapacitated after childbirth. They reported experiencing complicated childbirths, which seemed to contribute to the sense of feeling immobile in the initial part of the postnatal period.

This in turn left the women struggling in caring for their newborns which further impacted them psychologically.

For example, Shabana describes her difficulty in holding her son immediately after his birth:

> *" I was not that able to keep him in my arms or try to feed him, or do something, because I was haemorrhaging a lot, I was on one bottle, and erm... number one... number two: I could not move, number three: I lost 1000 mls of blood during the tear so I was just lying in the bed and that was it, not moving."*

Shabana reports the impact of this post-birth experience, and one learns about the guilt and the consequential postnatal distress she endured due to not being able to hold her son:

> *"The guilt was actually with… I still feel that, I mean, I didn't hug my child right after being born. I sometimes cry when I think about it."*

She elaborates further and one learns about the sequence of events that led to the post-birth difficulties and the feelings of guilt:

> *"I kept thinking about it after I even brought my son to home. I kept thinking about that, I kept thinking about that pain, I kept thinking about that ....the pain of the delivery and I kept thinking about why I didn't have my son when he was born. What was his problem?"*

Shabana describes experiencing intrusive thoughts about the labour pain and getting caught in a ruminative process following childbirth regarding her behaviour with her son. One senses that the above statement of the complicated labour is not necessarily the complete reason for not holding the newborn.

It seems her childbirth was traumatic:

> *"I had quite a traumatic... my delivery is actually called by the doctors a 'traumatic delivery' and the reason was that my son had turned on his side*

and.... unfortunately he could not deliver in a natural way – it was a vacuum delivery

....

Ultimately the baby was delivered with a ....third degree where his shoulder was dashing out and I was - 36 hours labour, I was alone, screaming badly, 'oh my God'."

She then describes how the trauma impacted her in the immediate moments after delivery:

"when my son was delivered he did not cry. Even though he was delivered I was shocked, I wasn't moving"

The traumatic delivery combined with the baby being mute as soon as he was born evoked a sense of shock within Shabana. In turn, the amalgamation of these events and the shocked emotion may have disabled her physically, leaving her unable to move. This resulted in her being unable to hold her son immediately after birth. Once she was outside of the trauma environment (the hospital) she seemed to ruminate on reasons for not holding her son and the emotions of guilt seemed to take over. One can see the power of post-birth physical immobility and the lasting psychological impact it seemed to leave on this woman during the postnatal period.

Shaheena had an emergency caesarean to deliver her son. She also described experiencing immobility post-birth:

"... the difference between the normal and the caesarean is like you can't do anything. You can't turn - you can't sleep, like, in a turning position. You can't give him milk, the baby, easily. And you know you have to sit down properly because of the stitches.

..... You feel normal but you can't walk normally. I think 20 days. It takes 20 days to recover, you know. So it's also very difficult."

It seemed that Shaheena felt unable to do certain tasks (physically), which she describes as beyond the realm of her control (repetition of the word: "*can't"*). This in turn brings the question of underlying helplessness being harboured within Shaheena's

uncontrollable experience of her body. Consequently, one is faced with the picture of distress that she endures in relation to her body.

4.3.3. Experiencing an unplanned pregnancy

The majority of the migrant Pakistani women reported experiencing an unplanned pregnancy, which emerged as a prominent theme through the transcripts. Such a complex experience was defined as shocking by all the participants who experienced the unexpected pregnancies.

Rahana described feeling as though the experience of motherhood had entered her life too young and too soon for a woman who had newly migrated to a vastly different country. The underlying thread of this unplanned pregnancy was sheer shock:

> *"I was still young, just come here and a month later I found out that I was already pregnant so that was a big shock."*

Rahana illustrates that she felt unprepared to experience any other relationship beyond her couples unit with her husband, who she yearned for time with before having a child, as they had an arranged marriage. Thus illustrating the reason behind the deep-seated shock:

> "*I just thought we hadn't really done anything yet, been out, had time… Because my marriage was completely arranged and I thought you know I haven't even really got to know you that well and I'm already pregnant. So it was a real shock to the system."*

The toll of migration and motherhood seems relevant here to Rahana's account of the shock of getting pregnant so soon after moving here. This suggests that an unplanned pregnancy can in itself take a toll on the migrant Pakistani woman who has just migrated to a Western country like the UK. This draws a link between the subtheme experiencing an unplanned pregnancy and the subtheme the toll of migration and motherhood.

Shabana also reported a deep sense of shock, feeling unprepared and there is a sense that her second pregnancy felt unwanted:

"Basically my second pregnancy, throughout had been kind of.... shocking. I mean, I did not want that but it happened."

"...I was not at all ready in five months, for it and for two children. I was really, really upset about it.....".

Psychological unpreparedness for pregnancy and motherhood was not the only reason for Shabana's distress, as she shows she viewed the unplanned pregnancy as a major obstacle to her future plans:

"Another thing why I was so depressed – I still do and I have always been longing to study here and when my son was.... four-months old I applied to so many universities here and I got unconditional offers. I was a hundred percent ready to start my studies....

.... You know my daughter was born in October and the session started in September so obviously what would I do? What else would I have to do other than cancel everything?

All my plans were gone. I was like oh my God."

When asked what else she felt during this time, she reported:

"*hurdled"*

and:

"*obstacled"*.

She further reported:

"I was shocked because my plans were disrupted; not disrupted – diminished."

One senses that during the process of acknowledging this pregnancy, she was also experiencing the loss of something so meaningful - a future that she had planned for herself. This seemed to be a great source of distress and a shocking experience as noted from the above evidence.

Similar to the other two participants, Shaheena's lived experience of a sudden unplanned pregnancy also left her feeling psychologically shocked:

> *"after four months I got again pregnant and it was very shocking news for me. It was, it was unplanned."*

Overall, this master theme illustrates the perceived level (or lack) of control the participants had on their body as part of motherhood and especially when entering the postnatal period. In actuality, this is the period when so much is demanded of women physically - be it physical tasks of looking after the baby or being able to feed the baby through one's body, something which is considered a natural bio-physiological process. It seems that the body requires space and time to recover from the physical demands of childbirth; yet the newborn infant is there and completely dependent on his/her mother to feed and nurture him/her and meet their every need. This is the battle that the women face as part of the postnatal period - the demands of the body versus the demands of the baby, on occasions creating a web of distress. In addition the shock of unplanned pregnancies which occurred either immediately after migration or very quickly after already having had a child, seems to be a source of great distress. It seems that the body is not given enough time to recover and recuperate or to adapt to a new country and is then made to quickly take on - an unplanned - secondary pregnancy. This illuminates the subordinate theme the toll of migration and motherhood.

4.4 Overview of Master Theme Four: Living with Postnatal Distress

Through the discussion of the above master themes, there is a sense that distress is deeply entrenched in every aspect of the postnatal period for these migrant Pakistani women. This master theme, aims to capture a deeper view into the distress itself, how it is experienced and what postnatal distress means for these women individually.

Every single woman subscribed some kind of meaning to distress based on physicality as well as deep emotional melancholy. There was also a sense of feeling burdened and unable to cope and the experience of isolation. All these subordinate themes are

examined and one learns that they make up the lived experience and meaning of postnatal distress for these migrant Pakistani women.

4.4.1. The experience and meaning of distress

All the migrant Pakistani women described a personal sense of distress that they experienced during the postnatal period. They all formed some kind of interpretation of their reality of distress.

Here Rahana viewed her constant mood state as representative of her distress:

> *"Just used to feel low all the time"*

She also described crying in privacy, where no one could see her tears, something which seemed important to her:

> *"At night time or sometimes when I was on my own awake with him. I used to think 'My God, this is like a nightmare'. Yes, I used to cry a lot. Not in front of anyone but sometimes if I was in the toilet or the shower or… you know, it's like I could wash it all away and no-one would see."*

Shabana understood her distress in terms of religious and spiritual disconnection as a result of her female bodily pollution. She describes herself as "unclean" due to the postnatal vaginal bleeding that was occurring, which was leaving her unable to engage in formal prayers:

> *"I was feeling that these things are happening only because I'm not having, I'm not getting, praying properly. I'm not clean inside"*

She describes how formal praying is forbidden during menstruation according to Islam and she experienced a lack of connection with God, which added to her feeling of distress:

> *"Muslim women are not, of course, allowed to pray, you know five times pray, we are not allowed to fast and - but generally if you want to recite something*

from Koran or something that is absolutely fine without getting abluted and everything, but formally you can't do it. .....You know when you are distressed if you don't have somebody.... you have your Creator with you; you've got God and you talk to him, you do, so it really helps also."

It seems that Shabana understood her distress as a consequence of spiritual disconnection. Her connection with God is through her prayers and without this, it seemed her relationship with God had almost been put on hold, like it had been disturbed. Not having this daily connection may have felt like she had lost a significant and meaningful relationship. This in turn caused her anguish.

Shabana also described herself feeling "heart-broken" due to the sudden second pregnancy, which occurred within her first postnatal period. This unexpected event led to the demise of her plans to study further. There is a sense that she is communicating the intense emotional angst she experienced as a result of having to end her plans:

"Broken. My plans were broken .... I felt my heart broken; I...because when you have made up your mind for something hundred per cent and when you can't do that, it is so breaking."

Shabana's sense of feeling broken and bloody (as explored above as part of the postnatal bleeding) even appears in her dreams:

"I used to see my parents badly ill, you know, this portion is (turns to right side and shows that side) *broken and blood coming out, so - such that I used to wake up to my husband and I used to be - I was screaming or something, no, no this is not possible, this is not possible."*

One gets a sense that Shabana experienced these nightmares as alarming and disturbing. The content of the dream could be reflecting her inner psychological state. On the face of it, it seems that Shabana is having a horrific and frightening nightmare about her father, a parental figure. However, her father could actually be a symbolic representation of parenthood; after all, her blueprint of parenthood is most likely to be her own parents. It's possible that the dream of this parental figure was in actuality a deeper representation of herself, because she in fact had now taken on the role of being

a parent and it seemed she was the one who was perhaps "*broken*" and *"blood[y]"* as she entered this phase in life. Evidence for this is illustrated in the transcript extracts provided above, where at various points Shabana points out the significance and impact of the postnatal bleeding.

Shaheena described PND and distress as a sense of dissatisfaction and restlessness, which is a literal translation of the Urdu words: *"chirchira pann",* words she used to describe her understanding of what it means to experience distress in the postnatal period.

Similar to Rahana, Shaheena reported that crying was a significant feature of distress in the postnatal period:

> *"I cried most of the time. I feel cry-crying"*

She also described viewing PND as a result of physical exhaustion:

> *"When he* [baby] *sleeps I completely finish my all works and then I feel tired. So as I feel tired, he awakes. So there is no time to take rest of me. That's why I think this depression comes to me."*

Shaheena also attached the feeling of "hate" - an extreme emotion to her experience and understanding of postnatal distress and depression. This description showed her immense lack of pleasure in every aspect of life:

> *"You hate everything and you doesn't like anything."*

Shazia on the other hand, perceived PND and distress as a creator and reinforcement of physical ailments. Her description illustrates her belief in a mind-body attachment:

> *"sometimes it make you, ...headache or sometimes make such a kind of stronger problem. It affect a person's body as well.*
>
> *You're physically depressed. If you are mentally depressed it has more effect on your body."*

4.4.2. Feeling burdened and unable to cope

All the women described a sense of feeling burdened with their child[ren], their role as a mother and managing other "duties". The women's experience of feeling burdened seemed to stem from often being the sole bearer of childrearing responsibilities. This appears to be an overwhelming job and an enormous challenge, in which the women feel compelled to helplessly manage whilst psychologically feeling unable to cope - thus defeated. This seemed to be another feature of living with depression and distress in the postnatal period.

> *"They've got more emotional and physical support there* [in Pakistan]. *This is very important, very important. Honestly, it is. If you don't get any of that then it's like all the burden is on - just on one person, the mother. I think so. This is what's happened to me. The whole burden was on me."* (Rahana)

Rahana's description shows that the distress she lived through with feeling burdened, in her view, was a result of social circumstances - the lack of emotional and physical support that seems to be readily available in Pakistan. Her last sentence shows that the lack of support meant she was left carrying the burden and thus overwhelmed. This draws a connection to the earlier theme of the importance of support from the marital partner (discussed earlier in the subordinate theme: experiencing difficulties in a marital relationship) and how lacking this can invoke this difficult experience of feeling burdened and unable to cope.

Rahana shows the struggle of coping with the night-time care of the baby:

> *"I used to be tired all the time..... Lack of sleep made me all depressed as well and he would cry the whole night and I would have to keep taking him on my shoulder and rocking him and you know sometimes I used to get really cross and say 'just go to sleep'. And one time, I just put him down really hard in the cot and said 'just sleep and don't wake up'. But he was crying his face off and then I would pick him up and then eventually when he would go to sleep, he would*

sleep for the whole... until 10 or 11 in the morning and I'm the one who would have to get up because my mother-in-law hated it if I slept."

The above description shows how Rahana seemed to be the sole parent taking care of the baby during the entire night. Her angrily desperate plea to the baby to '*just go to sleep*' echoes her helpless exhaustion and thus frustration. Then seeing the baby's distress, she has no choice but to take him back in her arms and aid to his needs. The entire scenario depicts a mother who is heavily burdened and struggling to cope during the postnatal period. Rahana also draws on how the demands of her mother-in-law effected her, it seems that she felt psychologically pressured to meet her mother-in-law's requirements (being up on time and not being able to catch up on sleep) at the detriment of her own (not getting sleep), which draws a link between the two subordinate themes and their relevant master themes (Feeling burdened and unable to cope [living with postnatal distress] and matriarchal power struggle[the experience of significant relationships]).

Shabana reports:

"You know managing with two kids, on your own, you know it's a bit difficult. .....They have got the same routine and when both of them started crying, I used to be panicky – oh my God how would I… let me stop her first and then he would not stop... crying. Let me check how he is doing and she would start crying again."

Shabana shows that managing practically with two children of such young ages (one-year apart) is a struggle.

She then elaborates further on how this impacted her:

"I used to be like.... not coping well. I mean sometimes I used to be like, if my daughter is crying, I used to let her cry; cry, I can't - I'm not going to come to you. She used to cry really badly, so I mean, I used to, I mean - it used to be cruel, I mean I don't want to say that, but this is what I did, this is how I think I could get on. I sometimes used to leave her on the side of the bed, I mean on the bed, and not come in to her. She used to cry for half an hour to 45 minutes and I would not come to her, and I mean.... it sounds cruel, but what would I do."

Shabana describes herself as refusing to attend to the constantly crying baby. She described this behaviour of hers as "*cruel*", showing that she may be harbouring negative thought processes about herself. She states that she does not "*want to say that*" suggesting that perhaps she feels ashamed of her actions. When she says: *this is how I think I could get on,* one senses that she struggled to cope and was looking for any way that she could survive the difficulty of a crying baby in the postnatal period. This is a key point here, Shabana's helpless choice (*what would I do)* to ignore the crying baby was perhaps her only survival mechanism.

The word *can't* makes an appearance in Shaheena's account as well, illustrating her experience of struggling to cope:

> *"I can't do anything. I can't - I'm not able to take care of the child"*

Shaheena's account shows that she perceives herself as incompetent in caring for her child, which illustrates the underlying hopelessness she may be experiencing.

Shazia's account was:

> *"it's a big duty to look after the baby and everything to manage, home or other activities"*
>
> *"I was just thinking it just a burden, you know, work, duties"*

When asked what it was like for her to manage everything, Shazia reported:

> "*it's difficult to do that, over here with the baby all the duties you are doing yourself."*

Shazia explicitly states that the demand of childcare along with managing so many other "*duties",* often in isolation and without solid support created a sense of feeling burdened. Thus demonstrating an 'overwhelming' experience.

4.4.3. Isolation and Loneliness

All the migrant Pakistani women described feeling deeply isolated and alone after the birth of their child, when they embarked on the journey of motherhood. There is a sense

that the women feel they lack emotionally based relationships, such as friendships or close family, where they can share their concerns and problems or even just share important matters in their life. They also describe missing their family members.

Rahana described her loneliness and isolation as a result of lacking family and friends:

> *"Well, alone in the sense that I didn't have any friends here and no family except my aunt, my mum's sister but she was quite far from us."*

She provides insight into why she may have struggled to be by herself and why feelings of isolation may have been so profound:

> *"I've lived there* [Pakistan] *for like almost 15/20 years you know, and there it's a normal.... it's an everyday thing to visit people. I felt all alone here with everyone else back there. It was a complete… The way I was brought up in a very protective environment, ...I never slept alone; I used to sleep with my grandmother. .....Also, any time if I ever went out anywhere or anything, I never went on my own anywhere. One of the servants, maids would come with me or my grandmother used to go with me. So that's why coming here it was like 'Oh my God, I'm totally alone' and that made me depressed and then I got pregnant and that made things even worse."*

Rahana describes how during her childhood she was raised protectively in Pakistan where she never experienced being alone, in her house, whilst sleeping or any time when she stepped outdoors. It seemed that she had never been socialised into being by herself. Therefore to then be in an environment without her family and friends and having to live in autonomy seemed to invite a deep sense of isolation and loneliness. As a result she experienced depression. This also illuminates the culture shock she described in the previous subordinate theme: the toll of migration and motherhood (under master theme: experiencing transitions). This shows a link between how migrating to such a vastly distinct culture and country can invoke a lonely and isolated experience as shown by Rahana's account.

Rahana also reported the loneliness of being home alone all day with a newborn:

> *"I used to be alone in the house with the small baby ..... I used to be all on my own at home. .... it was a very difficult time and I'm glad it's all gone and dusted with."*

We get a sense that the experience of looking after the baby without any support was an isolating and distressing experience in itself (*It was a very difficult time*). Rahana shows her relief at no longer having to live through that distress as she reports that she is *glad it's all gone and dusted with.*

Shabana describes how deeply rooted her experience of loneliness was:

> "*I was afraid of sleeping only because I did not see good dreams.*
> *I was seeing myself alone in the darkness and nobody with me and that was kind of, at that time, sometimes I used to feel that. Yes that is true, there is nobody with me."*

Shabana's loneliness seems so powerfully entrenched, that she cannot even escape it in her sleep, when it is her time for rest and recuperation. The loneliness in the darkness may also represent her inner psychological state of feeling as though things are confusing and unclear, as darkness often masks light, through which one can see clearly. It may also represent her getting lost into vast nothingness (*the darkness)* as she cannot feel her existence without others (*nobody with me*), once again this would be a manifestation of her isolation and loneliness.

Shaheena reported:

> *"You want to talk to your sister and your friends and here is no friends, no sisters, no, you know, no-anyone to listen you."*

The excerpt shows how Shaheena desperately wanted relational engagement and support with familiar people - her sisters and friends. She also shows a desire for someone to listen to her, one senses that this is something she was missing. Her social circumstances illustrate why this was perhaps the case:

> *"They* [family] *go outside and I was only the one person who is in the home and I'm - our child."*

Similar to Rahana, Shaheena shows the experience of her daily living being isolated and alone with the baby.

Shaheena also reported her distress of loneliness resulting from her engagement with her husband:

> *"I'm feeling so lonely at that time when he d-doesn't speak, doesn't talk to me. Even now if he doesn't talk to me and his appears very rude to me, I feel very lo-lonely. Now as well, you know?"*

It seems that when her husband withdraws all communication from her or provides negative engagement, Shaheena's sense of loneliness and isolation heightens. It is possible that the lack of other enriching relationships in her life (as mentioned above, no sisters or friends) has created a socially isolated life. Perhaps, her relationship with her husband is her only real relationship in the UK. During times of conflict with her husband her sense of being cut-off from all her other relationships and the emotional distance with her husband (her only source of relational support), may heighten her awareness of being alone and isolated. Such an experience ties in with her account of her relationship with her husband in the earlier subtheme: 'experiencing difficulties in marital relationship'. Shaheena stressed how the husband's role has the power to influence her emotional wellbeing and how important this relationship is to her wellbeing as a woman and mother (see 4.2.3). Her earlier account was specifically in relation to the importance of marriage, the relationship to the husband and how significant his support or lack of support may be. Here we are seeing more of the impact of the difficult marital relationship and how loneliness can be entrenched through the lack of communication with the husband.

Shazia also described her experience of social isolation and how she wished to share her feelings and experience after delivering her baby, but she had no friends who she could engage with or relate to. This in turn creates an experience of loneliness:

> *"And if you feel over here lonely, no one is here, how you feel after, during the delivery, how are you feeling, and pain, everything, you can't express it with anyone."*

Overall, this master theme illustrates that all the migrant Pakistani women experienced and lived with distress through the postnatal period. The picture of the lived experience of postnatal distress appears complex, but overall the women illustrate that they all attached meaning to distress whilst the experience of it was individual. The distress encompassed an intense struggle to cope especially where childcare was concerned and the women helplessly adopted strategies of survival to manage however they could. Isolation also played a role, in which women missed familiar and comfortable relationships and missed a confidant who they could share their experiences with.

4.5 Overview of Master Theme Five: Experience and Perception of Pakistani Culture

The majority of women perceived the Pakistani culture as holding poor gender attitudes towards females. There is a sense from the women's descriptions that some of them desire freedom and independence, thus steering away from the traditional female role of being a housewife.

In contrast the culture's positive aspects were also reported as some of the women described how Pakistani culture is built with support systems in place to aid women during the postnatal period, a time when rest and practical help is needed. This master theme captures two subordinate themes: Pakistani culture's negative gender attitudes and issues with female autonomy and supportive system within Pakistani culture; both these themes are discussed further.

4.5.1. Pakistani culture's negative gender attitude and issues with female autonomy

The migrant Pakistani women described how they perceived their freedom and independence as restricted by family members, such as parents (in the past), husbands and in-laws (in the present day). Some of the women describe experiences outside of the postnatal period, but this is still relevant because this curtailment to their freedom impacts them in terms of accessing help without fear of repercussions. Furthermore, the

strict environment they are embedded in, either forms part of the history of why they struggled during the postnatal period or how this environment is a source of distress.

Rahana described why she struggled so much in learning to adapt to the UK culture and with looking after her baby in complete autonomy:

> *"when I was growing up things were very protective. My friends were like that as well. If we had birthday parties and things, most of the girls were allowed to come to my house because they'd met my parents and they thought it was safe but even my friends used to be accompanied by somebody, a maid from their house or a servant girl or something and then they used to all sit in the kitchen with the rest of them. They were never allowed to come alone*."

Rahana's account shows how her early history may have played a role in the struggles she encountered in her later life experiences of migration and motherhood. It seems that whilst growing up in Pakistan, she was never socialised into believing in autonomy or being able to do things independently; she had never experienced being alone as this was not normal. These rules seem to be applied to other girls, which suggests that this was a cultural norm and females were raised in highly protective and restricted environments. From Rahana's account, it seems that being part of the UK where she had to be autonomous and manage being alone all the time in her home with a baby, without help and people around, felt strange and alien to her.

Rahana reflects that she feels her overprotective upbringing in Pakistan may not have been helpful in preparing her for the transitions in life that she had to face:

> *"Now, thinking of it, I suppose it was wrong in a way being so overprotective, which didn't help me coming here and then getting pregnant. It's like a bomb that exploded all of a sudden. You're in one extreme end and then you come to another extreme end. Then obviously falling pregnant really quickly, especially."*

Rahana's above accounts illustrate how the Pakistani cultural attitudes to gender and the issues of female autonomy tie in with the subtheme of the toll of migration and motherhood. It seems that lack of female independence and over protective upbringing

may have played a role in the culture shock and the toll that migration and motherhood simultaneously took on her when moving to the UK.

Shabana reports how there is a negative cultural attitude to the female gender:

> *"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. So I got that and gradually the feelings of happiness and contentment."*

Shabana shows how she experienced being valued because she had bore a son. This of course illuminates a positive part of her experience after having her firstborn baby, her "*powerful and more blessed*" son. However, she reports experiencing immense struggles and difficulties after the birth of her daughter. She described finding it difficult to tolerate her crying (as stated above in other themes), aiding her, feeling regretful for getting pregnant with her as this was not part of her plans, which in turn left her feeling "hurdled". Whilst all these aspects clearly contributed to her difficulties, one cannot help but also question the role that cultural attitude to the birth of the daughter may have played in her postnatal experience. She clearly states that bearing a son led her to be valued more (*So I got that*) which led her to gradually feel happy and content. It's possible that the lack of cultural value given to her - a mother of a daughter - may have played a role in how she perceived her newborn female child and therefore related with her. This may have also impacted upon Shabana's psychological state of feeling down and struggling to cope.

For example, there appears to be stark differences in how she appeared to feel about her son:

> *"bless him he is a darling. I mean even from that age, he used to listen to me and I used to say to him 'I am not feeling good please stay quiet' and he used to be quiet. He was one year old. Just bless him. Right now he is the best son I've ever seen in the world."*

and daughter: (mentioned as quote before):

"*I used to let her cry; cry, I can't - I'm not going to come to you. She used to cry really badly."*

Whilst Shabana did at times report loving thoughts towards her daughter, one cannot help but notice the circumstances in which the daughter was born (unwanted/unplanned pregnancy) and within a cultural dynamic where male births are celebrated and female births seen as problematic, this may have played a part in her experience of PND too.

Shaheena described how Pakistani women are controlled and restricted in life generally by their husbands and family. She reported that this in itself would probably stop women from accessing healthcare services and support that they may need, for fear of family and repercussions they may face. This in itself was why she claimed she would not report her true depressive feelings to the HV, if asked how she was feeling:

"Pakistani woman, they will not go to the NHS and they will not explain what they're feeling now. .... And they have problems. But they have a problem. They will not go.

.... in Pakistan the culture is really… for the girls… it's very... you know... conservative…and their husbands are very conservatives..... So that's why I know, no Pakistani woman will go outside and they will…[not] share."

....

"Because..... Speak to Doctor about it.... and the doctor will ask from his husband.... of her husband, her and her, you know, so the husband will react badly to her or something like that. Or will tell her family to Pakistan. Yes Pakistani women are very shy and very scared."

Shaheena reports how even if Pakistani women wish to access support from healthcare services, the family and cultural dynamics will stand in the way:

"But if she will - the Pakistani woman will want to co-operate with them, nobody will, you know allow them, like husband or mother-in-law or parents, you know? They will not allow her, to… you know, because they will feel like she's not happy with him. Like why she's not… Pakistani husband feels like if they will allow her, you know, to go there, she will be independent and it will be too

dangerous for him and if they will do like nothing... or something like that .... that if it is... if behaviour is not good, so she will go there and she will tell everything so it's not good for him. So that's why I think."

This is illustrating the degree to which female independence can be curbed and controlled in Pakistani culture, even to the point of accessing healthcare for postnatal needs.

Shaheena describes:

"You know, in the Pakistani culture, the, the woman's have, don't have any rights to do anything.

.... in our culture, we are… first of all we are not, you know, some husbands doesn't allow them, don't… that they go outside alone, alone, you know?"

One gets a sense that the wider cultural issues, containing strict gender attitudes, work against Pakistani women and specifically with Shaheena, it seemed she feels that her freedom and right to access support can be restricted by her family. This micro based issue in Shaheena's lived experience seems part of a wider macro level issue that she has honestly reported.

Shaheena also draws a comparison to Indian women and how they live their life in contrast to Pakistani women in the UK:

"I think for Pakistani woman who lives here, in my experience of Pakistani women, the difference between the Pakistani and Indian woman's, you know? I don't know Bengali, Indian woman's are very confident and Pakistani woman's are very shy. You know, in the Pakistani culture, the, the woman's have, don't have any rights to do anything and in Indian culture they are very independent. They live independently, they do, they do jobs, they do everything, but in our culture, we are… first of all we are not, you know, some husbands doesn't allow them, don't… that they go outside alone, alone, you know? Go with them or, or with friends. We can't do, we can't, you know, Pakistani woman's can't go lonely anywhere."

Shaheena demonstrates an honest account of what she has experienced and witnessed when comparing herself to women from other South Asian countries in Britain. Her awareness of Indian women's freedom and autonomy illustrates that she perhaps feels this is missing in her own life as a Pakistani woman. The repeated use of the word "*can't*" illustrates that she may feel helplessly controlled and restricted by her husband. When asked if she would have liked to do more things, she responded "yeah". This illustrates that she may feel her rights as a woman and human being are restricted and this may in itself form part of her distress and isolation, especially if she is prohibited from accessing support.

4.5.2. Supportive system within Pakistani culture

Some women reported how the Pakistani culture back home is built with supportive systems in place for women during the postnatal period. There is a sense that these women missed out on salient practices with having migrated to the UK.

Rahana reported how she felt compelled to go to Pakistan after the birth of her elder son as she felt she was over-weight due to being unable to take care of herself in the UK. She described this being due to lack of help and support:

> *"I went to Pakistan for six months because I was still struggling to lose weight and I said to him 'look, I need to sort myself out; I just can't do it here, I don't have any help here'."*

She reported that in Pakistan there is a cultural norm to have house maids and servants, which aids the manageability of a home and provides the much needed support for a woman, especially one who has the responsibility of motherhood. Such support could be invaluable during the postnatal period:

> *"Help in the sense that you know in Pakistan we've got servants in the house to clean so you have time for yourself but here, it was like I had to do everything; the cooking and the cleaning and looking after the child so it was no help in that respect."*

On some level, Rahana seemed to perceive Pakistan as a place which rescued her from her troubles and provided support to regain herself:

> *"I think you have more support there because when I took my son to Pakistan for the first time when he was about three months old, three and a half months old*
>
> .....
>
> .....
>
> *While I was there, I felt a lot better you know, because I was getting help from mum and dad to look after him and I was catching up with my sleep and I would go out with my friends as well."*

Rahana's above accounts demonstrate a link between this theme and the previously mentioned subtheme of: 'change in identity and experience of self". It seemed that by accessing the readily available and culturally normalised help and support in Pakistan (from her family) allowed Rahana to get herself, her identity back, which she described as losing in the previous subtheme (see section 4.1.3).

Shazia also reported how the family support system in Pakistan aids a woman, especially when she has just become a mother. She reports how the woman gets rest for the first month after delivery, which seems to be a salient and valued cultural practice:

> "...*The whole family is supporting you even…, in Pakistan if a girl, if a woman have a baby, 30 days [s]he can't do anything, [s]he will never do anything, everybody will do for him* [her], *his* [her] *baby* .....
>
> ..... *She, she just sleeping, all the time, sleeping, you can walk everything, you can do what.... but you can't the house duties, like making tea, like make baby's milk or change the nappies, these duties are not the women's, that's for your grandmother, your nani (maternal grandmother), your dadi (paternal grandmother), you know, the, yeah, these people are doing all these duties, you know. You don't."*

Overall, this master theme highlights how most of the migrant Pakistani Muslim women experienced a negative gender attitude in the Pakistani culture and issues with female autonomy. Being raised in an overprotective environment may not have helped them to

grow into independent individuals, which in turn may have taken its toll on them later in life when such skills and characteristics were required as part of migrating to England, a vastly different culture to the one they're used to. Then taking on motherhood would have taken an extra toll on them. This subtheme therefore does demonstrate a link to the previous subtheme: the toll of migration and motherhood. Negative gender attitudes to females can permeate through individual Pakistani women's psyche, in that it is possible they struggle to develop a healthy attachment to their baby daughters due to the infant belonging to a gender that is often undesired in the culture (as stressed by Shabana). Furthermore, the non-acceptance of female independence is entrenched to the point that women may feel prohibited from speaking out and accessing support in the NHS.

On the other hand, some of the women also described how Pakistani culture is built with support systems which they would have valued. One woman even went back to Pakistan as a way of regaining her lost self, which shows the link of this theme with the previously mentioned theme on change in self and experience of self. Another woman described how the entire family makes themselves available to support a woman who has given birth. This has implications and thus draws links with many previously mentioned subthemes, for example - lacking knowledge and experience of motherhood (if family members and elder females are around, they may be able to answer questions and help ease the woman into the motherhood role and caring for her infant). It also has implications for the subtheme: feeling burdened and unable to cope, as if the family is available to provide care and support (as Shazia described) then the burden of motherhood and childrearing is not just resting on the new mother. Such issues in turn would then also have implications for the experience and meaning of distress, which may not have been so deeply experienced as they would have been within supportive environments.

4.6 Overview of Master Theme Six: Patchy Provision of "Good" Healthcare

This theme captures the inconsistency in the quality of healthcare and service provision according to the women's accounts. Whilst three out of the four women reported

positive aspects about the healthcare and services they received, every single participant did describe issues of concern with healthcare and services. This was especially in regards to staff conduct, where the women's experiences ranged from - at best - lack of enquiry into their postnatal distress, and at worst - aggressive staff behaviour and violation of confidentiality. Two subordinate themes were identified under this master theme: poor experience of healthcare staff and services, and "healthy" healthcare and services.

4.6.1. Poor experience of healthcare staff and services

All the women described experiencing some form of difficulty with healthcare professionals, either them making lukewarm health inquiries or negative staff behaviour.

Two of the participants described health visitors (HVs) as not probing or enquiring deeper about their postnatal psychological wellbeing.

Shabana reported her experience after the birth of her second child:

> *"If she [HV] had talked to me about myself a little more that would have been a good help, it would be a good catharsis"*

The experience after the birth of her first child:

> *"The first one – the midwife was really nice. I mean the HV sorry. She did not actually ask me. I told her that I am missing my family quite a lot and then she was quite sympathetic and she was empathising also, so… If she would have asked me herself I think it would have been better."*

Shabana's report shows that she perhaps experienced the HV as giving her as the patient, little focus. She described believing that she would have attained emotional release had the HV probed further, which magnifies Shabana's wish to have explored her feelings more than she was given an opportunity to do.

Shaheena also described experiencing a lack of enquiry about her emotional wellbeing after childbirth:

> *"She* [HV] *noticed but - no not too much. She didn't ask me about depression."*

Shazia's report was more alarming. She described herself struggling with language barriers as her English language abilities are basic. She reported that she encountered frustrated behaviour and treatment from reception staff at a children's centre where she was trying to access antenatal healthcare:

> *"one time I came here, because at the time I was new and I don't have interaction with the people and I don't know the, over here, the people, that's why I was bit shy and what I can say, a bit, you know, that people is frightened… 'darrahua' (*frightened/scared in Urdu*) and I don't know how to talk with the people.... and the lady - [s]he might upset because of some other reason and [s]he just burst out me, 'What's the, what's your problem, what's your problem!? I can't understand what you are saying', like this; And just... that make me a bit frightened, I shouldn't come here again, and she's talking, how she's talking(!), and I didn't talk with anyone else"*

> *"The reception desk this happened to me"*

Shazia's description above shows that she was new to the country and somewhat anxious about communicating with service providers about her needs. There is a sense that she lacked confidence in her ability to communicate effectively. She describes experiencing the staff having a frustrated and slightly aggressive tone in response to her language and communication difficulties. This in turn causes Shazia to feel frightened and she blames herself to some degree for even attempting to attend the service. She withdraws herself from receiving any potential care.

Shazia also described how she was left feeling from this negative encounter:

> *"I was thinking might be happen every day with me, I shouldn't come here, that's why I just, I didn't come there"*

"That make me a bit depressed and, no, it make me angry too much. I want to burst out (gestures hand) *for her but I, at that time I wasn't know that here what should, what will be happen next if I will do this."*

Shazia's account shows that her worry and fear was evoked by the thought that she could receive this negative staff treatment again. She also described how during the moment of receiving this treatment, she experienced anger and wanted to react back in an aggressive manner to the receptionist, but she did not follow this through in her behaviour due to the thought that she was in an unknown environment and felt uncertain about the repercussions she would have to face. There is a sense of anxiety in how she describes such a worry.

Shazia also described how due to language and communication difficulties she was not aware that she was supposed to see a midwife regularly as part of her antenatal care:

"because I wasn't know about all these things, even though the whole, my whole pregnancy is gone without any.... err... appointment with the midwives. Because, I don't know, I was new here and I have a little bit problem with the language and because of that I missed all the appointments and after seven months I know there should be the appointments with the midwife, all these things."

However, Shazia was able to inform her GP of the treatment she encountered at the children's centre:

"*I talk with the doctor when next I have an appointment, when they called me, I told them I came here and no one was here good, they did not talk with me properly all like this."*

And her antenatal appointments were completed within one month towards the end of her pregnancy:

"*Then he manage all the appointment days and within one month they completed my all appointments."*

Shazia shows how she's aware that the midwife could have prepared her for the baby and provided knowledge on his care; perhaps if she had better communication skills, she may have then had improved contact with the service providers:

> *"midwives, they play their role a lot because during the pregnancy time most of your time is spent with the, if there is someone, the midwife, she can help you, she check you and everything, you can, she can talk to you, she can, told you before, about experience what is happening next."*

Rahana reported how her GP was a family friend and through this connection, she leaked Rahana's private healthcare information and breached the rules of confidentiality:

> *"When I'd come here I'd got registered with my mother-in-law's friend who was a doctor and this was really bad, ... whatever I told her she went and told everyone which is very unethical of a doctor to do you know? She went and told… everyone basically found out because she sent a letter to me, a copy of a letter or something from a HV or something stating that she thinks I'm suffering from postnatal depression but somehow all the information got leaked out somehow, I don't know, through her."*

Rahana describes her feelings in response to this experience:

> *"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.*
>
> *"I was very angry at that and that made me even more depressed."*

The above excerpts illustrates the anger Rahana experienced in response to her trust being violated by a healthcare professional. Rahana's use of the word "*wrong*" shows her viewpoint that she perhaps experienced the doctor's actions as a moral violation against herself. Her description of feeling "*even more depressed"* perhaps marks the helplessness she experienced with the doctors violation.

Rahana reported a more positive experience with her second GP (which is discussed in the second subordinate theme), but reported that more could have been done and they could have referred her for counselling:

> *"They could have offered a bit more sort of counselling or something I suppose..... They could have maybe suggested some support groups or something. Something like that I think that would have helped."*

4.6.2 "Healthy" healthcare and services

Whilst the women described experiencing insufficient or troublesome service from healthcare providers, majority of the women also reported experiencing positive aspects to the care they received.

Rahana described how her second GP provided a caring service, oriented around listening to the patients' needs and issues and providing psychosocial solutions to help her:

> *"It was only when we moved out and we registered in a local surgery, my GP was a very nice doctor, ...She would listen to me and advise me and tell me that maybe I should make friends"*

Shabana reported that the aspect of care she did appreciate from the HV was the informative advice that she provided to her as a new mother who lacked knowledge about practical aspects of caring for a baby:

> *"Perfectly, a brilliant help. Honestly. Because the HV used to tell me how to put the cot, the leaflets were very good, very informative, how should I put the baby into the cot and everything. You know these are techniques that I did not know, I got to know it because of them, through them."*

Shaheena reported why she felt her HV was "good":

> *"Because she told me about everything, you know, you have to go to children's centre, you have to go outside and no-one is smoking at home, and do like… she*

talked to me like very good things at that time. It was good, and she saw my house and everything is good she said, yep"

Whilst Shaheena is not completely clear as to what specific things she found helpful about the HV, there is a sense that she valued the HVs advice and information.

This final master theme illustrates a mixture of experiences regarding healthcare services. Positive experiences of healthcare services included feeling listened to by a GP and being provided with practical advice and solutions (by GP and HVs). Whereas negative experiences included: insufficient health enquiries into the women's emotional wellbeing (by HVs), aggressive behaviour from staff (receptionist at a children's centre) as a result of communication difficulties, and violation of patient confidentiality and trust (from a GP). This theme does draw links to the experience and meaning of distress (for example, Rahana's account of the GP who violated confidentiality, this left her feeling helpless and depressed) and also has implications for lacking knowledge and experience of motherhood (Shazia's experience in the children's centre during pregnancy could have hindered her from getting important care and advice which may have been related to her experience of needing to hospitalise the infant due to lack of feeding [4.1.1]).

4.7 Summary of Results Chapter

This chapter provided a detailed narrative account of migrant Pakistani-Muslim women's experiences and understanding of distress and depression in the postnatal period. The narrative account illustrated the multi-transitional process that the women reported that they had to endure as part of this experience. The first theme 'experiencing transitions' explores becoming a mother and learning this role. We also learn about the impact this has on their identity and sense of self, which also changes.

The second theme 'the experience of significant relationships' shows how certain relational dynamics can be supportive (such as that with their own mother and a positive marriage), but others can be critical and/ include unsupportive relationships with their mother-in-law and difficulties in their marriage. The latter therefore shows how difficult and unsupportive relationships can be unconstructive to migrant Pakistani-Muslim women's psychological wellbeing and experience of motherhood.

The third theme 'the body and motherhood' demonstrates how physical the experience of motherhood can be for these women and the impact that this can have on their wellbeing. It seemed from the narrative accounts that psychological wellbeing is intertwined with physical issues as part of motherhood.

The fourth superordinate theme 'living with postnatal distress' illuminates the psychological process that these migrant Pakistani-Muslim women encounter as part of their motherhood experience during the postnatal period. One learns about the experience and meaning of distress for these women, how they feel burdened and unable to cope, and experience immense isolation. All of these issues paint a picture of how they were 'living with postnatal distress'. This theme is the middle superordinate theme in the narrative account, which illustrates its core position, where all the other themes branch out from. This is illustrated in the radial diagram, in appendix 19.

The fifth superordinate theme 'experience and perception of Pakistani culture' showed the impact of the culture that these women had been raised in. It showed how growing up in a protective and conservative Pakistani culture may not have allowed the women to develop skills of autonomy, freedom and decision-making. These are all skills and traits that are valued in a Western society like the UK, which seems to be a vastly

different culture to the one they've been raised in. There was also a sense that such a culture may value a patriarchal culture which is evident in a cultural desire for women bearing male infants rather than females.

In contrast, the women also reported how there is a highly valued family support system in Pakistani culture which a lot of the women felt they missed out on and needed as part of their journey of becoming mothers in the postnatal period. This support could have allowed the women rest and recuperation and slowly eased them into the motherhood role.

The sixth theme, 'patchy provision of good healthcare' showed how the women generally reported experiences of maternity services and staff as somewhat inconsistent. We get a sense from the women's report that health visitors care and advice was highly valued but there needs to be more of a focus on the women's emotional wellbeing. The women's accounts highlighted the need for all staff to be open, trustworthy, and treat women from all backgrounds with dignity and sensitivity, including when language may be an issue.

CHAPTER FIVE

DISCUSSION

The aim of this chapter is to 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 the contribution this study has made to the discipline of counselling psychology.

Some of the literature introduced in this section will be new as qualitative research such as IPA often generates new themes and insights (Smith, Flowers and Larkin, 2009).

As motherhood cannot exist separately from psychological processes and as maternal distress is naturally enmeshed with the experience of motherhood, the majority of the themes simultaneously answer the research questions (see Appendix 20).

5.1. Summary of Findings

This study utilised an IPA approach to explore the experiences and understanding of PND from migrant Pakistani-Muslim women's perspective. Six themes emerged from the data: 'Experiencing transitions', 'the experience of significant relationships', 'the body and motherhood', living with postnatal distress', the experience and perception of Pakistani culture' and 'patchy provision of "good" healthcare'.

The findings illustrated that migrant Pakistani-Muslim women experience postnatal psychological distress as a product of psychosocial, cultural and physiological issues and stressors specific to motherhood. The findings showed how healthcare services have a role to play in their distress and how improvements are needed when working with women from this culture.

How do Migrant Pakistani-Muslim Women Experience Depression During the Postnatal Period and How do the Women with a Subjective Account of PND Experience Motherhood in the Postnatal Period?

5.2 Experiencing Transitions

Becoming a mother is a major life-event, which inevitably brings a transition, where one has to learn and adapt to the change that has occurred in life (Winson, 2009). The migrant Pakistani women in this research described experiencing multiple transitions as an outer (migration and motherhood) and inner (within their identity and self) psychological process, which appeared central to their experiences of depression and motherhood during the postnatal period. Adapting to a new world of experiences in which they lacked knowledge brought enormous challenges to these women's experiences of motherhood, which also brought with it, feelings of distress.

All the women experienced some form of "reassessment" of their identity and self-concept, whilst exercising their role of motherhood (a new life-event) during the postnatal period. This showed support for the life-course framework proposed by Sugarman (2010), as well as previous theories of transition (Schlossberg, 1981). Schlossberg reports that human transition involves role changes, which can include gains and losses and inevitably stress; and transitions can include positive and negative feelings. Some of the women in this study experienced the loss of a positive self/body-image and loss of core-belief of self as "brave"; whilst others gained a new self-perspective, such as developing assertiveness and confidence in the marital relationship and developing a new role as a homemaker. Similarly, Khan et al., (2009), found that a migrant Pakistani-Muslim woman, who was a doctor in Pakistan had to adapt to a change in her role and thus her identity since moving to Malaysia and becoming a mother. However, a change in self-concept and/or roles is not confined to migrant Pakistani women. A grounded theory study by Darvill, Skirton and Farrand, (2010) showed that White-European women in England experienced a change in their self-concept (and with it came losses as suggested by Schlossberg, 1981) during their transition to first-time motherhood.

The majority of the women reported experiences in relation to first-time motherhood, which involved a sense of newness, not knowing and having to learn about the unknown (1.1 Sub-theme: Lacking knowledge and experience of motherhood). This transition appeared challenging and included feelings of anxiety, distress and inadequacy for the women.

This showed support for LeMasters (1957) study which showed that parenthood is an event that can invoke a sense of crisis when adjusting to the birth of a child (especially the first) and parents are often "caught unprepared" (p.355) even if children have been planned, assumed or expected to happen.

The women in this study were also faced with adapting to a new country and culture, whilst away from any support. This also formed part of their transitional process and something they viewed as taking its "toll" on them due to the simultaneous demand of adjusting to migration and motherhood. Processes within this experience included: culture shock, living in over-crowded housing, lacking knowledge about the country, adapting to many duties and experiencing language barriers. Whilst motherhood generally is life-altering, it is these women's experiences whose " pattern of living..... [has been] .... radically altered" (LeMasters, 1957; p.355).

Previous research of migrant mothers in a new country (Taiwan) has also identified adaptation to a new environment as challenging (Huang and Mathers, 2008; Wittkowski et al., 2011). A recent meta-synthesis on motherhood and the lived experiences of migrant women by Benza and Liamputtong (2014) reveals that for migrant mothers, the transition to migration can involve feelings of isolation, which was identified in this research too. Whilst, Benza and Liamputtong (2014) found loneliness, depression and lack of support to be features of the lived experiences of migrant mothers as part of their transition to migration. The findings from this study revealed deeper depth to the transitional processes and the accompanying distress, such as the social circumstances experienced, culture shock and not knowing or lacking knowledge of a new country.

5.3 The Body and Motherhood

This research identified motherhood and postnatal distress being entwined with challenges in the body, which the women perceived they lacked control over. This was in relation to breastfeeding, immobility, and encountering an unplanned pregnancy.

Whilst the aim of this research was not to assess cause-and-effect relationships between breastfeeding and postnatal distress, a participant did voice that unsuccessful breastfeeding attempts did *make* her depressed, whilst another felt that symbiotic distress between mother and infant affected her lactation and milk supply to the baby. Yet another attributed the cause to having a caesarean and lacking knowledge about breastfeeding. Nonetheless the findings from this research do support previous claims of a relationship between breastfeeding problems and PND (Green, Broome & Mirabella, 2006; Henderson et al., 2003; Dennis and McQueen, 2009; Lau, 2001)

Whilst the benefits and importance of breastfeeding are well-documented, we must begin to be cautious about how we present such messages to *all* women. The "breast is best" concept may serve to position mothers into feeling highly pressured to meet some "ideal mother model", which may create a sense of frustration and anxiety. This in itself may not be conducive to successful breastfeeding and instead create a negative and damaging core-belief as a substandard and/or failing mother (like it did for Rahana), for not being able to provide immunity-boosting breast-milk to her infant. The benefit of this to the woman and the baby would then have to be called into question. This could explain recent findings by Borra, Iacovou and Sevilla (2014).

Post-birth immobility seemed to have an effect on the psychological wellbeing of these migrant Pakistani women. These women also described complicated childbirths, which has been known to be a contributory factor to PND (White et al., 2006; Yang et al., 2011; Emmanuel, Mazhar & Shahid, 2011). However, the relationship between the two is not straightforward. The participants' accounts illustrated that the difficult labours left them physically incapacitated and this seemed to bring on feelings of helplessness and distress. Bed-rest after childbirth and receiving ample practical support may alleviate

the stress of managing household matters and the demands of caring for a newborn. This does support the need for the 40-days rest period often practiced in Pakistan (and other non-Western countries; Fonte and Horton-Deutsch, 2005) to help women recover and then take on their motherhood role without the distress of being held back by their bodies.

An unplanned pregnancy was perceived as shocking, and for some as unwanted, which their body had taken on. These pregnancies were viewed as sources of psychological distress not only during the pregnancy but also after childbirth. There was a sense from the women's description that everything had occurred too soon and they felt unprepared psychologically. Either the women became pregnant too quickly after arriving in the country or it happened soon after having their first child. In the latter cases, they were still in effect - within their first postnatal period and trying to adjust to the transition of motherhood. Unplanned pregnancies contribution to PND has been identified in previous qualitative research with UK-based Asian women (Templeton et al., 2003), as well as other studies (Mohammad, Gamble and Creedy, 2011; Iranfar et al., 2005; Ali, Ali and Azam, 2009).

5.4 Living with Postnatal Distress

This particular theme was seen as a core theme, which permeated through all the other superordinate themes. Every woman described experiencing postnatal distress and depression after childbirth. The findings showed that these women were able to personalise and voice what the meaning of depression and distress was to them, for example - feeling broken, spiritually disconnected, low mood and tearfulness, overall dissatisfaction and restlessness and psychosomatic issues. These findings show that whilst "PND" may well be a Western concept stemming from a medical disease model, it does not mean that postnatal distress is nonexistent, it had a real meaning according to reports from the migrant Pakistani-Muslim women in this research.

Feeling burdened and unable to cope seemed to also be a feature of living with distress. Such experiences have been identified in the context of support in a study in India

(Rodrigues et al., 2003), among Hong Kong Chinese women (Chan et al., 2002) and Middle-Eastern migrant mothers in Australia (Nahas, Hillege and Amasheh, 1999) and in Pakistan (Husain et al., 2006). The overall description of this theme appeared to be that lack of support left the women as sole carers of their children and the home, which inevitably left them exhausted and burdened.

Isolation and loneliness has been identified as a contribution to PND and general depression in numerous qualitative and quantitative studies amongst migrant and/or women of South Asian origin and/or women in Pakistan (Nahas, Hillege and Amasheh, 1999; Templeton et al., 2003; Liamputtong and Naksook, 2003; Khan et al., 2009; Gask et al., 2011; Husain et al., 2012; Rahman and Creed, 2007). This further highlights the importance of support and emotionally-connected relationships where understanding and empathy could play a vital role in alleviating distress (which will now be discussed further below).

How do postnatally depressed migrant Pakistani-Muslim women perceive their experience of support during motherhood in the postnatal period?

5.5 The Experience of Significant Relationships

The migrant Pakistani-Muslim women described how significant relationships had a supportive/unsupportive role to play during their postnatal period. This study revealed how their own mother's support was imperative to their wellbeing in the postnatal period, perhaps even more as part of first-time motherhood. An Irish study, showed that support from one's own mother improves "maternal parental self-efficacy" and also has a positive impact on the psychological wellbeing of first-time mothers 6-weeks after delivery (Leahy-Warren, McCarthy and Corcoran, 2012). However, such findings have also been documented in the aforementioned grounded theory study (Darvill, Skirton and Farrand, 2010), which showed that all the women reported the importance of their own mothers support, both in pregnancy and after childbirth. The findings of the GT study correspond with this IPA research, in that women who lived far away from their

mothers felt disadvantaged in terms of getting practical support. The majority of the Pakistani women in this IPA study revealed the appreciation of their mother's practical support which was perceived as profound enough to prohibit the development of postnatal distress, especially second-time round for some Pakistani women who had learned the impact of not having, or receiving inadequate support the first-time (Shaheena and Rahana). Whilst other women expressed immense yearning (Shazia) and illustrated the deep attachment they had to their mothers as a daughter and as part of the transition to motherhood (Shabana). One participant revealed the mother's support being a cultural tradition, which seems interlinked to the 40-days postnatal rest-period invoked in many cultures in which female relatives take on the caring role, whilst the birthing woman recovers (Eberhard-Gran et al., 2010). Overall, this research illustrates that migrant Pakistan-Muslim women need practical support to aid their recovery after birth and manage in the early postnatal period, especially if it might minimise psychological distress and enhance wellbeing. Whilst none of the women explicitly stated so, it is also possible that that their own mother's may have been a knowledge-base on how to care for a baby and be his/her mother (thus demonstrating the inter-link between subtheme: 'lacking knowledge and experience of motherhood' and the 'important role of a woman's own mother'). It's possible that by having one's own mother present, it may help a migrant Pakistani-Muslim woman (or possibly any woman from any cultural background) model what it means to be a mother and how to care for their baby. This in turn could potentially ease the transitional process into motherhood.

Whilst the mother is seen in a yearned for and supportive light, it seemed from this study that the mother-in-law[25] was generally perceived as an unsupportive relationship. The features of this unsupportive relationship included the mother-in-law holding a dominant and powerful position, whilst the daughter-in-law held a subordinate position. The women described feeling powerless against this dominant force which rendered them in a helpless and melancholic state especially after

[25] those who had their mother-in-law's around

entering motherhood themselves, a time when they needed understanding and support rather than critical behaviour and dominance.

A difficult relationship with the mother-in-law has been identified as a risk factor for PND in Asian cultures (Roomruangwong and Epperson, 2011), Arab-Islamic countries (Green, Broome and Mirabella, 2006; Mohammad, Gamble and Creedy, 2011), in India (Chandran et al., 2002; Rodrigues et al., 2003) and in Hong Kong (Lee et al., 2004). But being from a quantitative stance, the detailed knowledge about why such a relationship has a negative impact is currently limited. In contrast qualitative studies have demonstrated an understanding of the relational issues between mother-and-daughter-in-laws in regards to their own transition to motherhood. A phenomenological study by Chan et al., (2002) identified that in Hong Kong, Chinese women experienced their in-laws, especially the mother-in-law as powerful and controlling which contributed to their unhappiness in the postnatal period. The researchers concluded that these experiences are a result of traditional beliefs in Chinese Confucian Societies (Slote and Devos, 1998 as cited in Chan et al., 2002) where male-domination prevails through all of Chinese society, but in the home the mother holds the powerful position and a mother-son attachment was primary rather than husband-wife attachment. Where such strong attachment is found between a mother and son, daughter-and-mother-in-law conflicts will be present. They also concluded that these conflicts are not specific to just Hong Kong, but many other Confucian societies. Wittkowski et al., (2011) reported that South Asian women in the UK felt their postnatal distress was a result of dictatorial behaviour from in-laws and lack of understanding. Bhopal (1998) provides an understanding of Asian family structures, by stating that mother-in-laws hold the main position of power, demonstrating a hierarchal order of power. Such reports correspond with the findings of this research.

The relationship with the husband was seen as immensely important during the postnatal period. It seemed that the husband had the power to create or prevent depressive feelings through his support - or lack of. However, one woman also reported how through her own distress and difficulties she used to create trivial

conflicts with her husband, which does suggest that cause-and-effect between PND and marital relational issues may be difficult to establish, especially if this was researched quantitatively.

Nonetheless, the findings from this study illustrate that after having a baby women need practical, physical and emotional support from their husband to aid their physical and emotional wellbeing. This necessary support from the husband can be conducive to marital satisfaction, which in turn may protect against PND. On the other hand lack of appropriate support can impede this much needed emotional wellbeing of a woman who now has a small, dependent life to manage after the major event of childbirth, which can create a cycle of marital dissatisfaction and postnatal distress, especially where the migrant Pakistani-Muslim women in this research were concerned. The importance of a supportive husband, and relationship issues during the postnatal period have already been well-documented cross-culturally and this finding adds to that scope of research (Rodrigues et al., 2003; Husain et al., 2006; Al Dallal and Grant, 2012; Wittkowski et al., 2011).

5.6 The Experience and Perception of Pakistani Culture

The findings from this study highlight that patriarchal power and deeply entrenched gender attitudes may be playing a role in keeping migrant Pakistani women in an unhappy and anxious state. It seems from this research that Pakistani women may not be socialised into being independent. Furthermore, the discouragement of female autonomy combined with being raised in an overprotective environment and then having an arranged marriage with a man from a country that values independence and individualism, may serve to culturally shock women and leave them feeling alienated about that new culture. The women may not have developed the psychological skills and coping mechanisms to adapt to such a distinct world to the one they grew up in. In such circumstances women who have migrated here from a traditional/collectivist society may feel culturally dislocated, which may result in an array of psychological difficulties, as stated by Helman (2003),

especially when amalgamated with becoming a mother often immediately after entering the UK. This is a very specific area of maternal health and culture, which requires further research to facilitate our understanding of the psychological processes and factors behind cultural adjustment and/or dislocation for migrating mothers. Qualitative research outside of the topic of maternal mental health, sheds some light on cultural adjustment issues. Xu, Gutierrez and Kim, (2008) found that Chinese immigrants who were socialised under a collectivist culture and had moved to the USA, struggled to adjust to the belief system, norms and values of the host country and "unlearn" the values and cultural norms which they had learned through their "primary socialisation" (p.42). This resonates with some of the experiences of the migrant mothers in this research.

Interestingly, one participant (Shaheena) stated how lack of independence was an issue, but also that exercising freedom of choice and personal autonomy for women remains problematic and restrictive within the Pakistani culture, which maybe why Pakistani women might not readily access support. This participant also expressed that Pakistani women are without rights. Women's rights in Pakistani culture, has been thoroughly documented as a cause of national and international concern (Apiidv.org, 2011; Niaz, 2004). This study helped illuminate the fear of repercussions that Pakistani women may hold, especially from the husband and in-laws. Whilst this study showed that the migrant Pakistani-Muslim woman holds a subordinate position in relation to the mother-in-law, the same can be said outside of home, where women - especially those in the marital age-group hold a subordinate position in society, both socially and economically, a human rights issue that pervades much of the South Asian countries (Niaz and Hassan, 2006).

Deeply entrenched cultural belief systems, practices and a patriarchal culture contributes to the disempowerment and destabilisation of female autonomy and plays a factor in controlling and/or subordinating Pakistani women (as well as the South Asian female society) at best, and sanctioning gender-based violence at worst (Niaz, 2004). In a sample of 759 women in Pakistan, Ali et al., (2011) found that over half experienced physical and sexual violence in the marriage and over 80% reported psychological

abuse. Such research findings are important and related to this study as it demonstrates that UK-based migrant Pakistani-Muslim women who voice concern over speaking about their maternal psychological health - as identified in this study, may well be harbouring fear of repercussions from the husband/in-laws. The difficulty of reaching out and providing individual support to women from such backgrounds who are immersed in a conservative socio-cultural system, has already been demonstrated by Almond (2013) who found that HVs detected Asian women's fear of speaking freely about their problems due to family and cultural barriers. This implicates the need for more of a systemic psycho-educational approach targeting awareness of gender-based attitudes and challenging male-dominated systems that render women (Pakistani as well as women from other cultures with similar issues) in a powerless position.

Conversely, Pakistani culture was also seen as aiding and supportive during the transition to motherhood. It seemed from the migrant women's accounts that women in Pakistan have support in the form of maids/house-servants and if not this, then their wider family provide practical help and support, which removes the burden of childcare and household management on the Pakistani woman. Lacking this type of support, which is seen as a norm in Pakistan and not here, may contribute to migrant Pakistani-Muslim women's sense of feeling burdened and thus distressed after having a baby. This corresponds with Rodrigues et al., (2003) and Husain et al., 2006. They reported that a reduction in large family-sizes in India and Pakistan may be contributing to the growth of PND amongst women due to the demise of traditional support systems, which means the burden of childrearing rests solely on mothers. This is what the women in this study are experiencing here when they migrate, as suddenly they are without support systems that they have traditionally known.

5.7 Patchy Provision of "Good" Healthcare

Good healthcare provision seems patchy according to the accounts of the migrant Pakistani-Muslim women. They described experiencing aggression and frustration from staff and violation of confidentiality. This highlights a need for improvements

in healthcare provision across the board, from reception staff in services, HVs to doctors. The healthcare needs to be proficient from pregnancy right through to the postnatal period. Failure to provide this can have negative consequences as shown by the findings of this research in which, one woman described receiving poor antenatal care and lacked necessary knowledge to take care of her newborn. This led to the baby requiring emergency care, which places a strain medically and financially on the emergency services, demonstrating that the cost of care came back full-circle on the NHS. In addition, it led to immense distress for a new mother in a new country.

5.8 Implications for Healthcare Practice

5.8.1 Better Antenatal Support

Maternity staff may need to provide better knowledge, care and support on breastfeeding to migrant Pakistani-Muslim women, especially during the antenatal period so they can be prepared, which could prevent postnatal distress. Whilst this information is provided through NHS antenatal classes, Pakistani women present a low-uptake of this service (Henderson, Gao and Redshaw, 2013). The uptake of antenatal classes need to be encouraged during GP visits and very first antenatal check-up's, so migrant Pakistani-Muslim women can learn why these classes maybe necessary to them. It must be borne in mind however, that migrant Pakistani women may feel uncomfortable openly discussing matters in classes as this research identified that cultural barriers curtail women from accessing healthcare services. With such issues, a private support could be more helpful, such as a Doula.

5.8.2 Investments in a Doula

Research shows that women who receive continuous support during labour are more likely to have a natural vaginal delivery (Hodnett et al., 2012). The support of a doula during childbirth reduces labour time, chances of a caesarean and/or other medical

interventions (Nommsen-Rivers et al., 2009) which has implications for issues such as post-birth immobility where recovery can place distress on a mother. In addition, a doula's support could lessen chances of breastfeeding problems as prolonged labours and emergency caesarean's are risk factors for delayed onset of lactogenesis[26] (Chapman and Perez-Escamilla, 1999), which in turn can lead to a lesser likelihood of any and/or exclusive breastfeeding in the early postnatal period (Brownell et al., 2012). With the support of a Doula, successful early breastfeeding is possible as women are more likely to have timely onset of lactogenesis (Nommsen-Rivers et al., 2009). It seems a Doula maybe able to provide the kind of care, information and support that midwives and Health Visitors may not be able to due to resource deficiencies, numerous other duties and being inundated with tasks.

A doula could provide migrant Pakistani-Muslim women with the kind of one-to-one personal support that they would usually get from their mothers or other female relatives Chee, 2013). This could be practical and emotional support, which is needed in the postnatal period, especially if they are unable to have their mother in the UK. A Doula could help the new mother gain knowledge through postnatal care and support, so she is not overwhelmed with the feeling of lacking experience as a first-time mother, something women from this study experienced, as stated above.

Other nations, such as the USA are taking note of the important role a Doula plays in supporting birthing women. States such as New York have even generated programmes funded by their Health Department to provide free doulas to women from low-income backgrounds where poor reproductive health and high infant mortality rates seem common (Pearson, 2013).

The study illustrates a need for better financial investment in NHS maternity services (Doula UK, 2013) to satisfy postnatal care needs of most likely *many women*, not just those from migrant Pakistani-Muslim backgrounds. Having the support of a Doula could alleviate the burden of caring for a newborn and/or other children as well as help

[26] > 72 hours post-birth

remove the migrant Pakistani woman from a sense of isolation and loneliness which also formed part of their depressive experience. In the UK, the financial cost of hiring a Doula usually rests on the couple as the NHS does not readily employ doulas like healthcare systems in other countries do (Mander and Murphy-Lawless, 2013), especially for migrant women (Expatica.com, 2009). If doulas are hired in the NHS, it tends to be purely for childbirth, rather than the postnatal support.

5.8.3 Psycho-education Needs

Support from the husband is vital for women's pregnancy, postnatal and general wellbeing. As show by Khan et al., (2009) Psycho-educating Pakistani men on the needs of their wives may help develop new learning and new ways of being with their partners, which could play a critical role in the wellbeing of a migrant Pakistani-Muslim woman and her wider family.

5.8.4 The Need for Psychological Therapy

This research identified a need for more focus on the postnatal-emotional-wellbeing of migrant Pakistani-Muslim women. During their postnatal visits, HVs need to tune in more to the emotional wellbeing of migrant Pakistani-Muslim women. However, Almond (2013) showed that health visitors (HVs) are aware of the cultural dynamics shown by some of the participants in this research. It's possible that HVs working with women from this BME community are experiencing a type of learned helplessness and feel unable to provide support due to their lack of culturally relevant knowledge and skills (Almond, 2013) and the prevailing cultural barriers that exist for the migrant Pakistani-Muslim women.

This highlights the need for cultural training for HVs by healthcare professionals who have knowledge and experience of the issues faced by migrant Pakistani-Muslim women and to that extension, perhaps the wider South Asian female community too.

However, whilst macro-level change maybe important, individual counselling for these women should not be cast aside. As some participants did voice they would have appreciated referrals to supportive services. Therefore, an assumption that Pakistani (or South Asian) women are *too* fearful to disclose and access support should not dominate HVs practice as there will be individual differences amongst women from this culture. However, even if HVs have counselling skills and acquire culturally relevant training, the study by Almond (2013) illustrates that they feel unable to put their counselling skills into practice due to time constraints and overwhelming case-loads that they have to deal with.

This echoes the need for maternity services to hire counselling and/or clinical psychologists who can provide the specialised psychological care and support to women from such BME communities, rather than sending them to CMHT's where their psychological needs may go unmet. Whilst perinatal mental health services are patchy in provision (Oluwatayo and Friedman, 2005), but provided nonetheless, they tend to deal with severe issues such as postnatal psychosis. There is a need for integration of psychology services within maternity healthcare, which again, a rare number of NHS healthcare trusts provide.

5.9 Evaluation of Methodology

One of the research strengths included utilisation of Yardley's (2000, 2008) guidelines to assess the quality and validity of this study. Provision of a thorough audit trail allowed checking the rigour of the claims. This was further reinforced by peer and mainly supervisory support who were in an experienced professional position to check that the data analysis was of sound quality and credibility.

Due consideration was given to reflexivity (chapter one) and a reflexive journal was kept in order to remain mindful of my thoughts and feelings through the research process.

Furthermore, interpretations were generated by keeping close attention to the participants' accounts in the data; this was based on Smith, Flowers and Larkin's (2009) guidance on IPA method and criteria for validity. Finally the study, being conducted from a qualitative stance, provided an opportunity for migrant Pakistani-Muslim women to voice their experience and meaning of depression in the postnatal period, which has been largely overlooked in previous literature.

Interestingly, this research provided evidentiary support for the need to study Pakistani, Indian and Bangladeshi communities within their own cultural groups rather than pooling them under one group as "South Asian". A particular participant (Shaheena) voiced how she perceived a clear difference between Pakistani and Indian women (she did not discuss Bangladeshi women as she stated not knowing many). She described how she viewed Indian women as having more independence and freedom to work, thus demonstrating their economic stability and security. This supports the idea that whilst South Asian communities may share commonalities, they are inherently distinct and unique culturally, religiously, regionally and thus psychologically. This calls for a continued movement in research methods and need to study Indian, Pakistani, Bangladeshi and Sri Lankan women separately to capture understanding of their unique cultures and diverse human experiences.

Whilst this study provided interesting findings, like any research, it is not without limitations. For example, whilst the interview schedules were drafted based on IPA guidance by Smith, Flowers and Larkin (2009), during the interview meetings when certain points were made by participants, sometimes closed and leading questions were asked when it seemed the participant was directing me as the researcher to a certain understanding. It may have been better to remain as open as possible and keep in mind that even when participants are close to saying something, the entire statement needs to come from them rather than them being led into making a point.

Furthermore, IPA is committed to idiography, it allows for a more in-depth and detailed exploration of a small-selection of participants to allow rich data to unfold (Smith, Flowers and Larkin, 2009). Whilst this provides a focus on the quality of individual's

personal life-world, it does not allow generalisability, which is considered to be the objective of all research. However, this outlook does once again subscribe to traditional scientism; in contrast, transferability of findings from group-to-group rather than generalisability is much more central to IPA and its qualitative roots (Hefferon and Gil-Rodriguez, 2011). Consequently, it could be argued that the findings from this IPA research may shed light on many migrant Pakistani-Muslim women's experiences as well as perhaps other migrant South Asian mothers.

Echoing some of the above, quantitative studies tend to have larger samples (probably to satisfy the traditional science generalisability objective) and many published qualitative studies also tend to have larger sample numbers. Hefferon and Gil-Rodriguez (2011) argue that this is due to a political agenda of appeasing "research boards.... in line with the quantitative monopoly within ... research" (p.756). The problem with larger samples is that it can hinder the comprehensive and lengthy concentration of in-depth case-by-case analysis (Pietkiewicz and Smith, 2012), which is the idiographic focus of IPA. Whilst an attempt to recruit more participants was made and whilst it could have added further to the analysis and findings, it cannot be negated that chasing a larger sample may have come at the expense of rich data-analysis. With this mind, the research heeds the advice of current IPA advocates that "less is more" (Hefferon and Gil-Rodriguez, 2011; p.756; Reid, Flowers and Larkin, 2005), especially when one is a novice IPA researcher (Smith, Flowers and Larkin,2009) and working under "pragmatic restrictions" (Pietkiewicz and Smith, 2012; p.364). This research also supports the continued need for small-scale projects, which explore human experiences and help advance psychologists understanding of human life by analysing rich and in-depth accounts of real-life people. Allowing qualitative approaches as a way of learning about human experiences can complement quantitative methodologies, which means that rather than dividing the methodologies, it may be important to understand that both methodologies have an important place in helping psychologists learn about human life.

5.10 Future Research

This research included a sample of women that were educated and able to voice their experiences in English, thus providing them with the power of communication. However, there are countless migrant Pakistani-Muslim women with very limited language abilities who may also experience similar issues to the women in this study, but have to face the added challenge of extreme language barriers, even slight language barriers - as shown by this study - can have damaging consequences. The question remains what the experiences maybe for migrant Pakistani-Muslim women who do not speak *any* English. Whilst IPA values the understanding of experiences being developed through researcher and participant, the demands of certain topics may require methodological modifications. To overcome issues such as language, interpreters may need to be involved into the research process to allow new insights to emerge and develop our knowledge further about migrant mothers and their experiences. This would also contribute to the development of cross-cultural counselling psychology (Eleftheriadou, 2010), just like this study has.

5.11 Personal Reflections

This research was a fascinating and challenging process. It is clear that a researcher's own personal identity, values and interests will inevitably affect the research process (Willig, 2001).

Before beginning each interview, I noticed that I felt nervous as to whether I would be able to engage the participant and ask the "correct" questions to elicit rich data. I was aware of being a novice IPA researcher and felt concerned about how this may impact the research. By building a good rapport and with time, I became comfortable in carrying out my role and conducting the research with confidence. With experience each interview process improved. Taking notes of how I felt before and after the interviews helped me to gauge an understanding of my feelings and thus manage the anxieties.

I was aware that being from a South Asian background myself, the participants may have struggled to be open, share their experiences and even harboured fears about me knowing someone within their community, especially in light of the recruitment difficulties. However, as a healthy rapport had been built, it seemed the women were able to share without fear. Furthermore, this research sample consisted of quite highly-educated migrant Pakistani-Muslim women who understood the research processes, so perhaps felt assured about confidentiality of their participation, thus enabling their openness to share experiences.

Moreover, I was very aware of certain cultural issues that permeate through many South Asian societies due to my own ethnicity; consequently, I may have given some non-verbal communication that might have naturally invited participants to respond in one way or the other. Or sometimes I jumped in too quickly with a statement to show my reflective understanding (which is part of a therapist role) to try and invite further discussion. Listening back to the tapes helped me be aware of this and try and remain more open in my interview approach.

An important area to reflect on here is that during the analysis, I felt an over-powering commitment to reflect and analyse the women's discussion in-depth. I noticed feeling that the women had given so much of themselves through their participation, perhaps even going against some of the cultural restrictions, by "speaking out" about their psychological experiences. It felt important to honour them by working thoroughly to make their experiences be heard and understood.

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Appendix 1: Social Constructionist View of Female Misery

Depression experiences within the South Asian community have also been examined using a discursive psychology approach (Burr and Chapman, 2004), which has been widely used in exploring PND, as well as research on women generally (Lewis and Nicolson, 1998; Nicolson, 1998; De Souza, 2004; Ussher, 2010). The approach is driven by feminist thinking and draws on social constructionism, which critiques positivist research for medicalising women's misery. This position declares that a patriarchal structure, with dominant forces in society (e.g. male doctors), pathologise female experiences by using gender stereotypes to position them as "symptoms". Even the psychometric tools used in the form of screening measures contain language that positions feminine behaviour as symptomatic. This in turn has resulted in a higher rate of diagnosis of women with psychological pathologies, in which women are then positioned in the illness category and go on to adopt the language and label that has been put on them through powerful discourses (Ussher, 2010; De Souza, 2004).

Lewis and Nicolson (1998) provide an example of how depression is socially constructed in early motherhood as their study[27] showed that some women expressed their experience of motherhood as a disappointment resulting from dominating discourses in their social world, which did not include ideas around motherhood being complex or challenging. The researchers identified that negative experiences can be a normal aspect of motherhood but there were limited discourses for this conception, which meant that dichotomous discourses of motherhood would be retained as – "unproblematic motherhood" and the powerful force of the medicalised "clinical" discourse of "PND" (p.177-197).

[27]The study was thematic analysis (drawing on grounded theory – GT – and discourse Analysis) of experiences which was also combined with discourse analysis (DA) in their 2 studies combined into one.

Appendix 2: The Benefits and Value of Breastfeeding to Infant's Wellbeing

UNICEF (2013) state that breastfeeding has immense nutritional value to an infant's health development and overall wellbeing in their early years as well as later adulthood. Breast-milk contains antibodies that help in preventing diseases and exclusively breastfed babies have a radically reduced risk of dying from respiratory infections and diarrhoea (Quigley, Kelly & Sacker, 2007). In contrast, non-breastfed babies have a greater risk of death, which applies to both HIC[28] and LMIC[29] (UNICEF, 2013).

Whilst UK rates of breastfeeding at birth appear promising with 69% of mothers breastfeeding from childbirth, only 1% of UK mothers continue to breastfeed their babies up to six months, as recommended by the UK health departments (Hscic.gov.uk, 2012).

[28] Higher Income Countries

[29] Lower & Middle Income Countries

Appendix 3: The Process of Breastfeeding, Lactation and Stress

Lau (2001) examined the effects of stress on lactation and considered that maternal behaviour can mediate the initiation and continued process of lactation. The role of lactation is to provide a baby with nutrition and therefore has a survival function. Lactation performance depends on supply and demand in which the greater the needs of the infant, the more the mother's milk will produce itself and the longer the lactation process. Lau goes on to suggest that lactation is mediated by a mother's interest in breastfeeding, which in itself is reinforced positively or negatively depending on whether a mother perceives herself as meeting or not meeting the baby's feeding needs. A mother's interest in breastfeeding is further tied up in her relationship with the baby. Overall Lau suggested that a harmonious and symbiotic interaction will have a positive impact on the mother and thus activate her milk production. However, a negative encounter can lead to the abrupt ending of the breastfeeding process and cessation of lactation.

Appendix 4: Philosophical Underpinnings of Interpretative Phenomenological Analysis (IPA)

Phenomenology and Edmund Husserl

Phenomenological inquiry pioneered by Edmund Husserl, suggests that we should "return to the things themselves, as experienced" (Smith and Osborn, 2008; p.11). Traditional phenomenology is conceptualised to belong in structuralist thinking (Willis, 2007) as the approach is geared towards examining underlying psychological structures. The approach is based on the premise that human beings possess consciousness whereas subjects of study in naturalistic science do not (e.g. plants and rocks), which positivistic researchers ignore. Phenomenological psychology tries to explore the perceived thing whilst simultaneously focusing on "consciousness and perceptions" (Willis, 2007; p.172).

Hermeneutic and Interpretative Activity - Martin Heidegger

Martin Heidegger extended phenomenology by stating that knowledge is embedded in interpretative activity. The idea is that we are not just experiencing and perceiving the world, but as people we are "embedded and immersed in a world of objects and relationships, language and culture, projects and concerns" (Smith, Flowers and Larkin, 2009; p.21). Heidegger's phenomenology suggests that whilst attention is paid to surface manifestations of a particular thing, it is also partly concerned with exploring concealed processes which transpire into light (Smith, Flowers and Larkin, 2009) and the two are interconnected. This corresponds with how Smith explains that there is an analytic process to IPA in which the researcher looks beyond the textual accounts of the participant and asks themselves if something more is going on in the deeper consciousness of the person, which she may be unaware of (Smith and Osborn, 2008; Smith, Flowers and Larkin, 2009).

Heidegger opposes Husserl by distinctively stating that our interpretation is influenced by - and will be a result of - our presuppositions. Therefore the analyst

brings to surface their preconceptions during the process of engaging with participants accounts and is then forced to explore the new material in light of their own previous experience. Smith, Flowers and Larkin (2009) therefore stress that researchers cannot avoid whatever pre-conceptions they hold; they exist, regardless of our desires. However, it can block us from freely interpreting and during this process one should prioritise the new emerging material rather than their preconceptions. So it seems that IPA is a dynamic hermeneutic research in which bracketing is cyclical and involves reflexive practice on ones preconceptions as they arise and there is acknowledgement that it cannot be entirely achieved (Smith, Flowers and Larkin, 2009). In addition, Smith and Osborn (2008) state that a "researcher's own conceptions" are required in the interpretative activity as a way of making sense of another person's life-world. Therefore, IPA involves a double-hermeneutic process in which "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (p.53).

Gadamer

Gadamer argues a similar aspect within the interpretive-phenomenological framework by suggesting ideas which resonate with psychodynamic concepts within counselling psychology. The idea is that during engagement with participants' material, the interpreter is always projecting meaning for the text. This is a similar process to the therapeutic relationship in counselling psychology where there is almost always transference and/or counter-transference which the therapist will have to process or make-sense of, to see which is their own material and which is the material the client is pulling them into. Just as we will not know which parts of our psyche are tapped into as therapists until it happens within a therapeutic relationship, similarly we will not know our preconceptions as researchers until the interpretative activity occurs. Smith, Flowers and Larkin, (2009) argue that these are the reasons why interpretative activity is a dynamic and complex process and sometimes our preconceptions do arise before interpretation is underway and other times it is during it. Regardless of when it happens, the analyst is hoped to remain

open about his or her preconceptions and remain as faithful as possible to the account by the participant and preconceived ideas can be compared and modified in light of the new material and as part of the sense-making process (Smith, Flowers and Larkin, 2009). Therefore, in relation to axiology this study is located within the interpretivist-constructivist paradigm as our values cannot be eliminated from the research, but it is the researchers' responsibility to acknowledge, bracket and remain reflective on their values (Reid, Flowers & Larkin, 2005*).*

Idiography

Where positivist research fail to account for individual human experiences in all its complexities and contexts, IPA is committed to idiography which allows rich and detailed examination of each individuals account, which satisfies the researchers world-view of seeking to explore each individual's psychological world, their particulars "rather than the universal" (Eatough and Smith, 2008; p.183). The wish to explore individuals interpretation of their reality, shows the commitment to a critical realist ontology (Ponterotto, 2005), suggesting specifically that an objective reality can exist outside of human consciousness, but there are different meanings which human beings attach to experiences and this is possible as they encounter different parts of reality (Fade, 2004).

Appendix 5: Rejecting Other Qualitative Approaches and their Foundations

Rejecting Social Constructionism and Discourse Analysis

Social constructionism[30] argues that language does not mirror, but creates reality. For example, by saying someone has PND, one is not just reflecting a reality but also taking part in constructing or creating it (Cosgrove, 2000). Therefore the label constructs women as pathologised. The notion is that meaning is given through language and the range of meanings that can be ascribed are mediated by specific dominant discourses that exist in a particular culture and point in time. Consequently, subjective experience is a result of discourses which can be studied through researcher-participant interaction involving interviews, therefore demonstrating that such qualitative approaches from a social constructionist framework also adopt a subjectivist epistemology. Discourse analysis (DA) is a research method within a social constructionist framework. Although social constructionism presents an interesting way of approaching and conceptualising postnatal depression, the biggest issue with the underpinnings of DA is that it does not take into account the individual as a perceptive and cognitive being. In contrast, the tenet of IPA is that people are essentially sense-making individuals and this is intertwined with their lived-experience; language can be used mainly as a resource to access this experience and sense-making processes (Smith, Flowers and Larkin, 2009). The research questions in this particular project are based on a natural premise that people are perceptual beings and cognition is not just isolated to thinking processes but also includes complexities, emotive and "embodied" processes (Smith, Flowers and Larkin, 2009; p.21). IPA allows the luxury to conceptualise participants in relation to the researcher's natural world-view.

DA would conceptualise that an individuals' experience of PND is mediated by discourses, language and dominant power relations. Therefore, the underpinnings of DA are heavily social constructionist and rely on a relativist ontology, in that it is

[30] part of relativist ontology and so part of interpretivist- constructivist paradigm too.

not concerned with ontological issues because it views phenomena not in terms of "being" and "out there" like IPA, but views phenomena as "produced" and then "reproduced" intersubjectively" (Cosgrove, 2000; p. 249), like multiple realities. Such ideas contradict the crux of IPA which holds dear Heideggerian concepts of being in the world. Furthermore, it was believed that the accounts that participants provide in relation to motherhood, would reflect how they experience reality and being in the world; which goes against some of the DA underpinnings.

With IPA being rooted in critical realism, it is argued that participants will be describing experiences of real events. A compelling case for the critical realist rather than social constructionist stance stems from a primitive ground, in that at birth, we are new to the world and do not possess language as a mechanical form which we can access. However, we do experience things like pain and hunger. Consequently, human experience exists prior to and exclusive of language, and does not necessarily socially construct experience.

Specifically in relation to PND, a social constructionist could argue that PND is a medicalised discourse, which is not reflective of its actual existence in the world but more a product of the public communication about it (Gergen, 1985).

It is imperative to stress that IPA does hold a mildly social constructionist belief that history, society and culture are embedded in our life and a part of how we experience and interpret life. There is also agreement that language is critical in this process and that who we are is partly a product of constant intersubjective communication (Eatough and Smith, 2008). But IPA's version of social constructionism is related more to symbolic interactionism and its worth noting that being on "the light end of the social constructionist continuum", means that as a hermeneutic-phenomenological thinker the researcher cannot reduce human-beings life world to linguistic or discursive constructions as this neglects the experiential realities of individuals and any "sense of self" (p.184). Therefore there is the acceptance that migrant Pakistani-Muslim women's reality of depression in the postnatal period and motherhood depends on, and can even be confined by, the language of the individual culture. Indeed, they may be alien to such a medicalised discourse that may or may not exist in the culture they come from. However, a lived

life is made up of many intricacies and variability's, which include the complex processes of a person's cognitive being. Therefore, to view the migrant Pakistani mother and her subjectively lived experiences of PND as socially and historically positioned linguistic interactions between individuals, seems somewhat reductionist (Eatough and Smith, 2008). There is a need to see beyond the talk of the participants experiences and see beyond the dominant discourses that are shaping their experiences.

Rejecting Grounded Theory

Another approach often compared with IPA, is grounded theory (GT) which is a qualitative method but there are noted to be several versions of it, which again may be beyond the scope of this paper to fully evaluate. Charmaz (2008) suggests that grounded theory proposed by Glaser and Strauss (1967) and the later evolved Strauss and Corbin (1990; both cited in Charmaz, 2008) version of GT grew from sociological roots. The approaches allied themselves closely to positivist (Glaser and Strauss) and post-positivist (Strauss and Corbin) assumptions, in which knowledge can be acquired by remaining objective and the focus is to generate a widely applicable theory. These approaches were committed to specifically studying social/social psychological processes (Charmaz and Henwood, 2008). Strauss and Corbin (1990) held a more post-positivist position as they centralised theory-falsification and suggested that formulaic techniques could be applied to the data (cited in Charmaz and Henwood, 2008). Clearly these approaches diverge from IPA, which holds dear hermeneutic-phenomenology as its underpinning and relates to the interpretivist-constructivist paradigm rather than positivist or wholly post-positivist position (which GT subscribes to); therefore GT was rejected on the grounds that it did not fit with the research aims and world-view.

Constructivist grounded theory (CGT), developed by Charmaz (2006; cited in Smith, Flowers and Larkin, 2009; p.43) is utilised more widely in psychology. This approach holds a similar epistemological position to IPA, suggesting that through

interaction with participants one can develop knowledge of subjective meanings attached to phenomena in an experiential context.

Where CGT differs to IPA is that the latter is committed to idiography, which is characterised by the researchers case-by-case approach to analysis in which researchers treat the next transcript account on its own terms, so the essence of the individual is captured. Here, it is important to bracket ones ideas, which have emerged from the previous case – as much as humanly possible – whilst beginning the analysis of the second transcript, to do justice by each individual (Smith, Flowers and Larkin, 2009). In contrast, general strategies of GT suggest that previous data analysis serve to inform following data collections through which tentative categories can be "refined" (Charmaz and Henwood, 2008; p.242), which is part of its approach to generate theory. Overall GT appears to be concerned with social processes and macro-analysis combined with an emphasis on meaning contextualised by human action and behaviour; this is evident in how Charmaz claims "we emphasize what people are doing" (Charmaz, 2008; p.90).

In relation to this study, the natural stance is not to just explore what migrant Pakistani-Muslim women are doing as part of their experience of PND; there is also a focus on the diversities of her experience, including her perceptive and emotive processes. Rather than the social, the IPA approach gives greater focus to the individual psychological process. Furthermore, there is an interest – not in drawing generalisable theoretical explanations of "human behaviour", but more on understanding how migrant Pakistani-Muslim women experience PND (Smith, Flowers and Larkin, 2009; Smith and Osborn, 2008; Eatough and Smith, 2008).

Appendix 6: Interview Schedule Guide

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: Table 1 of Participants Demographic Information

(All personally identifiable information was removed and names were changed to maintain confidentiality)

Participant	***Place of birth***	***Country of upbringing***	***Age***	***Languages spoken***	***Educational level***	***Reason for migration to the UK***	***Number of children***	***PND with which number child***
Rahana	England	Pakistan	39	Urdu/English	College in Pakistan	Marriage	2 sons	Mainly first child, but some with second too
Shabana	Pakistan	Pakistan	30	Urdu/Punjabi/English	University in Pakistan (Masters degree)	Marriage	2 children: 1 son and 1 daughter	Both
Shaheena	Pakistan	Pakistan	29	Urdu/Punjabi/English	University in Pakistan (Bachelors degree)	Marriage	2 sons	First child
Shazia	Pakistan	Pakistan	27	Urdu/Hindko/English	University in Pakistan (Masters degree)	Marriage	1 son	Only child

School of Psychology

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Water Lane

London E15 4LZ

Student ID: 0611261

Appendix 8a: Letter of Invite for Participants

30 March 2011. Version 1.

Dear xxxxx,

My name is Miss Rima Lamba. I am a Trainee Counselling Psychologist at the School of Psychology in the University of East London (UEL). I am conducting a research study as part of the requirements of my Doctorate in Counselling Psychology and I would like to invite you to participate.

I am interested in researching how migrant Pakistani-Muslim Women experience life after childbirth, specifically those women who experience sadness, distress and/or depression after having a baby. If you decide to take part, you will be asked to meet with me for an interview for approximately one hour. You will be asked questions about your experiences of sadness, depression or distressing feelings during the postnatal period. You will also be asked how you experienced motherhood during this period, and your experience of support during the postnatal period.

The meeting will take place at a children's centre after we have agreed on a suitable time. The interview will be audio-recorded so that I can accurately reflect on what is discussed. The audio-recordings will only be reviewed by members of the research team and I will be the individual that will transcribe and analyse the recordings. Once this has been completed the audio-recordings will be destroyed.

You may feel uncomfortable answering some questions, which is understandable. You do not have to answer any questions that you do not wish to.

It is hoped that the information you provide during the interview study, may help to gain deeper insights into postnatal experiences by migrant Pakistani-Muslim women. This may help counselling psychologist's - (and possibly other health professionals) - to think about ways of improving support and services for mothers from the Pakistani community, especially mothers who have moved to England.

Participation is confidential. The results of the study may be published or presented at professional meetings, but your identity (for example, your name, address or contact details) will not be revealed. Participation is anonymous, which means that no one (not even the research team) will know what your answers are.

You do not have to be in this study if you do not want to, you may also quit being in the study at any time or decide not to answer any questions you are uncomfortable with.

I will be happy to answer any questions you have about the study. You can contact me on: 07960 770 575 or email me: 0611261@uel.ac.uk Alternatively, if you need to, you can also contact my research supervisor: Professor Rachel Tribe at R.Tribe@uel.ac.uk.

If you have any questions about your rights as a research participant you can contact the Graduate School:

University of East London
Docklands Campus
4-6 University Way
London
E16 2RD
Tel: 0208 223 2976
Fax: 0208 223 2826.

Thank you for taking time in reading this letter and for considering this study.
If you have any questions you can contact me and I will discuss everything with you.

With kindest regards,

Miss Rima Lamba
Trainee Counselling Psychologist
Mobile: 07960 770 575.

Appendix 8b: Participant Information Sheet

Annexe 1

University of East London
School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

University Research Ethics Committee (UREC)
If you have any queries regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Fieulleteau, Ethics Integrity Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

The Principal Investigator(s)
Director of the Research Study:

Professor Rachel Tribe
University of East London
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Researcher:

Ms. Rima Lamba
Trainee Counselling Psychologist
M: 07960 770 575
E: u0611261@uel.ac.uk or rims82@hotmail.com

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
A Qualitative Study Exploring Migrant Pakistani-Muslim Women's Lived Experiences and Understanding of Postnatal Depression

Project Description

Aim of this research

The aim of this research is to explore and understand your experiences of postnatal depression during the postnatal period (meaning - after childbirth) as a migrant Pakistani-Muslim woman. This includes gaining a rich understanding of what it may have been like to have experienced sadness, distress and depression after childbirth and how you experienced motherhood during the postnatal period.

Your Contribution as a Participant

You have been invited to take part in the study because you are a migrant Pakistani-Muslim woman who has experienced being a mother in this country which may have involved all kinds of distressing moments. The researcher is interested in hearing and understanding your account of these experiences.

There are two ways that you might come to know about this research. One is through a voluntary organisation (Deanery Road Children's Centre) where you may be accessing services and the other is through self-referral through personal contacts.

Voluntary organisations:

The researcher has accessed a voluntary organisation to help with recruiting women who are happy to take part in this study. It is possible that you might have seen a flyer or poster about this research within the organisation (perhaps on their notice board or a space where they put adverts up).

Self-referral through personal contacts:

Another way that you might learn about this research is from someone you know, perhaps a friend, family member or a member in your community. This person may/may not have taken part in the study. If you tell them that you are interested in the research and state that you are happy to share your contact details with the researcher then the researcher will contact you on your telephone/mobile number.

What will I be asked do in order to take part in this study?

During your telephone conversation the researcher will tell you more about the study, why it is being carried out and how it will be carried out.

During this conversation, you will be asked if you are interested in taking part in this research, if so you will be sent the participant information sheet and consent form. You must read through these documents and send the consent form back to the researcher with your signature if you are interested in taking part. The researcher will then call you to arrange a convenient time and date for an interview meeting.

When you arrive for this meeting, you will be greeted and once again given an explanation about the aims of this research. You will already have received the details, but this meeting provides a chance to also go over the details in person. You can ask any questions at any point about the research. Following this, you will be asked if you are still satisfied with taking part in the study, if you agree the interview will begin. Remember you can withdraw at any time and this includes during or even after the interview has taken place.

The researcher will begin by confirming some basic information about yourself, for example, your age.

Following this, the interview will begin and it will involve the researcher asking you questions about your experiences of postnatal depression. The researcher will have an interview schedule guiding the questions being asked. The interview will be audio-recorded and may last between 60 to 90 minutes. This interview meeting will involve you talking about your experiences of postnatal depression to the researcher. You have the right to refuse to answer particular questions.

Is there any Hazard or Risk, any likely After-Effects, Discomfort or Distress which might be Experienced?

It is considered that there is little threat of risk to you for participating in this research. However, you will be talking about a situation that could be distressing. In such a situation we can stop the interview at any time should you feel unable to continue.

It is important to stress that if it appears to the researcher that you could be at risk of harming yourself or any other person, including an adult or child, then the researcher may inform either an organisational manager (if you were recruited through this method) and/or your GP could also be informed. This is important for your own personal safety as well as other peoples. The researcher will discuss this with you should such a situation arise. The researcher is also a Trainee Counselling Psychologist and is duty bound by the British Psychological society (BPS) to inform relevant bodies should there be cause for concerns, such as risk to self and others.

After-care

At the end of the interview you will be asked how you feel and if you have any questions. Should you need to access support - a list of services are available to you for you to contact (noted below). Once the interview is over and your questions have been answered, the researcher will walk you out of the room and leave you with her contact details should you need to ask questions following the interview meeting.

If you do feel upset by the questions asked and from discussing the difficult experiences then please do contact the researcher at rims82@hotmail.com or 0611261@uel.ac.uk.

If you require further support, then you will find details of an independent organisation listed below that can provide counselling support.

Will this affect any treatment or standard of care I receive?

It is up to you to decide to join the study. Taking part in this research does not affect any type of care or standard of care you receive.

Are there any Benefits to Taking Part in this Research

Carrying out this research will hopefully allow Counselling Psychologists to understand how postnatal depression is experienced by migrant Pakistani-Muslim women. It may help health professionals develop an understanding of how to provide support to migrant Pakistani-Muslim mothers during the postnatal period.

Confidentiality of the Data

How will confidentiality be maintained?

The researcher will follow ethical and legal practice and all information about you will be handled in confidence. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the site will have your name and address removed so that you cannot be recognised. For this reason, the information collected from you will have a specific number. In addition for confidentiality reasons, a false name - (a different name to yours) - will be used throughout the transcript and in any published research.

Furthermore, you will be given the transcription before any work is handed in to the University of East London, to check that your confidentiality is maintained at all times. If you feel that your confidentiality has been breached, changes will be made to the transcript.

What will happen to the information I give?

Following your meeting, the audio recorded interview will be transcribed verbatim (meaning – typed in a word for word format on paper) by the researcher. This is the data for the research. After this, the researcher will analyse the transcribed interview for the purpose of the research.

How will the data will be stored and what steps will be taken to protect its confidentiality?

The researcher will keep the interview data you provide in a secure location. Audio recordings and all printed documents (transcripts) will be kept in a lockable cabinet and lockable room, which only the researcher has access to. The researcher's personal computer will also be used to store data and this will be protected with a pass-code which only the researcher has access to. The interview recording will be required for the purpose of this research only.

What will happen to the data once the research has been completed?

It will either be destroyed or handed back to you once it is no longer required.

Location

The research interviews will take place at the organisation: Deanery Road Children's Centre, Stratford, London. If this is not convenient then the interview will be conducted in a room at the University of East London, Stratford. If these options are not suitable then the interview can be conducted in your home, providing there is a suitable and quiet space.

Remuneration

You will not be paid for taking part in this study.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during the interview. Should you choose to withdraw from the research you may do so without disadvantage to yourself and without any obligation to give a reason. Information collected from you will be destroyed by the researcher. However, if you decide to withdraw 3 months after the interview, it may not be possible for the researcher to remove/destroy the information you have provided as it may already be included and analysed as a part of the research as a whole.

Support Services:

Newham Asian Woman's Project provide counselling to Asian women. Tel: 020 8472 0528.

Sakinah is an organisation that provides counselling to individuals from the Muslim community. Tel: 0870 005 3084 / Mobile: 0791 991 1920

Appendix 8c: Advert/Poster for Children's Centre Notice board

ARE YOU A PAKISTANI WOMAN?

- Were you born or raised in Pakistan?
- Are you a mother?
- Did you feel sad, distressed or depressed after having a baby?

If the answer is yes to the above questions then you need to know that an important piece of research is taking place, which needs women like you to come forward and talk about your experiences.

If you wish to take part in the study then you will be interviewed by the researcher (for approximately 1 hour).

In this interview you will be asked about your experiences of the postnatal period – this is the time after you had a baby. You will be asked questions about what your life was like after having a baby and how you coped. You will also be asked about your feelings on postnatal depression and what you thought about it.

Your name and details will be kept a secret (confidential) and they will not be revealed to anybody if you take part.

If you are interested then you will be given more information and you can speak to the researcher. **Please call: Miss Lamba (Mobile: 07960 770 575).**

Yours sincerely,

Miss Lamba

Trainee Counselling Psychologist

Doctoral Researcher

(Mobile: 07960 770 575).

Appendix 8d: Participant Consent Form

Consent to Participate in a Research Involving the Use of Human Participants.

Title of the Study:

A Qualitative Study Exploring Migrant Pakistani-Muslim Women's Lived Experiences and Understanding of Postnatal Depression

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the interview programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time up to 3 months after the interview date, without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)
……..

Participant's Signature
……..

Investigator's Name (BLOCK CAPITALS)
……..

Investigator's Signature ……
Date: ……

Appendix 9: Initial Comments in Transcripts - Example from a Participant

Transcript	**Initial Notes**
the pain of the delivery and I kept thinking about why I didn't have my son when he was born. What was his problem? It was my problem and you know it was too... too... too traumatic - why was I like that? So the... probably there was some guilt or something like that that kept coming to me. So for one month you know erm... I kept having nightmares.	Questioned self for not holding son Questioned son's "problem" Guilt for her behaviour (unholding, withholding?)
Nightmares about you know I used to see darkness, darkness and darkness and *darkness*. And er... afraid... I was afraid I was alone, bad dreams you know, and that's what I read about in-on internet after when you face postnatal kind of depression, such things will happen.	Nightmares about darkness after childbirth Repeated use of word: "darkness" Fearfulness and loneliness after childbirth "Bad" dreams - use of word "bad", is this showing her splitting mechanisms or black & white thinking? e.g. earlier on she also described dreams of darkness, something which is extreme opposite of light Accessed sources of information on PND
So I took it, and so I.... if it's happening.... and so this-this is is me who is going to cope with it; so I tried to face it and at the same time I used to see my parents *badly* ill, you know, this portion is (turns to right side and shows that side) broken and blood coming out, so - such that I used to wake up to my	Attempted to be courageous this time, to "face it" "parents badly ill" Dreams represent or symbolise self as a

husband and I used to be - I was screaming or something, no, no this is not possible, this is not possible.	parent all bloody and broken? Nightmare sounds gory and horrific. It seems she is dreaming about her father - a parent. But this parent being in the dream could just be symbolic of parenthood. After the strongest experience and blueprint of parenting/parenthood she may have is of her own parents. Her parents could in actuality represent *her*. Because she has in fact become a parent and perhaps she is the one who felt "bloody" and/or "broken" as she entered this phase in life. She also talks about how she felt a little better 6 weeks after the birth, because the bleeding had stopped around this time. It's possible that this gory and horrific nightmare is her unconscious manifestation of herself as frightened by parenthood, of herself as bloody and broken. Screaming from nightmares Feeling nightmares are not possible.
So erm.... and obviously when you get third degree, it's a problem. I never had faced such a thing before in my life. So.... er.... (laughs a little)	Never faced difficulties of third-degree tear in vagina (never experienced childbirth complications, so this is new)
I needed my mother at that time, as in fact she gave birth to four of us. I'm three sisters and one brother and they were all natural delivery with no stitches. So I used to get some inspiration from her you know. Wishing she was there, even at that time. So that was the issue.	A mother's need for own mother Comparing self's childbirth experience with that of mother's. Perceives mother as inspiring
Well after-after this was gone, and... that one month period got quite difficult for me to cope with as I.... was not really used to this .... I really salute my husband. He has - had always been with me at all times. He didn't	Found the 1st month after childbirth difficult & challenging

let me climb the stairs. He used to be caring wherever he could. He did that and that is what I really appreciate,	"Salutes" husband Husband viewed as supportive Appreciated husband's care
but the thing is that a new baby - first baby, is your first time, and nobody is there to help you and how you are going to make up things, how you are going to keep it together...	Nobody around to help with the "first time" with a baby/first-time baby is novel, new Anxiety about "keep[ing] it together" as a first-time mother
Oh yes, that was the other thing, the health visitor had been quite co-operative, the doctors had been really co-operative, and everything had been perfect and the part of erm.... the.... hospital and everything, that had been perfect.	Health visitor = cooperative Doctors' = cooperative
I would never give any blame to that, that was perfect, but that wasn't psychologically and emotionally I wasn't good… but the only thing that I found and my mother told me to do is pray and persist so that is what I did	No blame to healthcare professionals. Heed's mother's advice to pray and persist , was she trying to heal herself spiritually? Heal her emotionally/psychological unwell self?

Appendix 10: Identifying Emergent Themes in a Transcript

Emergent Themes	**Transcript**
Questioning behaviour Birth = overwhelming trauma Guilt	the pain of the delivery and I kept thinking about why I didn't have my son when he was born. What was his problem? It was my problem and you know it was too... too... too traumatic - why was I like that? So the... probably there was some guilt or something like that that kept coming to me. So for one month you know erm... I kept having nightmares.
Postnatal nightmares of darkness Self-education	Nightmares about you know I used to see darkness, darkness and darkness and *darkness*. And er... afraid... I was afraid I was alone, bad dreams you know, and that's what I read about in-on internet after when you face postnatal kind of depression, such things will happen.
Attempting courage Symbolic dream representing self: bloody & broken Horrified by nightmares	So I took it, and so I.... if it's happening.... and so this-this is is me who is going to cope with it; so I tried to face it and at the same time I used to see my parents *badly* ill, you know, this portion is (turns to right side and shows that side) broken and blood coming out, so - such that I used to wake up to my husband and I used to be - I was screaming or something, no, no this is not possible, this is not possible.
Pain of torn body	So erm.... and obviously when you get third degree, it's a problem. I never had faced such a thing before in my life. So.... er.... (laughs a little)
A mother's need of own mother Comparing self with mother	I needed my mother at that time, as in fact she gave birth to four of us. I'm three sisters and one brother and they were all natural delivery with no stitches. So I used to get some inspiration from her you know. Wishing she was there, even at that

Own mother = inspiring	time. So that was the issue.
Difficulty coping in first postnatal month Appreciation of husband	Well after-after this was gone, and... that one month period got quite difficult for me to cope with as I.... was not really used to this .... I really salute my husband. He has - had always been with me at all times. He didn't let me climb the stairs. He used to be caring wherever he could. He did that and that is what I really appreciate,
Anxiety managing new motherhood	but the thing is that a new baby - first baby, is your first time, and nobody is there to help you and how you are going to make up things, how you are going to keep it together...
Health professionals = cooperative & perfect	Oh yes, that was the other thing, the health visitor had been quite co-operative, the doctors had been really co-operative, and everything had been perfect and the part of erm.... the.... hospital and everything, that had been perfect.
Prayer and persistence = mother's advice	I would never give any blame to that, that was perfect, but that wasn't psychologically and emotionally I wasn't good… but the only thing that I found and my mother told me to do is pray and persist so that is what I did

Appendix 11: Spatial Representation of Themes on Cork Board

Themes are printed and cut up and then individually fixed onto a cork board with a pin. This allowed me to explore spatially how themes may relate to one another. The different coloured draw pins provide a visual presentation of themes which relate to one another and form part of one group.

Appendix 12: Looking for Patterns and Connections across Themes

Smith, Flowers and Larkin (2009) state that there are specific techniques to exploring patterns and connections between emergent themes. But caution that this is not prescriptive and that researchers should fine their own way through the IPA analytic process:

Abstraction: The researcher places "like with like" and develops "a new name for the cluster" that has been formed (Smith, Flowers and Larkin, 2009; p.96).

Subsumption: An emergent theme may in itself require a "superordinate status" as it might help pool together a number of "related themes" (Smith, Flowers and Larkin, 2009; p.97). Example: *"Matriarchal power struggle" was initially an emergent theme but then was moved to a superordinate level both within a case and later across-cases. The theme was underlined on a cork board to show that it "brings together a series of related themes" (Smith, Flowers and Larkin, 2009; p.97) and therefore it holds a superordinate status within this individual case .*

Polarization: Assessing transcripts for "oppositional relationships between emergent themes" by directing attention to differences rather than similarities (Smith, Flowers and Larkin, 2009; p.97).

Contextualisation: "Identify the contextual or narrative elements within ... [the]... analysis", by "attending to temporal, cultural and narrative themes" (Smith, Flowers and Larkin , 2009; p.98). As "a transcript is shaped by a participant's narrative, it can be helpful to highlight constellations of emergent themes which relate to particular narrative moments, or key life-events" (p.98).

Numeration: Paying attention to the frequency of a theme.

Function: "Emergent themes can be examined for their specific function within the transcript. E.g. the interplay of meanings illustrated by organising themes by their positive and negative presentation maybe interpreted beyond what the participant presents in terms of their meaning, and rather as a distinct way of presenting the self within the interview" (Smith, Flowers and Larkin, 2009; p.98).

Appendix 13: One Cluster of Themes from Participant (Rahana)

Themes Identified	Page / Line number	Quote
1. Superordinate Theme: The Importance of Own Mothers Support		
2. Traditional practice = own mother's support	40/1021-1028	My mum was there because I was living at my mother in law's and she'd come because in us, it's a bit of a tradition as well that when your daughter has her first baby, well usually with every baby really, the mum usually comes and helps out and everything. So I was living with my mother in law at the time but my mum came and it was basically just to sort of help me a bit.
3. Mother's support = helpful	63/1600-1602	second one wasn't as bad when he was born because my mum was there to sort of… you know, help out a bit really.
4. Mother provides reassurance	48/1217-1221	Only my mum.... but at that time I used to say to her… She used to say 'no, no, it happens with everyone, just bear with it and calm down' and you know… 'Just be patient, everything will be fine', this and that

5. Own mother sought practical solutions for daughter	61/1533-1536	it gave me a chance to have a bit of a break as well. And while Mum was there she made sure that the cleaner was coming twice a week.
6. Mother's departure = catastrophic: cognitively & emotionally	58/1463-1470	And sometimes because my mum was there, we used to take the kids out in their prams and pushchairs and things but I remember the day when my mum had to leave, I suddenly felt as if the world had come crashing down on me and I thought 'Oh my God, how am I going to cope?' and what if the kids get ill or something?
7. Own mother's help = imperative	56/1411-1414 56-57/1422-1430	My mother was there for about six months with me. **Interviewer: With the second baby?** Participant: With the second one, yes. That helped because Mum was there to sort of help me out a bit. So if I had the baby and everything and bathed him and everything, she used to help me actually, and then after he's been fed and everything, either I used to go to sleep or if he wasn't

		asleep she used to say 'I'm going to my room' and used to sit and read in bed or something and 'I'll keep him with me while you go and have a rest'.
8. Own mother's support in postnatal year = helpful	59/1481-1488	But having my mum there for the first six months was a great help. Luckily for me my mum was quite young herself when she got married so when she became a grandmother for the first time as well, she was about my age really; she was only 42 when she became a grandmother. And then obviously four years later she was only 46/47 so she was still quite young.

Appendix 14: Audit Trail

Superordinate Themes from Individual Participants Interviews

Below is a list of all the superordinate themes from each individual case.

Themes highlighted in yellow are an example of themes with a theoretical connection. These were then relabelled to form the subordinate theme "The important role of a woman's own mother"

Interview 1 (P0001-SN)

1. The woman as a body
2. The role of the husband and marriage
3. Overwhelmed new mother
4. Loneliness
5. A rive of emotions wrapped in helplessness
6. Knowledge through experience
7. The process of change and growth over time
8. Who am I?
9. The many faces of depression
10. A world of fear
11. Female dependence or independence tied in with culture
12. Conflict
13. The significance of female relationships
14. The mother: power and control
15. The helpfulness of mother and baby's relational bond
16. Things that are helpful
17. Experience of services
18. Significance of 40 days rest period
19. The issue of needs and expectations

Interview 2 (P0003-SM1)

1. Impact of baby's health and emergency-care
2. A new and life changing experience
3. The experience of 'not knowing'
4. Life before baby vs. life after baby
5. Impact of baby on marital relationship
6. The effect of labour/childbirth
7. The role and significance of children's centre services
8. The meaning of duty
9. Motherhood: Pakistan vs. UK
10. Dealing with the baby
11. The psychological understanding of self and identity
12. Psychological preparation for motherhood
13. The attitudes and care of all staff in health services
14. The psychological process of postnatal depression
15. A mother's needs
16. The significance and power of language and communication
17. Impact of migration
18. The husband's role

Interview 3 (P0002-2B)

1. Polarised process
2. The many forms of self
3. A child's life tied in with the mother's
4. The lived experience of an unplanned pregnancy
5. Experience of health professionals
6. Social circumstances
7. The role of a woman's own mother
8. Courage and self-encouragement
9. Issue of justice
10. The experience of marital relation
11. A new experience
12. The physicality of motherhood
13. What was helpful
14. The severity of postnatal nightmares
15. The psychological process of postnatal depression
16. The meaning of diagnosis and disease
17. Spiritual disturbance
18. Psychologically debilitated by pain
19. A migrant Pakistani woman's ambitions and dreams
20. Interpretation of Pakistani Culture from a Pakistani Woman

Interview 4 (P0004-RB)

1. Matriarchal power struggle
2. Psychological experience of Postnatal depression is multi-faceted
3. The protective culture of Pakistan
4. Mixed experience of health professionals
5. The toll of migration and motherhood
6. The burden of child-rearing
7. The power of time
8. What can be helpful?
9. The importance of own mother's support
10. The experience and impact of isolation
11. The process of comparing
12. Feeling and experiencing loss
13. Difficult marital relationship
14. The experience of learning independence
15. The impact of body-image in motherhood
16. Gender preference: expectations unmet
17. The experience of guilt
18. The experience and impact of an unwanted pregnancy
19. Motherhood: A new experience
20. The experience and impact of unwanted children
21. Power and powerlessness
22. The woman's body and motherhood
23. Complicated experience of childbirth.

Appendix 15: Table 2: List of Master Themes

Participant	1: Experiencing Transitions		
	1.1: Lacking knowledge and experience of motherhood	**1.2: The toll of migration and motherhood**	**1.3: Change in identity and experience of self**
Rahana	Yes	Yes	Yes
Shabana	Yes	Yes	Yes
Shaheena	Yes	Yes	Yes
Shazia	Yes	Yes	Yes
Present in at least 50% of the sample	Yes	Yes	Yes

	2: The Experience of Significant Relationships			
	2.1: The important role of a woman's own mother	**2.2: Matriarchal power struggle**	**2.3: Experiencing difficulties in a marital relationship**	**2.4: Experiencing supportiveness & strength within a marriage**
Rahana	Yes	Yes	Yes	No
Shabana	Yes	No	Yes	Yes
Shaheena	Yes	Yes	Yes	No
Shazia	Yes	No	No	Yes

Present in at least 50% of the sample	Yes	Yes	Yes	Yes

Participant	**3: The Body and Motherhood**		
	3.1: Difficulties & distress with breast-feeding	**3.2: Post-birth immobility**	**3.3: Experiencing an unplanned pregnancy**
Rahana	Yes	No	Yes
Shabana	Yes	Yes	Yes
Shaheena	Yes	Yes	Yes
Shazia	No	No	No
Present in 50% of the sample	Yes	Yes	Yes

	4: Living with Postnatal Distress		
	4.1: The experience and meaning of distress	**4.2: Feeling burdened and unable to cope**	**4.3: Isolation and loneliness**
Rahana	Yes	Yes	Yes
Shabana	Yes	Yes	Yes
Shaheena	Yes	Yes	Yes
Shazia	Yes	Yes	Yes
Present in at least 50% of the sample	Yes	Yes	Yes

	5: Experience and Perception of Pakistani Culture	
	5.1: Pakistani culture's negative gender attitudes and issues with female autonomy	**5.2: Supportive system within Pakistani culture**
Rahana	Yes	Yes
Shabana	Yes	No
Shaheena	Yes	No
Shazia	No	Yes
Present in at least 50% of the sample	Yes	Yes
Participant	**6: Patchy Provision of "Good" Healthcare**	
	6.1: Poor experience of healthcare staff and services	**6.2: "Healthy" health-care and services**
Rahana	Yes	Yes
Shabana	Yes	Yes
Shaheena	Yes	Yes
Shazia	Yes	No
Present in at least 50% of the sample	Yes	Yes

Appendix 16: Table 3 - Quotes Representing Themes from all Four Participants

Subordinate Theme	**Rahana**	**Shabana**	**Shaheena**	**Shazia**
Superordinate Theme: Experiencing transitions				
Lacking knowledge and experience of motherhood	*"**I never knew** what it meant to have a child"* *"I think it was the **first time** and **I didn't know anything at all**. .....**I didn't know** that actually having a child was actually quite a difficult thing"*	*"the thing is that a **new baby** - first baby, is **your first time*** *.... how you are going to make up things, how you are going to keep it together"*	*"before the child, **I didn't know** anything about the baby"*	*"It was a **totally new experience** for me"* *"**I don't know how** to change the baby's nappy"*
The toll of migration and motherhood	*"Coming here was a complete **shock to the system**"* *"I didn't expect to get **pregnant that quickly**..... All that just took its **toll on me**"*	*"I was sharing a house at that time with 2 other families"* *"Its **migrating women**, so it's not always that you are going to get straight away a very nice and beautiful house"* *"I had only one room"*	*"what milk should I give him? And no one is here to help me at that time. I was also **new here** at that time"*	*"everything was **new**"* *"and the **same next year came your baby**"*
Change in identity and experience of self	*"I just went completely loopy"* *"I wasn't able to look after myself, I*	*"I used to think about myself as a brave woman - I will do it [labour], I would do that, ... but unfortunately I*	*"You know I was a very shy person.....* *.....I couldn't say anything. But*	*"I was bit shy"* *"I'm the ..... the member..., have a family to support,*

	completely let myself go" *"I ..... became like a complete fat slob"* *"I was sort of losing myself"*	*couldn't"*	*after delivery, after two months, ... I felt very changes in me that I can say now anything to my husband"* *"I'm not a good mum"*	*holding the whole home."*
Superordinate Theme: The experience of significant relationships				
The important role of a woman's own mother	*"it's a bit of a tradition as well that when your daughter has her first baby, well usually with every baby really, the mum usually comes and helps out and everything"* *"having my **mum** there for the first 6 months was a great **help**"*	*"In my first postnatal period I **needed my mother**"* *"I used to **miss my mother** a lot"* *"My mother **should have been here** whatever happens"*	*The second child **I didn't feel anything**... **because** .... **my mum** also come **here"*** *"So... this time..., **my mum take care** of my one child, the younger one"* *"**She... help me** too much"*	*"more **important** is your **mother**"* *"if the **mother** will be here it's **better** for the person"* *"I don't have anybody to look after me"*
Matriarchal power struggle	*"She's always tried to be... dominant"* *"My mother in law... She was a very difficult woman..... She has made my life miserable I think"* *"My own mother... saw it is a difficult time and I... need my rest.... whereas my mother in law wouldn't"* *"There is a lack of understanding*		*"the first baby... my mother in law was with me. She didn't give permission to my husband to come with me"* *"if she say will say me don't do this, I can't do anything"*	

	and feeling with these people"			
Experiencing difficulties in marital relationship	*"there wasn't any emotional or physical support"*	*"postnatal depression... you know your relationship is badly affected"* *"I used to fight with my husband"* *"It happened.... why was I sleeping with you!?"*	*"I feel very angry on him"* *"you are the strongest person if your husband will support you"* *"He just don't talk to me"* *"They doesn't help you in front of his mum"*	
Experiencing supportiveness & strength within marriage		*"I really salute my husband. He has - had always been with me at all times. He didn't let me climb stairs. He used to be caring wherever he could"*		*"He was good"* *"He do help me"* *"one week off he... take, just for me and my baby"*
Superordinate Theme: The Body and Motherhood				
Difficulties and distress with breast-feeding	*"obviously if he won't take it, it stopped coming so that made me really depressed... thinking that I couldn't breast-feed him"* *"I thought I was failing him as a mother"*	*"I couldn't concentrate on my baby. The feed is affected.... this is...100% sure - when you are distressed it does affect your supply of feed for the baby... I do believe it"*	*"The main thing was - depression was the how to breastfeed him"* *"It was very difficult to breastfeed him"* *"because I had a caesarean, the milk... didn't come out at that time"*	

Post-birth immobility		*" The guilt was..... I didn't hug my child right after being born. I sometimes cry when I think about it"* *"I was not that able to keep him in my arms or try to feed him, or do something, because I was haemorrhaging a lot"* *"I could not move"* *"I lost 1000mls of blood during the tear" (labour)* *"The doctor told me not to lift anything.... but my son... nappy changing"*	*"The difference between the normal and the caesarean is...you can't do anything"* *"You can't do anything. You can't turn.... You can't give him milk.... easily."*	
Experiencing an unplanned pregnancy	*"I was still young, just come here and a month later I found out that I was already pregnant .... that was a big shock"*	*"Unexpectedly"* *"my second pregnancy, ... had been ... shocking"* *"I did not like it"* *"I was shocked because my plans were ..... diminished"*	*"After 4 months I got again pregnant and it was very shocking news for me. ... It was unplanned"*	
Superordinate Theme: Living with postnatal distress				

The experience and meaning of distress	*"I used to cry a lot..... in the shower.... I could wash it all away and no-one would see"* *"feel low all the time"*	*"These things are happening .... because I'm not ... praying properly. I'm not clean inside"* *"feeling .... the second postnatal - quite broken"* *"heart broken"* *"Guilty"*	*"Chirchira pann" (in Urdu)* *Translation: sense of restlessness and dissatisfaction"* *"There is no time to take rest of me. That's why I think this depression comes to me"* *"I cried most of the time"* *"you hate everything"*	*"If you are mentally depressed it has more effect on your body"* *" it make you, you know headache"* *"the duties of all these things that I'm worried about and that is why it's happened with me"*
Feeling burdened and unable to cope	*"He wouldn't feed.... and... sleep"* *"I was finding it difficult to cope"* *"He used to have really bad tantrums and I used to get upset and .... think my God, I just can't take this anymore"* *"The whole burden was on me"*	*"I used to be like... not coping well"* *"I used to let her cry"* *"The second one was more because... coping with two little kids... and you are also alone and you have to manage things so it becomes difficult"*	*"I can't do anything. I can't - I'm not able to take care of the child"*	*"It's a big duty to look after the baby and everything to manage, home or other activities"* *"over here with the baby all the duties you are doing yourself"* *"It just a burden"*
Isolation and loneliness	*"I felt all alone here"* *"I didn't have any friends here and no family except my aunt... but she was ... far"*	*".... I did not see good dreams. I was seeing myself alone in the darkness and nobody with me and that was kind of, at that time, sometimes I used to feel that. Yes that is true, there is*	*"You want to talk to your sister and your friends and here is no friends, no sisters .... no-anyone to listen to you"*	*"no one was there with me to share with me"* *"I don't have friendly relation around me ..."*

		nobody with me"		
Superordinate Theme: Experience and perception of Pakistani culture				
Pakistani culture's negative gender attitudes and issues with female autonomy	*"the only time we ever got a bit of freedom to talk about things .... was .... in college"* *"when I was growing up things were very overprotective. My friends were like that as well. .... most of the girls were allowed to come to my house ....but even my friends used to be accompanied by somebody, a maid from their house ... or something."* *"They were never allowed to come alone."*	*"If you have a first daughter there are ... some problems in our culture. ....A son is considered more powerful and more blessed ..."* *"Asian ... women, ... have started liking to work and you know being mobile like men outside, working and making money .... .Usually in our culture women are not like that.* *.... Even if they have done PhD's they are housewives"*	*"in the Pakistani culture, the ... woman's have, don't have any rights to do anything"* *"in our culture .... some husbands, doesn't allow them, don't... that they go outside alone"* *"Pakistani woman's can't go lonely anywhere. Can't go... Alone"* *".... Their husband doesn't allow them to do job..."*	
Supportive system within Pakistani culture	*"Help ....in Pakistan we've got servants in the house to clean so you have time for yourself but here, it was like I had to do everything"* *"My cousin has ... two little girls ..... she doesn't have to worry about housework or anything because they've got servants there.."*			*"the whole family is supporting you ..... in Pakistan, if a ...woman have a baby, 30 days she can't do anything, he will never do anything"* *"you can't do the house duties, like making tea, like make baby's milk or change the*

	".... They've got more emotional and physical support there."			*nappies, these duties are not the women's, that's for your grandmother."*
Superordinate Theme: Patchy provision of "good" healthcare				
Poor experience of healthcare staff and services	*"When I'd come here I'd got registered with my mother in law's friend who was a doctor ...."* *"Whatever I told her she went and told everyone which is very unethical of a doctor to do"* *"She told my mother in law everything .... I think it's wrong."* *"I was very angry ..... and disappointed with her"*	*"The health visitor .... If she had talked to me about myself a little more that would have been a good help, it would be a good catharsis"* *"I told her that I am missing my family ..... she was quite sympathetic and she was empathising also, so... if she would have asked me herself I think it would have been better."* *"Unfortunately the midwife that I had got was not experienced"*	*"She [health visitor] noticed but - not too much. She didn't ask me about depression"*	*"she* [reception staff] *just burst out me, ... what's your problem!?"* *"[s]he just told me, 'what's your problem, I can't understand what you are saying' like this, I was just frightened and not go back"* *"I was thinking might be happen every day with me, I shouldn't come here, that's why I just, I didn't come there"*
"Healthy" healthcare and services	*"It was only when we moved out and we registered in a local surgery, my GP ... was very good. She would listen to me and advise me"* *"she said maybe I should try and make some friends and go out a bit"*	*"The health visitor used to tell me .... how should I put the baby into the cot and everything .... these are techniques that I did not know, I got to know it because of them, through them."*	*"She told me about everything, you know, you have to go to children's centre, you have to go outside ..... She talked to me like very good things at that time."*	

Appendix 17a: UEL Ethics Approval Letter

Rachel Tribe
School of Psychology, Stratford
ETH/11/44

03 June 2010

Dear Rachel,

Application to the Research Ethics Committee: A qualitative study exploring migrant Pakistani-Muslim women's lived experiences of postnatal depression. (R Lamba)

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Simiso Jubane
Admission and Ethics Officer
s.jubane@uel.ac.uk
02082232976

Research Ethics Committee: ETH/11/44

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date: .....

Please Print Name:

Appendix 17b: UEL Ethics Amendment Letter

Professor Rachel Tribe
School of Psychology
Stratford
ETH/11/44
09 September 2010

Dear Professor Tribe

Application to the Research Ethics Committee: A qualitative study exploring migrant Pakistani-Muslim women's lived experiences of postnatal depression (R Lamba)

I advise that Members of the Research Ethics Committee have now approved the amendments to the previously approved application.

The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Admissions and Ethics Officer
Direct Line: 0208 223 2976
Email: d.dada@uel.ac.uk

Research Ethics Committee: ETH/11/44

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date: .....

Please Print Name:

Appendix 17c: Ethical Approval Amendment from University of East London

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

28 April 2014

Dear Rima,

Project Title:	**A Qualitative Study Exploring Migrant Pakistani-Muslim Women's Lived Experiences and Understanding of Postnatal Depression.**
Researcher(s):	**Rima Lamba**
Principal Investigator:	**Professor Rachel Tribe**

I am writing to confirm that the application for an amendment to the aforementioned research study has now received ethical approval on behalf of University Research Ethics Committee (UREC).

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	**Principal Investigator / Local Collaborator**
Deanery Road Children's Centre, Stratford, London and University of East London	Professor Rachel Tribe

Approved documents

Document	***Version***	***Date***
UREC amendment to existing application form	3.0	17 April 2014
Participant Information Sheet	3.0	25 April 2014

Consent Form	3.0	25 April 2014
Newtec Children's Centre Permission Letter	1.0	10 March 2014

Summary of Amendments
Recruiting NHS patients to the study proved extremely difficult. It was decided to alter the inclusion criteria away from NHS patients with a diagnosis of postnatal depression to women who subjectively felt that they had experienced depression after giving birth to a baby.

UREC ethical approval for the original study was granted on 9 September 2010. Ethical approval from NHS South East Coast Surrey was granted on 19 July 2011.

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Fieulleteau
Ethics Integrity Manager
University Research Ethics Committee (UREC)
Email: **researchethics@uel.ac.uk**

Appendix 17d - NHS Ethics Committee Approval Letter

NRES Committee South East Coast - Surrey
Education Centre
Royal Surrey County Hospital
Egerton Road
GUILDFORD
Surrey
GU2 7XX

Telephone: 01483 406898
Facsimile:
19 July 2011

Miss Rima Lamba
Trainee Counselling Psychologist
University of East London
Stratford Campus
Romford Road
Stratford, London
E15 4LZ

Dear Miss Lamba

Study title:	**How do Migrant Pakistani-Muslim Women Diagnosed with Postnatal Depression Experience the Postnatal Period during Motherhood? An Interpretative Phenomenological (IPA) Study.Previous Title:A qualitative study exploring migrant Pakistani-Muslim women's lived experiences of postnatal depression.**
REC reference:	**11/LO/0565**
Protocol number:	**0611261**

Thank you for your letter of 13 July 2011, responding to the Committee's request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair.

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 revised documents, subject to the conditions specified below.

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).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System 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 approvals from host organisations

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).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*	
Covering Letter		12 June 2011	
Evidence of insurance or indemnity		12 April 2011	
GP/Consultant Information Sheets	1	12 June 2011	
Interview Schedules/Topic Guides	1	30 March 2011	
Investigator CV		11 April 2011	
Letter from Sponsor		12 April 2011	
Letter of invitation to participant	1	30 March 2011	
Other: Supervisor CV - Prof Rachel Tribe		Undated	
Other: University Ethics Approval		09 September 2010	
Other: Doctoral Research Progress		30 March 2011	
Other: Peer Review		05 November 2008	

Participant Consent Form	2	12 June 2011	
Participant Information Sheet	2	12 June 2011	
Protocol	1	30 March 2011	
REC application	3.1	04 March 2011	
Response to Request for Further Information		13 July 2011	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) 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 NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/LO/0565 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Prof David Russell-Jones
Chair

Email: rsc-tr.ethicscommittee@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Professor Rachel Tribe – email – r.tribe@uel.ac.uk
University of East London
Richard Pursand/ Ms Sylvie Westrup
North West London PCT
West London Research Consortium for Research & Innovation
Room 334, Third Floor, Reynolds Building
St Dunstans Road
London W6 8RP

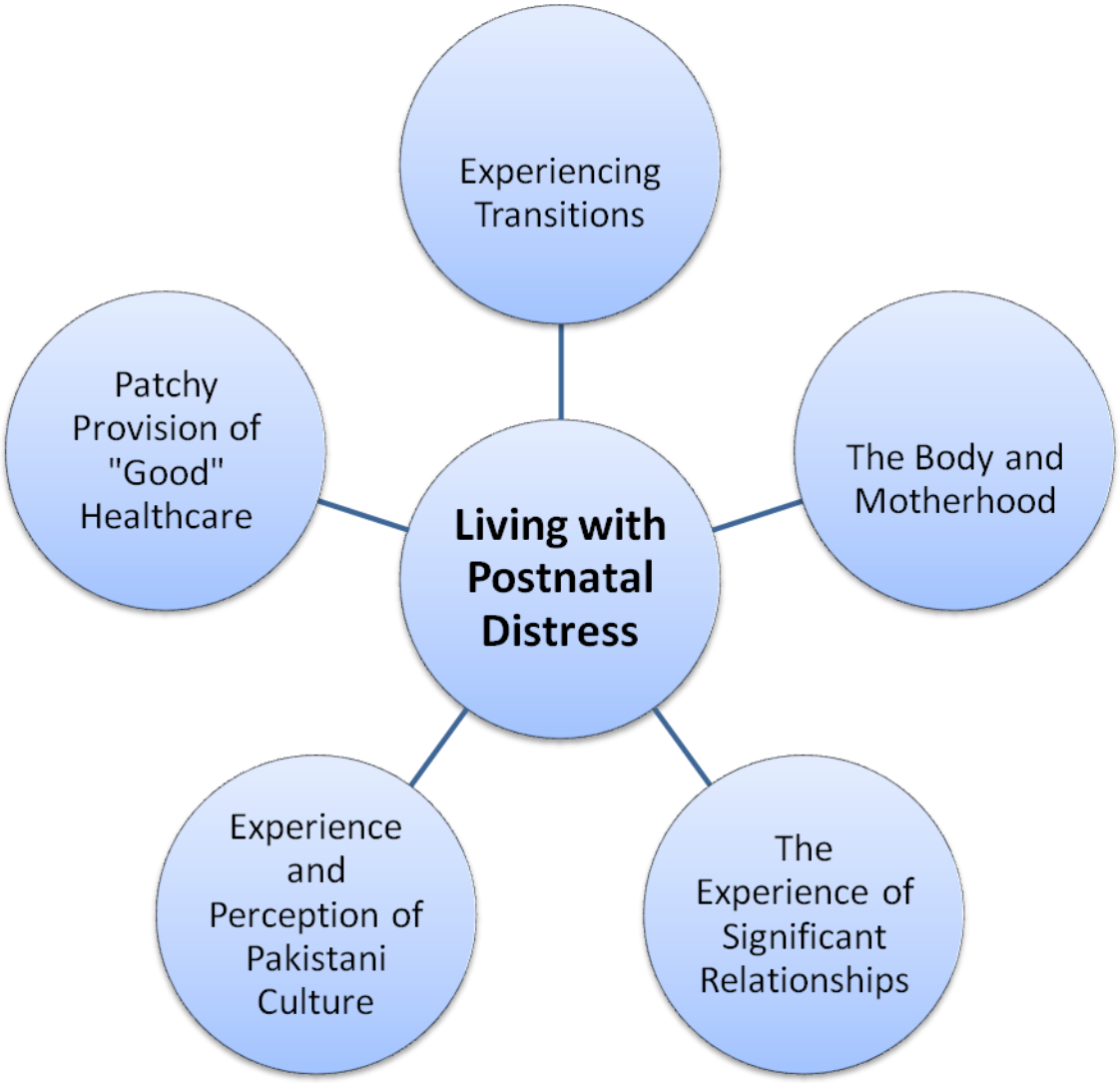
Appendix 18: Table 4: Participants' background information

Participant	***Years of residence in the UK***	***Mother's age during birth of first child***	***Number of children***	***Mode of delivery***	***Age of child[ren] during interview***	***PND with which number child***	***Timescale of Depression from Delivery***
Rahana	15	24	2 sons	Both Vaginal	15 and 12 years-old	Mainly first child, but some with second too	First pregnancy up to 4-yrs after birth of second child
Shabana	4	26	2 children: 1 son and 1 daughter	1st child: vacuum 2nd child: caesarean	Son: 3 years old Daughter: 2 years-old	Both	1st child: up to 4-6 months post-birth, till 3 months after birth of 2nd child. Approx. total of 15 months
Shaheena	2.5	28	2 sons	Caesarean	16 months and 2.5 months	First child	Up to 2-3 months post-birth
Shazia	2	25	1 son	Vaginal	16 months-old	Only child	Up to 6 months from birth

Appendix 19

Radial Diagram of Master Themes

The following radial diagram illustrates the relationships between the master/superordinate themes. It shows how the outer elements (all superordinate themes) are linked to one core theme: "Living with postnatal distress".



Appendix 20: Research Questions

The main research questions were:

- How do migrant Pakistani-Muslim women experience depression during the postnatal period?

- How do the women with a subjective account of postnatal depression experience motherhood in the postnatal period?

- How do these postnatally depressed women perceive their experience of support during motherhood in the postnatal period?