BRITISH PAKISTANI WOMEN’S LIVED EXPERIENCES OF POSTNATAL DEPRESSION AND HELP-SEEKING FROM PERINATAL MENTAL HEALTH SERVICES

by

SABRINA JAVED

A thesis submitted to the University of Birmingham for the degree of

DOCTOR OF CLINICAL PSYCHOLOGY

Department of Clinical Psychology
School of Psychology
The University of Birmingham
August 2024

Thesis Overview

This thesis is submitted by Sabrina Javed in partial fulfilment for the degree of Doctor of Clinical Psychology at the University of Birmingham. The thesis is comprised of four sections. The first section is a meta-ethnography which aims to review South Asian women's experience of perinatal mental illness and help-seeking in the United Kingdom. The second section is a qualitative empirical study which uses interpretative phenomenological analysis to explore British Pakistani women's lived experience of postnatal depression and help-seeking from perinatal mental health services. Both the meta-ethnography and the empirical research study have clear implications for the culturally sensitive support that British South Asian/Pakistani women with perinatal mental illness/postnatal depression should be offered by healthcare professionals. Finally, the third and fourth sections are comprised of two press-release documents which provide an accessible summary of the findings from both the meta-ethnography and the empirical research study.

Keywords: perinatal mental illness, postnatal depression, South Asian women, British Pakistani women

Dedications

To my beloved uncle Sajid, whose passing ignited a profound desire within me, to lend a hand to those seeking solace and hope. To my cherished grandfather and greatest advocate, Mohammed Rashid, for his contagious laughter and youthful spirit which brightened even the darkest of days. To my beautiful grandmother, Asha, whose generosity and kindness have shaped my understanding of compassion and community. Her life has been a testament to the power of an open heart, teaching me that the greatest achievements are not measured by personal success alone but by the positive impact we have on others. To my wise grandfather, Mohammed Hafeez, for his advice to my mother to educate me as she would a son which changed the entire trajectory of my life. I will forever remain indebted to him. To my beloved Aunt Sajida, for always being there to help me through difficult times. To my beloved Aunt Rukhsana, for championing my success since childhood. To my beloved Aunt Rosey, for always sharing in my happiness and celebrating every milestone with love and heartfelt joy. To my dearest mother, Asia, for nurturing my love for learning and for always believing in my potential, even when I doubted myself. To my sisters, Tanzila and Habibah, for our video calls which filled my days with warmth and laughter. To my brother, Bilal, for ensuring I always enjoyed the comfort of our mother's homecooked meals. To my darling husband and soulmate, Asif, for promising to stand by my side when all of this was just a dream and then keeping that promise through every challenge and triumph. To my past self, laden with self-doubt. You persevered against all odds, despite the critics surrounding you. To my future self, always remember to keep your light shining brightly and to never let anyone dim your spirit.

Finally, to my beautiful and graceful Aunt, Mussarat Javid.
I dedicate this work in her honour and memory.

Acknowledgments

بِسْمِ ٱللَّهِ ٱلرَّحْمَٰنِ ٱلرَّحِيمِ

In the name of Allah, the Most Compassionate and the Most Merciful

وَأَن لَّيْسَ لِلْإِنسَٰنِ إِلَّا مَا سَعَىٰ ﴿٣٩﴾

And that man shall have nothing but what he strives for.

(Surah An-Najm, 53:39)

First and foremost, I would like to thank God for granting me the strength, patience and determination to undertake and persevere through this research project. In completing this thesis, the verse from Surah An-Najm was a powerful reminder that success is directly tied to the effort we put forth. It emphasised that every obstacle was an integral part of the process, shaping not only the development of this work but also my personal growth. I wish to extend my heartfelt gratitude to the research participants. Their courage in opening up and sharing their stories has not only enriched this research but also contributed to giving a voice to those who are often unheard. A special thank you to my research supervisors, Dr Gary Urquhart Law and Dr George Johnson, for providing me with their invaluable guidance, support and expertise throughout the research process. I am also deeply grateful to my clinical supervisor, Dr Elizabeth Eman Penny, for providing me with her expertise and encouragement to persist through the challenges and uncertainties of the entire process. Thank you to my appraisal tutor Dr Darrelle Villa and clinical tutor Dr Michelle Fisher, for their guidance and support which has been invaluable throughout this journey. There aren't enough words to convey gratitude to my parents, for their unwavering belief in my abilities and the sacrifices they have made to support me in my academic endeavours. This achievement is as much theirs as it is mine. Finally, I would like to express my deepest gratitude to my husband. For his companionship, encouragement, endless love and support in my academic journey.

Table of Contents

List of Figures

1. Meta-Ethnography: South Asian Women's Experiences of Perinatal Mental Illness and Help-Seeking Within the UK

2. Empirical Research Paper: British Pakistani Women's Lived Experiences of Postnatal Depression and Help-Seeking from Perinatal Mental Health Services

List of Tables

1. Meta-Ethnography: South Asian Women's Experiences of Perinatal Mental Illness and Help-Seeking Within the UK

2. Empirical Research Paper: British Pakistani Women's Lived Experiences of Postnatal Depression and Help-Seeking from Perinatal Mental Health Services

A. Chapter and Section 1:

South Asian Women's Experiences of Perinatal Mental Illness and Help-Seeking Within the UK: a Meta-Ethnography

Abstract

Background: Perinatal mental health issues are a global health concern, however there is extensive literature indicating that South Asian women encounter unique challenges and cultural nuances that impact on their experiences of the perinatal period. This meta-ethnographic study aims to review South Asian women's experiences of perinatal mental illness and help-seeking.

Method: Four electronic databases including Web of Science, EMBASE, PsychINFO and Medline, were searched and relevant papers were identified using an inclusion and exclusion criteria. The quality of the selected papers was assessed using the Critical Appraisals Skills Programme checklist for qualitative research. Seven papers were identified as suitable for the review.

Findings: The synthesised findings revealed five themes which included: (1) cultural expectations of motherhood, (2) familial invalidation of mental health, (3) cultural preferences for help-seeking, (4) barriers to help-seeking (subthemes: a) fear of negative evaluation, b) fear of services, c) lack of awareness of Perinatal Mental Health (PMH) and Perinatal Mental Health Service (PMHS), d) lack of transparency and timeliness in care, e) cultural competence, sensitivity and bias in PMHS) and (5) linguistic expressions of PMH.

Discussion: The findings from the meta-ethnography are overall in line with the existing literature which has indicated a need for ongoing awareness of PMH and the role of PMHS amongst South Asian women.

Introduction

Perinatal Mental Illness or PMI is a term that refers to mental health issues during pregnancy and two years after birth (Monzon et al., 2014). It is a global health concern and has been found to be associated with poorer outcomes for both mothers and their infants (Beck, 1998; Kingston et al., 2012). Epidemiological studies have found deficits in cognitive, language and physical development, as well as psychosocial, emotional and behavioural problems in infants whose mothers experienced anxiety and postnatal depression (Kingston et al., 2012). Recent evidence from the United Kingdom (UK) has suggested that 23% of women who died during the postnatal period experienced mental health issues and suicide is now the second most common cause of maternal death (Knight et al., 2016).

In addition to this, PMI imposes a significant economic burden on society in the long term, as it costs approximately £8.1 billion pounds per annual cohort of births (Howard et al., 2014; MMHA et al., 2014). A fifth of these costs (£1.7 billion) is carried by the public sector, with the majority of it falling on the National Health Services (NHS) and other agencies such as social services (MMHA et al., 2014).

There is extensive evidence to suggest that individuals from Ethnic Minority (EM) groups are more likely to experience mental health issues, compared to individuals from White backgrounds (Anderson et al., 2017; Bhui et al., 2004; Onozawa et al., 2003). In addition to this, research has also found that it is likely that these mental health problems will not be detected or treated by services, including those occurring in the perinatal period (Prady et al., 2016). A national cohort study showed that women from EM groups were less likely to receive treatment, in the perinatal period, for anxiety and depression in comparison with White British women. This was despite EM women experiencing psychological distress at similar levels (Moore et al., 2019).

In relation to Perinatal Mental Health (PMH), some authors found that EM women experience high levels of psychological distress in the perinatal period and that this may become chronic and are often related to other health problems (Kotecha, 2009; Rahman & Creed, 2007; Rahman et al., 2003). Some authors have suggested that persistent and chronic PMI may be linked to unmet needs, as few of the women in studies of Black Caribbean and Pakistani women access care and treatment (Edge, 2007; Edge et al., 2004; Edge & Rogers, 2005; Husain et al., 1997).

Furthermore, the current literature has highlighted mental health vulnerabilities in particular EM subgroups. Smith et al. (2019) found that South Asian women residing in the UK experienced higher risks of developing PMH issues, with this being linked to social stigma and isolation, disparities in cultural values, language barriers and insufficient knowledge and education on PMH issues. Other contributing factors of higher levels of PMH included a high birth rate among South Asian women as well as a low female employment rate compared to other ethnicities in the UK (Masood et al., 2015).

A more recent study carried out in the UK found that, South Asian women accessed Perinatal Mental Health Services (PMHS) less than White British women and had a higher proportion of involuntary admissions (Jankovic et al., 2020). Earlier studies also found that South Asian women experienced higher rates of distress and reduced access to services (Bhui et al., 2004; Blais & Maïga, 1999). In addition to this, previous research found that South Asian women were 1.5 times more likely to attempt suicide than White women (Bhugra et al., 1999).

In relation to services, Bhui et al. (2001) found that South Asian groups were less likely to have their mental health difficulties recognised by their General Practitioners (GPs) and even after recognition, they were less likely to be referred to specialist services (Bhui et al., 2003). Additionally, a review by Williams et al. (2006) found that South Asian service users were less likely to be referred for talking therapies, compared to other ethnic groups. This is despite previous research reporting that South Asian service users, specifically women, expressed a preference for talking therapies over psychiatric medication (Hussain & Cochrane, 2002).

Meta ethnography

Meta-ethnography is a seven-stage approach to meta synthesising qualitative data and was developed by Noblit and Hare (1988). It is a method that is inductive and interpretative in its approach and is most commonly utilised for qualitative synthesis, particularly in the context of healthcare research (Hannes & Macaitis, 2021).

The existing literature considers migrant women's experiences and ways of dealing with PND, (Schmied et al., 2017), a systematic review of the equitability of the detection and management of perinatal mental health problems in the UK (Prady et al., 2014), a systematic review of EM women's experiences of perinatal mental health conditions in Europe (Watson et al., 2019) and a meta-ethnographic synthesis (Sorsa et al., 2021) and meta synthesis (Button et al., 2017) of help-seeking for perinatal psychological distress. The majority of this research has included studies of women from all ethnic backgrounds.

The term 'South Asian' refers to the category of individuals whose cultural backgrounds originate from Pakistan, India, Bangladesh and Sri Lanka (Marshall & Yazdani, 2000). Ethnicity is both complex and multi-layered and some authors have argued that grouping individuals into a single category (i.e. ethnic minority) is flawed as it involves taking a reductionist approach (Conneely et al., 2023). To date, there is insufficient research exploring PMH and help-seeking experiences of women from individual ethnic groups. As such, this meta-ethnography will include papers featuring Black women as participants; however, the primary focus will be placed on the experiences of South Asian women. A meta-ethnographic approach was chosen to allow for more nuanced interpretations that give space to marginalised perspectives and narratives.

Aims of this meta-ethnography

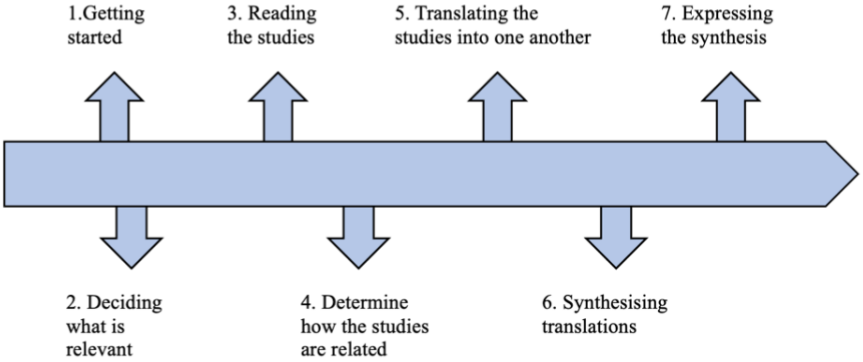
Based on existing literature, it is crucial to review the help-seeking experiences of South Asian women with PMI, to inform the development of services and to guide future policies and interventions within the UK. The aim of this meta-ethnography is to systematically synthesise the current literature, to identify key themes and insights into South Asian women's experiences of PMI and help-seeking in the UK.

Method

Type of review

A meta-ethnographic approach was taken, guided by Noblit and Hare (1988). Meta-ethnography is suggested as a method that enables a rigorous generation of interpretations by comparing and contrasting findings across multiple studies. It also allows for higher order interpretations, in comparison with conventional literature reviews (Atkins et al., 2008).

Figure 1. The seven stages of meta-ethnography (Noblit & Hare, 1988).



Much of the literature has highlighted the benefits of using qualitative synthesis approaches which includes enabling a more comprehensive and generalisable understanding of existing literature (Atkins et al., 2008; Sattar et al., 2021). The meta-ethnographic method of qualitative synthesis in particular is useful when there is a need to understand a phenomenon, both at a theoretical and conceptual level. It also can be used to influence decision-making, in relation to healthcare and policy (Cahill et al., 2018; Classen & Alvarez, 2015).

Noblit and Hare's (1988) seven stages of meta-ethnography have been presented above in Figure 1. A detailed outline of these stages has been provided in Table 1. Following this, explanations about how these stages were implemented will be included within the method section.

Table 1. An outline of the seven stages of meta-ethnography (Noblit & Hare, 1988).

Phase	Description
1. Getting started	Determining an area of interest whilst considering whether there is a requirement to synthesise the topic and if a meta-ethnographic approach fits with the research question.
2. Deciding what is relevant to the initial interest	Selecting studies to include in the synthesis and locating relevant studies. Creating inclusion and exclusion criteria. Quality appraisal of the included studies.
3. Reading the studies	Repeatedly reading the included studies and extracting raw data, in the form of first and second order constructs.
4. Determining how the studies are related	Considering the relationships between key concepts from different papers.
5. Translating the studies into one another	Examining the key concepts across all studies whilst checking for the presence or absence of the commonalities of key concepts.
6. Synthesising translations	Developing concepts across studies. Examining the relationship between studies and making decisions as to whether the synthesis is reciprocal, refutational or line of argument.
7. Expressing the synthesis	Compiling the synthesis and presenting it to the target audience.

The first stage began by identifying an area of interest which related to the researchers' own identity as a British Pakistani and interest in perinatal mental health. Through an exploration of the literature, it became apparent that there was very limited qualitative research exploring perinatal mental health within British Pakistani women. The researcher also found that research was mostly carried out in Pakistan and the methods employed were quantitative. In addition to this, further initial searches revealed that qualitative research within perinatal mental health often explored ‘South Asian’ or ‘Ethnic Minority’ women’s experiences. Therefore, the researcher expanded the search to include other South Asian ethnicities including Indian, Bangladeshi, and Sri Lankan.

Systematic literature search

After developing a research question, the researcher undertook a systematic search of the literature. This is the second stage of Noblit and Hare’s (1988) proposed method for conducting a meta-ethnography.

Search strategy

The search strategy was developed to detect papers that were relevant in answering the research question. The researcher decided not to limit the search to peer-reviewed journal articles, as it was discovered that within the ‘grey literature’, there were research studies that were able to contribute to answering the research question. The search strategy was shaped by a previous meta-ethnography by Schmied et al. (2017) and a systematic review by (Watson et al., 2019).

Table 2. Search terms

Search	**Description** [1]
1	Perinatal OR postnatal OR prenatal OR maternal OR postpartum
2	Barrier* OR help seek* OR health seek* OR support seek* OR access
3	Mental health OR mental health problem* OR mental illness*
4	South Asian OR Pakistani OR Indian OR Bangladeshi OR Sri Lankan OR Ethnic Minorit*
5	1 AND 2 AND 3 AND 4

* Indicates a truncation

---

[1] The only variation to this search strategy was for the database Web of Science where the search terms ‘perinatal mental health’ and ‘perinatal psychological distress’ were included to increase the number of results related to perinatal mental health.

The search strategy was applied to databases including Web of Science, EMBASE, MEDLINE and PsychINFO. Additionally, a search of theses was undertaken using the same search strategy on the following databases: Open Access, Pro Quest and EThoS. These databases were used to maximise the number of papers found. All papers found from the searchers were then exported into REFWORKS, a reference management software package.

Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied to the papers identified in the systematic search, as demonstrated in Tables 3 and 4.

Table 3. Inclusion criteria applied to papers that were identified in the systematic search

Number	Inclusion criteria
1	Qualitative research exploring experiences of perinatal mental healthcare
2	Participants were living in the UK
3	Participants were South Asian or from an Ethnic Minority background
4	English language

Table 4. Exclusion criteria applied to papers that were identified in the systematic search

Number	Exclusion Criteria
1	Not focused on perinatal mental health
2	Not qualitative
3	Not focused on help-seeking
4	Not based in the UK
5	Research below master’s level
6	Literature reviews including systematic reviews and meta syntheses

7	Books

Systematic screening process

The systematic screening process is displayed in the Figure 2 below. This resulted in 7 papers that were included in the meta-ethnography. Six of the studies were carried out in England and one was carried out in Wales. From these studies, a total of 103 participants were included in the meta-ethnography. An overview of the papers is provided below in Table 5. All participants had reported experiencing mental health issues in either the antenatal or postnatal period. Papers 1, 2, 3, 4 and 5 did not report the age of the participants. The age range of participants in paper 6 was between 23 and 40 and in paper 7, it was between 31 and 34.

There was a variety in the methods used to collect qualitative data. Five of the papers (1,2,3, 4 and 7) used semi-structured interviews and these were carried out either face to face or over the telephone. Two of the papers (5 and 6) used focus groups. In addition to this, to analyse the data: two papers (2 and 6) used framework thematic analysis; two papers (4 and 5) used qualitative thematical analysis; one paper (7) used interpretive phenomenological analysis; one paper (1) used reflective thematic analysis, and one paper (3) took a grounded theory approach. Although there were different methodologies used for data analysis, this is useful as it contributes to methodological triangulation which has been argued to enhance the reliability of a meta-ethnography (Carter et al., 2014). In relation to the findings, all papers reported several overarching themes and subthemes. The meta-ethnography included an analysis of eight subthemes (1), four overarching themes (2, 4 and 6), three overarching themes (3), two overarching themes (5) and seven overarching themes (7).

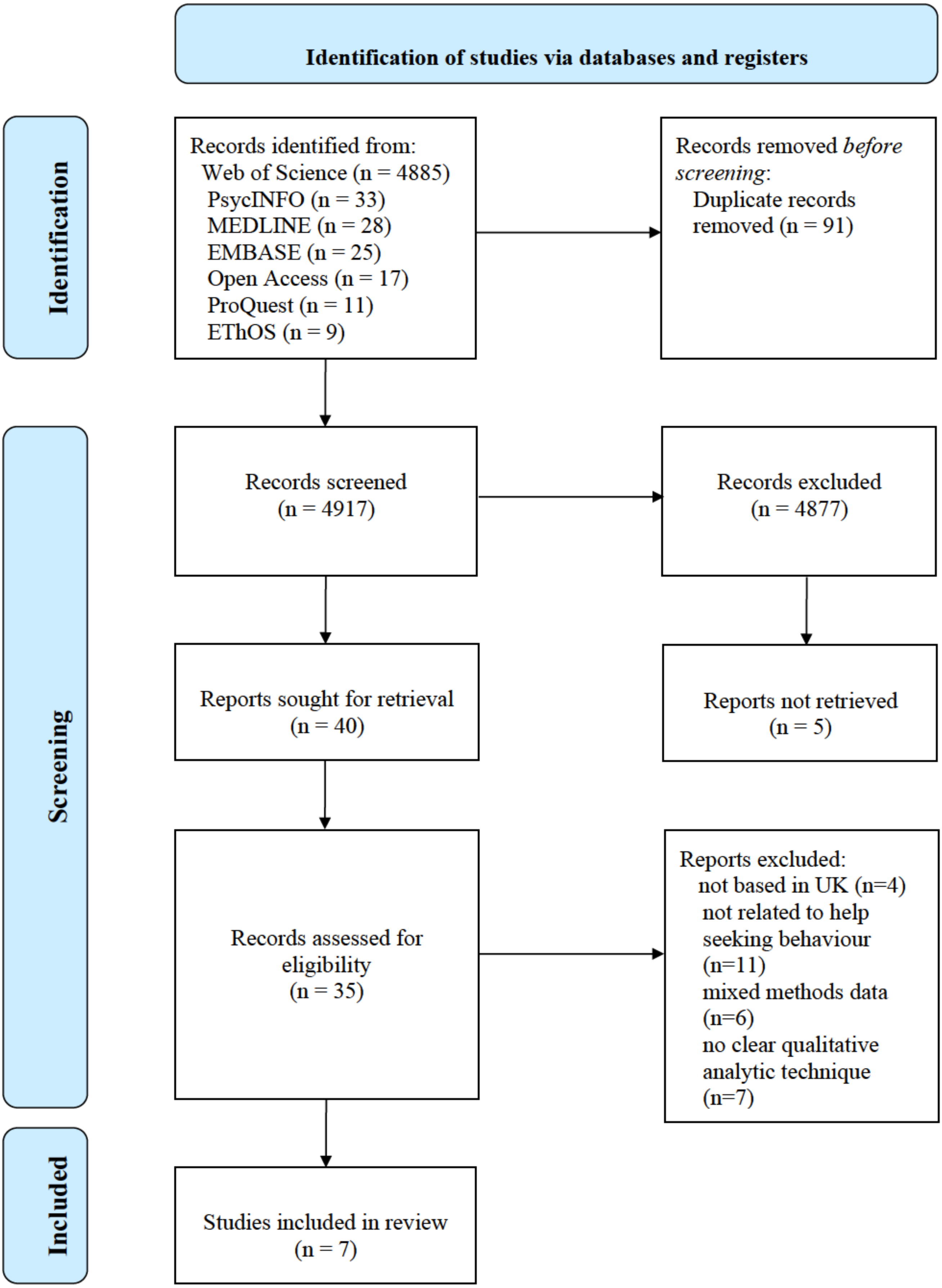


Figure 2. PRISMA diagram illustrating the systematic screening process (Page et al., 2021)

Table 5. An overview of the studies included in the meta-ethnography

Author(s) and year of publication	Aim(s)	Setting	Participants	Methodology and analysis	Findings
1. Pilav et al., (2022)	To explore minority ethnic women's experiences of access to and engagement with perinatal mental health care.	England-United Kingdom	18 women who self-identified as being from a minority ethnic group (Black, Asian, or any other minority ethnic background). These women were diagnosed with perinatal mental health difficulties and were supported in the community by a specialist perinatal mental health service.	Semi-structured telephone interviews. Data were transcribed verbatim and uploaded into NVivo. Reflective thematic analysis was used to interpret data.	Themes: 1) Shame and guilt in motherhood 2) Women as caregivers 3) Perceived to be strong and often dismissed 4) Blind faith in the medical profession 5) Family and community beliefs about mental health and care 6) Intergenerational trauma and family dynamics 7) The importance of understanding cultural differences 8) The power of validation, reassurance and support
2. Conneely et al., (2023)	The aim of this study was to answer two questions: how do Black and South Asian women experience (1) access to perinatal mental health services and (2) care received from perinatal	England-United Kingdom	37 women in total and of these women, 17 were South Asian. Four of these women were interviewed by an interpreter.	Semi-structured interviews, conducted over the phone or video call. Data were transcribed verbatim and analysed using framework analysis.	Themes: 1) Self-identity, social expectations and different attributions of distress deter help-seeking 2) Hidden and disorganized services impede getting support 3) The role of curiosity, kindness and flexibility in making women feel heard, accepted and supported by clinicians 4) A shared cultural background may support or hinder trust and rapport

		mental health services?				
3.	A. Wittkowski et al., (2011)	To better understand the experience of postnatal depression in South Asian mothers living in Great Britain.	England-United Kingdom	10 South Asian women (5= Asian Indian, 4= Asian Pakistani and 1= Asian Bangladeshi) with an EPDS score of ≥ 12.	Face to face interviews. Data analysed using a grounded theory approach.	Themes: 1) Internalising misery 2) Others will judge me and I feel on my own 3) I talk to my health professional and they don’t understand
4.	Templeton et al., (2003)	To describe the experiences of women suffering from postnatal depression in black and minority ethnic communities in Wiltshire, UK.	England-United Kingdom	6 women from a variety of minority ethnic groups, including Bangladeshi, Indian, Other Asian and ‘Other’ (2 women from Portugal and 1 woman who identified herself as mixed race).	Semi-structured interviews (face to face and telephone) and three focus groups. Qualitative thematical analysis.	Themes: 1) Issues specific to pregnancy and birth (including postnatal depression) 2) Issues specific to primary health care 3) Issues relating to culture, 4) Other issues including, family/marital problems, violence, drinking alcohol, bereavement, financial difficulties, unemployment, accommodation and (racial) harassment
5.	Hanley (2007)	To understand the emotional wellbeing of mothers and their	Wales, United Kingdom	10 Bangladeshi women, 9 spoke English and 1 woman required a translator.	Focus group. Qualitative thematical analysis.	Themes: 1) Sources of support 2) The importance of cultural values and religious beliefs

	perception of the postnatal period.				
6. Moghul (2018)	To explore South Asian women's views on factors (barriers and enablers) that influence help-seeking for perinatal mental health.	England-United Kingdom	17 South Asian women	5 focus groups, with 3 focus groups carried out in Urdu and 2 in English.	Themes: 1) Views about perinatal mental health 2) The barriers they experiences for their perinatal mental health 3) The factors they felt would enable help- seeking for mental health 4) Suggestions for improvement to local care pathways for perinatal mental health
7. Sihre (2021)	To deepen the understanding of women's beliefs about the causes of postnatal psychiatric illnesses and women's lived experiences of a severe postnatal psychiatric illness.	England-United Kingdom	5 South Asian women	Semi-structured, face to face interviews. Interpretive Phenomenological Analysis.	Themes: 1) Lack of understanding and knowledge about severe psychiatric illnesses and Perinatal Mental Health Services 2) Not feeling or acting normal 3) Beliefs about triggers of severe psychiatric illnesses 4) Reality of living with a severe psychiatric illness 5) Consequences of developing a severe psychiatric illness 6) Experiences of Perinatal Mental Health Services 7) Coping strategies

Quality appraisal

The quality of the studies included in the meta-ethnography were appraised using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies. The checklist was amended to include an understanding of help-seeking by the author (s). This was to further assess the relevance of the papers to the proposed research question (Appendix A).

Table 6. The Critical Appraisal Skills Programme checklist for qualitative studies

Section	Checklist Question
A) Are the results valid?	1. Was there a clear statement of the aims of the research?
	2. Is a qualitative methodology appropriate?
	3. Was the research design appropriate to address the aims of the research?
	4. Was the recruitment strategy appropriate to the aims of the research?
	5. Was the data collected in a way that addressed the research issue?
	6. Has the relationship between researcher and participants been adequately considered?
B) What are the results?	7. Have ethical issues been taken into consideration?
	8. Was the data analysis sufficiently rigorous?
	9. Is there a clear statement of findings?
C) Will the results help locally?	10. How valuable is the research?
Overall quality score	++ = Most of the criteria were met. + = Some of the criteria were met. – = Few or none of the criteria were met.

A systematic approach was used to judge quality by rating each study based on whether it met the criteria set out by the CASP for qualitative studies. As shown in Table 7, a tick (✓), was given if the answer to the question was ‘yes’, a cross (x) was given if the information was absent and a question mark (?) was given if there was insufficient information that would not allow the researcher to decide. Following this, an overall quality score (++, +, -) was awarded to each study.

Table 7. A detailed overview of the ratings of the studies using the **Critical Appraisal Skills Programme checklist**

Study	Theoretical approach			Study design	Data collection	Validity				Analysis						Ethics	Quality score
	Is a qualitative approach appropriate?	Is the study clear in what it seeks to do?	Is the qualitative method/analytic tool chosen appropriate for the aim?	How defensible/rigorous is the research design/methodology?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is there a clear understanding by the author(s) of help-seeking?	Is the data analysis sufficiently rigorous?	Are the data rich?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims of the study?	Are the conclusions adequate?	How clear and coherent is the reporting of ethical considerations?	
Pilav et al. (2022)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	++
Conneely et al. (2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	++
A. Wittkowski et al. (2011)	✓	✓	✓	?	?	?	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	+
Templeton et al. (2003)	✓	✓	✓	✓	✓	✓	?	?	✓	✓	✓	?	✓	✓	✓	✓	+
Hanley (2007)	✓	✓	✓	✓	✓	✓	✓	✓	×	?	✓	✓	✓	✓	✓	✓	+
Moghul (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	++
Sihre (2021)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	++

As shown in Table 7, four of the studies (1, 2, 6 and 7) were rated as meeting most or all of the CASP checklist criteria. The remaining three studies (3, 4 and 5) were rated as meeting some of the checklist criteria. Despite this rating, these three papers were included in the meta-ethnography as they were considered to make a meaningful contribution to the research question. The studies varied in relation to the reason for the reduction in their overall quality score on the CASP checklist. For the papers with the lowest quality scores (3, 4 and 5), there was a distinct lack of information regarding the validity of the studies. However, it must be noted that papers 3, 4 and 5 did meet 2 of the 4 validity criteria within the CASP checklist.

Data extraction

This process was guided by Noblit and Hare (1988) and initially involved taking an index paper as a way of identifying findings and comparing these with other papers. Noblit and Hare (1988) recommended repeatedly reading the included studies to extract key concepts. To begin the process, the researcher extracted the themes into a spreadsheet and then added quotes and authors interpretations', to enable her own interpretation of the themes presented in the studies (Appendix B). This was an essential step in preparation for the next phases of the meta-ethnography, as it illustrated key concepts that were present across individual studies. Additionally, quotes and themes from papers 1 and 2 were screened to exclude those contributed by Black women, to ensure the data specifically represented the experiences of South Asian women.

Data analysis and synthesis

Noblit and Hare (1988) propose three stages in the analysis and synthesis of data which includes Stage 4: Determining how the studies are related, Stage 5: Translating the studies into one another and Stage 6: Synthesising the translations. Although these are depicted as separate stages, the researcher was required to alternate between the stages for the development of themes. As shown in Appendices B to D, the researcher considered the relationships between key concepts across the studies.

Subsequently, the researcher checked for the presence or absence of these key concepts to synthesis the data, using a reciprocal, refutational or line of argument translation (Noblit & Hare, 1988). This process involved the researcher reading over key concepts and quotes and grouping existing concepts using a colour coded system (Appendix C). This led to the development of new themes (Appendix D). Stages 5 and 6 were repeated to re-assess the data whilst considering the new themes. This was to allow a thorough synthesis of the data, for the purpose of confirming or disputing the researchers own interpretation. To reduce bias and subjectivity in the researcher's analysis, a peer separately undertook stages 5 and 6. The researcher then engaged in a comparative analysis and engaged in discussions with the peer around their respective findings.

Reflexivity

As a South Asian researcher conducting this meta-ethnography on the experiences of South Asian women with PMI, reflexivity has been a crucial part of the research process. Throughout the study, I remained mindful of how my own cultural background, personal experiences and potential biases might influence the interpretation and synthesis of the data. Using a reflective diary, I engaged in continuous self-reflection and aimed to authentically represent the voices and experiences of the women in the reviewed literature. By maintaining a reflexive stance, I sought to balance insider knowledge with academic rigor, thereby enhancing the credibility and trustworthiness of the research findings. I participated in workshops with my peers and an experienced qualitative researcher which allowed me to reflect on my analysis and gain valuable feedback. Additionally, ongoing supervision helped me cultivate a flexible mindset, enabling me to connect with and tune into the participants' inner experiences.

Findings

The following five overarching themes and related subthemes were developed through the processes of reciprocal and refutational translations: 1) cultural expectations of motherhood, 2) familial invalidation of mental health, 3) cultural preferences for help-seeking, 4) barriers to help-seeking (subthemes: a) fear of negative evaluation, b) fear of services, c) lack of awareness of Perinatal Mental Health (PMH) and PMHS, d) lack of transparency and timeliness in care, e) cultural competence, sensitivity and bias in PMHS) 5) linguistic expressions of PMH.

1) Cultural expectations of motherhood

The most prominent theme across all papers was the culturally derived expectations of South Asian mothers. These women expressed a strong sense of duty and responsibility towards the care of their children, irrespective of their own mental health. This also applied to the caring roles they played for other members of the extended family, including in laws. There were also expectations for women to bear the responsibility of household chores, in the midst of their own mental health difficulties. It appeared that these women were juggling multiple demands and “had no other choice” (Pilav et al., 2022) but to accept a significant burden of familial responsibilities. Therefore, illustrating the multifaceted roles South Asian women are expected to fulfil within the family system, whilst also carrying out the responsibilities of being a mother.

> “They [my children] are mine...I should look after them” (Templeton et al., 2003).

> “She has to look after 3 brothers in law and do all the housework all day as well as looking after the Auntie’s popping in” (Moghul, 2018).

> "I had to carry on with all the housework and the midwife was telling me you shouldn’t be doing this because of risk of hernia etc. but I had no other choice" (Pilav et al., 2022).

South Asian women were also expected to dress a certain way and to conform to cultural standards, in matters of their clothing and hairstyle. There is an indication of a lack of individual autonomy and personal choice for the women during their pregnancy and this is orchestrated by their mothers. This may indicate that there are cultural norms that are passed down from generation to generation.

> “When I was pregnant, my mother would not allow me to wear bright clothes or fitting clothes. I could not wear my hair down. I always had to have it tied up.” (Hanley, 2007).

Women felt they were responsible for the happiness of others and hiding their personal distress was a way of achieving this. This reflects traditional expectations of South Asian women and collectivist cultures at large, whereby it is encouraged for women to put the needs of others above their own. These expectations were seen as different to those placed on women from other cultures. Thus, emphasising the need for awareness in relation to how women, particularly mothers, are perceived within their families and an understanding of the expectations placed upon them.

> “I do know that there are others in our culture that have to keep what they really think and feel to themselves just to keep other people happy, such as their husband or in-law.” (Wittkowski et al., 2011).

> “They need to know how this culture is different, how women are treated differently, how they have different expectations err from their culture" (Sihre, 2021).

2) Familial invalidation of mental health

A key concept emerged in relation to the experiences of invalidation from family members. Women expressed that their families downplayed the severity of the issues they faced, as they did not regard them as “serious” (Conneely et al., 2023). Additionally, women expressed that their families did not comprehend the depth of the challenges they experienced with their mental health. Thus leading to an exacerbation of their distress and caused them to isolate themselves from others. This isolation may have served as a way of the women protecting themselves from further emotional distress.

> “They wouldn’t, I dunno I feel like sometimes they wouldn’t take it that serious mental health. . . they think I’m just being down” (Conneely et al., 2023).
>
> “My husband just don’t understand how I feel” (Wittkowski et al., 2011).
>
> “I just feel I get worse when people don’t understand me, I get even more depressed and I tend to like push myself away from people even more because no one is understanding me” (Conneely et al., 2023).

Women also spoke about their family members refusing to accept or acknowledge their mental health issues, by denying their medical diagnosis and by focusing on societally defined markers of success and happiness. These included attending university, getting married, buying a house and having children. Thereby, further contributing to the invalidation of women’s experiences of mental health issues.

> “My other family “no you don’t have bipolar, you’ve worked you know you’ve been to uni you’re articulated” ...it was very hard for them to understand, my brother one of them was just dismissing, “no you’re not bipolar the doctor is talking rubbish”” (Sihre, 2021).

> “When I’d even mentioned it to her older sister [that she may be suffering from postnatal depression] ...she said ‘No! , she’s not depressed, she’s got a lovely home, she’s got money, she’s got this, she has everything, what does she need?” (Moghul, 2018).

Other consequences for familial invalidation involved women losing confidence in themselves. The lack of belief from others seemed to create a negative feedback loop, whereby women’s self-perception was negatively impacted. This may have led to women internalising the disbelief and may have caused them to question the validity of their own experiences. Thereby, contributing to a cycle of self-doubt and diminished confidence which further reinforces the sense of not being believed.

> "I certainly lose a lot of confidence...because nobody’s really believing in you and you feel that and so that’s how it works…." (Sihre, 2021).

For some women, the lack of understanding and validation from their husbands or partners stemmed from historical comparisons and cultural expectations. The emphasis on the control past generations had over situations indicates a belief that women should be able to behave or react in a similar manner. Thereby, implying a dismissal of contemporary challenges faced by South Asian mothers living in Britain. There were also suggestions for PMHS to provide additional services for husbands whereby attendance would be mandatory. Thus, further illustrating the lack of spousal support and the challenges women encountered when their husbands engagement with services was presented as voluntary.

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

> "At least one or two appointments where they have the spouse present maybe make it compulsory or something ... it's really hard to force your husband ... If he was told that he had to be present, then he would go and then he would understand" (Moghul, 2018).

On the other hand, some women reported that their husbands were the only members of the family who encouraged them to seek support for their mental health issues. The description of the husband as "British born" (Conneely et al., 2023) suggests exposure to a cultural context that may be more accepting or more willing to have conversations about women's struggles with mental health issues in the postnatal period. It also suggests that there are differing perspectives that exist within families. This illustrates the potential for individual family members to provide a supportive and positive role. Furthermore, the description of the husband as a "White in an Asian person's body" (Conneely et al., 2023) suggests that there are cultural differences in attitudes to help-seeking for mental health issues. Additionally, there is mention of the husbands professional background which enabled him to have an awareness and knowledge about mental health conditions. As a result, women may have more access to resources and accurate information and thereby increasing the likelihood of women experiencing a validating and empathetic familial environment.

> "If it wasn't for my husband insisting I get help I don't think I would have done it. He's very different, he's British born and his family is very backward but he's very different, he's very, I don't know, he's kind of like White in an Asian person's body. If it wasn't for him, I wouldn't have done it because my family would have discouraged me for sure" (Conneely et al., 2023).

> "He's a doctor so he kind of has a bit more understanding, he's like you know, he's heard about postnatal depre-erm psychosis" (Sihre, 2021).

3) Cultural preferences for help-seeking

There were varying perspectives in relation to cultural preferences for help-seeking. Some women felt that there was strong trust in the expertise of medical professionals within their communities. This implies that there may be cultural norms and values that encourage a reliance on medical professionals. Additionally, the use of the term 'blind faith' (Pilav et al., 2022) indicates that there is unwavering confidence in the authority of medical professionals. Subsequently, this may in turn shape the help-seeking choices of women when they are experiencing difficulties with their mental health.

> "There's kind of a blind faith in medical professionals and that's definitely cultural. Definitely in the Indian community" (Pilav et al., 2022).

Further to this notion of a strong reliance on medical professionals, women also voiced their expectations regarding the type of healthcare professionals they would prefer to engage with in the first instance. The preference to be seen by a psychiatrist may have been influenced by cultural beliefs, attitudes and the perceived hierarchy of expertise and authority of different healthcare professionals within the community.

> “I think earlier on I was expecting more [the doctor] to make contact with me. I was expecting a psychiatrist talking to me at the beginning, but it didn’t happen...what happened was the different one came in, she was a psychologist” (Pilav et al., 2022).

On the other hand, there was a strong emphasis on seeking support from within the community. This included seeking guidance from religious and spiritual figures and close social circles. Women highlighted a preference for non-medical interventions and a reliance on cultural healing practices, as opposed to conventional medical approaches, when addressing mental health concerns.

> “Go to your local mosque or your local Gurdwara, you know, go to your friends and family” (Conneely et al., 2023).

> “I know of some people who have been ill and have travelled to Bradford to see the Phirsabb (a local healer) …if he cannot help, they will be sent to Bangladesh to be cured” (Hanley, 2007).

Some women took a blended approach which involved seeking conventional medical advice, as well as engaging in traditional healing practices. These women demonstrated the sheer complexity of help-seeking for women navigating both Eastern and Western help-seeking practices.

> "I couldn't sleep and worried about everything. The doctor said I was suffering from 'postnatal depression' and gave me some Valium to take. My mother went to see a healer who gave me this amulet to wear around my neck. Within a few days I was better and I have worn this ever since. Some people would say I had Jinn, but I'm not sure" (Hanley, 2007).

In addition to this, women expressed an openness and a willingness to embrace various forms of support, beyond religious practices. This demonstrates a shift in attitudes, whereby there is an acknowledgement of the value of medical and psychological interventions.

> "I'm not that religious, that my prayer can easily heal me...I need medicine, I need therapy" (Sihre, 2021).

4) Barriers to help-seeking

Women across the studies spoke of both self-imposed and culturally or societally imposed challenges with seeking help for perinatal mental health issues, leaving the women to suffer in silence. Within this overarching theme, many barriers were identified which varied in nature and so these were split into the following 5 subthemes:

a) Fear of negative evaluation

South Asian women reported an internal barrier which involved struggling to admit to themselves that they needed support with their mental health. Women spoke about their challenges with "being a person that needs help" (Conneely et al., 2023) and implied that there are negative appraisals of individuals who have mental health issues and need help. In addition to this, seeking help itself was a difficult experience, as it involved accepting the possibility of receiving negative judgement from others, including their families or the wider culture where having a mental illness was viewed as shameful and a weakness. It was also suggested that individuals from Asian cultural backgrounds encounter additional layers of challenges in the context of mental health stigma.

> "It (seeking help from services) was the right thing to do, but it was a hard thing to do. It's hard to (hesitation) it is hard to get your head around being a person that needs help" (Conneely et al., 2023).

> “... people are going to think less of me” (Moghul, 2018).
>
> “Mental health is often seen as a sign of some kind of shame, weakness; you don’t want to be diagnosed with mental health” (Moghul, 2018).
>
> “I didn’t want to show people that I was so weak and I’ll I just wanted to be normal and show that I’m just a happy normal functioning person. I was ashamed, I was embarrassed to have this illness...everyone will judge me and they will I will feel like erm inferior I will feel like lower than others for having this illness” (Sihre, 2021).
>
> “There is a huge stigma of being mentally ill in the public, but for us Asians there is a double disadvantage” (Wittkowski et al., 2011).

The stigma surrounding mental illness elicited feelings of shame and the need to keep it a secret. This sense of shame was extended to healthcare professionals with shared ethnicity which had an impact on the women’s level of comfort and openness in the therapeutic relationship.

> "My therapist was Indian, she was the same as me, she was Punjabi, and initially I was really embarrassed, I was thinking, oh no, she’s even got the same name as my husband, this was a nightmare for me" (Conneely et al., 2023).

In line with a readiness to seek help, South Asian women expressed dissatisfaction that certain cultural practices that were presented as integral to religion, did not align with religious teachings and instead argued that help-seeking was encouraged.

> “Our religion (Islam) states that you should not suffer with illness, but that you should speak up ... We think one thing [culturally], but we should be doing another [In Islamic].” (Sihre, 2021).

b) Fear of services

A common concern across the papers, particularly from South Asian women, was that seeking support for mental health issues in the postnatal period might lead to the removal of their babies from their care. This highlights a deeply rooted and pervasive mistrust in mental health services. It may also explain why some women choose to delay help-seeking.

> “I didn’t get help for it because I thought they’re probably going to take my child away from me" (Conneely et al., 2023).

> "Women might feel that their baby is going to be taken away... So are they going to tell anyone?" (Moghul, 2018).

c) Lack of awareness of PMH and of PMHS

Women lacked an understanding about what they were experiencing, thereby making it challenging for them to recognise the nature of their distress. The word “crazy” was mentioned by South Asian women in the studies by Templeton et al. (2003) and Conneely et al. (2023) which indicated that there were cultural and interpersonal discourses at play. The perception that mothers with mental health issues were “crazy” demonstrates that there are stigmas in relation to mental illness.

> “In my ethnic background they don’t really understand it very much. They just think that you’re crazy, that she’s just gone crazy or loopy, you know and that’s the idea they have about it” (Conneely et al., 2023).

The lack of awareness regarding ‘perinatal mental health’, and ‘depression’ may indicate that these terms are not widely used or acknowledged by South Asian women. Subsequently, this creates an added layer of complexity for these women in relation to accessing dedicated and tailored services, in the perinatal period.

> “I don’t know what call it, in Pakistan where used to live, they don’t have depression there. There is no word in Urdu for depression, I don’t know what is happening to me, never seen it before…” (Wittkowski et al., 2011).

> "It’s not something you hear of. It’s not used commonly" (Moghul, 2018).

> "I don’t know what support is out there" (Templeton et al., 2003).

> “Never heard of it. When I was pregnant not even my GP mentioned anything, I never knew anything like this existed...I’ve never heard about the services" (Sihre, 2021).

On the other hand, when South Asian women demonstrated an understanding about PMI, this was mostly limited to postnatal depression. These women also came from healthcare professional backgrounds and demonstrated greater awareness of PMI, particularly in relation to postnatal depression.

> “I’ve heard of postnatal loads of times and other forms of depression” (Moghul, 2018)

> “I’ve read some of it *pauses* about postnatal depression actually” (Sihre, 2021).

d) Lack of transparency and timeliness in care

South Asian women experienced challenges relating to the timeliness of care, particularly during the post-partum period. Women highlighted the delays and insufficient approach in mental health screening post-birth.

> "When the midwife is filling out her papers, only then she asks if you are having any problems, do you feel pressure, how you feel?" (Moghul, 2018).

> “The first that I was asked about my depression, was that 6 week check, not at the hospital, none of the health workers asked me if I was okay, just the doctors asked me very quickly; ‘Are you okay, you’re not suffering from depression?” (Moghul, 2018).

Women spoke of other hurdles such as the self-referral process. This added additional layers of complexity, particularly for the women who found themselves in a vulnerable and distressed state.

> “Doctors [General Practitioners] are very reluctant I found, when you’re pregnant. The doctor I saw initially referred me to [a mental health charity], you have to self-refer which doing yourself is not easy. Then you wait for a call, then an interview, it’s all difficult to do when you’re in a bad place” (Pilav et al., 2022).

e) Cultural competence, sensitivity and bias in PMHS

Across most papers, a strong theme surfaced in relation to the cultural competence of PMHS and the potential for biases from healthcare professionals. Women expressed concerns about receiving discriminatory care, based on their ethnic backgrounds. Women questioned whether such treatment would occur if they were “White” (Wittkowski et al., 2011). Thus, raising concerns about potential racial disparities and implicit biases within healthcare professionals and services in the UK.

> “I got answers from professionals like, there is nothing wrong with you, go back home stop disturbing us, basically you are wasting our time, and they were horrible. It was a

> Doctor that said that to me, my husband was sat with me that day as well. I don’t know if they would have said that if I was White” (Wittkowski et al., 2011).

Women emphasised a need for healthcare professionals within PMHS, to have a deeper understanding of the South Asian culture. It was suggested that this understanding should extend further than merely at a superficial level and that there should be an in-depth analysis of the South Asian culture which would enable healthcare professionals to develop a nuanced understanding of the culture. In addition to this, women implied that for healthcare professionals to demonstrate cultural competence, there was a need to understand the languages spoken within the South Asian culture as well as a need for politeness.

Furthermore, some women highlighted differences between their own culture and British culture, in relation to the acceptance of certain norms and practices. These women suggested that without an understanding of these cultural differences, healthcare professionals may not be able to provide effective support as they may struggle to comprehend the cultural context of the difficulties experienced by women.

> “They need to know the culture, they need to study...because there are things in this culture which are very very unique, the South Asian culture...Secondly, they need to know the language as well...And they need to be more polite to the South Asians” (Sihre, 2021).

> “Understanding cultural differences is a big thing. In our society in Bangladesh, we are just with partner, we accept a lot of things which are not accepted in British society so if my counsellor doesn’t understand, they [the counsellor] cannot help me” (Pilav et al., 2022).

Conversely, some women reported that their ethnic and religious backgrounds were accepted and that they did not deter healthcare professionals from treating the women in a fair, equal and non-discriminatory manner. Thereby, illustrating the inclusivity and culturally sensitive approach undertaken by healthcare professionals within PMHS in the UK. Additionally, some women spoke of receiving person-centred care. The emphasis on receiving the “little things” and “not just medication” (Sihre, 2022), highlights the significance of taking a holistic approach in healthcare. Moreover, healthcare professionals recognised women as individuals within the context of their families. Women expressed that their feelings and experiences were normalised and validated. Their acceptance to perinatal mental health services became a source of reassurance for them. This led them to acknowledge that their need to seek help for their mental health difficulties was valid.

> "They don’t treat anyone differently, regardless of what faith, you know background, regardless of anything" (Conneely et al., 2023).

> “Yes, they understood me. (...) I told them about my religion, they asked me about my religion and then I told them. They were OK with it” (Conneely et al., 2023).

> “It’s little things, not just medication, they talk to us, they talk to us as a family, talk to me as an individual, they know me inside out and my whole care plan was based on exactly how they treated me, they’re really understanding themselves, they told me about their life experience, they made me feel like a person, that I’m not a thing, they made me feel very normal” (Sihre, 2021).

> “Only the perinatal team. There are the only ones who used to listen to me. Social services didn’t help. I am a different woman, they gave me my self-respect” (Pilav et al., 2022).

> “I didn’t feel at first, worthy? But I think like after I had been and I was reassured that I hadn’t been accepted into the service if I didn’t need it” (Pilav et al., 2022).

5) Linguistic expressions of PMH

Some papers contributed to the notion that women did not commonly use mental health diagnostic labels such as ‘postnatal depression’ to describe and capture their experiences of PMI. Instead, women used alternative terminology based on their own cultural and linguistic backgrounds. Some women also struggled to find the appropriate language to express their emotions and could only make sense of their difficulties through describing their physical symptoms or sensory-related sensitivities. Thus suggesting that South Asian women’s experiences of psychological distress did not align with Western definitions of mental health conditions.

> “It kills me, I can’t move, I feel like screaming [physical pain]” (Templeton et al., 2003).

> "I really don’t understand what is happening in my head. I have lots of thoughts going through my mind, I am not even sure what they are, just about how my life is crap…" (Wittkowski et al., 2011).

> “Everybody just keep saying Dimaak kharaab hai [mind is not working properly]” (Wittkowski et al., 2011).

> “I felt like my body had just been through war, I don’t wanna leave the bed, I don’t wanna communicate, I don’t even wanna lift my head up, open my eyes, I don’t wanna hear anything, I don’t wanna see light, I wanted to be like a turtle in a shell” (Sihre, 2021).

Nevertheless, although some women were not able to verbalise and further expand on the cognitive aspects of their difficulties, they did frequently refer to and acknowledge that their “mind” or “head” was the source of their difficulties. Thereby, illustrating that there was some recognition of the nature of PMI which did align with Western definitions. This may also highlight the need for PMHS to better meet the cultural linguistic needs of women who may not be accessing services, due a lack in the ability to provide sufficient explanations of their mental health difficulties to healthcare professionals.

Discussion

In this meta-ethnography, several themes emerged which highlighted South Asian women’s experiences of PMI and help-seeking in the UK. Within the themes, there was a strong emphasis placed on the significance of the South Asian culture and its power in shaping women’s experiences of PMI. In summary, the findings showed that South Asian women faced challenges that varied in nature. These included culturally derived expectations of motherhood, familial invalidation and barriers such as fear of negative evaluation, fear of services, lack of awareness of PMH and PMHS, lack of transparency and timeliness in care and cultural competence, sensitivity and bias when accessing services. Additionally, South Asian women communicated their distress in ways that were unique to their linguistic backgrounds.

The role of family

Throughout the meta-ethnography, there was an overarching sense of the integral role played by the wider family. Women expressed a strong sense of duty towards taking care of others, which included the extended family. Women felt a sense of responsibility for the happiness of others and this was further reinforced by South Asian cultural expectations of mothers. Women felt that their needs came after the needs of others and so they were viewed as less of a priority. This is in line with previous research which found that within the South Asian culture, the needs of the family are prioritised above the needs of the individual (Masood et al., 2009). Therefore, highlighting the collectivist nature of the South Asian culture.

In the context of the perinatal period, the family placed heavy importance on the wellbeing of the baby and the completion of household chores. This was primarily seen as the responsibility of the woman and so the pressure of needing to juggle it all, was thought to ‘trigger’ PMI for some women. This is in line with findings from previous studies of Bangladeshi and Indian women who reported feeling overworked and were frustrated by the lack of expectations within the culture, in relation to men carrying out domestic responsibilities (Edhborg et al., 2015; Gausia et al., 2009; Rodrigues et al., 2003).

Furthermore, women encountered a deeply profound sense of invalidation from their family members in relation to their PMH. Women conveyed that their families minimised the gravity of the challenges they experienced. Moreover, this meta-ethnography revealed a nuanced misconception held by the families of these women, in the assumption that mental wellbeing was determined by external indicators of success. These included marriage, house ownership, education and employment. Thereby, suggesting that the experience of PMI was exclusively reserved for women who were less accomplished in life. This may in essence reflect the views held by older and migrant generations of South Asian women who may have experienced less opportunities for education and employment. In support of this notion, a meta-ethnographic study by Schmied et al. (2017) found that migrant women experienced difficulties in the way of employment, housing and other significant stressors related to moving to a new country.

Additionally, women expressed that from among their family members, it was their husbands who played a pivotal role in encouraging them to seek professional help for their PMH issues. This is in support with previous literature, whereby the husband was viewed as the primary source of practical support for women in the perinatal period (Owens et al., 2016; Russo et al., 2015).

The roles of religion, stigma and taboo

The impact of stigma and the taboo nature of PMH issues within the South Asian culture was evident across the findings. Women encountered both a public as well an internal stigma of suffering with PMI. The meta-ethnography found that the lack of knowledge and awareness of PMH and PMHS contributed to the women's fear of PMHS and so seeking support in the form of medication and therapy was seen as a taboo act. This is in line with findings from a systematic review by Watson et al. (2019) who found that stigma had a disproportionate impact on women from ethnic minority backgrounds.

The meta-ethnography highlighted a sense of distrust towards services within South Asian women, particularly in relation to concerns about PMHS potentially separating a mother from their baby. However, findings from earlier studies show that White British women also experienced similar fears about being viewed as an unfit parent due to their PMH issues and that this might result in their child being removed from their care (Edwards & Timmons, 2005; Hall, 2006). Thereby, demonstrating that such fears or concerns about PMHS can span across cultural backgrounds and that there is a crucial ongoing need for improved awareness and education about PMHS and the services they provide.

Moreover, the meta-ethnography revealed varying perspectives regarding cultural preferences for help-seeking within South Asian culture. On one hand, women conveyed the notion that seeking help for mental health issues from healthcare professionals was not a common cultural practice. Instead, women were encouraged to seek help from religious places of worship and spiritual healers. This is in line with previous research which found that South Asian individuals sought religious interventions as an initial and culturally preferred choice for the treatment of mental health issues (Ali et al., 2017; Hussain & Cochrane, 2004).

On the other hand, findings from more recent studies included within this meta-ethnography illustrated that there has been a gradual shift in attitudes towards seeking professional support from PMHS. This is a key finding, as it suggests that there is a growing acceptance, within British South Asian communities, to engage and access PMHS.

Comparison with other meta-ethnographies/syntheses

In the context of other meta-ethnographies/syntheses, this meta-ethnography is one of the first to wholly focus on South Asian women's experiences of PMI and help-seeking in the UK. Additionally, a recent systematic review looked at the experiences of EM women in Europe (Watson et al., 2019) which primarily included the UK. This review reported similar findings to those in the meta-ethnography. This included cultural expectations and stigma, a lack of awareness of PMH and culturally insensitive health services which all impacted on the abilities of EM women, to receive effective PMH support (Watson et al., 2019).

Prajapati and Liebling (2021) carried out a meta-ethnography of the experiences of British South Asian service users in seeking help from mental health services. The authors found that South Asian service users encountered institutional racism and cultural dissonance which hindered them from accessing quality and effective mental healthcare. This is in line with findings from a meta-synthesis by Smith et al. (2019).

A more recent systematic review by Insan et al. (2022) looked at the perceptions and attitudes around PMH within South Asian countries, including Pakistan, Bangladesh and India. They found that physical or somatic symptoms of PMI were more accepted and widely discussed than affective symptoms. This was due to the perception that women with PMH issues were ‘crazy’ or ‘mad’. The review also found a lack of awareness of PMH and high levels of stigma which is consistent with the review by Watson et al. (2019) and this meta-ethnography.

Critique of the review

The meta-ethnography is subjective in nature as it relies on interpretations made by the authors (second order perspective), as well as interpretations made by the researcher (third order perspective). However, to reduce researcher bias, triangulation was implemented in several forms. Firstly, the researcher frequently attended peer workshops, whereby the interpretations were discussed with other peers and research supervisors. Secondly, as mentioned previously, the findings were peer reviewed and discussions were held to settle any differences.

A limitation of this meta-ethnography is that it encompassed a relatively small number of studies. Additionally, two papers included the perspectives of Black women which limited the contribution they could make to the wider research question. However, when critically appraised, the majority of the studies were deemed to be of high quality and represented 103 participants in total.

In reflecting on the assumptions I brought to this review, I recognise that my understanding of terms like "recognition" and "understanding" in the context of mental health and illness is influenced by a predominantly Western framework. In Western contexts, "recognition" often implies a formal diagnosis or acknowledgment of mental health conditions, while "understanding" is frequently grounded in clinical or psychological theories. However, it is important to note that in South Asian cultures, these concepts may be framed differently, incorporating traditional beliefs, social norms, and community practices that may not align with Western definitions.

Clinical implications

This meta-ethnography highlighted that there has been a gradual and progressive shift in the attitudes and beliefs of British South Asian women experiencing PMI. It has also illustrated the important role that is being played by PMHS in supporting South Asian women, by providing them with reassurance and validating their experiences. On the other hand, the meta-ethnography also showed that these women continue to face barriers when accessing PMHS and that these are both structural and sociocultural in nature. Therefore, it indicates a need for ongoing awareness of PMH and the existence and role of PMHS, particularly within primary care services that are currently utilised by South Asian women such as GP surgeries. This may help to improve the rates at which women are referred to specialist services when presenting with PMI symptoms.

References

Ali, N., McLachlan, N., Kanwar, S., & Randhawa, G. (2017). Pakistani young people's views on barriers to accessing mental health services. *International Journal of Culture and Mental Health*, *10*(1), 33-43.

Anderson, F. M., Hatch, S. L., Comacchio, C., & Howard, L. M. (2017). Prevalence and risk of mental disorders in the perinatal period among migrant women: a systematic review and meta-analysis. *Archives of women's mental health*, *20*, 449-462.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology*, *8*(1), 1-10.

Beck, C. T. (1998). A checklist to identify women at risk for developing postpartum depression. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *27*(1), 39-46.

Bhugra, D., Desai, M., & Baldwin, D. S. (1999). Attempted suicide in west London, I. Rates across ethnic communities. *Psychological Medicine*, *29*(5), 1125-1130.

Bhui, K., Bhugra, D., Goldberg, D., Dunn, G., & Desai, M. (2001). Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychological medicine*, *31*(5), 815-825.

Bhui, K., Bhugra, D., Goldberg, D., Sauer, J., & Tylee, A. (2004). Assessing the prevalence of depression in Punjabi and English primary care attenders: the role of culture, physical illness and somatic symptoms. *Transcultural psychiatry*, *41*(3), 307-322.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review . *The British Journal of Psychiatry*, *182*(2), 105-116.

Blais, R., & Maïga, A. (1999). Do ethnic groups use health services like the majority of the population? A study from Quebec, Canada. *Social Science & Medicine*, *48*(9), 1237-1245.

Button, S., Thornton, A., Lee, S., Shakespeare, J., & Ayers, S. (2017). Seeking help for perinatal psychological distress: a meta-synthesis of women's experiences. *British Journal of General Practice*, *67*(663), e692-e699.

Cahill, M., Robinson, K., Pettigrew, J., Galvin, R., & Stanley, M. (2018). Qualitative synthesis: a guide to conducting a meta-ethnography. *British journal of occupational therapy*, *81*(3), 129-137.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology nursing forum*, *41*(5), 545–547. https://doi.org/10.1188/14.ONF.545-547

Classen, S., & Alvarez, L. (2015). Evidence-informed reviews—Moving occupational therapy practice and science forward. *OTJR: Occupation, Participation and Health, 35*(4), 199-203.

Conneely, M., Packer, K.C., Bicknell, S., Janković, J., Sihre, H.K., McCabe, R., Copello, A., Bains, K., Priebe, S., Spruce, A. and Jovanović, N., (2023). Exploring Black and South Asian women's experiences of help-seeking and engagement in perinatal mental health services in the UK. *Frontiers in Psychiatry, 14,* p.1119998.

Edge, D. (2007). Perinatal depression and Black Caribbean women: lessons for primary care. *Primary Health Care, 17*(2), 32-36.

Edge, D., & Rogers, A. (2005). Dealing with it: Black Caribbean women's response to adversity and psychological distress associated with pregnancy, childbirth, and early motherhood. *Social science & medicine, 61*(1), 15-25.

Edge, D., Baker, D., & Rogers, A. (2004). Perinatal depression among black Caribbean women. *Health & social care in the community, 12*(5), 430-438.

Edhborg, M., Nasreen, H. E., & Kabir, Z. N. (2015). "I can't stop worrying about everything"—Experiences of rural Bangladeshi women during the first postpartum months. *International journal of qualitative studies on health and well-being, 10*(1), 26226.

Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health, 14*(5), 471-481.

Gausia, K., Fisher, C., Ali, M., & Oosthuizen, J. (2009). Antenatal depression and suicidal ideation among rural Bangladeshi women: a community-based study. *Archives of women's mental health, 12*, 351-358.

Hall, P. (2006). phenomenological analysis. *Community Practitioner, 79*(8), 256-260.

Hanley, J. (2007). The emotional wellbeing of Bangladeshi mothers during the postnatal period. *Community Practitioner, 80*(5), 34-38.

Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: update on a review of published papers. *Qualitative research, 12*(4), 402-442.

Howard, L. M., Piot, P., & Stein, A. (2014). No health without perinatal mental health. *The Lancet, 384*(9956), 1723-1724.

Husain, N., Creed, F., & Tomenson, B. (1997). Adverse social circumstances and depression in people of Pakistani origin in the UK. *The British Journal of Psychiatry, 171*(5), 434-438.

Hussain, F. A., & Cochrane, R. (2002). Depression in South Asian women: Asian women's beliefs on causes and cures. *Mental Health, Religion & Culture, 5*(3), 285-311.

Hussain, F., & Cochrane, R. (2004). Depression in South Asian women living in the UK: a review of the literature with implications for service provision. *Transcultural psychiatry*, *41*(2), 253-270.

Insan, N., Weke, A., Rankin, J., & Forrest, S. (2022). Perceptions and attitudes around perinatal mental health in Bangladesh, India and Pakistan: a systematic review of qualitative data. *BMC Pregnancy and Childbirth*, *22*(1), 1-13.

Jankovic, J., Parsons, J., Jovanović, N., Berrisford, G., Copello, A., Fazil, Q., & Priebe, S. (2020). Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study. *BMC medicine*, *18*, 1-12.

Kingston, D., Tough, S., & Whitfield, H. (2012). Prenatal and postpartum maternal psychological distress and infant development: a systematic review. *Child psychiatry and human development*, *43*(5), 683–714. https://doi.org/10.1007/s10578-012-0291-4

Knight, M., Acosta, C., Brocklehurst, P., Cheshire, A., Fitzpatrick, K., Hinton, L., Jokinen, M., Kemp, B., Kurinczuk, J. J., Lewis, G., Lindquist, A., Locock, L., Nair, M., Patel, N., Quigley, M., Ridge, D., Rivero-Arias, O., Sellers, S., Shah, A. (2016). Beyond maternal death: improving the quality of maternal care through national studies of 'near-miss' maternal morbidity. *Programme grants for applied research*, (9).

Knight, M., Nair, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Brocklehurst, P., & Kurinczuk, J. (2016). *Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths In the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14*. Oxuniprint.

Kotecha, N. (2009). Black and minority ethnic women. *Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook. 2nd edition. Oxfordshire, UK: Routledge*, 58-71.

Marshall, H., & Yazdani, A. (2000). Young Asian women and self-harm. *Women's health: Contemporary international perspectives*, 59-69.

Masood, N., Okazaki, S., & Takeuchi, D. T. (2009). Gender, family, and community correlates of mental health in South Asian Americans, *Cultural Diversity and Ethnic Minority Psychology***,** 15(3), 265-274.

Masood, Y., Lovell, K., Lunat, F., Atif, N., Waheed, W., Rahman, A., Mossabir, R., Chaudhry, N. and Husain, N., (2015). Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. *BMC women's health*, *15*, pp.1-8.

MMHA, Khan, Thompson, P., Rodell, H., Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., Adelaja, B. and Brown, M. (2014) Perinatal mental health services, Guidance for commissioners of perinatal mental health services.

Moghul, F. (2018). Help-seeking for perinatal mental health: South Asian women's experiences in Luton.

Monzon, C., di Scalea, T. L., & Pearlstein, T. (2014). Postpartum psychosis: updates and clinical issues. *Psychiatric times*, *31*(1), 26-26.

Moore, L., Jayaweera, H., Redshaw, M., & Quigley, M. (2019). Migration, ethnicity and mental health: evidence from mothers participating in the Millennium Cohort Study. *Public health*, *171*, 66-75.

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). sage.

Onozawa, K., Kumar, R. C., Adams, D., Dore, C., & Glover, V. (2003). High EPDS scores in women from ethnic minorities living in London. *Archives of Women's Mental Health*, *6*, s51-s55.

Owens, C., Dandy, J., & Hancock, P. (2016). Perceptions of pregnancy experiences when using a community-based antenatal service: a qualitative study of refugee and migrant women in Perth, Western Australia. *Women and birth, 29*(2), 128-137.

Page, M.J., McKenzie, J.E., Bossuyt, P.M., Boutron, I., Hoffmann, T.C., Mulrow, C.D., Shamseer, L., Tetzlaff, J.M., Akl, E.A., Brennan, S.E., & Chou, R. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *bmj*, *372*.

Pilav, S., De Backer, K., Easter, A., Silverio, S. A., Sundaresh, S., Roberts, S., & Howard, L. M. (2022). A qualitative study of minority ethnic women's experiences of access to and engagement with perinatal mental health care. *BMC pregnancy and childbirth*, *22*(1), 1-13.

Prady, S. L., Pickett, K. E., Gilbody, S., Petherick, E. S., Mason, D., Sheldon, T. A., & Wright, J. (2016). Variation and ethnic inequalities in treatment of common mental disorders before, during and after pregnancy: combined analysis of routine and research data in the Born in Bradford cohort. *BMC psychiatry*, *16*(1), 1-13.

Prajapati, R., & Liebling, H. (2021). Accessing mental health services: a systematic review and meta-ethnography of the experiences of South Asian Service users in the UK. *Journal of Racial and Ethnic Health Disparities*, 1-22.

Rahman, A., & Creed, F. (2007). Outcome of prenatal depression and risk factors associated with persistence in the first postnatal year: prospective study from Rawalpindi, Pakistan. *Journal of affective disorders*, *100*(1-3), 115-121.

Rahman, A., Iqbal, Z., & Harrington, R. (2003). Life events, social support and depression in childbirth: perspectives from a rural community in the developing world. *Psychological medicine*, *33*(7), 1161-1167.

Rodrigues, M., Patel, V., Jaswal, S., & De Souza, N. (2003). Listening to mothers: qualitative studies on motherhood and depression from Goa, India. *Social science & medicine*, *57*(10), 1797-1806.

Russo, A., Lewis, B., Joyce, A., Crockett, B., & Luchters, S. (2015). A qualitative exploration of the emotional wellbeing and support needs of new mothers from Afghanistan living in Melbourne, Australia. *BMC pregnancy and childbirth, 15*(1), 1-13.

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC health services research, 21*, 1-13.

Schmied, V., Black, E., Naidoo, N., Dahlen, H. G., & Liamputtong, P. (2017). Migrant women's experiences, meanings and ways of dealing with postnatal depression: A meta ethnographic study. *PloS one, 12*(3), e0172385.

Sihre, H. K. (2021). *Lived experiences of South Asian women with severe postnatal psychiatric illnesses and experiences of perinatal mental health services* (Doctoral dissertation, University of Birmingham).

Smith, M. S., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ open*, *9*(1), e024803.

Sorsa, M. A., Kylmä, J., & Bondas, T. E. (2021). Contemplating help-seeking in perinatal psychological distress—a Meta-ethnography. *International journal of environmental research and public health*, *18*(10), 5226.

Templeton, L., Velleman, R., Persaud, A., & Milner, P. (2003). The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. *Ethnicity & health*, *8*(3), 207-221.

Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PloS one*, *14*(1), e0210587.

Williams, P. E., Turpin, G., & Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK: a review of the literature. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *13*(5), 324-338.

Wittkowski, A., Zumla, A., Glendenning, S., & Fox, J. R. E. (2011). The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. *Journal of Reproductive and Infant Psychology*, *29*(5).

A. Chapter and Section 2:

British Pakistani Women’s Lived Experiences of Postnatal Depression and Help-Seeking from Perinatal Mental Health Services

Abstract

Background: Postnatal Depression (PND) or Postpartum Depression (PPD) has a profound impact on mothers worldwide, affecting their mental wellbeing and their capacity to care for their infant. Despite the widespread occurrence of PND, there is currently a lack of understanding of the nuanced ways in which it manifests and the challenges it brings for British Pakistani women. The present study seeks to address this gap in the literature and to explore the accessibility of Perinatal Mental Health Services (PMHS) for British Pakistani women.

Method: A qualitative approach was used to interview seven British Pakistani women, aged between 25 and 34 years old. The interview transcripts were analysed based on the principles of Interpretative Phenomenological Analysis.

Findings: Five group experiential themes were identified from the transcript data and included the following: 'loss of self', 'ambivalent familial support', 'cultural hush', 'tensions in tradition' and 'perinatal support in the shadows'.

Discussion: The research findings illustrate the multifaceted nature of British Pakistani women's experiences of PND and accessing support from PMHS. The study also highlighted the need for culturally sensitive approaches by healthcare professionals. Furthermore, future research and interventions should focus on enhancing community awareness, fostering supportive environments and improving accessibility to PMHS.

Introduction

Postnatal Depression (PND) also known as Postpartum Depression (PPD), affects an estimated 13% of women around the world (World Health Organisation, 2020). Postnatal Depression has become increasingly recognised as a global health issue, due to the detrimental impact it has on mothers, infants, and their families (Almond, 2009; Fisher et al., 2011). Research indicates that PND has negative effects on the psychological and cognitive development of children (Murray et al., 2018). Additionally, PND has been associated with an increased risk of suicide and in recent years, it has been identified as a leading cause of maternal deaths (Lee et al., 2022).

Postnatal Depression is a type of mood disorder and mental health condition which affects women and occurs after childbirth (RCPSYCH, 2018). Symptoms tend to include sadness, irritability, tiredness, sleeplessness, changes in appetite, loss of pleasure in activities, negative thoughts and guilt, anxiety, social isolation, hopelessness, thoughts of suicide and self-harm and a decrease in libido (RCPSYCH, 2018). Postnatal Depression stems from a combination of various factors including biological, hormonal, familial, social, psychological and cultural factors (Mughal et al., 2022). Some authors have argued that while there is an abundance of literature of PND, particularly from a biomedical perspective (Ramadas & Kumar, 2015), a comprehensive understanding of PND requires a careful consideration of cultural factors (Varma et al., 2022).

Research has highlighted discrepancies across cultures in the prevalence of PND and its symptoms. For instance, Wang et al. (2021) found a prevalence rate of 21.50% for PND in the United Kingdom (UK), while in Pakistan, this rate was notably higher at 35.45%. Furthermore, Shakeel et al. (2018) found the prevalence of postpartum depressive symptoms to be higher in ethnic minorities (12.7%) than in Western Europeans (4.8%). Therefore, suggesting that cultural factors may play a part in shaping the prevalence of PND across different populations.

The current literature presents a tendency to group women from distinct South Asian communities into a singular overarching group (Lamba, 2015). A recent study by Sihre (2019) looked at the lived experiences of South Asian women with severe postnatal psychiatric illnesses. Another study by Conneely et al. (2023) explored Black and South Asian women's experiences of help-seeking and their engagement with Perinatal Mental Health Services (PMHS). Although both studies provided meaningful insights, their sampling populations support Lamba's (2015) argument of the tendency to homogenise South Asian women's experiences.

Furthermore, Husain et al. (2012) argued that there are marked differences between South Asian communities (i.e., Pakistani, Bangladeshi, Sri Lankan and Indian), in relation to language, dialects, diet, religious beliefs and cultural practices. Such differences may have a profound impact on the way PND is perceived, understood and experienced, amongst individuals within each subgroup. For instance, variations in cultural norms regarding motherhood and family dynamics may influence the availability of social support networks and help-seeking behaviours.

In relation to studies of British Pakistani women, an earlier study by Husain et al. (2012) looked at the maintaining factors of PND. These authors found that PND in British Pakistani women was associated with social isolation, poor social support and severe and persistent social difficulties. In addition to this, these women were more likely to experience linguistic and cultural barriers in accessing services and interpersonal relationship problems (Husain et al., 2012).

Using a qualitative approach, Lamba (2015) looked at the experiences of four migrant Pakistani women living in the UK, who subjectively experienced PND during the postnatal period. She found that Pakistani women experienced PND as a product of cultural, psychosocial, physiological and stressors that were specific to motherhood. Lamba's (2015) study also highlighted participants' perception of differences between Pakistani and Indian women, particularly in relation to financial stability and independence. These nuanced cultural differences emphasised the importance of carrying out separate research on each subgroup of South Asian women including, Pakistani, Bangladeshi, Indian and Sri Lankan. Through recognising and highlighting these differences, Lamba's (2015) study strengthened the need for more targeted qualitative research in understanding the unique and diverse experiences of South Asian women with PND. However, a limitation of Lamba's (2015) study is that the small sample size and narrow focus on migrant Pakistani women's experiences, may have restricted its applicability to the broader population of Pakistani women in the UK. In addition to this, the study may not have captured the diversity within the population of Pakistani women in the UK.

Aims and Objectives

Following on the study by Lamba (2015) and using Interpretative Phenomenological Analysis (IPA), the present study aims to provide a rich and in-depth personal account of British Pakistani women's experiences of PND and help-seeking from PMHS. In addition, this study hopes to bring forward new insights and perspectives for the value of the discipline of clinical psychology, as well as healthcare professionals working in perinatal mental healthcare.

Method

Ethics

The study was granted ethical approval by an NHS Research Ethics Committee (Appendix E) and the Research and Development Department of a local NHS Trust (Appendix F). Sponsorship for the study was provided by the Research Governance, Ethics and Integrity Committee, as part of The University of Birmingham (Appendix G). To maintain participant anonymity and confidentiality identifiable participant information has been removed in this paper and participant names have been replaced with pseudonyms.

Design

The qualitative approach used was IPA (Smith et al., 2021) which is rooted in phenomenology and dedicated to exploring how individuals make sense of their lived experiences. The analytical process of IPA is often described as a double hermeneutic (Smith et al., 2021), which refers to the process whereby the participants interpret their experiences, followed by the researcher interpreting the participants' interpretations. This study employed semi-structured interviews/topic guides to explore the personal meanings given by British Pakistani women in relation to their lived experiences of PND and of help-seeking from PMHS. Furthermore, the researchers' critical realist epistemological stance and personal experiences may influence the double hermeneutic process and so this is further discussed below.

The semi-structured interview schedule consisted of two sections, with prompts as and when appropriate (Appendix H). The first section explored general themes including participants' experiences of the postnatal period and how cultural traditions and practices may have influenced their understanding and experiences of PND. The second section focussed on the participants' experiences of seeking and accessing support from perinatal mental health services.

The interview schedule was reviewed by two Peer Support Workers (PSW) from a perinatal mental health service, who commented on the usefulness and appropriateness of the questions, as well as the addition of prompts (Appendix I). One of the PSW's identified as a British Pakistani woman and the second PSW was a Bangladeshi woman married into a Pakistani family. Both PSW's spoke about the importance of including the word 'Pakistani' when questioning participants about cultural practices and traditions, due to the dual cultural experiences of British Pakistani women. They also emphasised the importance of reiterating confidentiality, both at the beginning and end of the interview, to ensure that participants continually felt safe and comfortable in sharing their experiences.

Epistemological position

The researcher adopted a 'critical realist' position which recognises that each individual's experience is shaped by their unique relationship within the world they inhabit. Therefore, participants' statements are understood to reflect their own perceptions (Smith et al., 2009).

Why IPA?

Initially, the researcher considered both IPA and Reflexive Thematic Analysis (RTA) methodologies to determine which approach aligned better with the aims of the study. Interpretative Phenomenological Analysis was chosen due to the following reasons; firstly, IPA provides an in-depth focus on individual experiences, which would allow for a rich exploration of how British Pakistani women personally navigate PND and help-seeking. Whilst RTA offers a broader view of a topic and so may not capture the nuanced insights that can come from exploring individual experiences. Secondly, IPA enables a contextual understanding of lived experiences, which may be useful for acquiring insight into the specific social and cultural contexts that shape British Pakistani women's experiences of PND and of help-seeking.

Recruitment

Participants were recruited from three perinatal community mental health teams, located within a single service. Due to the ideographic nature of this study, a purposive sampling method was used. This sampling approach allowed for the selection of particular individuals who possessed specific characteristics or experiences relevant to the study's research objectives and aims. As an IPA study is concerned with the experiences of individuals in depth, a small sample size of six to eight participants was deemed appropriate to generate adequate data (Smith et al., 2021).

Participants

Initially, twelve women meeting the inclusion and exclusion criteria outlined in Table 1 and Table 2, expressed an interest in participating in the study. Five women did not respond to follow-up enquiries. Resultingly, a total of seven women consented and participated in the study. The demographics of the seven participants are displayed in Table 3.

Table 1. Inclusion criteria

Number	Inclusion criteria
1	Female Sex
2	Identify as British Pakistani
3	Fluency in English
4	Minimum age 18

5	Experience of giving birth to and keeping care of at least one child in the last 3 years
6	Subjective experience of depression during the postnatal period (up to 2 years post-birth)
7	Ability to provide informed consent
8	Based in West Midlands

Table 2. Exclusion criteria

Number	Exclusion criteria
1	Migrant Pakistani women
2	Patients admitted to Mother and Baby Unit (due to existing safeguarding concerns and the mother may not be keeping care of the baby).
3	Comorbidity of postnatal psychosis diagnosis and/or subjective experience of psychosis. This is because there is a different referral pathway for postnatal psychosis and so professional help-seeking may be different.
4	Patients in the acute phase of postnatal depression (at the clinicians discretion).
5	Women who have been discharged from a perinatal service.

Table 3. Participant demographics

Participant	Age Range	Sex	Ethnicity/ Nationality	Marital status	Number of children
Hafsa	25-34	Female	British Pakistani	Divorced	2
Khadijah	25-34	Female	British Pakistani	Married	2

Asiya	25-34	Female	British Pakistani	Married	1
Zaynab	25-34	Female	British Pakistani	Married	2
Maryam	25-34	Female	British Pakistani	Married	1
Fatima	25-34	Female	British Pakistani	Married	1
Halima	25-34	Female	British Pakistani	Married	2

Procedure

Initially, lead psychologists from Perinatal Mental Health Teams (PMHT) across the West Midlands were contacted, for the purpose of introducing the study to their teams. An advertisement of the study (Appendix J) was placed within the communal areas of the perinatal sites. Clinicians were asked to screen their individual caseloads for potential participants using the inclusion (Table 1) and exclusion criteria (Table 2) and were asked to provide those that were eligible with the Participant Information Sheet (PIS; Appendix K). Eligible participants were given up to 3 days to read the PIS and to consider their involvement. The lead clinicians within each recruitment site/service subsequently contacted eligible participants to inquire about their interest in participating and, if interested, to obtain verbal consent to share their contact details with the researcher. Upon contacting the eligible participants, the researcher answered questions about the research and arranged timeslots for the interviews. Participants were reminded of the voluntary nature of the study and of their right to withdraw from the study.

Participants were offered flexibility in relation to where the interview took place. Four of the women chose to take part in the interview on-line via Microsoft Teams videocall. Three of the women expressed a preference for having a face to face interview and this was accommodated using confidential clinic rooms across the perinatal sites. Participants who were interviewed remotely were sent an email containing the consent form (Appendix L), through a shared perinatal psychology mailbox. The researcher followed this up with a phone call to the participant, to ensure they had received the consent form and to offer another opportunity to ask questions. Participants who were interviewed face to face signed paper copies of the consent form. The average duration of the semi-structured interview was 72 minutes (range 62 to 86 minutes). Towards the end of the interview, participants were given the opportunity to ask questions and to provide further information on anything they felt relevant to the topic of discussion. Upon completing the interview, participants were provided with a debrief sheet and a £20 Amazon voucher for their participation.

Analysis

Interviews were recorded using an encrypted Dictaphone and were transcribed verbatim by the researcher. Transcripts were read and re-read by the researcher which ensured familiarity with the data before it was analysed, in line with the IPA process stated in Smith et al. (2021). This process is outlined in Figure 1.

Figure 1. IPA analysis process

The analysis began by creating line by line exploratory notes (Appendix M) to capture any initial impressions, thoughts or questions that arose from reading and listening to the data. These served as a foundation for the participants' experiential statements. Experiential statements were shorter statements that summarised the initial notes and captured significant elements of the transcript (Appendix N).

The next step involved clustering the experiential statements together according to a common theme. These formed the participants' Personal Experiential Themes (PETs; Appendix O). This required multiple changes and re-workings to create PETs which closely matched the participants' experiences and also met the aims of the study. The above two processes were repeated for each participant.

The PETs were then reviewed and organised into clusters based on their similarities and connections. This clustering process involved grouping related PETs together to identify overarching themes that captured commonalities across different participants' experiences.

The clustered PETs were synthesised into Group Experiential Themes (GETs). This was achieved by creating a table with the PETs and experiential statements (Appendix P) and by moving the PETs around to form the GETs. These GETs represented broader, shared themes that encapsulated the collective experiences of participants. The final list of GETs were also reviewed in line with the aims of the present study.

Reflexivity

Reflexivity is defined as "deliberate, controlled reflection" and is considered to be a fundamental component of IPA (Smith et al., 2009). Within research methodology, reflexivity is a means of enhancing the validity and rigour of the research. To mitigate researcher biases, reflexivity should be an ongoing process, from establishing the rationale, to developing the research question(s) and study design, through data collection and analysis, and during the discussion of the findings.

I am a 30 year old fourth-generation British Pakistani woman and have resided in England for all of my life. I am the daughter of a third-generation British Pakistani mother and a third-generation Pakistani father, who migrated from Pakistan to live in England in the 1990s. I first learned of PND from my mother who often spoke of her experiences, particularly the lack of understanding from within her social circle. Although PMHS were not available in that time period, my mother received support from healthcare professionals which she described as "lifesaving". Additionally, my experience of working in the NHS for the past decade has made me aware of the ongoing health inequalities faced by Pakistani women, particularly in accessing healthcare services such as PMHS. Subsequently, I developed an interest in exploring British Pakistani women's experiences of PND and in understanding how the Pakistani culture may have influenced either the improvement or exacerbation of their mental wellbeing. I was also intrigued by the quality of the support these women received from PMHS and sought to explore their individual experiences, which motivated the development of the present study.

Throughout the research, I was conscious of how my personal background and experiences might intersect with the participants' narratives, particularly concerning gender, ethnicity, and motherhood. Following each interview, I documented my reflections on how my familiarity with Pakistani cultural norms and my experiences within the NHS could shape my interpretation of the data. Thereby, enabling me to track any emerging patterns or biases and to assess their potential impact on my analysis. I also participated in IPA workshops, where I was guided by both my peers and a highly experienced qualitative researcher. This support was instrumental in helping me critically evaluate my own assumptions in relation to the participants' narratives, ensuring that my analysis remained firmly rooted in their lived experiences. I received ongoing supervision which encouraged me to develop fluid as opposed to rigid thinking styles and to connect with each of the participants' inner world.

In exploring the subjective experiences of British Pakistani women with PND, I was mindful of the potential biases introduced by using a medical construct, particularly the diagnostic label of postnatal depression. Although my study aimed to capture the personal and cultural narratives of the participants, relying on this clinical diagnosis might have imposed a Western medical framework on their lived experiences. To address this, I ensured that my analysis stayed rooted in the participants' subjective accounts by including perspectives that potentially diverged from or challenged traditional clinical definitions of PND.

Results

Five Group Experiential Themes (GETs) were identified from the transcript data and included the following: ‘loss of self’, ‘ambivalent familial support’, ‘cultural hush’, ‘tensions in tradition’ and ‘perinatal support in the shadows’. An outline of these GETs is presented in Table 4 below and details regarding the contributions of participants towards the themes can be found in Appendix Q. Further description follows, as well as associated quotes to assist the development of the themes.

Table 4. Summaries of the Group Experiential Themes

Group Experiential Themes	Summary
1. Loss of self	Six of seven participants contributed to this theme which revealed a disconnection from their sense of selves due to PND.
2. Ambivalent familial support	All seven participants contributed to this theme which explored the contradictory nature of family support whilst dealing with PND. This theme also has two subthemes including ‘supportive familial ties’ and ‘disempowerment in motherhood’- “They’re not my babies”.
3. Cultural hush	All seven participants contributed to this theme which looked at the social stigma with PND and PMHS within the Pakistani community. This theme has three subthemes including ‘what will people say?’- “log kiya kahenge?”, ‘absence of language, dialogue and recognition of PND’ and ‘seeking solace in shared experiences’.
4. Tensions in tradition	Five out of seven participants contributed to this theme which explored the conflicts between cultural differences in dietary norms, gender roles and in navigating Western traditions. It also encompassed challenges to practices like the ’40 day rest

	period'. This theme has two subthemes including 'disruption of rest' and 'clash of cultures'.
5. Perinatal support in the shadows	Six out of seven participants contributed to this theme which delved into the limited awareness and availability of PMHS within the Pakistani community. It also highlighted participants challenges in obtaining timely and continuous care from PMHS. This theme has two subthemes including 'visibility and availability of PMHS' and 'challenges in accessibility and continuity of care'.

1. Loss of self

One of the aims of the present study was to understand British Pakistani women's personal experiences of Postnatal Depression (PND). With the exception of Maryam, all participants expressed losing their identities and largely attributed this phenomenon to PND. Women spoke of the struggles they experienced in reclaiming their sense of self, amidst their ongoing challenges with PND. Hafsa spoke about losing interest in activities she once enjoyed, such as applying makeup. She described this as a "passion" and the fact that she had stopped engaging in it, suggested a significant shift in her personal identity:

> "I think that's a signal that I was losing myself cuz even after my ex-husband left and I had the babies, I wouldn't put make up on and my mum said that's my passion, that was my passion like putting makeup on, that was me, everyone knew me that I'd always buy makeup and things and I just stopped doing that". (Hafsa)

For Khadijah, there was a strong emphasis placed on the sense of loss and longing for her former self. There was also a significant change and stark contrast in her personality and demeanour, prior to PND. Despite reporting some improvement in her mood, Khadijah noted that she carried a lingering sense of sadness and perceived herself as being unable to fully reclaim the past version of herself:

> “I’m not the person who I used to be. I used to be much happier and more talkative. I’m not as depressed as I was before, much better than I was back then but even that little bit of sadness somehow still stays with you. Maybe because I know I can’t bring my old self back, no matter how hard I try. It feels like I’ve lost her”. (Khadijah)

Khadijah struggled to articulate the extent of her transformation which may suggest that her experience with PND changed her in ways she could not fully describe or comprehend:

> “I feel that I'm such a different I'm a different person now compared to who I was before having kids. It’s more like- I don’t even know how to describe it. I feel like I've just changed. Like I’ve lost who I was. Yeah, I'm definitely not my previous self”. (Khadijah)

Asiya reflected on the profound struggles she experienced in reconciling her sense of self after becoming a mother. She expressed a sense of grief for losing the person she used to be and also acknowledged the difficulties of accepting the new version of herself, as a result of motherhood:

> “I just struggle with my identity since becoming a mum. I feel like part of me is lost, like I’m grieving that part but also knowing and trying to embrace…the new version of myself which is quite difficult to be honest”. (Asiya)

Asiya acknowledged her evolving identity as well as the impact of her experiences in shaping her view of her present self. Her statement “I think it’s who I am now” reflected a resigned acceptance of her current state, implying that her experience of PND had deeply influenced her sense of self:

> “I was actually experiencing low mood two days ago. I felt…I just felt really rubbish and don't want to do anything I didn't want to be around anybody. Other than that, I think I've come a long way in terms of…I've accepted and, kind of well, not accepted. I say…I think it’s who I am now”. (Asiya)

Fatima reflected on feeling dissatisfied with the changes brought by PND in her overall demeanour and mental well-being. Thus, signifying the multifaceted effects of PND for Fatima which not only impacted her emotional wellbeing but also her sense of self and her ability to socialise:

> “It's changed me as a whole person. I actually don't like who I am anymore. Because I was a very confident, outgoing person. I was maybe shy, but I was still sociable. Now I'm not and I get triggered so easily and like my mood, I'm more low than high”. (Fatima)

Zaynab referred to her experience with PND as *“brain chemistry”* which was outside of her control. She explained the detrimental impact of PND to her sense of self-worth, as it led her to believe that she was underserving of kindness and positive experiences:

> “I felt almost as though I needed to be punished for, things not being a certain way and me not being able to control my brain chemistry almost as I said, I was very unkind to myself. I used to or I still sometimes do. So, yeah, it's, generally been very unkind to

> myself, not feeling like as though worthy of things. Not feeling as though, you know, I deserve nice things as well". (Zaynab)

Halima also shared her belief about her own lack of worthiness, highlighting this as a common and distressing aspect of PND. She struggled to recognise her self-worth or any positive qualities within herself:

> "I felt like I was not a good person, I was useless, I was worthless, I was not worth keeping. I had zero value for myself during the postnatal depression". (Halima)

2. Ambivalent familial support

This theme explores the conflicting nature of familial support experienced by the participants, amidst their struggles with PND. With the exception of Halima, three participants conveyed that the support they received focused on the practical aspects of postpartum recovery, rather than addressing the profound impact of PND. Nevertheless, there was a strong sense of feeling comforted and receiving encouragement from family members. On the other hand, there was also a sense of frustration with being overlooked and side-lined in their maternal role. For some participants, this disempowerment triggered the onset of their PND and for others, it exacerbated their ongoing ordeal with PND.

2.1 Supportive familial ties

The first subtheme revolved around the vital support participants received from family and friends, whilst they dealt with PND. This support manifested in various forms, including practical assistance with cooking and encouragement for self-care. Whilst acknowledging the absence of recognition for her experience of PND, Asiya reflected on the practical support of families cooking meals, as part of the Pakistani cultural postpartum tradition:

> “Although there wasn’t any emotional support or even recognising that what I was experiencing is postnatal depression, there was the practical help which did help me a lot you know? My mum and my family, you know they’d come around and they'd cook, they would cook dinners and that helped a lot”. (Asiya)

There was a further emphasis on the cultural significance of traditional Pakistani food, in the context of postnatal recovery. Fatima emphasised the positive role of Pakistani cultural dietary practices and familial support in promoting physical and emotional wellbeing. There was an internal assumption made by Fatima, that engaging in these practices would aid her recovery from PND:

> “My mum made traditional stuff, like certain good wholesome food which should help heal they say like your wounds, give you strength back in your body. Like, you know, nutty stuff or certain grains that they make and if you eat that, it's good for you, and it clears your inside. My mum made something called ‘Panjeeri’. It's the first time I tried it. My mum said eat it because, it'll help clear your insides like you know, detoxing your blood and all of that and it will make you feel better. I used to have it by force because I didn't like it. But I used to eat just like spoonful’s because my mum's made it for me and I used to think, I'm going to feel better”. (Fatima)

Fatima also highlighted the importance of having the right support system and stated that without it, she may have struggled to cope with PND:

> “If I didn't have the right support around me, I don’t know how I would have coped with my depression, like with my mum, knowing that she was cooking and sending food, coming down to see me”. (Fatima)

For Maryam, the Pakistani cultural practice of an “open door policy” allowed her to combat the isolative experience of PND. She reflected on her need for companionship and how the Pakistani culture made it easier for her to connect with adults. She contrasted her experience with the experience of mothers from other cultural backgrounds, whom she suggested may choose to seek adult company at playgroups or within their workplaces:

> “I think having that open door policy where people come in and gossip and talk and have tea and, you know, that helped because on those days I had a couple of hours of company, you know, and a lot of mums would probably say that I think in the Pakistani culture you will get to see people even if you didn't leave your house. If you've got that sort of community around you, whereas I know mums, they go to work for adult company or they go to play groups for adult company, whereas I could stay at home and I'd probably see two people that will come and visit”. (Maryam)

Maryam spoke about the support she received from her extended family who may not have fully understood her experience with PND, but reflected on their presence as providing her with comfort and company when she needed it. Despite their lack of awareness about her struggles, their readiness to be present and to provide her with support during difficult times improved her bond with them. Maryam emphasised the importance of emotional support and connection within her familial relationships which transcended the need for having a comprehensive understanding of PND:

> “I think it’s (postnatal depression) made my relationships with my extended family better. I think because I felt like they were there. You know, when I was, when I needed that company. Yes, they didn't know what was going on, but they were there”. (Maryam)

In similarity with Maryam’s experience, Zaynab also encountered strong familial support. She described her family rallying around to offer practical assistance, such as providing childcare for her son and ensuring that she received freshly cooked meals daily. Thus, signifying the importance of communal support networks within Pakistani families, where each family member played a role in facilitating the mother’s well-being. Zaynab also illustrated the importance of collective support and solidarity in navigating postnatal recovery and parenting struggles:

> “I think that kind of sense of community. So as a family, when, for example, my daughter was in hospital, I didn't have to worry about childcare for my little boy. It was all covered. I didn't have to worry about food being dropped off. I used to have food dropped off to me every single day. I'm a big lover of Asian boiled tea. Like, you know, really hard boiled tea. I used to have a big thermos dropped off first thing in the morning. My dad before work used to drop it off”. (Zaynab)

For Halima, there was a significant and positive shift in her husband’s perception towards her ongoing ordeal with PND. This change enabled her to feel seen and heard, thus reducing her feelings of invisibility and isolation which had accompanied her experience of PND. Halima's experience of spousal support highlighted the transformative impact of empathy and validation:

> "My husband has started to acknowledge me as someone who's not choosing to be sad all the time but as someone that needs help and support. To even acknowledge that means so much to me. Whereas before it was like, when are you going to snap out of it? Now it's like, I hear you. I can see you. Now, it means so much more to me that-he's just changed because I'm not invisible anymore. My pain is not invisible anymore. I'm not even shouting off the top of my lungs anymore. He's just much more supportive and considerate of my needs". (Halima)

Halima also described her husband as signifying the possibility for family members to evolve and embrace a more supportive stance, particularly towards the mental wellbeing of women experiencing PND. She perceived her husbands' increased awareness of the impact of childbirth on maternal mental health as a willingness on his part, to learn and empathise. She witnessed this through his efforts to educate himself through watching videos and having open discussions:

> "My husband is a big example of how people can change because he comes from the typical Pakistani culture and he's changed so much in that way of understanding. He sees that a woman has to go through so much to have a baby. That it does have a big impact on her mental health. He started watching more video clips and things about, and like he's open about it as well". (Halima)

2.1 Disempowerment in motherhood- "They're not my babies"

This subtheme arose from participants expressing their frustrations with feeling overlooked and side-lined in their role as the primary caregiver, particularly by their family members. There was a strong emphasis placed on giving birth for the family and feeling like the baby belonged to others rather than to themselves.

Halima used the word ‘incubator’ to suggest that she felt reduced to a container for carrying and delivering her baby. It indicated that she felt devoid of any sense of ownership or agency over her role as a mother. It also highlighted feelings of disempowerment as a result of receiving external interference from extended family members and alluded to the onset of her experience with PND:

> “After I gave birth, that’s when it started. I felt like I was just the incubator that carried the baby and then after delivery time the baby was theirs and I kind of just faded into the background and everyone else took over that is until the baby cried for milk”. (Halima)

Similarly, Hafsa felt that familial involvement overshadowed her role as a mother. Her use of the term “surrogate” illustrated her detachment from motherhood. She portrayed herself as bearing and delivering her twin babies, with the unintended purpose of transferring the responsibility of their care to extended family members:

> “I didn’t feel like they were my babies, they were everybody else’s babies, they were my aunties babies, my uncles and everybody else’s babies except for mine and I used to joke about it and I said. I used to say, “oh I’m just the surrogate, oh I’ve just given birth for everybody else”. (Hafsa)

Hafsa continued to express her sense of detachment and lack of ownership over her role as a mother. She described feeling as though others, particularly family members, took control in caring for the babies and this led to her feeling disconnected and side-lined in her maternal role:

> “I didn’t feel like I was in charge of the babies, I felt like everyone else had the babies and they weren’t mine like cuz of the way they were speaking the way like my family were, they didn’t feel like my babies, like they felt like their babies. I felt detached a bit”. (Hafsa)

Khadijah described herself as feeling like she was nothing more than a means to produce babies, due to the behaviour of her in-laws. She recalled how her mother-in-law attempted to assert dominance over the care of her daughter. Furthermore, Khadijah’s desire to bond with her baby was disrupted by her in-laws taking the baby away from her, without considering her needs or wishes. This sense of powerlessness and lack in autonomy may have contributed to the development of Khadijah’s experience with PND:

> “With the way my in laws are, I felt like a baby making machine. I didn’t feel bonded with my daughter. My mother-in-law, like with my daughter she fully tried to take over with her. Like she would literally try to be my daughter’s mum. She like fully took over with her. There were times she would come into my house and take my child and be like, oh yeah, we're going to look after the baby, you just rest and she thought that was helpful. And at the time, all I wanted was my child next to me. Yes. She would constantly do that. My in laws would just come into the house and take my child and

> tell they’ll bring her back in a few hours and probably wouldn't see her the whole day. So that was kind of that's probably what made it even worse because I'm like, I need I want to see my child. I’ve literally had a baby and they’ve just taken her away. That was quite a crap experience”. (Khadijah)

Khadijah also reflected on Pakistani cultural norms and expectations, where she proposed that the baby was seen as a collective responsibility. For Khadijah, these norms reinforced the perception that her child belonged to the wider family and thus hindering her ability to develop a strong bond with her baby:

> “…because of what happened with them taking my child away from me constantly. I feel like I didn’t bond with her properly. I didn't get the chance to because they would constantly just want my child. It was like…it wasn't my baby. It was a family baby. Like, that's what I was told. Like it wasn't my child, it was everyone’s child and because it was their first grandchild. I think. I think it was the first grandchild and the first, like, niece. Yeah, it was like everyone else’s baby but mine and sometimes it still feels like that. It's still everyone else's baby but mine. I'm not allowed to do certain things which is annoying. But again, I think that that relates back to the Pakistani culture, you know, she’s a family baby”. (Khadijah)

Familial interference not only impacted on the mothers’ perceived sense of detachment from the mother-baby bond, but for Fatima it also had an impact on her breastfeeding journey. She described feeling discouraged by her sister-in-law which left her feeling disempowered in her maternal role and potentially further exacerbating her experience with PND:

> “His one aunty, I mean would come and she'd like to take over. I still believe that she was trying to take over my child. I was really trying to breastfeed, which wasn't working very well, and I was expressing. I was only probably getting an ounce of milk. Obviously not enough for my child and then because I was struggling in the breastfeeding side of stuff. My sister in law would like to say, oh, don't worry, you can do it later and do it later like put me off from doing the breastfeeding”. (Fatima)

3. Cultural hush

This theme illustrates the pervasive social stigma surrounding PND and Perinatal Mental Health Services (PMHS) within the Pakistani culture. It underscores the reluctance to openly discuss PND, due to a fear of negative evaluation from the wider Pakistani community as well as the pressure to uphold the family reputation. Furthermore, it sheds light on the lack of awareness, acknowledgement and language related to PND within the Pakistani culture.

3.1 What will people say? - “Log kiya kahenge?”

Six of the seven women spoke about how the social stigma of PND compelled them to hide it from their extended family and the Pakistani community. Hafsa shared a Pakistani cultural expectation of maintaining a ‘positive’ image and the importance that is placed on upholding familial “izzat”, meaning respect and honour. Thereby, denoting that her PND was viewed as a threat to the preservation of the family’s reputation:

> “I think he wanted to keep that ‘izzat’, he doesn’t want them to think his wife is crazy, he said to me oh you’re my wife, you’re supposed to be respected and stuff like that, you’ve got status in the family because he was the eldest and he was the first child to

> get married erm so he had certain expectations, like the way I spoke to them, or what I would wear, or like sorting my hair out before I spoke to them on video calls”. (Hafsa)

Hafsa repeatedly emphasised the pressure for her to uphold a positive image in front of her husband’s family which involved concealing her difficulties with PND. Her husband’s reluctance to disclose her use of antidepressants may have indicated a fear of judgement and ostracisation within the Pakistani community. Hafsa also highlighted the cultural taboo associated with medication for mental health in Pakistan. Thereby, reinforcing the challenges experienced by British Pakistani women in accessing appropriate support:

> “He just didn’t want them to know, he was a bit like, like I said before, he was like respect…he didn’t want my respect to go away thinking that I was taking medication and then they’d think I’m some weird woman taking antidepressants cuz they don’t do that in Pakistan”. (Hafsa)

Alongside familial reputation, there was also a cultural pressure to avoid negative scrutiny and judgement from the wider Pakistani community. Khadijah believed that her in-laws were particularly concerned about how the family and community perceived them. Her reluctance to openly share her experiences with PND may have stemmed from the likely repercussions within her cultural and familial context:

> “I think it’s caring about what people will think and feeling judged by everyone else. Yeah, I think that's really what it is, just being judged and they think, oh, you know, people are going to talk about us in the family and the community. That’s why I haven’t told anyone about my PND”. (Khadijah)

Fatima's insight sheds light on the complex relationship between Pakistani cultural norms and the challenges that come with postnatal depression. She suggested that the apprehension of receiving negative judgment from peers, may cause women to internalise their emotional suffering and avoid seeking external support. Subsequently, these women may experience isolation which in turn intensifies their experience of PND and further perpetuates the cycle of social stigma:

> "I think there's a massive stigma in the Pakistani culture that prevents women from openly sharing their experiences with postnatal depression and worrying that other people, especially other women in their social circles, might judge them and look at them differently". (Fatima)

She also added that many of her friends and family members had also experienced PND but chose to remain quiet about it. Thus, suggesting a pivotal role played by self-stigma in maintaining the silence surrounding PND:

> "There are so many women that I know. A lot of them have been close, like in relation to friends or family, have suffered it but never said anything and there's this idea of it being shameful and they do their best of hiding it from people. Because I think they feel that they're going to get penalised, or they're going to get looked at in a different way because they mentioned depression". (Fatima)

Furthermore, there was an emphasis placed on the role of shame, as expressed by Maryam using the Urdu phrase "log kiya kahenge?" (what will people say?). This phrase captures the pervasive fear of societal judgement and stigma within the Pakistani culture that surrounds PND:

> “I think there is a massive bit about shame and in Urdu they say “log kiya kahenge?” You know? What would people say if they found out that you're not attached? You're not forming an attachment with a baby. You know, they're going to think you're horrendous. What are people going to say if they find out that you're depressed? You know after having a baby?”. (Maryam)

Halima discovered the stigma and misconceptions associated with seeking help for PND, within the Pakistani culture during her own struggle with the condition. She observed a deeply rooted fear amongst the Pakistani community, that utilising perinatal mental health support would result in the removal of the baby. She also highlighted a perception within the Pakistani community, that accessing the PMHS would reflect her inadequacy as a mother and her incapability of caring for her child:

> “I later found out when I went through it that it's a taboo within the Pakistani community that if you go to services- because that's what you're labelled. You're not perinatal. You're not just the help that's there for mothers. You're "the services", and the services take the baby away. The services prove that mums not capable of looking after the children. The services pass your children on to other relatives without your permission. You know, like, this is the kind of perception that they had and I discovered that later when I was getting help from perinatal. I would be consistently told, be careful what you say and like what would people say if they found out you’re getting help from a

> mental health service? Do you want other people to think you’re not a good mother and that you can’t even take care of your own child?”. (Halima)

Asiya also expressed a similar belief held by the Pakistani community, regarding the utilisation of PMHS as signifying maternal inadequacy or mental instability. This perspective reflected a wider societal misconception within the Pakistani community, where help-seeking from PMHS is stigmatised. It also highlights a need for a cultural shift in accepting and understanding the significance of perinatal mental health support:

> “I feel as though in the Pakistani culture. I feel as though there is a general myth that you’re kind of, you’re defective if you are using this service or if you’re having help with therapy and with perinatal, you’re not good enough. You’re not- there’s something wrong with you. You’re not mentally right”. (Asiya)

3.2. Absence of language, dialogue and recognition of PND

Five of the seven women emphasised the lack of acknowledgement, understanding and open dialogue surrounding PND within the Pakistani community. For Maryam, the lack of specific terminology for PND in the Pakistani culture led her to believe that “it doesn’t happen to Pakistani women” or that “it only happens to Western women” (Maryam). Therefore, suggesting that the absence of vocabulary for PND within the Pakistani culture may perpetuate the misconception of PND as being a Western phenomenon.

For Zaynab, the absence of terminology for PND illustrated a broader Pakistani cultural reluctance to accept or address such mental health conditions:

> “I'm Pakistani, but we speak a language called Pashto and there's no such word as depression in Pashto and that goes to show how we don't accept depression”. (Zaynab)

She added that the availability of words to describe PND in the English language, prompted her to find comfort in individuals outside of her cultural circle. Therefore, illustrating linguistic barriers that exist within Pakistani communities and potentially resulting in a culturally isolative experience:

> “…the fact that there's no words for things like depression, things like feeling low, baby blues, you know, all of these kind of conversations means that often I find more comfort in people who are not from my culture because they're able to understand it. So I have a neighbour who's daughter, who's older now. She's like the age of my mum, but I can talk to her about my depression so openly in English, even though she's a complete outsider, but because I can verbalise it and I can put it into words”. (Zaynab)

In addition to the lack of linguistic expression for PND, there was a lack of understanding amongst some family members. For Khadijah, this came from her mother-in-law who lacked an understanding of her struggles with PND and instead attributed it to moodiness and anger:

> “My mother in law doesn’t even understand she was like “oh you were so moody when you gave birth”, she doesn’t understand that I was just depressed, she just thinks I was moody. I was angry all the time. I don’t even think she knows what the term is. She just thinks I was moody and angry, and that’s her understanding. She doesn’t understand that I was full on going through something”. (Khadijah)

Khadijah also described a generational gap in the understanding and recognition of PND within the Pakistani community, particularly older Pakistani women like her mother-in-law. She suggested that these women may be more likely to dismiss or deny the existence of PND. She cited this as a reason for her reluctance in openly sharing her struggles with PND:

> “It's like not even a thing for older Pakistani women. Like, my mother in law is very old school. If somebody said they’ve got postnatal depression, she'd be like you’re fine like, there is nothing wrong with you. Like, you know, she's the type of woman -she doesn't know that I've gone through it and stuff. So I don't discuss stuff like that with her because she's very old school. She doesn’t understand it at all. If she knew she would say, you’re not depressed, you're fine. You should …you should go out more. That's her helpful tip (sarcasm). You should go out more”. (Khadijah)

There was also a strong emphasis on the lack of open discussions in relation to PND, within the Pakistani culture. Asiya noted that PND was rarely spoken about and that instead, the cultural norm involved conveying best wishes. Thus, leaving new mothers to navigate their experiences without an awareness:

> “I think there is a lack of education, a lack of understanding, a lack of awareness because no one in our culture talks about it. Yeah. It's not spoken about. Postnatal depression is not spoken about. Everyone just says congratulations, you're having a baby and then you have the baby and you’re left to it”. (Asiya)

Some women spoke about the importance of having open conversations, to aid women in preparing themselves in becoming better equipped to dealing with PND. Maryam expressed a sense of regret for not recognising the signs earlier within herself and felt that if discussions about PND were more common within her culture and family, she might have been able to do so:

> “…I thought it was never going to happen to me. Whereas if I was prepared a little bit more and I had seen it with other people. I'm sure I've seen it with other people, I've just not recognised it or it wasn't discussed oh so and so suffered from post-natal depression, I think from my own culture, maybe from my family then I would have probably dealt with it better recognised it earlier maybe”. (Maryam)

Halima shared a similar sentiment in relation to PND and mentioned that prior to experiencing it for herself, she had not been aware of others who had also experienced PND. The lack of acknowledgement and awareness of PND within the Pakistani culture led her to a feel a sense of unpreparedness. She mentioned noticing that others started to acknowledge and speak more openly about it, whilst she was experiencing it herself:

> “I've seen people suffer from depression and other mental health illnesses, but not postnatal depression. I haven't seen that all within my culture. But then everyone starts telling you when you're going through it. How could you not have said something before? So it can prepare you”. (Halima)

This shift in recognition and understanding of PND came as a surprise to Halima, thus highlighting the need for greater visibility around PND within Pakistani communities to better prepare women for the potential challenges they may experience.

3.3 Seeking solace in shared experiences

This subtheme highlighted the significance of shared experiences amongst British Pakistani women, particularly in dealing with familial and cultural dynamics. Khadijah proposed culturally exclusive group sessions, as a means of normalising PND and creating spaces where British Pakistani women could seek support without the fear of judgement. She emphasised the importance of knowing she was not alone in her ordeal and commented on the benefits of a shared awareness of Pakistani cultural practices that may be otherwise unheard of in other cultures:

> “Having maybe a session just for British Pakistani women because there's only certain things that only, like we would understand because of the culture because of the families and the way they are, like people from other cultures may not understand what we're going through so maybe have like group sessions. You don’t know that other people are going through the same thing…you just don't know. You just think, oh yeah, I'm the only person that's going through this, and the whole world it’s just me and no one else. Everyone else is perfect. But no, it's not true. Other British Pakistani women are going through same thing too. The same traditions like having loads of guests at your house straight after giving birth. I think it'd be helpful to just sit down with other women that are going through the same thing. That would be quite helpful and nice to know someone is going through the same shared experiences as you”. (Khadijah)

Zaynab reflected on the struggles of British Pakistani women in having to navigate two cultures, whilst dealing with challenges like PND and motherhood. She expressed the difficulty in finding acceptance and understanding in various communities. She suggested informal gatherings such as coffee mornings with other British Pakistani women, to provide a supportive environment where women would be validated by those sharing similar experiences and cultural backgrounds:

> “As British Pakistanis, we're an amalgamation of two cultures. We're trying hard to fight for our culture that our parents left behind, but also trying to forge a new culture here. It's difficult trying to navigate all of that whilst having a child whilst having depression it’s really, really hard because you're lacking understanding in so many different communities. You don't find that acceptance. So I think perhaps like a coffee morning with other British Pakistani women, kind of makes it a lot more informal. But at the same time, you kind of feel that you understood you're in a group of women that understand exactly where you're coming from and why you could possibly be upset at certain situations”. (Zaynab)

Maryam expressed a sense of isolation and longing for support which was tailored specifically to her cultural, religious and linguistic background. Although she recognised that she was not alone in her experience of PND, she still felt isolated due to the lack of help-seeking within the Pakistani community. She suggested that connecting with others that shared her cultural background and experience of PND would have helped her to feel more comforted:

> “If there was something for Muslim women or Pakistani women in English and Urdu, I think that would be great. You know, because I still feel like I'm the only Pakistani woman that's been through this. You know and I know I'm not but I feel like I am. If I'd gone to a community centre where there were others and they were getting help, and I would have felt more at ease”. (Maryam)

She further highlighted the necessity for the NHS to establish safer and “less-stigmatising” spaces, tailored for British Pakistani women. Her use of the words “just like you” implied that she sought a sense of solidarity and community amongst British Pakistani women facing difficulties with PND. This indicated her recognition of the importance of cultural sensitivity and the need for inclusive support services within the healthcare system:

> “I definitely think, you know there's a massive need to create safe maybe less stigmatising places within the NHS for British Pakistani women, where they can be told if you are experiencing postnatal depression, this is what to do and also that you’re not alone you know? There are other women just like you that are experiencing this too”. (Maryam)

4. Tensions in tradition

This theme explored various conflicts arising from clashes between traditional Pakistani cultural practices and personal needs and preferences. It encompasses disruptions to the Pakistani cultural practice of a ’40 day rest period’ following childbirth which conflicted with the Pakistani cultural tradition of hosting guests immediately after birth. These clashes also extended to cultural differences within marital and familial relationships, some of which included dietary expectations, gender roles and the negotiation of Western traditions.

4.1 Disruption of rest

Three women contributed to this subtheme by sharing their experiences of not being able to rest and recover, amidst family events and Pakistani cultural practices. They highlighted the challenges they had faced in trying to maintain their privacy and autonomy. Hafsa emphasised the overwhelming presence of guests in her house after returning from the hospital. She described feeling unable to rest, due to the influx and continuous presence of extended family members. She described the necessity to adhere to cultural expectations of modesty and found herself compelled to partake in the activities:

> "…when I came home, with the children, like there were loads of people in the house like extended family, my family, his family, elders as well. I couldn't rest cuz I had to make sure that I was dressed and I couldn't dress properly cuz of my c-section so it was really painful but then I had to dress in loose, long dresses to cover myself because the elders were there and they were like doing prayers like dua's and doing the circumcision, shaving the hair off. I didn't have the energy for it. I just wanted to sleep and to recover but I couldn't because I had to take part in like doing all of that and standing there and watching the hair being shaved off and then collecting the hairs and then giving it in, converting it to like money and like giving it to charity and erm yeah it was a lot to take in, there was a lot of people". (Hafsa)

Khadijah expressed similar feelings of overwhelm, due to Pakistani postpartum cultural practices hindering the ability to recuperate. She suggested the tradition of remaining indoors for 40 days, coupled with the traditional Pakistani custom of hosting immediately after childbirth, contributed to the onset of her depression. She described her personal experience of feeling overwhelmed and sleep deprived but that despite this, she had to present herself as well-groomed and put together. Therefore, illustrating the additional burden placed on Khadijah to uphold certain standards of appearance even in times of physical and emotional vulnerability. Khadijah's reference to "their culture" implied that she had emotionally detached or disassociated herself from Pakistani postpartum traditions. This distancing from cultural norms may suggest that she perceived herself to be separate or perhaps even at odds with the cultural norms imposed by her culture. Furthermore, it may have also implied a strain between her cultural identity and her personal experiences:

> “So you’re encouraged to not leave the house for 40 days but I feel like it makes you worse because they have the relatives around straight away, there's no breaks as soon you come back from hospital, there’s relatives around, and that makes it worse because you're so sleep deprived. I remember the first when I gave birth to my daughter, I came out of hospital and the next day I had relatives. I didn't sleep that night and had relatives, inside my house, sitting down downstairs (laughs). My mother in law coming in and saying look you just have to deal with it. I remember just crying my eyes out thinking to myself, thinking, I've not slept a wink because the baby's crying all night, and, I had to get up, put my full Asian outfit on and do my makeup and straighten my hair and get ready to see these visitors downstairs. When I was going through, the sleep deprivation. So I think it made it worse, to be honest with the traditions and that's in their culture. They have to see the relative straight away. I'm not talking about one or two relatives. With my daughter, there was definitely well over 100 guests. I feel like that was the start of my depression”. (Khadijah)

She went on to express her frustration at the non-existence of the 40 day rest in her personal experience. Khadijah’s reflections revealed the clash between traditional Pakistani cultural practices which encouraged rest and the realities of social expectations that involved prioritising the arrival of guests:

> “The idea of rest within the 40 days is like non-existent. It would be lovely. I think I'd appreciate the rest. But there’s never any rest because of all the guests that come that want to see you and the baby”. (Khadijah)

Maryam reflected on her struggle with PND and spoke of the 40-day period of rest as a challenging ordeal. Although she recognised the benefits of this tradition, as providing women with support with domestic chores and aiding recovery, she found it to exacerbate her difficulties. She experienced a sense of feeling confined indoors and yearned for outdoor activity. However, her deviation from cultural norms led to tensions with her mother who appeared to adhere more strictly to Pakistani cultural practices:

> “…my mum was like oh yeah in the 40 days you need to stay inside and for me, that was the worst thing, because I was fighting this horrible feeling of depression and I think going for a walk would definitely help. Once I was physically able to do it, I wanted to get out of that bedroom because I felt like I was stuck in my bedroom and it's dark all the time and the mood swings, so I wanted to get out. So I think it was about week three when I could barely walk. I just took her, put her in my wrap and went out because nobody was home that day and I went out and I came back and my mum made a big, massive deal about it. So I think sometimes it helps women who may not suffer from postnatal depression because it's good recovery and they get the help with the household housework and stuff. But for me, it wasn't a positive thing”. (Maryam)

4.2 Clash of cultures

This subtheme highlighted cultural clashes experienced by some of the women, whilst navigating between Western and Pakistani cultures, as well as the varying cultural identities and practices within the Pakistani culture itself. Halima described herself as ‘Mirpuri Kashmiri’ and was married into a ‘Pathan’ family originating from Pakistan. She spoke of the differences between her husband’s family and her own family, in relation to the importance placed on following postnatal cultural dietary traditions. Halima’s aversion to partake in traditional Pakistani postpartum practices led to tension with her mother-in-law, who expected her to adhere to these customs:

> “There was certain traditions of, what you had to eat once you had a baby, like it’s called ‘chuwani’. So that was another culture shock, because there's certain foods that I didn't like that they only ate like it was sort of different stuff in our family. My mother in law, would get upset with me saying no to her what she wanted to give me. I just found her really overwhelming and not being able to express myself, say out loud because I'm being rude, you get labelled as you're rude, you're misbehaving, and you're disrespecting an elder. I would just be like, I just want an English coffee with two pieces of toast and that's it. That's fine for me.”. (Halima)

The words “culture shock” implied that Halima experienced a sense of confusion and discomfort when expected to consume traditional foods. Halima’s struggle to express her preferences which were more aligned with a Western diet, was exacerbated by the pressure to follow Pakistani cultural dietary practices.

For Hafsa, there was a clash of cultural values even prior to giving birth. She spoke of her personal desire to embrace Western traditions and her husband’s adherence to Pakistani traditions. This clash highlighted the tension between the two cultural perspectives regarding pregnancy traditions, such as letter writing to the babies and gender reveal parties:

> "I was trying to get him to do more Western things when I was pregnant, like writing letters to the babies and he'd say so stupid, why should I do this for?. I said, it's what other people do and like you know the gender reveal, he never- that was a big argument- they don't do it in Pakistan, they don't do gender reveals…erm and we argued up until the day about doing it…erm my family sort of forced it on him- that we're doing it- I just want to know the babies- he said it's not a big deal- it is a big deal in this country like if you're having a boy or a girl". (Hafsa)

Hafsa further elaborated on the disagreements with her family regarding traditional Pakistani postpartum practices. She recalled instances where her husband and mother-in-law insisted on following certain Pakistani cultural practices and superstitious rituals, such as a placing metal object under the mattress to ward off any evil eye. Thereby, illustrating the challenges Hafsa experienced in navigating cultural beliefs in a familial context:

> "He would say to me "oh you need to do this, you need to do that, you need to like eat food" and I said, "I don't want to eat food." He goes "you need to eat it but you need to eat like 'Panjeeri' but I didn't want to and with the babies like when they first came home, he put like a metal spoon or something underneath the mattress to get rid of evil eye and I said "no they don't need that" and he goes "no" and his mum and my mum were arguing about the traditions, like my son when he had his circumcision erm his mum was saying "oh you need to put some oil on it" or something I don't know something on it and my mum goes "no we need to follow what the doctors said" I think it was Sudocrem or Vaseline, something like that and yeah there was a lot of arguments about that kind of stuff". (Hafsa)

Asiya described her upbringing in a traditional Pakistani household where gender roles were more clearly defined. She stated that women were expected to take care of the babies whilst the men worked. However, she described marrying into a blended cultural family where she perceived her husband to be influenced by his English heritage, as he wanted to be actively involved in parenting:

> “I came from a traditional household where there was an expectation that a woman takes care of the babies, and the men go out of work and I’m married into a family where it's quite Western and my husband's mixed race so he is half Pakistani and half English and they’ve been brought up more with Western culture, so he wanted to be really hands on and always wanted to go out with, usually in the Pakistani culture you just stay at home with the baby and just get on with it. He wanted to experience things, he wanted me to experience things and the baby, but it was just too much for me. It's like I've just had a baby. I just, I just, I feel a bit low. I don't want to do anything”. (Asiya)

The pressure to conform and balance both Western and Pakistani cultural norms, whilst managing the challenges of new parenthood may have exacerbated Asiya’s emotional distress. Thus, highlighting the intersection between PND and cultural clashes.

5. Perinatal support in the shadows

This theme highlighted the limited understanding and uptake of PMHS among the Pakistani community. Women spoke of their fear of relapse and the dependency they developed on the support they received from the PMHS. There was also a sense of frustration with the limited duration of perinatal support offered to them. For some of the women, this caused them to feel anxious about the continuity to their care.

5.1 Visibility and availability of PMHS

This subtheme explores the lack of awareness and utilisation of PMHS within the Pakistani community. Women expressed astonishment and frustration at the pervasive ignorance about these services within their social circles. Despite experiencing PND themselves, they discovered that neither they nor others around them were aware of PMHS. This lack of awareness was extended to older generations of Pakistani women, as well as women raised in Britain:

> "…it just wasn't…it wasn't a thing that I heard about from older women like oh yeah that person's got postnatal depression and they're getting support from a perinatal service. I mean, anti-depressants from their GP? Sure. But nothing other than that". (Khadijah)

Khadijah suggested that the use of antidepressants prescribed by General Practitioners, was more widely acknowledged within the Pakistani community than the support offered by the PMHS. This may reflect a cultural reliance on medical professionals and a tendency to turn to traditional medical interventions which may result from a lack of understanding of the range of support services available. Similarly, Maryam expressed a sense of surprise and concern that despite the obvious need for support, she had not encountered anyone who had accessed the PMHS:

> “The fact that there is a service that helps women, helps mothers is not common knowledge amongst Pakistani women, even those born and bred here. I know women who have desperately needed support but I’ve not heard of anyone accessing the perinatal service, not anyone I know”. (Maryam)

Asiya also reflected on the lack of visibility of PMHS, particularly within her own social circle. She was astonished and bewildered that people within her social circles were not familiar with the service, except when informed through her own experience. She described her sister’s experience of PND as being more challenging than her own and highlighted the stark contrast in awareness:

> “Nobody, nobody around me knows. I literally mean this. There's not a single person in my social circle that even knows what perinatal is, and if they know, it's because of my experience with perinatal. I spoke to my sister about perinatal. She had…I would feel her postnatal depression experience was a lot more difficult than mine and she didn’t know of perinatal or any services. I don’t know why no one knows about it. Why isn’t it common knowledge?”. (Asiya)

Asiya repeatedly emphasised the lack of awareness of the PMHS within her social circle and stated that this was despite living in a large city where she interacted with many mothers. She also spoke about the importance of increasing the awareness of these services, to ensure Pakistani women were receiving support beyond antidepressants. Asiya stressed the need for PMHS to be the primary recommendation for Pakistani women experiencing perinatal mental health difficulties:

> “No one in my social circle and I live in the city, as you know, it's a big city and, even when I was working and I dealt with a lot of women that had babies and, you know, came in to have makeovers, to make themselves feel better. There's not a single person that I've spoken to that even knows perinatal exists. So I think fundamentally it is so important for kind of to get the service out there, for Pakistani women to know because when you ring your GP, they’ll just say, oh, you're probably feeling low you need to go and anti-depressants. This service is not recommended and I think it should be the first port of call because it has been helpful. So yeah, my point is no one knows about it in my social circle and I have a really big social circle”. (Asiya)

For Halima, there was a noticeable lack of encouragement about accessing support during the perinatal period, indicating a general sense of unfamiliarity about the existence of PMHS within her social circle:

> “None of them, to be honest, really advised me to get help when it came to perinatal. Some of my friends relatives, like, 1 or 2 told me to reach out when I first got my mental health issues. But when it came to having children, no one really advised me to reach out and get help. Maybe they didn’t know it existed. As a mother myself, I didn't really know the perinatal service existed”. (Halima)

Halima’s reference to herself as a “mother” who lacked an awareness of PMHS prior to accessing it highlighted the barriers to accessing information about such services within the Pakistani community. It may have also pointed to a lack of understanding or recognition of the importance of seeking help during pregnancy and after childbirth, within the Pakistani culture.

5.2 Challenges in accessibility and continuity of care

Six of the seven women contributed to this subtheme and shed light on the challenges they experienced in relation to the timeliness, responsiveness and continuity of care. It also highlighted other issues such as lengthy waiting times for NHS therapies and communication hurdles from healthcare professionals which led to unmet expectations of the availability of certain support services.

Khadijah expressed her disappointment in not being able to access parent-toddler sessions, due to a breakdown in communication between the nursery nurse and the resources available at the PMHS. Her expression of guilt may represent an internal conflict of her struggles with PND and her desire to provide the best support for her child:

> “I get really depressed and can’t leave the house sometimes so my little girl was just couped up in the house and the nursery nurse did mention parent and toddler sessions, like quite small and intimate but I didn’t experience any of that so that was a bit crap because I was expecting something like that because that would have been helpful. I mainly experienced guilt that I wasn’t taking my daughter out like letting her experience play outside”. (Khadijah)

Khadijah’s experience demonstrated the importance of accurate and clear communication about the availability of resources, particularly for women experiencing limited mobility due to PND.

Other challenges reported by the women included the limited availability and the difficulties in accessing psychological support. Maryam acknowledged engaging in a nursey nurse-led intervention, however she perceived it to be insufficient in meeting her needs and expressed a preference for specialised support from a psychologist. Maryam’s reflections revealed her difficulty in accessing this support during periods of heightened distress. Her repeated emphasis on the expertise of psychologists indicated her desire for targeted and effective therapeutic interventions that were tailored to meet her needs:

> “In terms of getting support, I did do the nursery nurse stuff in the summer, but the actual like, high level support like therapy like getting that when I needed it I would say was difficult. I just didn't want to go and talk to somebody for the sake of talking to them. I wanted someone expert like a psychologist who has the expertise in this area that will be able to help me”. (Maryam)

Maryam also expressed her belief that having earlier access to therapy would have allowed her to avoid much of the emotional distress she experienced. She also reflected on how her own insights may have had the potential to positively shape her relationship and interactions with her daughter:

> “I think after having it, I understand my behaviours more, you know, and some of the stuff that I was battling through that now I can rationalise would have, would have been dealt with earlier, if that makes sense? I would have not gone through some of the emotional trauma or whatever you want to call it if I had the therapy earlier because I would have understood, especially the circle of security. If I understood that like a little bit earlier, a lot of the difficult times I had with my daughter would have not happened. Like, you know, forcing her to sleep if I'd understood actually, that's more me than her. She would sleep when she wants to sleep. I don't have to force her to sleep”. (Maryam)

Hafsa shared similar sentiments about the potential value of earlier access to therapy in navigating difficulties. She believed that therapy would have helped her to process her emotions more effectively and may have provided her with validation. She acknowledged the difficulty of revisiting and reprocessing past experiences, due to a delay in receiving therapy:

> “I think when I was going through the stuff with my ex and my children…therapy would have helped me process my emotions a lot better and talk about the rights and wrongs. Sort of validating my feelings and saying you are right; he shouldn’t have done this and its ok for the babies to cry if you’re getting them milk. Just that reassurance that I was doing the right thing, that would have been really helpful. But now, I’m having to like, when I go to (local mental health charity), I’m having to re-live it and re-process everything which is ten times harder, so to be able to do it then”. (Hafsa)

Hafsa also expressed an ongoing need for therapeutic support, particularly from a psychologist. She illustrated the challenges in scheduling therapy sessions around her work commitments and emphasised her openness to alternative modes of therapy delivery. Thereby, demonstrating her proactive approach to help-seeking and her willingness to participate in therapy despite encountering logistical difficulties:

> “I would have liked, when I started working, last year in February, and that’s when I was referred to a psychologist, so like talking therapy. But they could only do it during working hours, but I really wanted it, I really needed it, I still do need it…erm but it’s difficult because I’m working Monday to Friday 9 till 5 and no one’s doing it evenings

> or weekends erm and I said even if it's on the phone, like I don't mind, it doesn't have to be in person". (Hafsa)

Asiya expressed frustration in relation to the lack of responsiveness and immediacy of the support she received from the PMHS, particularly during moments of distress. She reflected on the infrequency of communication and long gaps between appointments which she perceived as inadequate for effectively meeting her needs. Furthermore, Asiya placed a strong emphasis on the importance of frequent check-ins, to provide ongoing support and validation during difficult times:

> "I think what it is, the thing that I find the most challenging is that if I'm having a really tough day and I text or, I feel as though I can't make a phone call, which understandably, you know, that there's a clinic and they have appointments. But if I text saying that, you know, which I was told that, you know, if you're struggling just text in and we'll arrange a call. They've been far and in between. Like there's not really been…the only thing would be just have more regular contact with someone. When, when I was struggling, just to even just have a conversation about how I'm feeling. I think the appointments are like a month apart, which a lot happens in a month, I think, you know, obviously when you're struggling. Just a little bit more checking, maybe just to see, even if it's a five minute phone call". (Asiya)

There was also a sense of apprehension concerning the impending discontinuation of the support received from the PMHS. Fatima reflected on her challenging journey of seeking help from two different perinatal mental health teams. She acknowledged the uniqueness in her experience, recognising that not every woman will have undergone the same struggles. She expressed ambivalence in relation to the sufficiency of the duration of support provided by the PMHS, as she did not perceive herself as fully recovered. Interestingly, Fatima pointed out her experience of "being pushed to have tablets". This may suggest that medication was presented to her as the primary course of treatment. She then makes mention of receiving the "right support" which may signal a more comprehensive approach that met her needs:

> "…because he's turning two and you know, they want to say, you know. That's it when he's two, you know they withdraw like certain services from me, which I think. I don't know. Obviously, not every woman will go through what I went through in a year of being pushed to have tablets and then get the right support after a whole year later, and which delayed me getting better or feeling better in myself. So maybe yeah, it works up until two, but my child's two next month. I'm still not 100%". (Fatima)

Halima's narrative revealed a sense of fear and anxiety of being abandoned and left without support. Her worry seemed to stem from the daunting process of navigating help-seeking alone, with the added complexities of the tasks involved like making calls and completing paperwork. Halima grappled with the idea that the support she has depended on may not be readily available for her in the future:

> "I've been panicking and worrying that I'm just going to get left alone again and I won't know where to get help because perinatal are open arms and are so available for you. I wouldn't know where to start. For me personally, I find it hard to try and reach out for help and reach out for, you know, making phone calls, filling out forms. It's like a big task to me. So also, how am I supposed to get this help again?". (Halima)

Discussion

The present study aimed to contribute to existing research, by providing rich and detailed accounts of how Pakistani cultural norms and traditional practices may influence British Pakistani women's lived experiences of PND. The study also explored these women's experience of seeking and accessing help from PMHS.

Summary of findings

The following five group experiential themes were identified from the data and have been presented above, including: 1) loss of self, 2) ambivalent familial support, 3) cultural hush, 4) tensions in tradition and 5) perinatal support in the shadows.

In relation to the first theme, participants spoke about how their experiences of PND created a sense of detachment from their sense of self. The phenomenon of losing oneself whilst experiencing PND is not a novel concept in the literature as it has been shown in previous research to be a significant aspect of PND (Lamba, 2015; Stone & Kokanovic, 2016; Vik & Hafting, 2012). These authors found that women experiencing PND may struggle to recognise themselves or maintain their identity amidst the challenges they face. Thus, highlighting the universality of the loss of self in the experiences of women with PND.

In the second theme, participants spoke about the conflicting nature of the assistance they received from their family members. This contrast in familial support can be explained using Olson's (2000) "Circumplex Model", with its emphasis on balanced cohesion and flexibility within families. Participants experienced support in line with Pakistani cultural expectations, suggesting a cohesive family system. However, participants also reported feeling side-lined in their role as a mother which may reflect a lack of flexibility within families to adapt to the needs of women with PND. Furthermore, the emphasis on birthing a baby for the extended family may further illustrate the interdependence and interconnectedness of Pakistani families, as explained in Olson's (2000) model.

In relation to the third theme, the term 'cultural hush' was used to describe the social stigma surrounding PND within the Pakistani community. This stigma has also been reported in recent literature (Insan et al., 2022; Mccauley et al., 2020; Sakina et al., 2022). Within the present study, participants spoke of the pressure to conceal their struggles with PND from the wider Pakistani community, due to a fear of judgement. One participant (Maryam) used the phrase "log kiya kahenge?" (what will people say?), to illustrate the significant weight placed upon societal opinions within the Pakistani culture. A recent meta-ethnography of South Asian service users in the UK found that women were reluctant to speak openly about their mental health difficulties because they feared negative repercussions from the wider community (Prajapati & Liebling, 2021).

Moreover, one participant (Hafsa) expressed a pressure to maintain familial honour and respect by concealing her struggles with PND from her husband's family. A study by Chaudhry and Chen (2019) found that South Asian individuals were more vulnerable to a specific form of mental illness stigma called 'courtesy stigma'. This term refers to a phenomenon whereby individuals with mental health conditions and their family members are considered to be "socially tainted" (Chaudhry & Chen, 2019). Thus, emphasising the intricate dynamics of stigma within the South Asian community, impacting help-seeking behaviours and exacerbating the challenges faced by British Pakistani women with PND.

Furthermore, the fourth theme highlighted conflicts arising from clashes in cultural expectations and personal needs and preferences. Of these expectations was the 40 day rest period which is traditionally observed within the Pakistani culture, following childbirth. A recent study by LeMasters et al. (2020) found a negative association between this traditional cultural practice and the symptom severity of PND. The authors identified this practice as a protective factor against the development and exacerbation of PND. It is important to note that LeMasters et al. (2020) was set in rural Pakistan whereby the concept and experience of the 40-day rest may drastically differ to that observed elsewhere. In the present study, most participants were unable to benefit from this traditional practice, due to reasons such as the Pakistani cultural tradition of hosting guests soon after childbirth.

Finally, the fifth theme considered the limited awareness and uptake of PMHS among the Pakistani community. Participants revealed that prior to accessing the service, they were unaware of its existence and that this lack of knowledge extended to their social circles. This raises questions about the dissemination of information regarding PMHS within the Pakistani community. It also highlights the importance of targeted outreach initiatives, to improve the utilisation of and awareness of PMHS for British Pakistani women.

Participants also spoke about the difficulties they experienced in accessing support from the PMHS. A study by Kapadia (2017) highlighted a broader pattern of access barriers, as it found that British Pakistani women were less likely to access mental health services. Thus, indicating significant disparities in the provision of mental health care services at large among this demographic. Therefore, it appears crucial that targeted interventions and culturally sensitive approaches are employed by PMHS, to address the disparities and to ensure equitable access to perinatal mental health support for British Pakistani women.

Clinical implications

A number of recommendations for clinical practice emerged from the findings that may significantly impact patient care, as well as healthcare policies and guidelines. Firstly, to address the lack of personal agency experienced by British Pakistani women with PND, PMHS may consider implementing a range of interventions designed to empower these women in their help-seeking journey. These interventions may include, fostering supportive environments that validate their experiences, encouraging self-advocacy through peer support networks and creating opportunities for these women to actively participate in their care plans.

Additionally, services may consider adopting a co-production model through which British Pakistani women are actively involved in the design and delivery of mental health interventions. This model would ensure that services are tailored to their cultural needs and preferences, improving both engagement and efficacy. By involving British Pakistani women in co-designing interventions, PMHS can create more culturally relevant and accessible support systems, addressing specific barriers such as stigma or the lack of understanding of PND within the Pakistani community. Co-production may also enhance trust and promote a more inclusive and supportive environment for those women seeking help.

Secondly, participants emphasised the absence of emotional support from their families, stemming from a lack of acknowledgement and recognition of PND. Given the significant extent of familial involvement during the postnatal period, it appears crucial for Pakistani families to receive psychoeducation regarding PND. This psychoeducation could take various forms to effectively address and mitigate the barriers identified. For instance, educational workshops or seminars could be organised within communities and primary healthcare settings, tailored to the cultural and linguistic needs of Pakistani families. These sessions would aim to enhance understanding of PND by explaining its symptoms, causes, and the impact it can have on both the individual and the family unit. By demystifying PND and normalising the experience, these educational efforts can help to reduce societal stigma and promote a more supportive environment.

Furthermore, culturally adapted informational materials, such as brochures, videos, and online resources, may be developed in multiple languages. The purpose of these resources would be to provide clear and accessible information on recognising the signs of PND, the importance of seeking help, and how family members can offer effective support. Greater emphasis may be placed on practical strategies for family members to assist their loved ones, such as active listening, providing emotional support and encouraging engagement with mental health services.

Finally, participants highlighted a disconnect between the availability of specialist PMHS for women and the awareness of these resources amongst their “social circles", including other British Pakistani women. This discrepancy may indicate a gap in the visibility and accessibility of PMHS within the British Pakistani community. This gap illustrates the importance of PMHS collaborating with community leaders and organisations accessed by British Pakistani women, to disseminate information about available resources and destigmatise help-seeking for PND. Moreover, there is a critical need to train healthcare staff within PMHS, to better understand and address the unique cultural and social aspects impacting British Pakistani women’s experience with PND.

Strengths and limitations

There are various strengths and limitations to consider within the present study. In relation to strengths, the use of IPA methodology facilitated the representation of British Pakistani women's perspectives and allowed for them to narrate their experiences using their own words. Additionally, the semi-structured interview allowed for flexibility within the interview by enabling participants to elaborate on any topic and so the researcher was able to prioritise the participant's perspective (Alamri, 2019). Furthermore, there is limited research regarding the lived experiences of PND among South Asian women from distinct communities. This study contributes to the literature as the first study to explore British Pakistani women's experiences of PND and help-seeking from PMHS. However, it is important to acknowledge that IPA is not without its limitations. One limitation is that due to its subjective nature, the interpretation of the data relied heavily on the researcher's perspective which in itself may have introduced biases into the findings, although consideration was given to addressing this within the study. In addition, it is worth noting that all participants were receiving help from the PMHS at the time of the interviews. Therefore, the findings may not be generalisable to British Pakistani women who lacked access to support from PMHS.

Further research

This study explored the experiences of British Pakistani women who were service users at PMHS. Given the stigmatisation of PND and PMHS highlighted within the present study, it is crucial that further research includes British Pakistani women from non-NHS organisations such as community hubs. This may be instrumental in capturing the experiences of a 'hidden population' of women who may not have been reached by PMHS or may not have chosen to engage in with professional services. Such research may also shed light on community-based support networks and may inform the integration of formal and informal organisations, to better meet the needs of British Pakistani women with PND. Furthermore, despite concentrated efforts to ensure that participants constituted a homogenous sample, most of the participants were at different stages of their help-seeking journey. Therefore, there may be nuanced differences in their experiences of help-seeking that were not identified within the present study. Future research may seek to explore British Pakistani women's experiences of accessing support from PMHS much earlier in the process, as it may provide valuable insight into the factors influencing the timeliness of help-seeking.

References

Almond, P. (2009). Postnatal depression: a global public health perspective. Perspectives in Public Health, 129(5), 221-227.

Chaudhry, N., Husain, N., Tomenson, B., & Creed, F. (2012). A prospective study of social difficulties, acculturation and persistent depression in Pakistani women living in the UK. *Psychological Medicine, 42*(6), 1217-1226.

Chaudhry, T., & Chen, S. H. (2019). Mental illness stigmas in South Asian Americans: A cross-cultural investigation. *Asian American Journal of Psychology*, *10*(2), 154.

Conneely, M., Packer, K.C., Bicknell, S., Janković, J., Sihre, H.K., McCabe, R., Copello, A., Bains, K., Priebe, S., Spruce, A. and Jovanović, N., (2023). Exploring Black and South Asian women's experiences of help-seeking and engagement in perinatal mental health services in the UK. *Frontiers in Psychiatry*, *14*, p.1119998.

Fisher, J. R. W., Cabral de Mello, M., Izutsu, T., & Tran, T. (2011). The Ha Noi expert statement: recognition of maternal mental health in resource-constrained settings is essential for achieving the Millennium Development Goals. International Journal of Mental Health Systems, 5(2).

Husain, N., Cruickshank, K., Husain, M., Khan, S., Tomenson, B., & Rahman, A. (2012). Social stress and depression during pregnancy and in the postnatal period in British Pakistani mothers: A cohort study. *Journal Of Affective Disorders,* 140(3), 268-276.

Insan, N., Weke, A., Rankin, J., & Forrest, S. (2022). Perceptions and attitudes around perinatal mental health in Bangladesh, India and Pakistan: a systematic review of qualitative data. *BMC Pregnancy and Childbirth*, *22*(1), 293.

Kapadia, D., Brooks, H. L., Nazroo, J., & Tranmer, M. (2017). Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research. *Health & social care in the community*, *25*(4), 1304-1317.

Lamba, R. (2015). *A Qualitative Study Exploring Migrant Pakistani-Muslim Women's Lived Experiences and Understanding of Postnatal Depression* (Doctoral dissertation, University of East London).

LeMasters, K., Andrabi, N., Zalla, L., Hagaman, A., Chung, E. O., Gallis, J. A., Turner, E.L., Bhalotra, S., Sikander, S., & Maselko, J. (2020). Maternal depression in rural Pakistan: the protective associations with cultural postpartum practices. *BMC public health*, *20*, 1-12.

Lee, Y. L., Tien, Y., Bai, Y. S., Lin, C. K., Yin, C. S., Chung, C. H., ... & Wu, G. J. (2022). Association of postpartum depression with maternal suicide: a nationwide population-based study. *International journal of environmental research and public health, 19*(9), 5118.

McCauley, M., Avais, A. R., Agrawal, R., Saleem, S., Zafar, S., & van Den Broek, N. (2020). 'Good health means being mentally, socially, emotionally and physically fit': women's understanding of health and ill health during and after pregnancy in India and Pakistan: a qualitative study. *BMJ open, 10*(1), e028760.

Murray, L., Halligan, S., & Cooper, P. (2018). Postnatal depression and young children's development. *Handbook of infant mental health, 4*, 172-186.

Mughal, S., Azhar, Y., Siddiqui, W., & May, K. (2022). Postpartum depression (nursing). In *StatPearls [Internet]*. StatPearls Publishing.

Olson, D. H. (2000). Circumplex model of marital and family systems. *Journal of family therapy*, *22*(2), 144-167.

Prajapati, R., & Liebling, H. (2021). Accessing mental health services: a systematic review and meta-ethnography of the experiences of South Asian Service users in the UK. *Journal of Racial and Ethnic Health Disparities*, 1-22

Ramadas, S., & Kumar, R. (2016). Postnatal depression: a narrative review. *International Journal of Culture and Mental Health, 9*(2), 97–107.

RCPSYCH (2018) Postnatal depression. UK: Royal College of Psychiatrists. Retrieved 26 April 2024 from https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-natal-depression.

Sakina, R., Khan, S. E., & Chaudhry, A. G. (2022). Stigma of postpartum depression: The role of lady health workers in health care—A qualitative study. *Health Care for Women International*, *43*(9), 1095-1104.

Shafiq, S. (2020). Perceptions of Pakistani community towards their mental health problems: a systematic review. *Global Psychiatry, 3*(1), 28-50.

Shakeel, N., Sletner, L., Falk, R. S., Slinning, K., Martinsen, E. W., Jenum, A. K., & Eberhard-Gran, M. (2018). Prevalence of postpartum depressive symptoms in a multiethnic population and the role of ethnicity and integration. *Journal of affective disorders*, *241*, 49–58. https://doi.org/10.1016/j.jad.2018.07.056

Sihre, H. K. (2021). *Lived experiences of South Asian women with severe postnatal psychiatric illnesses and experiences of perinatal mental health services* (Doctoral dissertation, University of Birmingham).

Smith, J. A., Flowers, P., & Larkin, M. (2021). *Interpretative Phenomenological Analysis: Theory, Method and Research*. (Second ed.). SAGE Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. (First ed.). SAGE Publications.

Stone, M., & Kokanovic, R. (2016). "Halfway towards recovery": Rehabilitating the relational self in narratives of postnatal depression. *Social Science & Medicine*, *163*, 98-106.

Varma, D. S., Kukreti, P., & Chandra, P. S. (2022). Social and cultural factors in perinatal mental health. *Oxford Textbook of Social Psychiatry*, 433.

Vik, K., & Hafting, M. (2012). “Smile through it!” keeping up the facade while suffering from postnatal depressive symptoms and feelings of loss: Findings of a qualitative study. *Psychology*, *3*(09), 810.

Wang, Z., Liu, J., Shuai, H., Cai, Z., Fu, X., Liu, Y., Xiao, X., Zhang, W., Krabbendam, E., Liu, S., Liu, Z., Li, Z., & Yang, B. X. (2021). Mapping global prevalence of depression among postpartum women. *Translational psychiatry*, *11*(1), 543.

World Health Organisation Mental Health and Substance Use. (2020). Retrieved from https://www.who.int/mental_health/prevention/suicide/lit_review_postpartum_depression.pdf

Section 3: Press release for the Meta-Ethnography

Breaking Taboos: Understanding South Asian Women's Perinatal Mental Health

In recent years, a growing body of literature has shed light on the mental health challenges experienced by South Asian women within the perinatal period. Research has identified several factors contributing to these challenges including cultural stigma, social isolation, South Asian cultural norms and expectations, language barriers and a lack of knowledge and awareness of Perinatal Mental Health (PMH) issues and Perinatal Mental Health Services (PMHS).

A recent meta-ethnographic study conducted at the University of Birmingham, synthesised findings from seven qualitative studies, exploring South Asian women's experiences of Perinatal Mental Illness and help-seeking in the UK. The review found that South Asian women juggled caregiving responsibilities for their baby and extended family, while also managing household chores and neglecting their own mental health in the process. There was also a strong emphasis placed on prioritising the wellbeing of others over themselves which reflected South Asian cultural norms rooted in collectivism. These inherited norms underscore the multifaceted roles expected of South Asian mothers.

Another key finding was centred around the lack of understanding and support from family members which further exacerbated their distress and led to them feeling isolated and losing their self-confidence. However, husbands from professional backgrounds demonstrated greater support and awareness. Therefore, illustrating the potential for positive familial dynamics for South Asian women navigating perinatal mental health difficulties.

More importantly, the review highlighted several barriers faced by South Asian women when accessing support from PMHS. These barriers included social stigma, fear of services, lack of awareness of PMH and PMHS, lack of timeliness in care and cultural biases within PMHS. On the other hand, the study also found that culturally inclusive and sensitive care can positively impact South Asian women’s willingness to seek help and their overall experience with PMHS.

Furthermore, South Asian women primarily expressed their distress through physical symptoms, with some women relying on terminology from their cultural backgrounds. However, many women acknowledged that their “head” or “mind” was the source of their issues. Thus, showing recognition of PMH issues in line with Western explanations of mental health conditions.

Sabrina, Trainee Clinical Psychologist said: “This review supports the urgent need for tailored interventions for South Asian women experiencing challenges with their mental health in the perinatal period. It is clear that cultural norms as well as family dynamics, play a significant role in shaping the experiences and help-seeking behaviours of South Asian women. As healthcare professionals, we must prioritise culturally sensitive approaches and involve family members in the care process, to effectively meet the mental healthcare needs of South Asian mothers in the perinatal period. By fostering understanding within the cultural context, we can enhance our support for these women in accessing and engaging in perinatal mental health services. Thereby, ultimately improving their wellbeing and that of their families”.

Further research is needed to delve into the distinct linguistic and cultural nuances surrounding South Asian women’s experiences of PMH. Additionally, it is important that newer research is able to identify effective strategies for South Asian women to overcome barriers when accessing PMHS. Moreover, interventions should be developed in collaboration with South Asian communities, to maximise their impact and effectiveness.

-END-

Section 4: Press release for the Empirical Research Paper

"I was just the incubator"- a candid look at British Pakistani women's journey with Postnatal Depression

In recent years, Postnatal Depression (PND) has gathered significant attention as a global epidemic. A ground-breaking study at the University of Birmingham delved into the lives of seven British Pakistani women and their ongoing journey with PND and with seeking support from Perinatal Mental Health Services (PMHS). Through in-depth interviews, these women shared their profound struggles with PND and the challenges they faced in accessing adequate support.

One of the key revelations from the study was the profound loss of identity attributed to PND. Participants grieved for their sense of self, as they grappled with the impact of PND on their lives. Furthermore, struggles with self-worth and loss of interest in activities they once enjoyed, were also common experiences amongst the women.

The study also discovered the nuanced nature of familial support experienced by British Pakistani women with PND. Whilst some participants highlighted the invaluable support they received from their families and friends; others expressed frustration at being overshadowed in their maternal role. The sense of disempowerment led to difficulties in bonding with their babies, as well as contributing to an exacerbation of their PND.

Furthermore, participants spoke about the cultural expectation of presenting a positive image of themselves and the negative consequences of being perceived as mentally unwell, within the Pakistani community. This fear of judgement and ostracisation led women to conceal their struggles with PND which further perpetuated a cycle of silence and social isolation.

More interestingly, participants expressed a sense of astonishment and bewilderment at the lack of awareness of PMHS amongst British Pakistani women. Thus, raising questions about the dissemination of information regarding PMHS within the British Pakistani community. Additionally, the study uncovered challenges in accessing timely and responsive care from PMHS. Participants from the study spoke of issues such as the limited availability of psychological therapies, communication breakdowns and lengthy waiting lists which all illustrated systemic barriers of accessing support.

Despite the obstacles, participants stressed the importance of creating safe and culturally inclusive spaces for British Pakistani women, to enable them to seek solace in their shared experiences. There were suggestions for informal gatherings such as “coffee mornings” which underpins a deep rooted desire for the presence of a supportive environment for British Pakistani women with PND, to connect and find comfort within their cultural identities.

Lead author Sabrina, explained:

> “The findings from our study shed light on the complex intersection of familial dynamics, cultural expectations and the personal challenges experienced by British Pakistani women with Postnatal Depression. It highlights the critical need for culturally sensitive perinatal mental health services, to address the unique challenges faced by this demographic. By providing safe and inclusive spaces, we can work towards breaking down the barriers surrounding postnatal depression within the Pakistani community and ensure that all women receive the support they need in this vulnerable time”.

Further research is needed to examine the effectiveness of culturally tailored interventions, in meeting the specific needs of British Pakistani women with PND. In addition to this, research should explore the role of healthcare providers and community leaders, in promoting the awareness of PMHS and in destigmatising PND within the British Pakistani community.

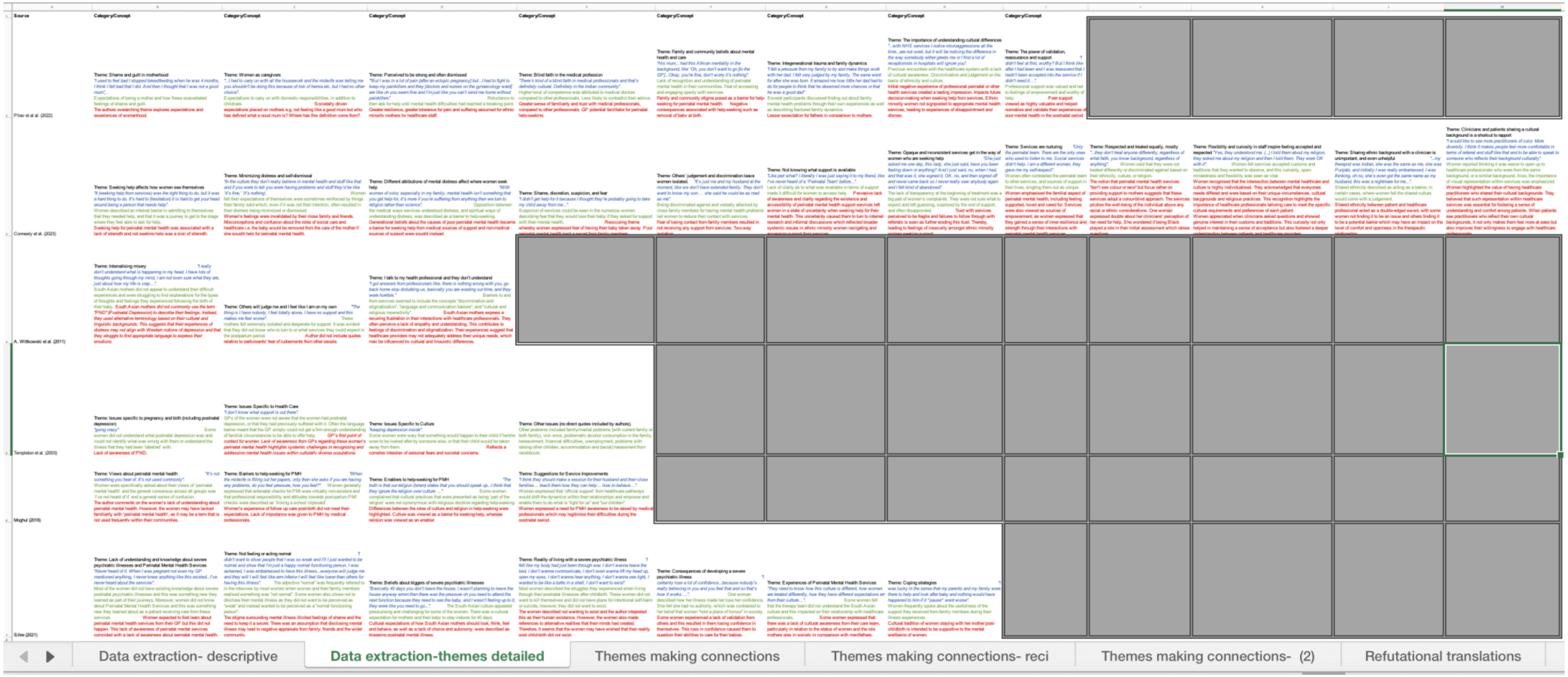
-END-

B: Appendices

Appendix A: Critical Appraisal Skills Programme (CASP) for qualitative research

	Questions	**Yes**	**No**	**Can’t tell**
Section A: Are the results of the study valid?	1. Was there a clear statement of the aims of the research?			
	2. Is a qualitative methodology appropriate?			
	3. Was the research design appropriate to address the aims of the research?			
	4. Was the recruitment strategy appropriate to the aims of the research?			
	5. Was the data collected in a way that addressed the research issue?			
	6. Has the relationship between the researcher and participants been adequately considered”?			
Section B: What are the results?	7. Have ethical issues been taken into consideration?			
	8. Was the data analysis sufficiently rigorous?			
	9. Is there a clear statement of findings?			
Section C: Will the results help locally?	10. How valuable is the research?			

Appendix B: Stage 3 of meta-ethnography, reading the studies (Noblit & Hare, 1988)

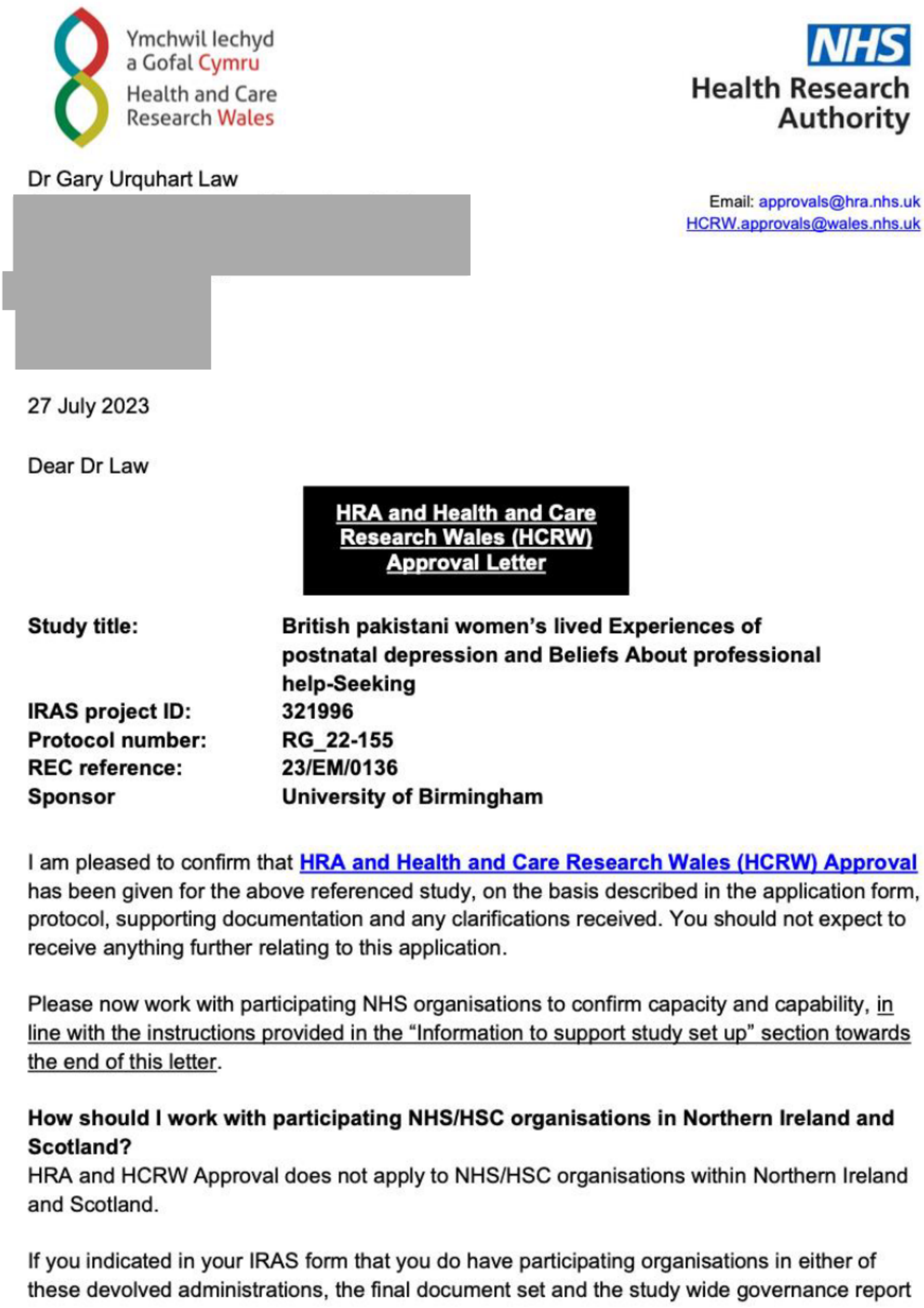


Appendix C: Stage 4 of meta-ethnography, determining how the studies are related (Noblit & Hare, 1988)

Appendix D: Stages 5 and 6 of meta-ethnography, translating the studies into another and synthesising translations (Noblit & Hare, 1988)

A	B	C	D	E	F	G	H	I	J
				Barriers to help seeking					
	Cultural expectations of motherhood	Familal invalidation	ltural preferences for help-seeki	Fear of negative evaluation	Fear of services	Lack of awareness of PMH and PMHS	Lack of transparency and timeliness in care	Cultural competence, sensitivity and bias in PMHS	Realities of living with PMH
Pilav et al al. (2022)	"I used to feel bad I stopped breastfeeding when he was 4 months, I think I felt bad that I did. And then I thought that I was not a good mum", "...I had to carry on with all the housework and the midwife was telling me you shouldn't be doing this because of risk of hernia etc. but I had no other choice". "I felt a pressure from my family to try	"His mum... had this African mentality in the background, like 'Oh, you don't want to go [to the GP]...Okay, you're fine, don't worry it's nothing".	"There's kind of a blind faith in medical professionals and that's definitely cultural. Definitely in the Indian community" . "I think earlier on I was expecting more [the doctor] to make contact with me. I was expecting a psychiatrist talking to me at the beginning, but it			"Doctors [General Practitioners] are very reluctant I found, when you're pregnant. The doctor I saw initially referred me to [a mental health charity], you have to self-refer which doing yourself is not easy. Then you wait for a call, then an interview, it's all difficult to do when you're in a bad place" (Pilav et al., 2022).	The doctor I saw ini- tially referred me to [a mental health charity], you have to self-refer which doing yourself is not easy. Then you wait for a call, then an interview, it's all difficult to do when you're in a bad place."	"...with NHS services I notice microaggressions all the time...are not overt, but it will be noticing the difference in the way somebody either greets me or I find a lot of receptionists in hospitals will ignore you".	
Conneely et al. (2023)		"In the culture they don't really believe in mental health and stuff like that and if you were to	"With women of color, especially in my family, mental health isn't something that you	"It (seeking help from services) was the right thing to do, but it was a hard thing to do. It's hard to (hesitation) it is hard to get your head	"I didn't get help for it because I thought they're probably going to take my child away	"Like peri what? I literally I was just saying it to my friend, like I've never heard of a 'Perinatal Team' before...".	"She just asked me one day, this lady, she just said, have you been feeling down or anything? And I just said, no, when I had, and that was it, she signed it, OK, no, and	"Well, it (culture) wasn't asked about and there were certain things where I said, no, I'm just not going to mention it because I know what they're going to say like co-sleeping and they kept on saying don't co sleep, don't	
Templeton et al. (2003)	"They [my children] are mine...I should look after them" (Templeton et al., 2003).				"keeping depression inside".	"going crazy" "I don't know what support is out there".			"It kills me, I can't move, I feel like screaming [physical pain]".
A. Wittkowski et al. (2011)		"I got answers from professionals like, there is nothing wrong with you, go back home stop disturbing us,	"I do know that there are others in our culture that have to keep what they really think and feel to themselves just to keep other					"I got answers from professionals like, there is nothing wrong with you, go back home stop disturbing us, basically you are wasting our time, and they were horrible. It was a Doctor that said that to me, my husband was sat	I feel totally alone, I have no support and this makes me feel worse". "I really don't understand what is
Hanley (2007)	"When I was pregnant, my mother would not allow me to wear bright clothes or fitting clothes. I could not wear my hair down. I always had to have it tied up".		"I couldn't sleep and worried about everything. The doctor said I was suffering from 'postnatal depression' and gave me some Valium to take. My						
Moghul (2018)	"She has to look after 3 brothers in law and do all the housework all day as well as looking after the Auntie's popping in".	the midwife is filling out her papers, only then she asks if you are having any problems, do you feel pressure, how you		"... people are going to think less of me". "Mental health is often seen as a sign of some kind of shame, weakness; you don't want to be diagnosed with mental health".	"Women might feel that their baby is going to be taken away... So are they going to tell anyone?".	t's not something you hear of. It's not used commonly".	.. the first that I was asked about my depression, was that 6 week check, not at the hospital, none of the health workers asked me if I was okay, just the doctors asked me very quickly ; 'Are you okay, you're not suffering from depression ?'		
Sihre (2021)	"They need to know how this culture is different, how women are treated differently, how they have different expectations err from their culture…".	"I certainly lose a lot of confidence...because nobody's really believing in you and you feel that and so that's how it works….".		"I didn't want to show people that I was so weak and I'll I just wanted to be normal and show that I'm just a happy normal functioning person. I was ashamed, I was		"Never heard of it. When I was pregnant not even my GP mentioned anything, I never knew anything like this existed...I've never heard about the services".	.	"They need to know the culture, they need to study...because there are things in this culture which are very very unique, the South Asian culture...Secondly, they need to know the language as well...And they need to be more polite to the South Asians" (Sihre, 2021).	"I was lucky in the sense that my parents and my family were there to help and look after baby and nothing would have happened to him if it "pause" went worse".

Appendix E: Letter of HRA approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Gary Urquhart Law
[redacted]

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

27 July 2023

Dear Dr Law

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

Study title:	**British pakistani women's lived Experiences of postnatal depression and Beliefs About professional help-Seeking**
IRAS project ID:	**321996**
Protocol number:	**RG_22-155**
REC reference:	**23/EM/0136**
Sponsor	**University of Birmingham**

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is [redacted] Please quote this on all correspondence.

Yours sincerely,

[redacted]

Helen Poole
Approvals Specialist
Email:approvals@hra.nhs.uk

Copy to: *Dr Birgit Whitman*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Research poster]	V1.0	10 February 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Certificate]		28 April 2023
GP/consultant information sheets or letters [GP notification letter]	V1.0	12 January 2023
Interview schedules or topic guides for participants [Interview topic guide]	V1.0	14 April 2023
IRAS Application Form [IRAS_Form_23052023]		23 May 2023
Letter from sponsor [Sponsorship letter]		28 April 2023
Organisation Information Document [Organisation Information Document]	V1.0	12 May 2023
Other [Response to validation queries]		26 May 2023
Other [REC responses letter]	N/A	17 July 2023
Other [Sponsor Employers Liability Cover]		01 August 2022
Other [Sponsor Clinical Trials Cover]		01 August 2022
Other [Sponsor Clinical Trials Cover with MP extension]		01 August 2022
Other [Chief Investigator GCP Certificate]		24 January 2023
Other [Researcher GCP Certificate]		
Participant consent form [Consent form]	V2.0	17 July 2023
Participant information sheet (PIS) [Participant Information Sheet]	V2.0	17 July 2023
Research protocol or project proposal [Research Protocol]	V1.0	20 April 2023
Schedule of Events or SoECAT [Schedule of Events]	V1.0	20 April 2023
Summary CV for Chief Investigator (CI) [CI CV]	V1.0	20 January 2023
Summary CV for student [Researcher CV]	V1.0	12 January 2023
Summary CV for supervisor (student research) [Academic supervisor]	V1.0	20 January 2023

Appendix F: Email confirmation of R&D approval from participating site

Dear Sabrina

IRAS: 321996 – British Pakistani women's lived experiences of post-natal depression and professional help-seeking. Confirmation of Local Capacity and Capability at Birmingham and Solihull Mental Health NHS Foundation Trust

This email **confirms** that Birmingham and Solihull Mental Health NHS Foundation Trust **has** the capacity and capability to deliver the above referenced study.
Please find **attached** the agreed Organisation Information Document as confirmation.

Start and end dates:

We agree to start this study OR **with immediate effect**.

We understand that recruitment will end on **30/09/2024.** We are aware that at this point, archiving is the responsibility of researchgovernance@contacts.bham.ac.uk

Recruitment figures:

Please note that you will be contacted by the R&D department periodically to obtain your current recruitment figures.

The target date for first patient recruited is **27/10/2023** – 30 days post confirmation of local capacity and capability.

During your study:

During the study, researchers are required to fulfil the following duties:

- Inform R&D of any amendments to the study, both substantial or non-substantial
- Inform R&D when the study has completed at the Trust - Inform R&D of the total recruitment number at the Trust - Submit a final report to the R&D department.

* All of the above can be submitted to bsmhft.researchanddepartment@nhs.net

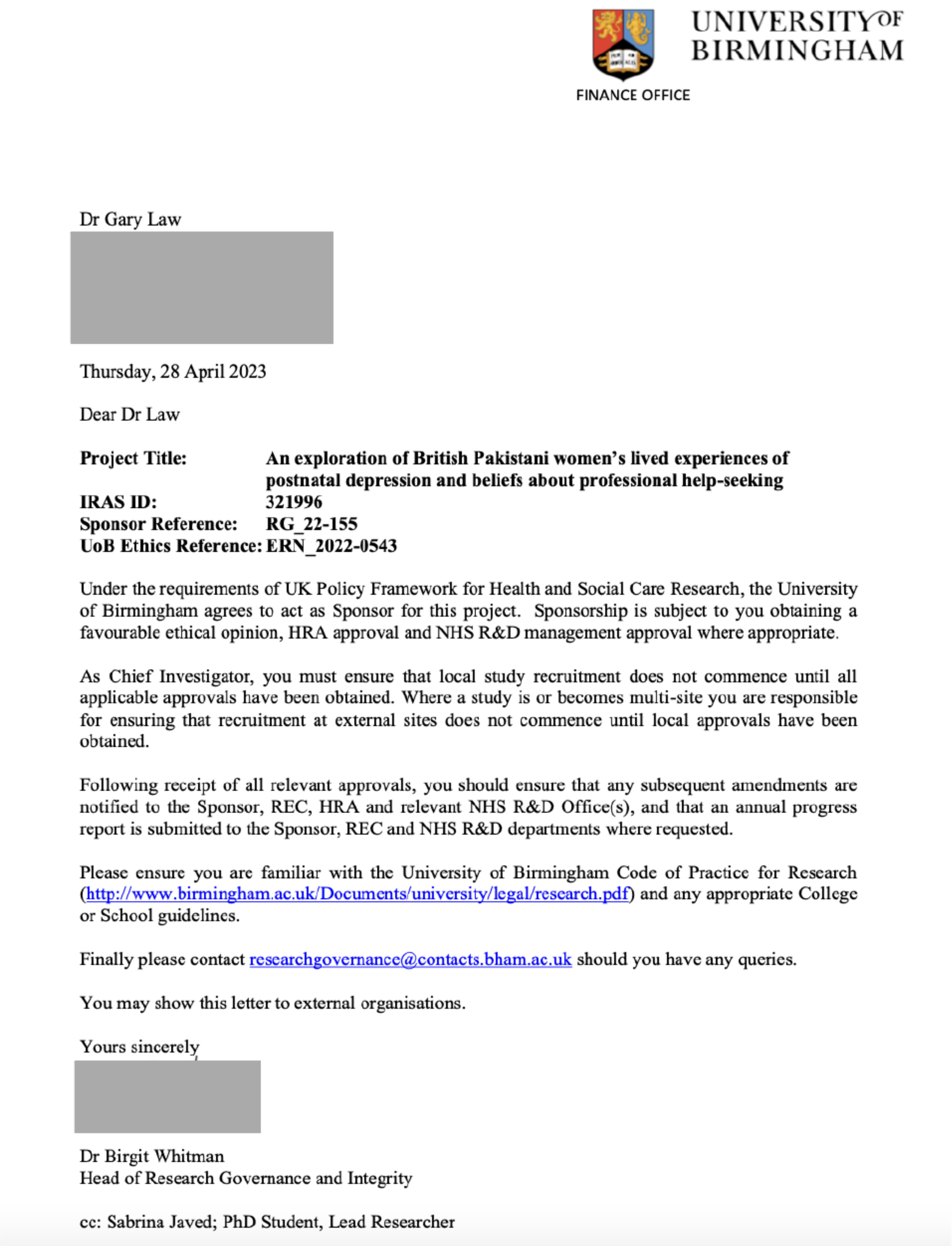
If you wish to discuss further, please do not hesitate to contact us.

Finally, we would like to wish you all the best with your research.

Kind regards
Research and Development

[redacted]

Appendix G: Sponsorship letter



UNIVERSITY OF
BIRMINGHAM
FINANCE OFFICE

Dr Gary Law
[redacted]

Thursday, 28 April 2023

Dear Dr Law

Project Title: **An exploration of British Pakistani women's lived experiences of postnatal depression and beliefs about professional help-seeking**
IRAS ID: **321996**
Sponsor Reference: **RG_22-155**
UoB Ethics Reference: **ERN_2022-0543**

Under the requirements of UK Policy Framework for Health and Social Care Research, the University of Birmingham agrees to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable ethical opinion, HRA approval and NHS R&D management approval where appropriate.

As Chief Investigator, you must ensure that local study recruitment does not commence until all applicable approvals have been obtained. Where a study is or becomes multi-site you are responsible for ensuring that recruitment at external sites does not commence until local approvals have been obtained.

Following receipt of all relevant approvals, you should ensure that any subsequent amendments are notified to the Sponsor, REC, HRA and relevant NHS R&D Office(s), and that an annual progress report is submitted to the Sponsor, REC and NHS R&D departments where requested.

Please ensure you are familiar with the University of Birmingham Code of Practice for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) and any appropriate College or School guidelines.

Finally please contact researchgovernance@contacts.bham.ac.uk should you have any queries.

You may show this letter to external organisations.

Yours sincerely

[redacted]

Dr Birgit Whitman
Head of Research Governance and Integrity

cc: Sabrina Javed; PhD Student, Lead Researcher

Appendix H: Interview schedule/Topic guide

British Pakistani women's lived experiences of postnatal depression and professional help-seeking

Interview schedule guide

The interviews with participants will follow a semi-structured format whereby, an interview schedule will be used but the order in which questions are asked and answered could vary according to the responses of the participant. The questions have undergone critical scrutiny by peer support workers at the perinatal mental health services, as part of the Birmingham and Solihull Mental Health NHS Foundation Trust. Follow-up questions will be asked and the clarification of points which may arise.

1) What was your experience of the postnatal period like?
   Prompts: How did you feel after giving birth?
   How did this compare to how you felt during your pregnancy?

2) What changes in yourself (if any) did you notice in relation to your mood?
   Prompts: When did things start to feel like they were not quite right?
   Did anyone else pick up on anything? Such as family members, or friends.

3) When did you (or family) first realise that you might have postnatal depression?
4) Prompts: What did you understand about postnatal depression?
   What signs or symptoms did you recognise first?
   What signs or symptoms did your family recognise first? (if applicable)

5) In what way did Pakistani cultural practices influence your understanding of postnatal depression?
   Prompts: Was there anything that was unhelpful? Was there anything that was helpful?

6) In what way did Pakistani cultural practices impact on your experience of postnatal depression?
   Prompts: Was there anything specific to Pakistani cultural practices that was helpful?
   Was there anything that was unhelpful?

7) How did the postnatal depression period affect the way you viewed yourself?
   Prompts: How did you view yourself before this period? How do you feel about yourself now?

8) Did you experience mental health difficulties prior to your experience of postnatal depression? If yes, please explain.

9) What impact did postnatal depression have on your relationships?
   Prompts: With your partner (if applicable)? With your immediate/extended family?
   With your newborn? With other children? (if any)

10) How did you learn about the perinatal mental health service?
Prompts: Was it suggested by a healthcare professional? Such as a health visitor, GP, OR midwife?
OR any community organisations?
OR was it a family member/friend?
Did you know of anyone who had used the service before?
Were you encouraged to seek help?

11) What was your experience of accessing support from the perinatal mental health service?
Prompts: What did you find helpful? What was unhelpful?

Participants will be thanked for taking part and will be further encouraged to discuss any issues that they feel is relevant to their subjective experience of postnatal depression.

Appendix I: Interview schedule/Topic guide as reviewed by Peer Support Workers

The interviews will follow a semi-structured format whereby an interview schedule will be used but the order in which questions are asked and answered could vary according to the responses of the participant. Follow-up questions will be asked and the clarification of points which may arise.

Interview schedule guide

1) How did you experience the postnatal period?
   Prompts: How did you feel during and after giving birth? What made you feel this way? How did this compare to how you were feeling during pregnancy?

2) What is your earliest memory of feeling depressed after giving birth?
   Prompts: How did you know you were feeling depressed? What thoughts did you have? What changes in yourself (if any) did you notice in relation to your mood? When things didn't feel right?

   Did family members pick up on anything?

   Earliest memory= difficult to pinpoint, consider rewording, difficult to recognise when the low mood

   Two different realities/narratives- one reality for the mother, and one for family/community

   Mother is "forgotten"

3) What was your understanding of postnatal depression prior to your personal experience?
   Prompts: What did you think when you first heard it? How does it make you feel now?

4) In what way did Pakistani cultural practices influence your understanding of postnatal depression?
   Prompts: Was there anything that was unhelpful? Was there anything that was helpful?

   Practices- definitive, not ambiguous
   e.g. archaic practice of laying new-born's head on a plate to shape head
   comparisons drawn in terms of breast milk, unsolicited advice
   Birth of child= birth of 'mother' role

5) In what way did Pakistani cultural practices impact on your experience of postnatal depression?
   Prompts: Was there anything specific to Pakistani cultural practices that was helpful? Was there anything that was unhelpful?

6) How did the postnatal depression period affect the way you viewed yourself? relationship with yourself?

   Prompts: What were you like before the postnatal depression? How do you feel about yourself now? E.g. self-esteem, confidence

7) Did you experience mental health difficulties prior to your experience of postnatal depression? If yes, please explain

8) How did postnatal depression affect your relationships?

   Prompts: With your partner/husband (if applicable)? With your extended family? With your newborn? With other children? (if any)

9) How did you find out about the perinatal mental health service?

   Prompts: Was it suggested by a healthcare professional? E.g. health visitor, GP, midwife (pathways),
   Community organisations
   Family member/friend- did you know of anyone who had used the service before?

10) What was your experience of (seeking help?) accessing support from the perinatal mental health service?

   Prompts: What did you find helpful? What was unhelpful?

11) What was your experience of the support you received from the perinatal mental health service?

   Prompts: What other support would you like to have received? How would this have helped you?

|Confidentiality will be maintained. To state this at the beginning of interview and should be reiterated at the end.

Participants will be further encouraged to discuss any issues that they feel is relevant to their experience of postnatal depression.

Key:

🟩 Peer support worker 1 comments

🟨 Peer support worker 2 comments

Appendix J: Advertisement of study

IRAS Project ID: 321996 **Version 1.0 Date: 10.02.2023**

UNIVERSITY OF BIRMINGHAM

NHS
Birmingham and Solihull
Mental Health NHS Foundation Trust

Would *you* like to participate in our study:

British Pakistani Women's Lived Experiences of Postnatal Depression and Help-Seeking

What is this study about?

This study aims to explore British Pakistani women's personal experiences of postnatal depression and seeking professional help from perinatal mental health services. We hope that by doing this research, we can support perinatal mental health services to better meet the needs of British Pakistani women.

What will happen?

- **You will be asked to take part in a one-to-one 60-75 min interview with the study researcher about your past experiences of postnatal depression and seeking professional help.**
- **Your participation is voluntary and you will be free to end your participation if desired.**
- **Your personal information will be kept confidential and in strict accordance with the Data Protection Act (2018) and General Data Protection Regulation (GDPR)**
- **You will be reimbursed a £20 voucher for your participation.**

Who are we looking for?

- **British Pakistani women over the age of 18 who have a lived experience of postnatal depression (two years post-birth).**
- **Have experience of giving birth to and keeping care of at least one child in the last 3 years.**

Chief Investigator: Dr Gary Law

Email: [redacted]

Address: University of Birmingham, School of Psychology, Edgbaston, Birmingham, B15 2TT

If you would like to know more, please contact:

Study Researcher: Sabrina Javed

Email: [redacted]

Appendix K: Participant Information Sheet

British Pakistani women’s lived experiences of postnatal depression and professional help-seeking

Participant Information Sheet

What is the purpose of this study?

The purpose of the study is to understand British Pakistani women’s personal experiences of postnatal depression and seeking help from perinatal mental health services.

Postnatal depression is a type of depression that affects a woman, weeks or months after giving birth. Some symptoms include low mood, irritability, fatigue, changes in sleep and appetite and feelings of anxiety and hopelessness. Postnatal depression is estimated to affect 13% of women around the world. However, previous research has shown higher rates of postnatal depression amongst women of Pakistani heritage.

Why have I been invited to participate?

We are asking you to take part because you are being seen by the perinatal mental health service and meet the following inclusion criteria:

- Aged 18 and over
- Female
- British Pakistani
- Fluent in English
- Able to provide informed consent
- Giving birth to and keeping care of at least one child in the last 3 years
- Personal experience of depression during the postnatal period (two years post-birth)

Do I have to take part?

Participation is completely voluntary. If you choose not to be involved, this will not impact your ability to access support or services. Once you have read this information sheet and you decide to participate in the study, you will be asked to sign a consent form. You will be given a copy of this to keep. Your General Practitioner’s (GP) details will be collected and they will be informed of your participation in the study.

What will happen if I choose to take part?

You will be asked to attend an interview with the study researcher which is expected to last approximately between 60 to 75 minutes. This will take place at either a local Children’s Centre, your GP surgery or at the University of Birmingham. The audio from the interview will be recorded using an encrypted Dictaphone, for the purpose of data collection. The audio recordings will be uploaded onto the University of Birmingham's secure Research Data Store, where it will remain for 10 years. This is in line with the University's Code of Practice for Research. The audio will be permanently deleted from the Dictaphone, once transcription is complete. The transcription process will involve converting the audio into written text. This will be the responsibility of the study researcher. Any identifiable information including your name or address, will be anonymised and kept confidential by the study researcher.

Are there any limits to confidentiality?

Yes. During the interview, if there is a concern raised that you are at risk of potential harm to yourself or others, then confidentiality will be breached to inform your healthcare team. Additionally, local safeguarding procedures will be followed. The study researcher will discuss this with you should such a situation arise. The study researcher will inform your psychologist, care coordinator and/or your GP could also be informed. This is important for your own personal safety and the safety of other people. The researcher is also a Trainee Clinical 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.

Once you have completed the interview, we will not contact you again, unless you have given indication that you would like to see the results of the research. You may choose to withdraw your data from the study, up until two weeks from participating in the interview. You can do this by informing the researcher of your decision.

Are there any risks to taking part?

We anticipate minimal risks for participating in this study. However, during the interview, you will be asked sensitive questions which you may find upsetting, difficult or may lead you to recall challenging moments in your life. If during the interview you do become distressed, the researcher will pause the interview and will only continue if you are happy to do so. You also have the right to stop the interview and withdraw your participation. The researcher will provide you with a list of organisations that you can contact for further support.

Are there any benefits to taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will contribute to the provision of improved perinatal mental health care for British Pakistani women experiencing postnatal depression.

What if there is a problem?

If you have any concerns about the study you can speak to a member of the research team in the first instance. If you remain unhappy with their response or wish to make a complaint then you can contact the Birmingham and Solihull Mental Health NHS Foundation Trust Patient Liaison Services (PALS), via their telephone number: 0800 953 0045. Alternatively, you can send them a text on 07985 883 509 or send them an email: bsmhft.customerrelations@nhs.net.

Will I receive any reimbursements for taking part in this study?

You will receive £20 as reimbursement for taking part in this study.

How will you use information about me?

This study will comply with the Data Protection Act (2018). We will need to use information from you for this research project. This information will include:

- Your name
- Initials
- Contact details such as email address

People will use this information to do the research or check your records to make sure the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. Contact details, i.e., email addresses only for those wishing to read a lay summary, will be deleted within three months of the study's completion or as soon as a lay summary can be sent. We will keep all information about you safe and secure.

The findings from this study will be used as part of a clinical psychology doctoral thesis project. The anonymised research data might also be used for additional or subsequent research. You may choose to receive a summary which will be emailed to you. We are also keen to publish our findings in scientific journals, but this may take up to three years from the end of the study. The people who will have access to this data are the study researcher and the supervisors of this study. We will write our reports in a way that no one can work out that you took part in the study.

What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can I find out more about how my information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by contacting the University of Birmingham's Data Protection Officer:
  Email: dataprotection@contacts.bham.ac.uk

Who is organising and funding the research?

This study is sponsored by the University of Birmingham and is being undertaken at the department of Psychology at the University of Birmingham. The research will contribute to the doctoral thesis of the study researcher at the University of Birmingham.

The University has in place Clinical Trials indemnity coverage for this study, which provides cover for harm which comes about through the University's, or its staff's, negligence in relation to the design or management of the study and may alternatively, and at the discretion of the University provide cover for non-negligent harm to participants.

The NHS Trust has a duty of care to its patients, in the event of clinical negligence being proven, compensation will be available via the NHS indemnity.

Has this research been approved?

All research which takes part in the NHS is looked at by an independent group of people who protect patient interests. This group is called a Research Ethics Committee (REC).

Who is conducting this research?

The research project is organised by Sabrina Javed of University of Birmingham, who is a Trainee Clinical Psychologist. The project is supervised by Dr Gary Law, Dr George Johnson and Dr Elizabeth Penny.

Who do I contact if I have a concern about the research or wish to complain?

If you have a concern about any aspect of this study, please contact Sabrina Javed, [redacted] and I will do my best to answer your query. I will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. You can also contact the main supervisor for this project, by emailing [redacted]

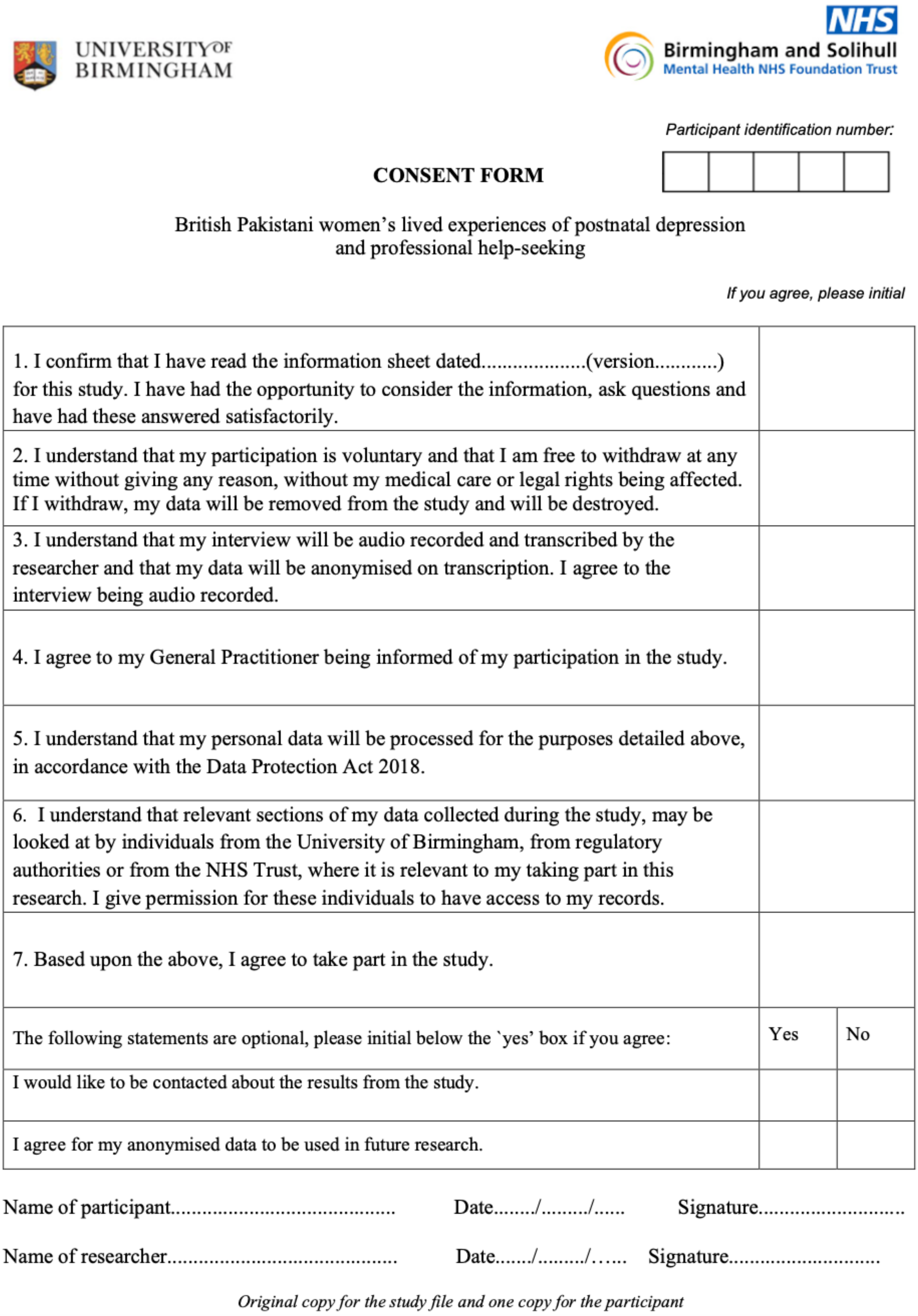
Data Protection

The University of Birmingham is the data controller with respect to your personal data and as such will determine how your personal data will be used in the research. The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest.

What should I do next?

If you would like to take part and are happy to have your contact details shared with the study researcher, please inform your care team. Upon receiving this information, you will have a minimum of 48 hours to make this decision.

Appendix L: Participant consent form



UNIVERSITY OF BIRMINGHAM

NHS
Birmingham and Solihull
Mental Health NHS Foundation Trust

Participant identification number:

CONSENT FORM

British Pakistani women's lived experiences of postnatal depression
and professional help-seeking

If you agree, please initial

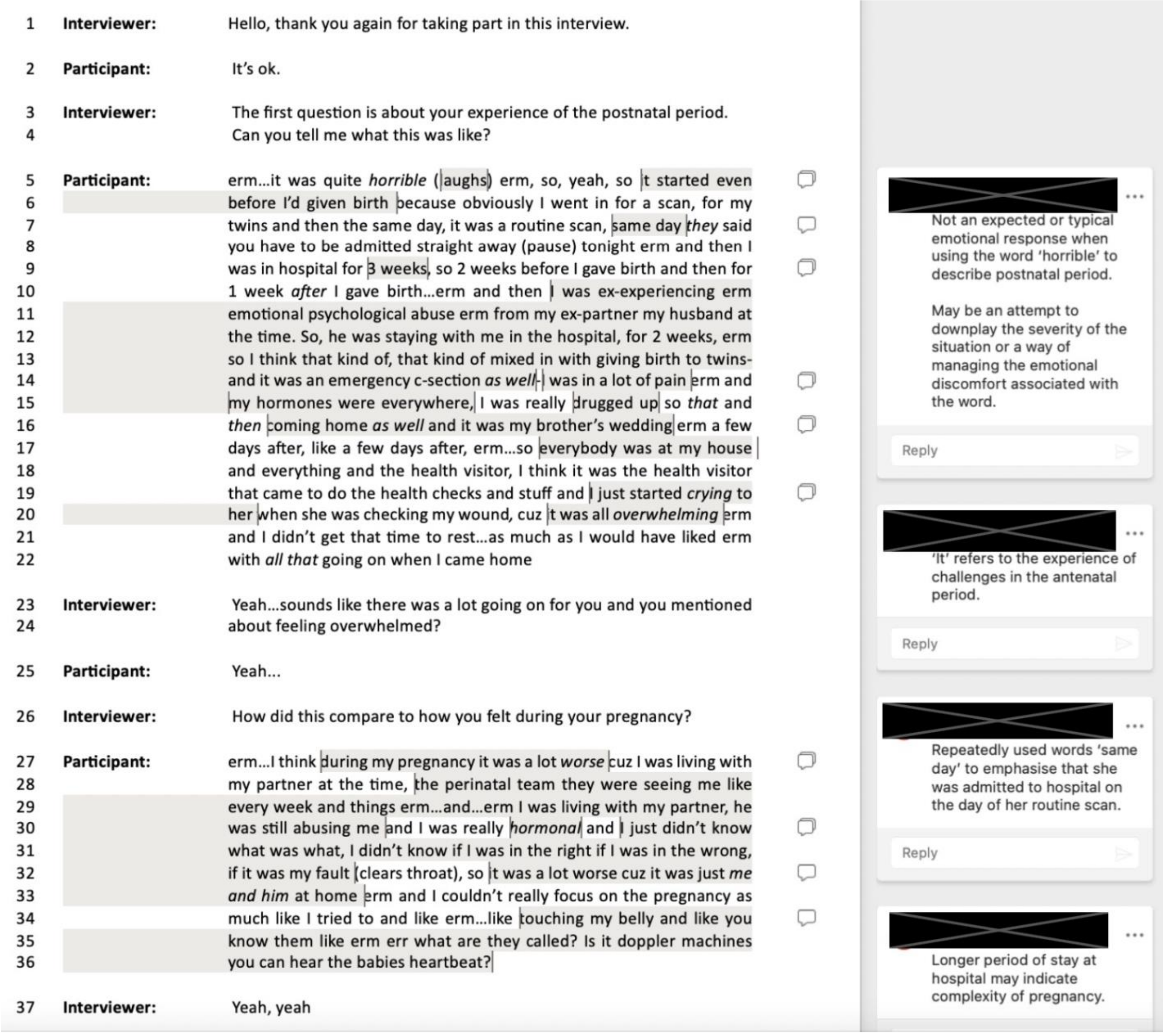
1. I confirm that I have read the information sheet dated...................(version...........) for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. If I withdraw, my data will be removed from the study and will be destroyed.		
3. I understand that my interview will be audio recorded and transcribed by the researcher and that my data will be anonymised on transcription. I agree to the interview being audio recorded.		
4. I agree to my General Practitioner being informed of my participation in the study.		
5. I understand that my personal data will be processed for the purposes detailed above, in accordance with the Data Protection Act 2018.		
6. I understand that relevant sections of my data collected during the study, may be looked at by individuals from the University of Birmingham, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.		
7. Based upon the above, I agree to take part in the study.		
The following statements are optional, please initial below the `yes' box if you agree:	Yes	No
I would like to be contacted about the results from the study.		
I agree for my anonymised data to be used in future research.		

Name of participant.. Date......./......../..... Signature...........................

Name of researcher... Date......./......../….. Signature............................

Original copy for the study file and one copy for the participant

Appendix M: Exploratory notes from an interview transcript



Interviewer: Hello, thank you again for taking part in this interview.

Participant: It's ok.

Interviewer: The first question is about your experience of the postnatal period. Can you tell me what this was like?

Participant: erm…it was quite *horrible* (laughs) erm, so, yeah, so it started even before I'd given birth because obviously I went in for a scan, for my twins and then the same day, it was a routine scan, same day *they* said you have to be admitted straight away (pause) tonight erm and then I was in hospital for 3 weeks, so 2 weeks before I gave birth and then for 1 week *after* I gave birth…erm and then I was ex-experiencing erm emotional psychological abuse erm from my ex-partner my husband at the time. So, he was staying with me in the hospital, for 2 weeks, erm so I think that kind of, that kind of mixed in with giving birth to twins- and it was an emergency c-section *as well*- I was in a lot of pain erm and my hormones were everywhere, I was really drugged up so *that* and *then* coming home *as well* and it was my brother's wedding erm a few days after, like a few days after, erm…so everybody was at my house and everything and the health visitor, I think it was the health visitor that came to do the health checks and stuff and I just started *crying* to her when she was checking my wound, cuz it was all *overwhelming* erm and I didn't get that time to rest…as much as I would have liked erm with *all that* going on when I came home

Interviewer: Yeah…sounds like there was a lot going on for you and you mentioned about feeling overwhelmed?

Participant: Yeah...

Interviewer: How did this compare to how you felt during your pregnancy?

Participant: erm…I think during my pregnancy it was a lot *worse* cuz I was living with my partner at the time, the perinatal team they were seeing me like every week and things erm…and…erm I was living with my partner, he was still abusing me and I was really *hormonal* and I just didn't know what was what, I didn't know if I was in the right if I was in the wrong, if it was my fault (clears throat), so it was a lot worse cuz it was just *me and him* at home erm and I couldn't really focus on the pregnancy as much like I tried to and like erm…like touching my belly and like you know them like erm err what are they called? Is it doppler machines you can hear the babies heartbeat?

Interviewer: Yeah, yeah

[redacted]

Not an expected or typical emotional response when using the word 'horrible' to describe postnatal period.

May be an attempt to downplay the severity of the situation or a way of managing the emotional discomfort associated with the word.

[redacted]

'It' refers to the experience of challenges in the antenatal period.

[redacted]

Repeatedly used words 'same day' to emphasise that she was admitted to hospital on the day of her routine scan.

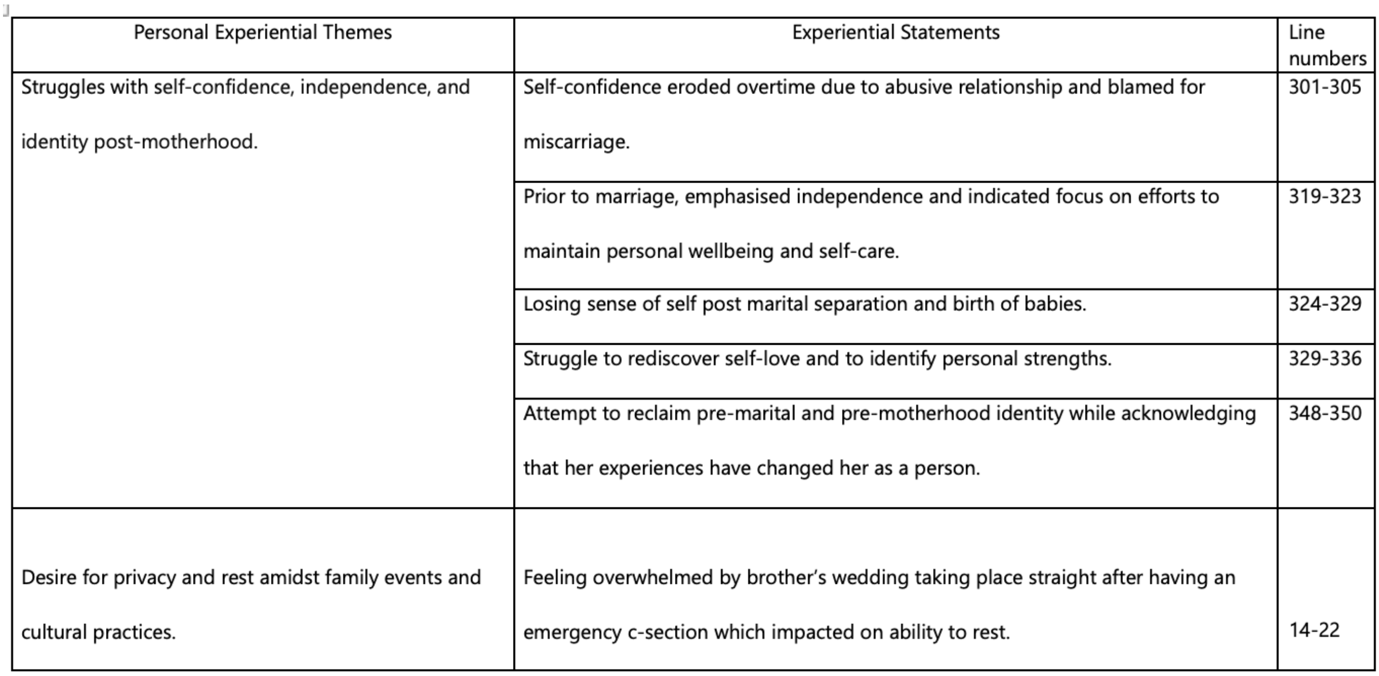
[redacted]

Longer period of stay at hospital may indicate complexity of pregnancy.

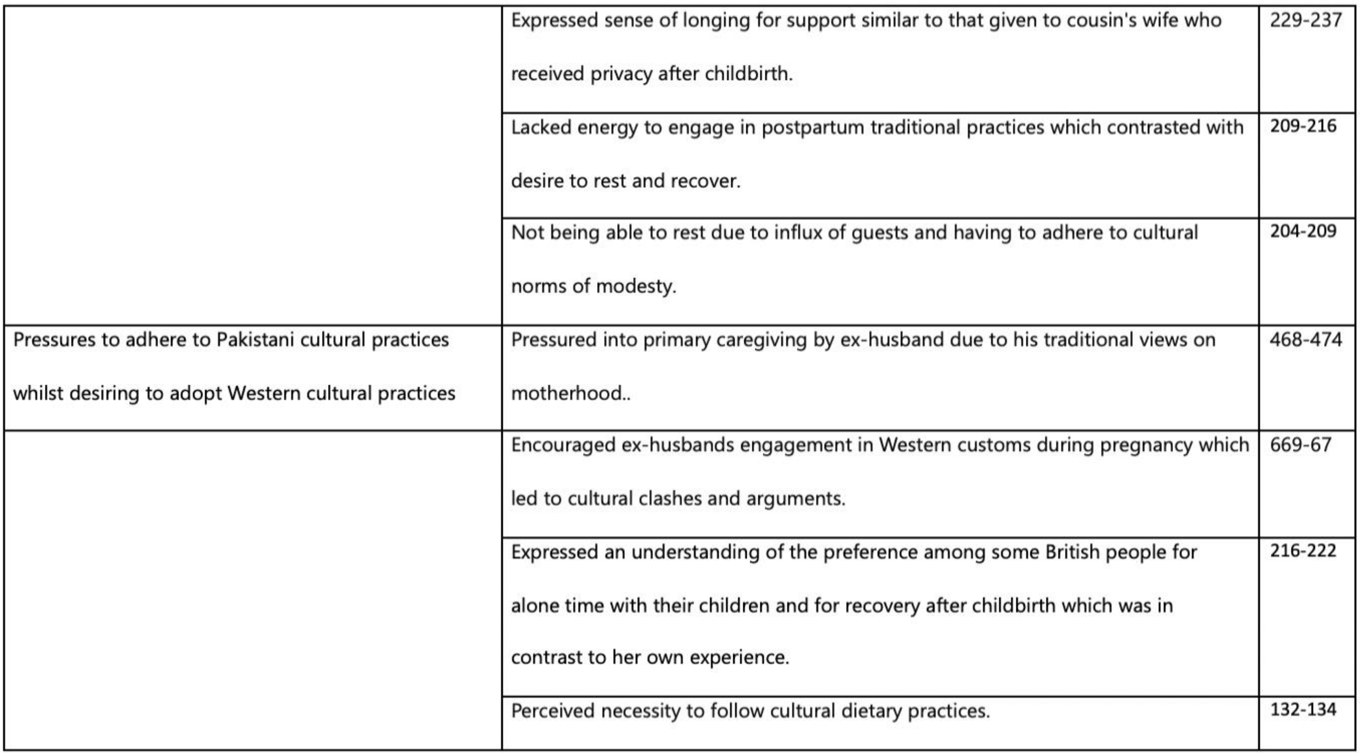
Appendix N: An example of experiential statements used to create Personal Experiential Themes

Experiential statement	Line numbers
Hospital stay coupled with ongoing abuse from husband created additional layers of challenges to an already challenging experience of birthing twins via a c-section.	10-15
Expressed emotional vulnerability to health visitor, in response to feeling overwhelmed by having to participate in brother's wedding immediately after giving birth.	15-20
The immediate return to a bustling household following brother's weddings impacted on ability to engage in meaningful bonding with babies.	20-22
Pregnancy exacerbated distress due to living with abusive partner.	27-28
Living with abusive partner during hormonal imbalance led to confusion and self-blame	29-32
Struggling to focus on pregnancy amid attempts to bond with the baby and instead feeling like pregnancy is similar to an illness.	33-40
Attempted to make the pregnancy more tangible using private scans.	40-42
Struggling to bond with new-borns amid feelings of detachment and external pressure to engage in bonding activities, leading to uncertainty and resistance.	45-53
Experiencing discouragement and pressure from hospital staff led to the decision to stop breastfeeding.	53-63
Perceived exclusion or marginalisation in her role as the mother.	65-68
Desire to present a positive image or meet perceived expectations of perinatal team.	74-78
Struggling with bonding and avoiding caretaking tasks due to emotional detachment and personal discomfort, despite external pressure from family to engage in caregiving activities.	82-88

Appendix O: An example of Personal Experiential Themes



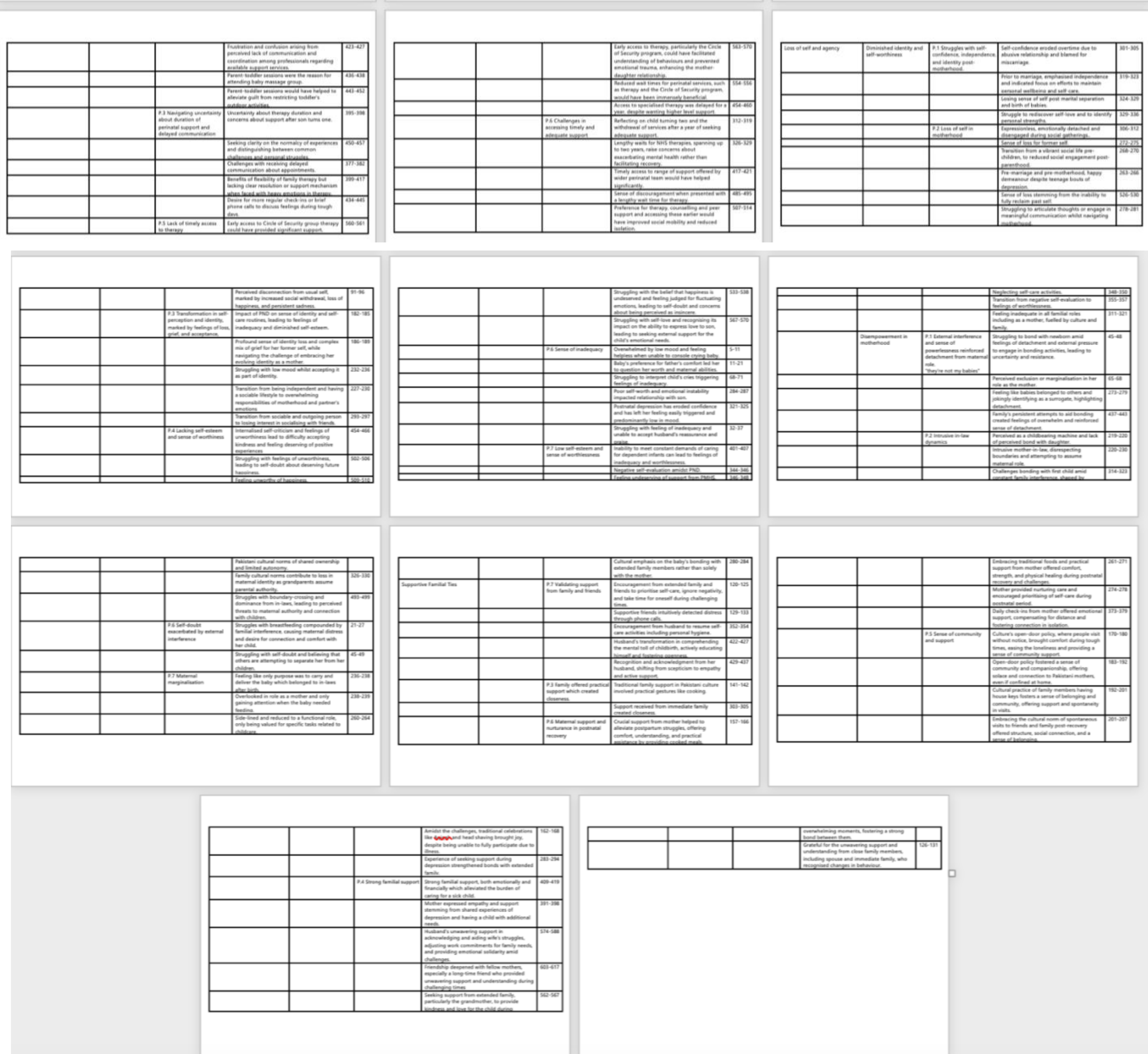
Personal Experiential Themes	Experiential Statements	Line numbers
Struggles with self-confidence, independence, and identity post-motherhood.	Self-confidence eroded overtime due to abusive relationship and blamed for miscarriage.	301-305
	Prior to marriage, emphasised independence and indicated focus on efforts to maintain personal wellbeing and self-care.	319-323
	Losing sense of self post marital separation and birth of babies.	324-329
	Struggle to rediscover self-love and to identify personal strengths.	329-336
	Attempt to reclaim pre-marital and pre-motherhood identity while acknowledging that her experiences have changed her as a person.	348-350
Desire for privacy and rest amidst family events and cultural practices.	Feeling overwhelmed by brother's wedding taking place straight after having an emergency c-section which impacted on ability to rest.	14-22



	Expressed sense of longing for support similar to that given to cousin's wife who received privacy after childbirth.	229-237
	Lacked energy to engage in postpartum traditional practices which contrasted with desire to rest and recover.	209-216
	Not being able to rest due to influx of guests and having to adhere to cultural norms of modesty.	204-209
Pressures to adhere to Pakistani cultural practices whilst desiring to adopt Western cultural practices	Pressured into primary caregiving by ex-husband due to his traditional views on motherhood..	468-474
	Encouraged ex-husbands engagement in Western customs during pregnancy which led to cultural clashes and arguments.	669-67
	Expressed an understanding of the preference among some British people for alone time with their children and for recovery after childbirth which was in contrast to her own experience.	216-222
	Perceived necessity to follow cultural dietary practices.	132-134

Appendix P: Group Experiential Themes

Group Experiential Themes (GETs)	Subthemes	Personal Experiential Themes (PETs)	Experiential Statements	Line numbers
Cultural hush	What will people say? "Log kiya kahenge?"	P.1 Cultural stigma enforce hiding mental health issues to safeguard family reputation.	Husband's concealment of postnatal depression from extended family, minimising and misrepresenting the severity of the situation.	118-120
			Cultural expectation to maintain positive image of the wife and uphold familial respect and honour.	123-128
			Pressured to not disclose mental health issues as this may result in a loss of respect.	192-196
			Recognised partner's attempts to avoid association with mental health stigma and safeguarding family's reputation in Pakistani community.	197-204
		P.2 Stigma and secrecy surrounding Postnatal Depression within family dynamics	Taboo around acknowledging or addressing mental health issues, particularly postnatal depression.	156-161
			Hesitant to disclose engagement with perinatal mental health services due to fear of misunderstanding and societal taboo, particularly within traditional family dynamics.	471-476
			In laws fear receiving negative judgement from wider family and community.	170-173
		P.3 Cultural stigma and scrutiny for seeking assistance with perinatal mental health concerns.	Highlighting stigma surrounding seeking perinatal mental health support, perpetuating feelings of inadequacy or self-doubt.	485-489
			Experienced negativity for seeking help in relation to perinatal mental health issues.	492-493
		P.5 Lack of discourse within community	Shame and fear of judgment surrounding attachment and depression.	628-633
			Lack of understanding surrounding PND results in uncertainty about triggers, treatment, and access to support services.	645-651
		P.6 Stigma and fear of negative evaluation	Despite experiencing postnatal depression, many women remain silent due to fear of negative judgment.	210-215
			Social stigma surrounding postnatal depression inhibits open discussion, leading to fear of judgment	531-534
		P.7 Stigma and misconceptions of PMHS	Discovered stigma and misconception surrounding perinatal services within the Pakistani community after seeking help.	140-151
			Advised to conceal suicidal thoughts out of fear of negative consequences, such as losing custody of the baby or being involuntarily hospitalised.	153-157
			Battling societal taboos and misconceptions and being labelled as "crazy" or dependent on drugs.	544-550
	Absence of dialogue and recognition of PND	P.2 Lack of acknowledgement for PND	Mother experienced PND without acknowledgement and therapy.	103-105
			Mother-in-law is traditional and is dismissive of postnatal depression.	135-137
			Reluctance to disclose mental health struggles due to perceived lack of understanding from traditional mother-in law.	138-141
			Generational lack of acknowledgement of postnatal depression.	150-153
			Lack of comprehension and acknowledgment from mother-in-law, regarding the depth and complexity of postnatal depression, attributing it instead to moodiness and anger.	476-482
		P.3 Lack of open dialogue about PND	Lack of education, understanding, and awareness within culture leads to silence surrounding postnatal depression, with little acknowledgment or support offered after childbirth.	113-117
			Lack of open dialogue about emotional struggles due to cultural norms and mother's upbringing.	133-136
			Absence of terminology and dialogue around postnatal depression.	142-145
			Absence of open dialogue and dismissing women's birthing experience.	155-160
		P.4 Absence of language for depression within Pakistani culture	Cultural attitudes towards mental health, exemplified by the absence of the word "depression" in the Pashto language.	356-358
			Absence of specific terms in language for depression suggests a cultural reluctance to acknowledge or discuss mental health issues.	771-775
			Finding comfort in individuals outside cultural community when discussing depression, due to shared experiences and a common language to articulate mental health struggles.	777-788
		P.5 Lack of awareness, acknowledgement and normalisation of PND.	Absence of language for mental health issues lead to denial or belief it affects only Western women.	65-67
			Lack of awareness and open discussion within cultural and familial context hindered recognition and management of post-natal depression.	75-80
			Lack of awareness and normalisation surrounding postnatal mental health issues within the culture, challenging the notion that it's merely physical trauma.	582-586
			Emphasising the existence of PND across generations and cultures, particularly amongst new British Pakistani mothers who lack adequate support.	586-590
			Cultural stigma and societal pressure suppressed open dialogue about postnatal depression, leaving her unable to discuss their struggles.	86-96
			Complexity surrounds mental health issues among Pakistani women, lacking attention and discourse in professional, religious, and community settings.	695-698
			Social alienation due to misunderstanding and stigma surrounding mental health in religious communities, resulting in isolation and lack of support.	635-645
			Social alienation due to misunderstanding and stigma surrounding mental health in religious communities, resulting in isolation and lack of support.	635-645
		P.6 Cultural silence and desire for awareness	Despite encountering others who've experienced PND, there was societal silence around the topic.	178-184
			Lack of awareness of postnatal depression until experiencing it first-hand, leading to a lack of preparation.	186-190
			Open dialogue about postnatal depression provides insight and support, enabling early recognition and intervention for affected women.	200-207
			Importance of Pakistani women being open and supportive about postnatal depression and preparing others going through similar challenges.	517-526
	Seeking solace in shared experiences	P.2 Tailored support for British Pakistani women	Recognising the commonality of experiences among British Pakistani women and the value of shared understanding and experiences in navigating familial dynamics.	518-526
			Specific support for British Pakistani women due to perceived uniqueness of struggles in postnatal period.	514-518
		P.4 Need for supportive spaces for British Pakistani mothers	Reflected on the complexities of being British Pakistanis, navigating the blend of two cultures while trying to uphold their religious roots.	805-810
			Amidst the challenges of parenthood and depression, struggles to find acceptance and understanding within different communities.	811-814
			Informal gatherings, like coffee mornings with other Pakistani women, as a means to foster understanding and support.	814-819
			Casual and inclusive setting, with smaller groups of individuals sharing similar experiences, could offer a more supportive environment.	730-732
			Proposed creating spaces like stay-and-play sessions, tailored for mothers experiencing similar emotions or challenges with motherhood.	715-723
			Proposed idea of group check-ins or chats as a supportive measure for mothers facing similar challenges.	698-702
		P.5 Advocating for safe and culturally relevant spaces	Need for safe spaces for British Pakistani women to inform and signpost rather than for them to suffer in silence.	601-607
			Cultural and religious community connections could enhance support by fostering shared identity.	657-663
Tensions in tradition	Disruption of rest	P.1 Desire for privacy and rest amidst family events and cultural practices.	Feeling overwhelmed by brother's wedding taking place straight after having an emergency c-section which impacted on ability to rest.	14-22
			Lacked energy to engage in religious practices which contrasted with desire to rest and recover.	209-216
			Not being able to rest due to influx of guests and having to adhere to cultural norms of modesty.	204-209
		P.2 Cultural tradition of guests visiting impacted on desired rest	Pressure to adhere to cultural norm of hosting guests immediately after birth, despite severe sleep deprivation.	182-197
			Conflict between the tradition of 40 day rest and presence of visiting guests.	212-214
		P.5 No perceived benefit of cultural 40-day rest	Cultural expectations to stay indoors for 40 days perceived as a negative tradition as it contrasted with need for activity and support	136-145
			Breaking the confinement and seeking fresh air became crucial for mental well-being	145-149
			Comparison of sisters' regretful experience of engaging in full 40 days of rest, in contrast to her own experience of leaving the house early.	152-156
			Being confined with feelings of distress hindered the experience.	157-162
	Clash of cultures	P.7 Cultural clashes strained in-law relationships	Clash between personal preferences and cultural dietary expectations surrounding food choices after childbirth.	240-243
			Challenges in expressing personal boundaries and preferences due to cultural expectations of respecting elders.	243-258
			Cultural disparity between upbringing as a Mirpuri Kashmiri in Britain and husband's Pashtun background, emphasising the differences in traditions and values.	208-218
		P.1 Pakistani vs Western culture	Encouraged ex-husbands engagement in Western customs during pregnancy which led to cultural clashes and arguments.	669-678
			Perceived necessity to follow cultural dietary practices.	132-134
			Conflicting familial opinions relating to adherence to cultural practices.	135-142
		P.3 Cultural clashes in determining gender roles	Internal struggle in accepting husband's desire for involvement which clashed with culturally defined traditional gender roles.	46-49
			Struggle with contrasting cultural norms and gender roles defined by her traditional Pakistani upbringing and husband's Western upbringing, whilst coping with feelings of low mood.	201-210
			Navigating cultural clashes in parenting gender roles while dealing with uncertainty and confusion regarding maternal responsibilities.	212-218
Comprehensive and empowering care		P.1 PMHS offered holistic approach through coordinating with medical services and social support networks.	PMHS offered holistic approach to support and simplified care journey.	519-537
			PMHS facilitated medical coordination which enhanced accessibility and reassurance.	577-586
			Joint meetings with health visitor and midwife provided reassurance on safeguarding, with PMHS coordinating social services referral.	615-622
		P.2 Enhanced mobility and independence through transport support.	Transport assistance provided relief from relying on husband's availability and helped regain a sense of independence.	388-394
			Transport arrangements eased the burden of logistical challenges with two children.	456-459
			Appointments provided essential respite from confinement.	461-463
		P.3 Helpful support from PMHS	Therapy from PMHS enabled recognition of being a good mother	311-314
			Therapy helped to address parenting fears, social isolation, low mood as well as offering emotional outlet and access to information.	358-264
			Appreciation of follow up by Advanced Nurse Practitioner.	356-358
			One to one therapy was useful and allowed her to feel heard but limited commitment.	388-395
			Access to family therapy has been helpful but pace of therapeutic process perceived to be slow.	364-368
			Easy to reach PMHS and ANP on telephone.	383-385
			Acknowledging the positive intentions of a service while recognising the regular contact and support provided by an appointed individual.	433-434
		P.5 Positive support received from PMHS	Appreciation for accessible communication channels and supportive professionals within PMHS.	488-493
			Reflective insight through video observation (PIIOS), prompting self-awareness and potential adjustments in caregiving practices.	494-498
			Positive experience with therapy emerged once it commenced.	513-514
		P.6 Enhanced support from changing perinatal teams	Moving and changing perinatal teams enabled her to receive better support, including peer support, psychology sessions, and VIG sessions for connection with child.	305-309
			Discovered a new dimension in her relationship with her son through Video Interaction Guidance (VIG).	368-371
			Expressed gratitude for the progress made with CBT therapist and prospect of further support through bereavement counselling.	497-502
		P.7 Empowered maternal bonding through comprehensive perinatal support	Involvement with perinatal support services facilitated a deeper understanding of maternal experiences and bonding with the baby.	275-280
			Perinatal team emphasised interactive techniques like massages, talking, and playing to enhance maternal-infant bonding.	287-290
			Life-saving impact of perinatal support service.	321-324
			Criticised for perceived inability to breastfeed and later discovered through perinatal support that child's cries were rooted in the need for maternal comfort and security.	467-472
			Transitioning from cultural expectations to understanding individuality of children through programs like Circle of Security which empowers mothers with a new perspective.	478-485
			Despite ongoing emotional struggles, progress is evident as newfound self-worth fosters enhanced confidence and resilience.	513-515
			Perinatal support empowers recognition of maternal instincts over cultural norms.	515-519
			Supportive and patient perinatal staff facilitated openness.	591-594
			Building trust and rapport with a nursery nurse from PMHS, who transitions from a caregiver to a supportive confidante, offering reassurance, confidentiality, and validation.	595-604
			Perinatal services offer a holistic approach, providing diverse therapies like CBT, VR, and emotional coping skills.	604-608
Perinatal support in the shadows	Visibility and availability of PMHS	P.2 Help-seeking is outside of cultural norms	Seeking help for PND not common practice.	124-127
			Limited awareness of access to therapy amongst older generation including mother.	127-129
			Receiving counselling for postnatal depression was not viewed as the norm.	130-132
		P.3 Lack of awareness surrounding perinatal mental health support	Reflected on the lack of awareness among social circle regarding PMHS and perplexed that it remains largely unknown.	347-352
			Absence of knowledge about perinatal support among peers and acquaintances.	465-470
			Discontent with GPs' tendency to recommend antidepressants over perinatal support.	472-476
		P.5 Limited awareness of alternatives to anti-depressants	Cultural reliance on medical professionals leads to limited awareness and consideration of other support services within the community.	417-427
			Lack of awareness about perinatal support services among Pakistani women leads to underutilisation.	435-441
			Limited awareness and availability of non-pharmacological alternatives exacerbate reliance on medication, hindering exploration of more specialised support options.	614-621
		P.7 Lack of awareness of PMHS as a distinct service	Lack of guidance and awareness from social circles about PMHS.	133-138
			Absence of encouragement for seeking help with maternal mental health issues, limited to suggestions for medication review.	571-573
			Lack of awareness of PMHS, limited to support from midwives.	564-568
			Pakistani community do not differentiate between services, instead place them together.	168-170
	Challenges in accessibility and continuity	P.7 Concerns about perinatal support duration and continuity of care	Disparity between perinatal and community mental health services in speed and supportiveness.	362-365
			Fear of relapse and dependency on perinatal support for mental well-being.	365-367
			Anxiety and fear of abandonment post-treatment coupled with reliance on perinatal support for continuity of care.	373-375
			Lingering effects of negativity, loss of self-worth, and confidence necessitate ongoing assistance for recovery and well-being.	383-384
			Absence of adequate support prolongs recovery, exacerbates suffering, and deepens the negative effects of postnatal struggles.	395-401
			Navigating the shift from general community mental health services to perinatal care, experiencing anxiety and uncertainty about the continuity of support during pregnancy and postpartum.	554-561
			Outside perinatal services, lengthy waits for assistance, whereas perinatal support offers continuous availability fostering confidence in seeking help and sharing struggles openly.	608-618
			Sense of abandonment and isolation upon completion of perinatal services, fearing regression without ongoing support.	621-635
			Dissatisfaction with the limited duration of perinatal support compared to extended healthcare services for children.	640-651
			Concerns over limited duration of perinatal support.	358-362
		P.1 Challenges with perceived lack in support, timeliness, continuity and responsiveness from PMHS	Variable responsiveness from the perinatal team's duty line impacted sense of support and urgency during hospitalization	604-615
			Frustration from frequent turnover of CPN's which disrupted pre-existing therapeutic relationships.	681-685
			Lack of access to 1:1 therapy outside of working hours posed challenges.	630-639
			Support during tough times with ex-husband would have aided emotional processing, validation, and reassurance.	644-650
			Challenges in revisiting and reprocessing past experiences at the local mental health charity.	650-652
		P.2 Inconsistent and mixed communication from PMHS.	Lack of consistent communication from PMHS caused frustration.	383-386
			Parent and toddler classes were a means to overcome anxiety-related challenges in taking child out.	394-403
			Disappointment and dissatisfaction due to the lack of expected parent-toddler sessions.	403-405
			Desire for inclusive bonding experiences with both the baby and toddler.	409-414
			Unmet expectations for small, intimate parent and toddler sessions due to social anxiety	414-421



			Frustration and confusion arising from perceived lack of communication and coordination among professionals regarding available support services.	423-427
			Parent-toddler sessions were the reason for attending baby massage group.	436-438
			Parent-toddler sessions would have helped to alleviate guilt from restricting toddler's outdoor activities.	443-452
		P.3 Navigating uncertainty about duration of perinatal support and delayed communication	Uncertainty about therapy duration and concerns about support after son turns one.	395-398
			Seeking clarity on the normalcy of experiences and distinguishing between common challenges and personal struggles.	450-457
			Challenges with receiving delayed communication about appointments.	377-382
			Benefits of flexibility of family therapy but lacking clear resolution or support mechanism when faced with heavy emotions in therapy.	399-417
			Desire for more regular check-ins or brief phone calls to discuss feelings during tough days.	434-445
		P.5 Lack of timely access to therapy	Early access to Circle of Security group therapy could have provided significant support.	560-561
			Early access to therapy, particularly the Circle of Security program, could have facilitated understanding of behaviours and prevented emotional trauma, enhancing the mother-daughter relationship.	563-570
			Reduced wait times for perinatal services, such as therapy and the Circle of Security program, would have been immensely beneficial.	554-556
			Access to specialised therapy was delayed for a year, despite wanting higher level support.	454-460
		P.6 Challenges in accessing timely and adequate support	Reflecting on child turning two and the withdrawal of services after a year of seeking adequate support.	312-319
			Lengthy waits for NHS therapies, spanning up to two years, raise concerns about exacerbating mental health rather than facilitating recovery.	326-329
			Timely access to range of support offered by wider perinatal team would have helped significantly.	417-421
			Sense of discouragement when presented with a lengthy wait time for therapy.	485-495
			Preference for therapy, counselling and peer support and accessing these earlier would have improved social mobility and reduced isolation.	507-514
Loss of self and agency	Diminished identity and self-worthiness	P.1 Struggles with self-confidence, independence, and identity post-motherhood.	Self-confidence eroded overtime due to abusive relationship and blamed for miscarriage.	301-305
			Prior to marriage, emphasised independence and indicated focus on efforts to maintain personal wellbeing and self care.	319-323
			Losing sense of self post marital separation and birth of babies.	324-329
			Struggle to rediscover self-love and to identify personal strengths.	329-336
		P.2 Loss of self in motherhood	Expressionless, emotionally detached and disengaged during social gatherings.	306-312
			Sense of loss for former self.	272-275
			Transition from a vibrant social life pre-children, to reduced social engagement post-parenthood.	268-270
			Pre-marriage and pre-motherhood, happy demeanour despite teenage bouts of depression.	263-266
			Sense of loss stemming from the inability to fully reclaim past self.	526-530
			Struggling to articulate thoughts or engage in meaningful communication whilst navigating motherhood.	278-281
			Perceived disconnection from usual self, marked by increased social withdrawal, loss of happiness, and persistent sadness.	91-96
		P.3 Transformation in self-perception and identity, marked by feelings of loss, grief, and acceptance.	Impact of PND on sense of identity and self-care routines, leading to feelings of inadequacy and diminished self-esteem.	182-185
			Profound sense of identity loss and complex mix of grief for her former self, while navigating the challenge of embracing her evolving identity as a mother.	186-189
			Struggling with low mood whilst accepting it as part of identity.	232-236
			Transition from being independent and having a sociable lifestyle to overwhelming responsibilities of motherhood and partner's emotions	227-230
			Transition from sociable and outgoing person to losing interest in socialising with friends.	293-297
		P.4 Lacking self-esteem and sense of worthiness	Internalised self-criticism and feelings of unworthiness lead to difficulty accepting kindness and feeling deserving of positive experiences	454-466
			Struggling with feelings of unworthiness, leading to self-doubt about deserving future happiness.	502-506
			Feeling unworthy of happiness.	509-510
			Struggling with the belief that happiness is undeserved and feeling judged for fluctuating emotions, leading to self-doubt and concerns about being perceived as insincere.	533-538
			Struggling with self-love and recognising its impact on the ability to express love to son, leading to seeking external support for the child's emotional needs.	567-570
		P.6 Sense of inadequacy	Overwhelmed by low mood and feeling helpless when unable to console crying baby.	5-11
			Baby's preference for father's comfort led her to question her worth and maternal abilities.	11-21
			Struggling to interpret child's cries triggering feelings of inadequacy.	68-71
			Poor self-worth and emotional instability impacted relationship with son.	284-287
			Postnatal depression has eroded confidence and has left her feeling easily triggered and predominantly low in mood.	321-325
			Struggling with feeling of inadequacy and unable to accept husband's reassurance and praise.	32-37
		P.7 Low self-esteem and sense of worthlessness	Inability to meet constant demands of caring for dependent infants can lead to feelings of inadequacy and worthlessness.	401-407
			Negative self-evaluation amidst PND.	344-346
			Feeling undeserving of support from PMHS.	346-348
			Neglecting self-care activities.	348-350
			Transition from negative self-evaluation to feelings of worthlessness.	355-357
			Feeling inadequate in all familial roles including as a mother, fuelled by culture and family.	311-321
	Disempowerment in motherhood	P.1 External interference and sense of powerlessness reinforced detachment from maternal role. "they're not my babies"	Struggling to bond with newborn amid feelings of detachment and external pressure to engage in bonding activities, leading to uncertainty and resistance.	45-48
			Perceived exclusion or marginalisation in her role as the mother.	65-68
			Feeling like babies belonged to others and jokingly identifying as a surrogate, highlighting detachment.	273-279
			Family's persistent attempts to aid bonding created feelings of overwhelm and reinforced sense of detachment.	437-443
		P.2 Intrusive in-law dynamics	Perceived as a childbearing machine and lack of perceived bond with daughter.	219-220
			Intrusive mother-in-law, disrespecting boundaries and attempting to assume maternal role.	220-230
			Challenges bonding with first child amid constant family interference, shaped by Pakistani cultural norms of shared ownership and limited autonomy.	314-323
			Family cultural norms contribute to loss in maternal identity as grandparents assume parental authority.	326-330
			Struggles with boundary-crossing and dominance from in-laws, leading to perceived threats to maternal authority and connection with children.	493-499
		P.6 Self-doubt exacerbated by external interference	Struggles with breastfeeding compounded by familial interference, causing maternal distress and desire for connection and comfort with her child.	21-27
			Struggling with self-doubt and believing that others are attempting to separate her from her children.	45-49
		P.7 Maternal marginalisation	Feeling like only purpose was to carry and deliver the baby which belonged to in-laws after birth.	236-238
			Overlooked in role as a mother and only gaining attention when the baby needed feeding.	238-239
			Side-lined and reduced to a functional role, only being valued for specific tasks related to childcare.	260-264
			Cultural emphasis on the baby's bonding with extended family members rather than solely with the mother.	280-284
Supportive Familial Ties		P.7 Validating support from family and friends	Encouragement from extended family and friends to prioritise self-care, ignore negativity, and take time for oneself during challenging times.	120-125
			Supportive friends intuitively detected distress through phone calls.	129-133
			Encouragement from husband to resume self-care activities including personal hygiene.	352-354
			Husband's transformation in comprehending the mental toll of childbirth, actively educating himself and fostering openness.	422-427
			Recognition and acknowledgment from her husband, shifting from scepticism to empathy and active support.	429-437
		P.3 Family offered practical support which created closeness.	Traditional family support in Pakistani culture involved practical gestures like cooking.	141-142
			Support received from immediate family created closeness.	303-305
		P.6 Maternal support and nurturance in postnatal recovery	Crucial support from mother helped to alleviate postpartum struggles, offering comfort, understanding, and practical assistance by providing cooked meals.	157-166
			Embracing traditional foods and practical support from mother offered comfort, strength, and physical healing during postnatal recovery and challenges.	261-271
			Mother provided nurturing care and encouraged prioritising of self-care during postnatal period.	274-278
			Daily check-ins from mother offered emotional support, compensating for distance and fostering connection in isolation.	373-379
		P.5 Sense of community and support	Culture's open-door policy, where people visit without notice, brought comfort during tough times, easing the loneliness and providing a sense of community support.	170-180
			Open-door policy fostered a sense of community and companionship, offering solace and connection to Pakistani mothers, even if confined at home.	183-192
			Cultural practice of family members having house keys fosters a sense of belonging and community, offering support and spontaneity in visits.	192-201
			Embracing the cultural norm of spontaneous visits to friends and family post-recovery offered structure, social connection, and a sense of belonging.	201-207
			Amidst the challenges, traditional celebrations like Aqiqah and head shaving brought joy, despite being unable to fully participate due to illness.	162-168
			Experience of seeking support during depression strengthened bonds with extended family.	283-294
		P.4 Strong familial support	Strong familial support, both emotionally and financially which alleviated the burden of caring for a sick child.	409-419
			Mother expressed empathy and support stemming from shared experiences of depression and having a child with additional needs.	391-398
			Husband's unwavering support in acknowledging and aiding wife's struggles, adjusting work commitments for family needs, and providing emotional solidarity amid challenges.	574-588
			Friendship deepened with fellow mothers, especially a long-time friend who provided unwavering support and understanding during challenging times	603-617
			Seeking support from extended family, particularly the grandmother, to provide kindness and love for the child during overwhelming moments, fostering a strong bond between them.	562-567
			Grateful for the unwavering support and understanding from close family members, including spouse and immediate family, who recognised changes in behaviour.	126-131

Appendix Q: Group Experiential Themes, subthemes and the participants contributing to each.

Group Experiential Themes	Subthemes	Hafsa P1	Khadijah P2	Asiya P3	Zaynab P4	Maryam P5	Fatima P6	Halima P7
1. Loss of self and personal agency	_________________	X	X	X	X		X	X
2. Ambivalent familial support	2.1 Supportive familial ties			X	X	X	X	X
	2.2 Disempowerment in motherhood- “They’re not my babies”	X	X				X	X
3. Cultural hush	3.1. What will people say? “*log kiya kahenge?”*	X	X	X		X	X	X
	3.2. Absence of language dialogue and recognition of PND		X	X	X	X	X	
	3.3 Seeking solace in shared experiences		X		X	X		
4. Tensions in tradition	4.1. Disruption of rest	X	X			X		
	4.2. Clash of cultures	X		X				X
5. Perinatal support in the shadows	5.1. Visibility and availability of PMHS		X	X		X		X
	5.2. Challenges in accessibility and continuity of care	X	X	X		X	X	X