Lived Experiences of South Asian Women with Severe Postnatal Psychiatric Illnesses & Experiences of Perinatal Mental Health Services.

by

Harpreet Kaur Sihre

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

DOCTOR OF PHILOSOPHY

The Institute of Applied Health Research
College of Medical and Dental Sciences
University of Birmingham

September 2019

UNIVERSITY OF BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

Thesis Abstract

Background Experiences and conceptualisations of postnatal psychiatric illnesses can vary in mothers across cultures. This is important to understand in an era of superdiversity in the UK.

Aims 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.

Methods Two comprehensive qualitative systematic reviews using Noblit and Hare's meta-ethnography were conducted that explore a) women's beliefs about the causes of postnatal depression b) women's experiences of a severe postnatal psychiatric illness. The empirical research study uses Interpretative Phenomenological Analysis to explore 5 South Asian women's experiences of living with a severe postnatal psychiatric illness and experiences of Perinatal Mental Health Services.

Findings This thesis reports various explanatory models that can contribute to the onset of a postnatal psychiatric illness in new mothers. Not only was biology reported, but psychosocial, cultural, religious and spiritual factors. Mothers' experiences were also diverse and mothers from an ethnic minority background can have unique experiences that are shaped by their social and cultural milieu, which may impact help-seeking behaviour and treatment preferances.

Discussion To achieve culturally competent Perinatal Mental Health Services, it is imperative for clinicians to understand mothers' subjective understandings and experiences of their psychiatric illness.

Dedication

I wholeheartedly dedicate this thesis to the following people in my life:

My beloved grandparents, Mathaji & Pithaji and Naniji & Bhaji,

My loving and caring Mum and Dad,

My inspiring big brothers and sister-in-laws,

Gurdev Paji & Jasmine Bhabiji and Harpal Paji & Tini Bhabiji

And my adorable little nieces, Avneet & Anushka.

Acknowledgements

It is my pleasure to express my gratitude to my supervisors, Dr Qulsom Fazil, Dr Antje Lindenmeyer & Professor Paramjit Gill who have guided and supported me through this PhD project.

I am thankful to Waheguru Ji for giving me continuous strength and blessings to complete this PhD.

I would like sincerely to thank my mum and dad who have been a constant source of support for me. The values they have instilled within me were central to my determination in pursuing the PhD topic of research.

I would like to say a special thanks to all the incredible and inspiring women who agreed to take part in the study and who offered to share their life experiences with me. Their life stories made this PhD project possible.

A big thanks to colleagues at the PHaR group as Aston University including Dr Michael Larkin, Dr Rachel Shaw and Dr Christopher Wagstaff.

I would like to thank my friends, who have experienced this PhD journey alongside my journey, who have offered their expertise and support and most importantly, who have shared many laughs and memories with that will live on with me always.

Contributorship Statement

All of the content of this thesis is entirely the product of my own work. I received continuous support and guidance from academic supervisors, Dr Qulsom Fazil, Dr Antje Lindenmeyer and Professor Paramjit Gill during the concept, design, analysis and interpretation of the study. All of my academic supervisors provided continuous feedback and comments for all publications included in this thesis, as well as for each chapter.

Dr Dinush Lankage was the second reviewer for the systematic review in chapter 2. Dr Anne-Marie Simons was the second reviewer for the systematic review in chapter 3 and provided feedback for the publication in chapter 3.

Dr Mary McGuinness, Dr Giles Berrisford, Dr Jelena Jankovic, Dr Minaxi Patel, Dr Jona Lewis provided subject-specific advice for the conduct of the empirical study and all provided feedback for the publication in chapter 4.

Table of Contents

Introduction..... 1
Origins of this thesis..... 1
Self-contextualising..... 3
Thesis overview..... 4

Chapter 1: *Psychiatry of Early Motherhood*..... 7

Psychiatry of early motherhood in the postnatal period..... 8
Depression and anxiety in the postnatal period..... 10
Postnatal depression in early motherhood
Anxiety in early motherhood
Generalised anxiety disorder
Obsessive-compulsive disorder
Posttraumatic stress disorder
Panic disorder
Identification and treatment for postnatal depression and anxiety
Severe psychiatric illnesses in early motherhood..... 18
Severe postnatal depression
Postnatal psychosis
Postnatal bipolar disorder
Postnatal schizophrenia
Identification and treatment for severe postnatal psychiatric illnesses
Understanding psychiatric illness..... 25
A historical perspective on psychiatry in early motherhood
The biomedical model of health and illness
The biopsychosocial model of health and illness
Individuals' experience of psychiatric illnesses..... 34
Patient explanatory models
A cultural phenomenon in psychiatry
Religiosity, spirituality and supernaturalism in psychiatry
Superdiversity in the UK..... 48
National policy initiatives
Equality and diversity considerations

Chapter 2*: Women's beliefs about the causes of postnatal depression: A systematic review*..... 55

Abstract..... 56
Step 1 Introduction..... 57
Steps 2 -3 Method / design..... 59
Results..... 61

Steps 5 – 7 Findings: Women's beliefs about the causes of PND..... 70
Discussion..... 81
Limitations and strengths..... 84
Implications for clinical practice and future research..... 84
Review Update..... 85

Chapter 3: *Women's experiences of severe postnatal psychiatric illnesses: A systematic review*..... 91

Study protocol..... 92
Step 1 Introduction..... 99
Steps 2 – 3 Method / design..... 102
Results..... 105
Steps 5 – 7 Findings: Women's experiences of severe postnatal psychiatric illnesses..... 112
Discussion..... 124

Chapter 4: *Methodology & Methods*..... 129

Study protocol..... 130
Methodology..... 137
Qualitative methodological approaches..... 137
Narrative Research
Grounded Theory
Ethnography
Case Study
Phenomenology
Interpretative Phenomenological Analysis..... 141
The relevance of IPA to health and illness
The Theoretical Underpinnings of Phenomenological Research..... 142
Edmund Husserl's Phenomenology
Martin Heidegger's Hermeneutics
The ontological and epistemological positioning of IPA
Objectivity and subjectivity
Characteristics of IPA..... 149
Experience
Idiographic
Inductive
Interrogative
Methods..... 152
Research design..... 152
Justification for the empirical study..... 153

The research question(s) 156
Research objectives
Patient and public involvement
Peer review & external review
Ethical approvals
Study setting
Sampling strategy and sample size
Eligibility criteria
Participant identification and recruitment
Study participants and demographic information
Methods of data collection
Ethical practice..... 167
Consent
Participant withdrawal
Benefits to participants
Deception
Confidentiality
Psychological discomfort and distress
Safe-working practices
Data storage
Methods of data analysis
Step 1: Reading and re-reading
Step 2: Initial noting
Metaphors in talk of illness
Step 3: Development of emergent themes
Step 4: Searching for connections across emergent themes
Step 5: Moving to the next case
Step 6: Looking for patterns across cases
Credibility and validity of the analysis..... 177
Reflections and challenges faced..... 178

Chapter 5: *Research Findings*..... 180

Reflexivity..... 182
Individual idiographic statements..... 184
Namita (meaning humble and kindness)
Aaryaa (meaning noble)
Haniya (meaning polite and bubbly)
Serina (meaning a calm and tranquil nature)
Jiya (meaning lucky)

Superordinate and Subordinate themes..... 190
Superordinate Theme 1: *"Never heard of it"*..... 193
"the first time actually I heard about this kind of illness"
"I've never heard about the services"

Superordinate Theme 2: *"I wasn't acting normal"*..... 196
"I wasn't acting normal"
"how many 70-year-old Asians who come from India Pakistan, you know they've never heard of anything like this"
"I didn't really tell anyone"
Superordinate Theme 3: *"That triggered it off"*..... 205
"cultural expectations"
"The baby he couldn't breathe properly"
"We tried breastfeeding it wasn't working"
"a lot of stress"
"the child was quite demanding"
"I still couldn't sleep"
"something is lacking in my brain"
"my illness always triggers from religion"
"she's done black magic on me"
"we were in hospital because of him"
Superordinate Theme 4: "I was like there but not there"..... 226
"I don't want to exist"
"everyday it was a struggle…I felt like I had died"
"state of mind"
"mentally so so powerful"
"I just went crazy"
"the world's against you"
"I had so much paranoia kicking in me"
"Do not start an argument with me"
Superordinate Theme 5: *"I've completely lost me"*..... 241
"I've completely lost me"
"my head was like you're a bad mum"
"it affected our relationship a lot"
"I have more sympathy"
"that stigma…would stay with you forever"
Superordinate Theme 6: Experiences of Perinatal Mental Health Services..... 250
"I need medicine, I need therapy"
"I was able to care for baby"
"They were so focused on me"
"they were not culturally sound"
"I suffered through the red tape as well"
Superordinate Theme 7: *"it used to take it all out"*..... 266
"it used to take it all out"
"my parents and my family were there to help"

Chapter 6: *Discussion, Conclusion & Implications for Clinical Practice & Future Research*..... 271

A summary of the IPA findings..... 272

What are the lived experiences of South Asian women with severe postnatal psychiatric illnesses? 275
A lack of knowledge and understanding
Women's identity
Normality
Women's identity as a South Asian woman
Women's identity as a new mother
Women's redefined identity
Living with a severe postnatal psychiatric illness
South Asian women's multiple models of illness
What are South Asian women's experiences of Perinatal Mental Health Services, care and support? 296
Healthcare experiences
Culturally competent services
Coping strategies
Conclusion..... 305
Strengths and limitations..... 306
Limitations
Strengths
Implications for clinical practice and future research..... 308
Implications for clinical practice
Cultural competency in healthcare
Information needs for new mothers
Implications for future research
Thesis conclusion..... 313
References..... 315
Appendices..... 334

List of Tables

Table 1. *Summary of postnatal depressive and anxiety disorder*
Table 2. *Summary of severe postnatal psychiatric illnesses*
Table 3. *A step-by-step guide to completing a meta-ethnography*
Table 4. *Study characteristics of all included papers*
Table 5. *Study quality results for primary studies*
Table 6. *A summary of main themes and sub-themes*
Table 7. *Study characteristics of included studies (review update)*
Table 8. *Study quality results for primary studies (review update)*
Table 9. *Search terms*
Table 10. *A summary of the study characteristics.*
Table 11. *Study quality results for primary studies*
Table 12. *Participant demographics*
Table 13. *IPA Initial noting*
Table 14. *Table of Superordinate and subordinate*

List of Figures

Figure 1. *Ethnic groups in England and Wales*
Figure 2. *UK Specialist Community Perinatal Mental Health Teams*
Figure 3. *Study selection flowchart.*
Figure 4. *Study selection flowchart.*
Figure 5. *Five main approaches in qualitative research*
Figure 6. *Summary of IPA analysis*
Figure 7. *Women's experiences living through their psychiatric illnesses*

List of Appendices

Appendix 1. *Summary of findings about women's beliefs about the causes of PND*
Appendix 2. *Summary of findings about women's experiences of severe postnatal psychiatric illness*
Appendix 3. *Sponsor Confirmation Letter*
Appendix 4. *Insurance Confirmation Letter*
Appendix 5. *Fully Authorised CI Agreement*
Appendix 6. *Public & Products Liability Certificate*
Appendix 7. *Generic Insurance Letter*
Appendix 8. *Employers Liability Insurance*
Appendix 9. *NHS Health Research Authority approvals*
Appendix 10. *NHS Research Ethics Committee approvals*
Appendix 11. *Confirmation of Capacity and Capability at CNWL*
Appendix 12. *Confirmation of Capacity and Capability at BSMHFT*
Appendix 13. *Research Passport*
Appendix 14. *Clinical Clearance*

Appendix 15. *DBS Enhanced Certificate*
Appendix 16. *Study Advertisement*
Appendix 17. *Study Recruitment Script*
Appendix 18. *Letter of Invitation to Participant*
Appendix 19. *Consent to Contact Form*
Appendix 20. *Letter of Invitation to Participant (Sent in the Post)*
Appendix 21. *Participant Information Sheet*
Appendix 22. *Interview Schedule*
Appendix 23. *GP Notification Letter*
Appendix 24. *Informed Consent Form*
Appendix 25. *Safety Protocol*
Appendix 26. *An example of initial noting from each transcript*

List of Abbreviations

BME	Black, Minority and Ethnic
CBT	Cognitive Behavioural Therapy
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
EPDS	Edinburgh Postnatal Depression Scale
Et al.	Et alia (and others)
GAD	Generalised Anxiety Disorder
GP	General Practitioner
ICD-11	International Classification of Diseases – 11th Revision
IPA	Interpretative Phenomenological Analysis
IPT	Interpersonal Psychotherapy
MBU(s)	Mother and Baby Unit(s)
OCD	Obsessive Compulsive Disorder
PD	Panid Disorder
PHQ	Patient Health Questionnaire
PND	Postnatal Depression
PPI	Patient Public Involvement
PTSD	Post-Traumatic Stress Disorder
UK	United Kingdom
NICE	National Institute for Health Care and Excellence
US	United States
WHO	World Health Organisation

Thesis Format

Chapter 1 *Psychiatry of Early Motherhood*

The first chapter will provide the context of this thesis. I have introduced a definition of *psychiatry of early motherhood*, including clinical manifestations, risk factors and adverse outcomes for each type of moderate and severe psychiatric illness after childbirth. I have then described the diagnosis pathway and management. Following this, I present a historical and contemporary understanding of postnatal psychiatric illnesses, followed by the importance of mothers' subjective experiences and explanatory models in a *superdverse* era.

Chapter 2 *Women's beliefs about the causes of postnatal depression: A systematic review*

The second chapter of this thesis comprehensively reviewed the existing qualitative literature on women's beliefs about the causes of postnatal depression (PND).

Chapter 3 *Women's experiences of severe postnatal psychiatric illnesses: A systematic review*

The third chapter of this thesis comprehensively reviewed the concurrent qualitative literature on women's experiences of severe postnatal psychiatric illnesses. Given the lack of research in this field, I broadened the research question to explore women's experiences, including their explanatory models.

Chapter 4 *Methodology & Methods: Interpretative Phenomenological Analysis*

The fourth chapter of this thesis discusses the methodological approach, Interpretative Phenomenological Analysis, and the qualitative methods that I chose to employ in the empirical study on UK South Asian women's lived experiences of severe postnatal psychiatric illnesses, and their experiences of Perinatal Mental Health Services, care, and support.

Chapter 5 *Research Findings*

The fifth chapter presents the main findings from the Interpretative Phenomenological Analysis (IPA) empirical study described in chapter 4. Eight superordinate themes will be discussed that were developed from 5 in-depth interviews with South Asian women.

Chapter 6 *Discussion, Conclusion & Implications for Clinical Practice and Future Research*

The final sixth chapter discusses the findings from chapter 5 and earlier review findings from chapters 2 and 3, in light of psychological concepts and theoretical understandings. The thesis ends with some concluding remarks and considerations for clinical implcations and possible areas for future research.

Introduction

Origins of this thesis

The essential question when positioning myself in relation to the topic of this research is *"How does my doctoral research topic, lived experiences of severe postnatal psychiatric illnesses, connect to myself?"*

My personal interests to explore mothers' experiences of the use of Perinatal Mental Health Services were inspired by an experience during my Masters in Psychology, which I accomplished at the University of Birmingham in 2015. During my Masters, I completed a clinical placement at the Mother and Baby Unit (MBU) in Birmingham. This provided me with real-life experience and practical insights into severe perinatal psychiatric illnesses, whilst I was completing a systematic review that examined the effectiveness of evidence-based psychological therapies for perinatal depression. At the MBU, all of the mothers were diagnosed with a severe psychiatric illness after childbirth and were from various ethnic backgrounds. Almost five years ago now, and I specifically remember two patients on the psychiatric unit who were both South Asian mothers. We frequently sat together and they shared with me their life stories and experiences, as well as general conversations. During my time on the MBU, I also observed the language barriers and cultural differences such as childbearing practices among these two South Asian women. Most importantly, I learned so much about their lives and I did not view them as patients in a ward, but people with their personal life stories and experiences. I identify as a South Asian woman and this inspired a natural interest in the topic and development of the current thesis and empirical study.

Thus, I was searching for a doctoral research project where I would be able to pursue my research interests and this PhD project was initially advertised by Dr Qulsom Fazil as *'Understanding depression in a South Asian population'*. In an initial consultation with Dr. Fazil, I expressed my research interests in understanding South Asian women's beliefs and experiences about their postnatal psychiatric illnesses. And so, in agreement, Dr Fazil and I developed the proposal to explore PND in UK South Asian women in primary care services, using qualitative methods of data collection and analysis. After a review and interview process, I was accepted onto the PhD programme, based at the Institute of Applied Health Research, College of Medical and Dental Sciences, University of Birmingham. This was a surreal and exciting moment for me as I was fortunate enough to pursue my passion.

In year 1 of my PhD, I conducted a systematic review of women's beliefs about PND (chapter 2) and this revealed a qualitative research study on South Asian women's experiences with PND living in Great Britain. Therefore, given that PND in South Asian women had been explored, in consultation with established contacts from the clinical placement at the MBU I undertook during my Masters, including clinical psychologist, Dr Mary McGuinness and consultant psychiatrist, Dr Giles Berrisford, and my academic supervisors, the scope of the empirical research study progressed from moderate to severe psychiatric illnesses in South Asian women. Therefore, during year 2, I conducted a comprehensive qualitative systematic review of all women and their experiences of severe postnatal psychiatric illnesses (chapter 3). Because of the scarcity of existing qualitative literature, I broadened the research question to not only explore women's belief systems, but also experiences. When scoping the literature, and completing a systematic review, I found no study that explored South Asian women's experiences of severe psychiatric illnesses in the postnatal period. Therefore, I took this

opportunity to develop the IPA empirical study that explores South Asian women's experiences of a severe postnatal psychiatric illness and also as these women were receiving/received care from Perinatal Mental Health Services, I also aimed to explore their experiences of these services.

Self-contextualising

I was born and raised in a migrant Indian, Punjabi Sikh family and I consider that my cultural background may have provided me with certain ideas, beliefs and assumptions that informed my research practice. A woman's life completely changes when she gives birth to her baby and it is this life experience I wanted to explore. New mothers typically have new skills to learn, new responsibilities and it may be a completely new experience. Inevitably, having a new baby will have an impact on the mother. Some mothers may enjoy and embrace this feeling, however, some mothers may feel overwhelmed and unprepared for the realities of motherhood may lead to cause psychiatric illnesses. I was interested to understand how mothers made sense of their psychological illnesses through their own world view, just like the women on the MBU. Offering a more personal connection to the research topic, I believe every woman experiencing psychiatric illnesses should have the opportunity to access Perinatal Mental Health Services. Society is consumed by a stigmatising attitude towards individuals with mental health and because of this, individuals may be ashamed of disclosing their mental illnesses. Therefore, it was my aspiration to make a difference by contributing to the knowledge base of postnatal psychiatric illnesses.

Thesis overview

The following thesis comprises three qualitative components that address the following research questions:

1. ***What do women believe caused their PND?***
2. ***What are the experiences of women with a severe postnatal psychiatry illness?***
3. ***What are the lived experiences of South Asian women with a severe postnatal psychiatric illness and South Asian women's experiences of Perinatal Mental Health Services, care and support?***

The first research question *"What do women believe caused their PND?"* has been addressed in chapter 2, taking the form of a worldwide systematic review of qualitative studies that explored women's beliefs about the causes of PND. The findings that revealed women's belief systems about causation were grouped into social difficulties, social-support, culture, biological/physical, obstetric/paediatric, psychological and spiritual. Only one study documented South Asian women's beliefs about PND in the UK and reported the myriad of cultural and social reasons. For the following systematic review, I aimed to explore women's experiences of severe postnatal psychiatric illness. Therefore, the second systematic review (chapter 3) answered: *"What are the experiences of women with a severe postnatal psychiatric illness?"* Women's experiences of illnesses varied and were categorised into experiences of illness (e.g. isolation and delusional thoughts), consequences of illness (e.g. stigma and guilt), illness explanatory models (e.g. biological and spirituality), social difficulties (e.g. practical and emotional support) and women's unmet expectations about motherhood. The systematic review did not find any study that explores experiences of severe postnatal psychiatric illnesses in South Asian women, and so this developed the rationale for the empirical study part of this thesis.

With so many different mothers, living various cultural and social situations in the UK, there is a wealth of experience to understand in a superdiverse era. The term superdiversity is defined as:

> *"'the diversification of diversity': 'not just in terms of bringing more ethnicities and countries of origin, but also with respect to a multiplication of significant variables that affect where, how and with whom people live'. Superdiversity is about understanding 'the dynamic interplay of […] new, small and scattered, multiple-origin, transitionally connected, socio-economically differentiated and legally stratified immigrants'"* (1).

I suggest that we should attempt ways to understand the subjective experience of individuals through asking questions rather making assumptions, which will lead to improved understandings. Although severe psychiatric illnesses are highly treatable, living with this illness can be an ongoing experience and can make life psychologically challenging in the long-term. Through eliciting the lived experiences of a South Asian group of women, this thesis aims to offer empirical evidence of the lived experience of severe postnatal psychiatric illnesses that can offer a better understanding of the phenomena. Phenomenology and hermeneutics are the philosophical approaches that I draw from, which allows me to understand and elucidate human experience and sense-making through a qualitative inquiry.

The main focus of this thesis will be on severe postnatal psychiatric illnesses and South Asian women. A survey that presented data on the current perinatal mental health provision for Black and Minority Ethinic (BME) women in the UK found that Asians or South Asians (44%) constituted the largest group of BME women in participating services. Within this group, British

Asian and Pakistani women were the most commonly cited South Asian/Asian sub-group (2). Moreover, over a period of 12 months, in a survey that examined bed occupancy in MBUs, the occupancy rate revealed that South Asians were one of the biggest ethnic minority groups. Among South Asians, Pakistani women were the largest sub-group (2). Therefore, in the final empirical study (chapter 5), after receiving ethical approvals, I interviewed five South Asian women with lived experience of a severe postnatal psychiatric illness and in receipt of Perinatal Mental Health Services prior to or at the time of the interview. I utilised a phenomenological methodology to explore the lived experiences of severe postnatal psychiatric illnesses. I was guided by Heidegger's interpretive approach to investigate this psychiatric phenomenon. Through employing IPA, I present my findings that illuminate women's experiences that emerged from the interviews, which are then critically discussed (chapter 6) in light of the reviewed literature and previous literature. My inquiry was driven by a desire to understand the essence of the experience and a need to provide an opportunity for women to share their experiences with others.

Chapter 1

Psychiatry of Early Motherhood

Psychiatry of early motherhood in the postnatal period

Becoming a mother epitomises an important transition in life for many women (3). However, early motherhood is a common life transition that can be viewed as a paradox (4-6). Becoming a mother is recognised as a joyful time in both Western and non-Western cultures and it is believed to be a happy event in family life (5). Although it is abundantly clear that childbirth is a major life event, it can be psychologically, emotionally, socially and economically challenging for most women, requiring a significant adjustment period and posing substantial physical and mental health risks (5-8).

In this doctoral thesis, I used the term *psychiatry* as a comprehensive word that relates to all of the diagnosable types of psychiatric/mental illnesses/disorders and its treatment options in both primary and secondary healthcare settings. For the purpose of this thesis, *early motherhood* will encompass the *postnatal period*. The World Health Organisation (WHO) defines the postnatal period as beginning after the birth of the baby and continuing for about six weeks (9). However, the postnatal period can be extended up to a year after childbirth for the purpose of defining various psychiatric illnesses (9-11). The terms *puerperium*, *puerperal* or *postpartum* are also commonly used to describe this period, however, I refer to the *postnatal period* throughout this thesis.

The postnatal period represents a high-risk time for mothers to develop a psychiatric illness (12). Women are likely to develop a new onset of psychiatric illness as well as experience exacerbation of existing or relapse of pre-existing psychiatric illness during pregnancy (13). The mainstream Western medical view is that postnatal psychiatric illnesses divide into three categories: 1. the “baby blues”; 2. depressive and anxiety illnesses and 3. severe and

incapacitating illnesses such as severe depression, postnatal psychosis, schizophrenia and bipolar disorder (14-16). It has been reported that approximately 20% of mothers will experience some variation of postnatal psychiatric illness (17). Given how common the “baby blues” are, they are considered as a normal experience as opposed to a psychiatric illness; for the purpose of this thesis, I maintain the focus on moderate to severe postnatal psychiatric illnesses.

In the next section of this chapter, I have provided an overview of moderate and severe types of postnatal psychiatric illness, which will include clinical manifestations, risk factors and outcomes for the mother and the infant and family members. I also give information about how these psychiatric illnesses are recognised, detected and diagnosed and subsequently how they are managed and treated in primary or secondary healthcare services in the UK.

Depression and anxiety in the postnatal period

Depression and anxiety are the most common forms of postnatal psychiatric illnesses and it has been reported that they affect approximately 15 – 20% of women during early motherhood (16). The most common type of depressive illness is PND among women. Anxiety can vary during the postnatal period and include generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and panic disorder (PD). The prevalence rates for each depressive and anxiety illness varies, however, there is a general consensus among the literature that approximately 13 – 19% of new mothers will experience PND in the first year after delivery. For anxiety, up to 8% of new mothers will experience GAD, 9% of new mothers experience PD, 2 – 3% of new mothers experience OCD and 3% will experience PTSD in early motherhood (11, 18-23). Table 1 presents a summary of the clinical manifestations, risk factors and adverse outcomes for depression and anxiety that occur in new mothers during the postnatal period.

Table 1.
Summary of postnatal depressive and anxiety illnesses

Type of postnatal psychiatric illness	Clinical manifestations	Risk factors	Adverse outcomes
Depressive Disorder	Lethargy Feelings of guilt Irritability Irrational thoughts Poor appetite Insomnia Difficulty concentrating Inadequacy Loss of interest in usual activity/sexual functioning Negative/Irrational thoughts Feelings of worthlessness	Prenatal depression Self-esteem Childcare stress Prenatal anxiety Life stress Low levels of social support Marital relationship History of previous depression Infant temperament Maternity blues Marital status Socioeconomic status Unplanned/Unwanted pregnancy Cultural factors	Poor mother and baby interactions and bonding Child cognitive behavioural and emotional development Family relations
Anxiety Disorders	Uncontrollable and excessive worry Restlessness Fatigue Difficulty concentrating Irritability Muscle tension Sleep disturbance	Women who have excessive worries Positive family history of anxiety disorders Suffer from another form of psychiatric illness including anxiety or mood disorders	Low maternal self-confidence Child development Parenting behaviour Mother and infant bonding Maternal responsiveness Negative neurodevelopmental outcomes in infants
Obsessive-Compulsive and Related Disorders	Recurrent and persistent thoughts Urges or images that are intrusive or unwanted (obsession) Images that are neutralised by repetitive behaviour (compulsions)	Personality disorders Premenstrual factors History of depression Caesarean delivery Maternal age	Disruptions in mother and infant bonding Negative impact on infant development
Trauma and Stressor Related Disorder	Recurrent and distressing Flashbacks Nightmares Avoidance Sweating Trembling Irritation Sleep disturbances	Traumatic birth experience Prolapsed cord Unplanned caesarean section Cardiac arrest Postpartum haemorrhage Induction Forceps delivery Premature birth Separation from infant Lack of support/reassurance Domestic violence Previous sexual trauma Previous adverse childbirth complications A history of psychopathology Inadequate pain relief during childbirth	Impaired mother and infant relationship Difficulty bonding with and breastfeeding the infant Negative impact on maternal mental health problems or child development Children may be impacted and experience delayed intellectual development
Panic Disorder	Shortness of breath Palpitations Chest pains Fear of losing control Nausea Chocking Hysterical crying Distortion of time Painful feelings in the head	Ovarian hormonal changes A previous history of panic symptoms	Impact a woman's self-esteem

Postnatal depression in early motherhood

PND is recognised non-psychotic illness and has similar symptomology as a depressive illness outside of the childbearing period (24, 25). Mothers who develop the illness of PND will begin to present a range of physical and mental characteristics (26). The common signs and symptoms of PND include lethargy, feelings of guilt, irritability, wanting to cry often, irrational thoughts, poor appetite, difficulty sleeping and difficulty in concentrating (27). New mothers may also experience low moods as a result of a loss of happiness, sexual functioning, self-esteem and social relationships (5, 28, 29). Mothers may feel ashamed, as they have not lived up to the expectations of motherhood or do not feel they responded well to their infant (28, 30). As a result of this and the worry of not meeting expectsions, some mothers manage to hide their symptoms and do not always admit to feeling depressed.

In the literature to date, there have been many risk factors associated with PND. Beck identified 13 significant risk factors which included, prenatal depression and anxiety, self-esteem, childcare stress, life stress, social support, marital relationship, history of previous depression, infant temperament, maternity blues, marital status, socioeconomic status and unplanned/unwanted pregnancy (31). More recently, coming from an ethnic minority, especially Asian, or being born in a non-English speaking country, has been highlighted as a risk factor for PND (32). A literature review was conducted by Klainin & Arthur to examine risk factors for PND in Asian cultures and their findings revealed five major themes: biological/physical (e.g. history of medical conditions), psychological (past psychiatric history), obstetric/paediatric (unplanned or unintended pregnancy), socio-demographic (e.g. economic difficulties) and cultural factors (e.g. gender preference of infant) (33).

Anxiety in early motherhood

While it is well-known that women can develop depression after childbirth, it is less known that women can feel anxious after having a baby. Anxiety during the postnatal period has received less attention in the literature than depressive disorders, despite it being comorbidity with depression (34). As previously mentioned, anxiety illnesses include GAD, OCD, PTSD and PD (13, 35, 36).

Generalised anxiety disorder

GAD is most commonly characterised by uncontrollable and excessive worries, such as maternal wellness, fears for the infant, illness in the partner and parental mortality, that can cause functional impairment in women after childbirth (37). Unlike the extensive quantitative literature on PND, specific risk factors have not yet been fully explored for GAD after childbirth. Nonetheless, it has been recognised that GAD more frequently appears in women who have excessive worries, positive family history of anxiety disorders and suffer from another form of psychiatric illness including anxiety or mood disorders (37). Furthermore, stress and elevated cortisol levels during late pregnancy and the early postnatal period have been associated with the increased risk of GAD (38). Similar to PND, studies have demonstrated adverse outcomes of GAD that include mother and infant bonding disruptions. Other negative outcomes that have been recognised in the literature include a decrease in maternal self-confidence, child development and parenting behaviour (39, 40). Maternal responsiveness to the infant and neurodevelopmental outcomes in infants have also been suggested as negative outcomes of mothers with GAD (37, 41, 42).

Obsessive-compulsive and related disorder

OCD is another type of anxiety that is mainly presented by symptoms such as obsessions and compulsions (20). Obsessions are unwelcome and recurrent images, thoughts, doubts or ideas that cause distress for the mother (20, 27). As a result of these obsessional thoughts, the mother repetitively responds compulsively with excess behavioural or mental acts (20, 43, 44). Women with the postnatal onset of OCD often experience obsessional thoughts about harming the baby therefore may impact their ability to care for their baby (45). Examples of aggressive images include the baby's head cracked or bleeding, throwing the baby down the stairs, putting the baby into a microwave or the baby dying from suffocation (20, 46). Studies that have examined risk factors for the clinical explanation of OCD include personality disorders, premenstrual factors, a history of depression, Caesarean delivery and maternal age (47). Serotonin dysregulation has also been suggested in the aetiology of postnatal OCD (48). Furthermore, a rapid increase in levels of oxytocin may trigger the onset of OCD (48). Similar to PND and GAD, untreated or undiagnosed OCD can cause disruptions in mother and infant bonding (48). Additionally, postnatal OCD may also negatively affect infant development (20).

Trauma and stressor related disorder

Symptoms of PTSD following childbirth are recognised by recurrent and distressing flashbacks and nightmares, avoidance, sweating, trembling, irritation and sleep disturbances (49-51). New mothers may also experience altered mood state and intense and prolonged psychological distress following a traumatic event (27). It is generally accepted that PTSD is the consequence of a woman's traumatic birth experience (52, 53). Risk factors associated with PTSD during childbirth include prolapsed cord, unplanned caesarean section, cardiac arrest, postpartum haemorrhage, induction, forceps delivery, premature birth, separation from

infant, and lack of support/reassurance (24, 51-55). Additional significant risk factors include, domestic violence, previous sexual trauma, previous adverse childbirth complications, a history of psychopathology, inadequate pain relief during childbirth and poor social support (27, 43, 51, 52, 56, 57). There is a wide range of evidence to suggest that PTSD after childbirth is consequential for the infant, the childbearing woman and her family (51, 58, 59). Again similar to PND, GAD and OCD, PTSD may be detrimental for both mother and infant, causing impaired mother and infant relationship and difficulty bonding (51, 60). PTSD may have long term negative impact on maternal mental health problems or child development (15). Children may experience delayed intellectual development and some form of psychiatric disorder (61, 62).

Panic disorder

Postnatal PD was first recognised by Metz et al. who urged clinicians to distinguish depressive disorders from panic disorders during the postnatal period (63). PD during the postnatal period is characterised by physiological symptoms similar to a panic attack, such as shortness of breath, palpitations, chest pains, fear of losing control, nausea and choking (13, 63). PD is also often associated with a sudden onset of terror (13, 63). Additional clinical indicators of PD included hysterical crying, distortion of time and painful feelings in the head (63). The presence of a panic attack is usually characterised by consistent anxiety about a reoccurring panic attack and worries about the consequences of the panic attack, including behavioural changes (27). The role of ovarian hormonal changes during the postnatal period has been suggested to play a role in a woman's vulnerability to the postnatal onset of PD (64, 65). Furthermore, a previous history of panic symptoms is reported risk factors for postnatal PD (66). PD during the postnatal period can have serious negative effects on a mother's life. PD has been reported to impact a woman's self-esteem (63).

Identification and treatment for postnatal depression and anxiety

Depression and anxiety are important to recognise because of the detrimental short and long-term adverse consequences for the mother and infant. Screening should be the first initial steps in detecting the signs and symptoms of an anxiety or depressive disorder, followed by a diagnosis and the development of a care plan, if necessary (67). The UK National Institute for Health and Care Excellence (NICE) issued clinical guidance for perinatal mental health problems (last updated in April 2018): *Antenatal and postnatal mental health: clinical management and service guidance* (16). In the UK, recognition and management of postnatal depression and anxiety falls within the remit of primary healthcare professionals in routine clinical practice (11). During the woman's first visit within primary care (usually at four to six weeks postnatal), healthcare professionals (such as midwives, obstetricians, health visitors and General Practitioners (GPs)) are advised to administer the following two *'Whooley'* questions to identify possible PND (68):

- *During the past month, have you often been bothered by feeling down, depressed or hopeless?*
- *During the past month, have you often been bothered by having little interest or pleasure in doing things?*

If the woman answers *"yes"*, she will be asked to complete a validated screening tool that will screen the woman with PND, such as The Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9). The EPDS is a national screening strategy for PND. Similar to the initial recognition of PND, for anxiety, the NICE recommends that 2-item Generalised Anxiety Disorder Scale (GAD-2) should be considered during a woman's first visit within primary care services:

- *Over the last two weeks, how often have you been bothered by feeling nervous, anxious or on edge?*
- *Over the last two weeks, how often have you been bothered by not being able to stop*

or control worrying?

If the woman scores three or more on the GAD-2, she should be referred to her GP or a mental health professional and further assessment. A validated tool such as the Generalized Anxiety Disorder Scale-7 (GAD-7) should be administered for suspected anxiety in the postnatal period. If the woman has been detected with either depression or anxiety, she should be referred for a mental health assessment for a formal diagnosis that meets the diagnostic criteria via the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-V) or the International Classification of Diseases – 11th Revision (ICD-11).

Fortunately, depressive and anxiety illnesses that occur in women during the postnatal period are highly treatable conditions and interventions are widely available within UK primary care. The NICE clinical guidance for perinatal mental health problems recommend a range of evidence-based pharmacological and non-pharmacological interventions. Information should be provided regarding the benefits and risks of psychological treatments and medication, the possible consequences of receiving no treatment, and the consequences of abruptly stopping the treatment without consulting a health professional. For new mothers who develop PND self-treatment strategies such as, low-intensity psychosocial interventions or group-based Cognitive Behavioural Therapy (CBT) are recommended. For a woman with anxiety during the postnatal period, a low-intensity psychological intervention such as facilitated self-help or a high-intensity psychological intervention such as CBT should be offered as initial treatment.

Severe psychiatric illnesses in early motherhood

So far in this chapter, I have introduced postnatal psychiatric illnesses that occur in early motherhood and are recognised and managed within primary healthcare services. This section will review severe psychiatric illness that a woman may experience during early motherhood and that will be treated within secondary healthcare services, such as Perinatal Mental Health Services. Severe postnatal psychiatric illnesses include postnatal psychosis, severe depression, bipolar disorder and schizophrenia (9, 16, 69-71). Generally, the symptoms of a postnatal psychiatric illness in new mothers are mild to moderate and short-lived, however, a minority of women will develop severe psychiatric illness (72). Postnatal psychosis occurs in approximately two per 1000 women who give birth. A further two per 1000 women experience other severe postnatal psychiatric illnesses (17). Table 2 provides a summary of clinical manifestations, risk factors and outcomes for each type of severe postnatal psychiatric illness.

Table 2.
Summary of severe postnatal psychiatric illnesses

Type of postnatal psychiatric illness	Clinical manifestations	Risk factors	Adverse Outcomes
Major depressive disorder (severe)	Suicidal behaviour Feelings of guilt Psychomotor slowing and agitation High level of cognitive disorders Anxiousness Feelings of hopelessness Hyprochronidria and somatic symptoms Hearing voices Unusual beliefs	Oestrogen and progesterone levels Previously been treated by a psychiatrist Past history of severe psychiatric illness Family history of perinatal psychiatric illness	Increased risks for behavioural problems in children Lower mathematics grades Depression in adolescence in children
Psychosis "with postpartum onset"	Mania Psychotic thoughts Severe depressive symptoms Feeling excited or elated Inability to sleep Feeling more active than normal Loquaciousness Paranoia Bewilderment Cognitive disorganisation Thoughts of infanticide and suicide Auditory hallucinations	Antenatal depression Primiparous mothers who are single Women who are aged older or hormonal problems	Mother neglecting, abusing, or even killing the infant An increased risk of suicide
Bipolar and related disorders	Manic episodes Hypomania Episodes of depression Postpartum psychosis	History of bipolar disorder Interference with circadian rhythm Sleep deprivation	Increased risks for suicide in new mothers and infanticide
Schizophrenia spectrum	Social withdrawal Cognitive disorganisation Misinterpretation of reality Hallucinations Seeing things that others cannot see Difficulty in focusing attention Memory problems Difficulty maintaining a conversation	Multiple obstetric complications Prematurity Low birth weights, stillbirth and death Medication non-adherence Low levels of social support	Disturbances in the mother and infant interactions A high rate of custody loss Malformation and low birth weight Infanticide

Major depressive disorder

A major depressive disorder in the postnatal period has similar features to a moderate depressive psychiatric illness as discussed above. However, additional and more severe features include suicide and infanticide, psychomotor slowing and agitation, high level of cognitive disorders, anxiousness, and feelings of hopelessness, hypochondria, somatic symptoms, hearing voices and have unusual beliefs (73-76). Stupor or also known as a state of near-unconsciousness is found in new mothers with severe depression after childbirth (15). There are known risk factors for severe depression after childbirth that include a sudden drop in oestrogen and progesterone levels (73). Women are also at a higher risk of severe depression if they have a past history of severe psychiatric illness and whether there is a family history of perinatal psychiatric illness (69). Recent findings have demonstrated adverse outcomes for mothers with severe postnatal depression, which included increased risks for behavioural problems in children, as well as lower mathematics grades and depression in adolescence (77).

Psychosis "with postpartum onset"

The clinical features of postnatal psychosis can be dramatic and include mania, psychotic thoughts and severe depressive symptoms (78, 79). Some women may experience symptoms such as feeling excited or elated, the inability or not needing to sleep, feeling more active than normal and loquaciousness (79, 80). Women may also develop paranoia and bewilderment (35). Similar to severe depression, mothers may experience thoughts of infanticide, which often centre on the baby resulting in impulses to harm the baby or oneself as a command of auditory hallucinations (81). Some women experience hallucinations and delusions with content often focused towards harming the infant or the self or in extreme cases killing the

baby or religious in content (80, 82). These features represent a dramatic change from their normal selves and functioning (83). The strongest and most established risk factor recognised in the literature and by clinicians for postnatal psychosis is a past history of bipolar disorder or any severe postnatal episodes (8, 84, 85). Other risk factors that may increase the risk of postnatal psychosis include antenatal depression, primiparous mothers who are single, women who are aged older or have hormonal problems (80). There are adverse consequences of postnatal psychosis for both the mother and the new-born including the mother neglecting, abusing, or even killing the infant and an increased risk of suicide (80).

Bipolar and related disorders

Bipolar disorder is typically characterised by a wide range of mood changes varying between manic episodes, hypomania or episodes of depression (86). Postpartum psychosis may be the first presentation of bipolar disorder for some women (8). Women with a history of bipolar disorder are vulnerable and have a twofold higher risk of developing a postnatal episode of bipolar disorder, especially after childbirth (10, 35, 87). Interference with circadian rhythm during the third trimester of pregnancy and sleep deprivation may also contribute to the development of postnatal onset of bipolar disorder (87).

Schizophrenia spectrum

Schizophrenia is a complex brain disorder (88). Symptoms can be debilitating and include social withdrawal, cognitive disorganisation, misinterpretation of reality, hallucinations i.e. seeing things that others cannot see. Cognitive symptoms include difficulty in focusing attention, memory problems and difficulty maintaining a conversation (88). Schizophrenia during the postnatal period has been associated with multiple obstetric complications, prematurity, low

birth weight and stillbirth and death (89). Medication non-adherence and low levels of social support have also been highlighted as risk factors (90). Disturbances in the mother and infant interactions including mothers who are psychologically withdrawn from their infant have been identified as a negative outcome in mothers with postnatal schizophrenia (91, 92). Studies have also demonstrated a high rate of custody loss in mothers with schizophrenia (93). Malformation and low birth weight may also be outcomes of women with schizophrenia (70). Infanticide may be the ultimate tragic consequence of this psychiatric illness (70).

Identification and treatment for severe postnatal psychiatric illnesses

Postnatal psychiatric illnesses are largely underdiagnosed and untreated, which can have deleterious consequences for both the mother and infant (94). Therefore, early diagnosis and treatment are crucial (94). Severe psychiatric illness after childbirth is recognised as a psychiatric emergency that requires prompt treatment within secondary or tertiary care services (25). According to NICE, the following questions should be asked at a woman's first contact with UK services during the antenatal and postnatal period:

- *Any past or present severe mental illness?*
- *Past or present treatment by specialist mental health services, including inpatient care?*
- *Any severe perinatal mental illness in a first-degree relation (mother, sister or daughter)?*

If the woman has any past or present severe mental illness or family history of severe perinatal mental illness, a referral to a specialist mental health service should be made, for further assessment, diagnosis and treatment. The current NICE guidelines recommend the DSM-V or the ICD-11 as a 'gold standard' diagnostic procedure for appropriate mental health professionals who are competent in performing a clinical diagnosis. The DSM-V does not recognise severe postnatal psychiatric illnesses as a separate condition, however, episodes of

severe postnatal psychiatric illness with onset within four weeks following childbirth can be flagged with *"peripartum-onset specifier"*. Some authors have proposed to extend this to three or even six months (95, 96). Several perinatal psychiatrists recommended changes to enhance early detection of perinatal psychiatric illness i a special issue in the Women's Mental Health Journal (57).

If a woman is experiencing a complex or severe psychiatric illness in the postnatal period, she will be referred to receive care from Specialist Perinatal Mental Health services. It is reported that 3% of women will be referred to Secondary Psychiatric Services (17). However, access to Specialist Perinatal Mental health services remains variable and some areas of the country do not have a specialist community team, therefore in practice a referral may not always be possible (97). Although some women may require hospitalisation, the prognosis is generally favourable and most women go on to recover fully (98). As a service user, the woman should receive assessment and management of her psychiatric illness. These services are characterised by:

- Specialist community perinatal mental health teams
- Inpatient Mother and Baby Units

Secondary care consists of specialist community perinatal mental health teams on referral by a primary care physician, who offer specialist biopsychosocial assessments and care plans for women experiencing a complex or severe psychiatric illness during the first year after delivery of the infant. Specialist community perinatal mental health teams are multidisciplinary and include psychiatrists, psychologists, occupational therapists, nurses, nursery nurses and social workers (15). An MBU is a specialist inpatient psychiatric tertiary care service with several beds

for joint admission of a very severely ill mother and her baby up to a year after childbirth (17, 99). A large body of research suggests the short and long-term negative impact on the child due to separation from the mother. Therefore, this joint admission allows for the mother to be treated appropriately for her psychiatric illness and also maintain the mother and infant relationship (17). In the late 1940s after the Second World War, psychiatric wards in Britain and Australia began successfully incorporating MBUs where mothers suffering from a postnatal psychiatric disorder could remain close to her infant. Prior to this, mothers with mental illness were kept away from their infants due to the potential danger to the baby (100). Currently, MBUs exist in the United Kingdom, the United States, Canada, Australia, New Zealand, France, Belgium and Germany (17, 101-106). India has also adopted a Western model to meet cultural and resource needs and first established a MBU in July 2009 (107). Studies that examined the outcomes of mothers and their babies admitted to an MBU revealed significant improvements in women's psychiatric symptoms and health and social functioning, mother and infant interactions and decreased adverse effects on child development (99, 108).

Patients will be administered medication, which can be administered in combination with or without a psychotherapy treatment. The prescribing of a suitable medication might help such a woman to engage with psychological aspects, especially when mental illness is severe. Pharmacological treatment for a severe postnatal psychiatric illness may include rapid tranquillisers, antipsychotics and lithium. Psychological interventions such as CBT and Interpersonal Psychotherapy (IPT) can also be considered for severe psychiatric illness. For very severe forms of psychiatric illness, Electroconvulsive Therapy may also be considered as an intervention. For women receiving pharmacological treatment options, the impact on breastfeeding should also be discussed and the possible harms for the mother and baby.

So far in this chapter, I have provided a broad overview of the types of psychiatric illnesses a mother may experience in the postnatal period. The next section will move on to discuss how psychiatric illnesses in early motherhood are viewed and framed in society and medicine through different theoretical understandings. I begin with a historical biomedical perspective, which will lead me to a more contemporary perspective.

Understanding psychiatric illness

There are many Western theories that aim to provide a conceptual framework to understand psychiatric illnesses. I will now present the various frameworks of psychiatric illnesses that help to understand the experience. Theoretical models are used to help people explain and understand the complex issues related to psychiatric illness. Stickley and Wright provide an explanation of the term theory:

> *"Theory uses ideas or concepts to explain individual experience, observations of behaviour and relationships. Traditionally a theory organises concepts so that their relationship to each other is explain and phenomena can be both described and predicted. Theories therefore help…to find meaning and to understand experience; to describe knowledge and to raise questions leading to new insights and ways" (109).*

Thus, theory enables us to try and make sense and meaning of the processes involved in the development of psychiatric illnesses. Theoretical models have evolved from traditional perspectives (e.g. biomedical) to fairly new concepts (e.g. biopsychosocial, cultural) and these will be introduced and discussed below in relation to postnatal psychiatric illnesses.

A historical perspective on psychiatry in early motherhood

> *"Case V - The wife of Epicrates…On the day following her delivery, she was seized with acute fever…from the time she was seized with the fever, became delirious…all the symptoms exacerbated; insomnolency; delirium, thirst; stools bilious, and high coloured" (110).*

Although postnatal psychiatric illnesses in early motherhood seem like a new phenomenon, the explanatory frameworks have been emergent in the literature from 400 B.C. to the present day (111, 112). The majority of the early literature was focused on postnatal psychosis (112). Early speculation of psychological mood disturbance in early postnatal mothers was noted by Greek Physician, Hippocrates of Kos (c.400 BC) (111, 113). Hippocrates proposed that lochial discharges from the uterus after delivery may travel to the woman's brain and result in agitation, attacks and delirium, which he termed *puerperal fever* (114, 115). His hypothesis became dogmatic and survived for over a thousand years by his contemporaries.

Speculations concerning psychological disturbances in mothers following childbirth continued through to the Middle Ages. During the 12th century, a female physician, Trotula de Ruggiero of Salerno (c. 1040s – 1097), contributed her own theories to women's disease and disorders whilst keeping faithful to the teachings of Hippocrates (116). She believed that increased moisture after childbirth resulted in postnatal mood disturbances (117). Trotula wrote, *"If the womb is too moist, the brain is filled with water, and the moisture running over the eyes, compels them to involuntarily shed tears"* (117). Moreover, English Christian mystic, anchoress Margery Kempe (c. 1373 – 1439) gave an emotional vision of her personal experience of a *"spiritual crisis"* following the birth of her first child, challenging contemporary views (118, 119). Margery's fears were entrenched in her religious beliefs as concerned with the possibility

of death and damnation. She experienced hallucinations, which presented visual and auditory demons from hell, which made her say things *"out of character"* (118). Her crisis was eventually resolved after her vision of Christ encouraged her religious learning (118). Moreover, women were involved with assisting childbirth, which was viewed with intense suspicion by both the medical profession and the Church. In general, women were believed to be weakened by original sin and were, therefore, suspects of demonic influences (116). The Malleus Malificarum (1486) identified midwives as prime suspects of witchcraft, thus maternal distress would be viewed as sin or demonic possession rather than medical illness (118). Also in the middle ages, Hieronymus Mercurialis (1530-1606), Professor of Medicine, concluded that the flow of milk to the woman's breast diverted to the uterus causing yellow discharge from the woman's vagina (115). The name 'milk fever' was given as a deadly and dreaded disease of childbearing women (115).

It was not until the modern and contemporary age that the predominant religious discourse regarding problems women experience after childbirth were rapidly overridden by important medical development (116). Puerperal insanity was first described in the psychiatric literature by physician Jean-Etienne Esquirol (1805) and later by Dr. Louis-victor Marce (1858) (120). Esquirol had become one of the first physicians to provide 92 case reports of postnatal psychiatric illnesses. He suggested that the number of women experiencing postnatal delirium and melancholy was higher than the number of cases he identified in the hospital. Esquirol suggested home treatments such as careful nursing, tepid baths and purgatives (121). In 1858, Marce published a the first comprehensive monography surveying knowledge of psychiatric disorders in pregnant and postnatal women titled "*Traité de la folie des femmes enceintes, des nouvelles accouchées et des nourrices, et considérations médico-légales qui se rattachent à ce*

sujet" (Treatise on insanity in pregnant, postpartum, and lactating women). Marce's monograph included clinical descriptions of 310 pregnant and postpartum women with psychiatric disorders that were systematically categorised. Marce noted many features that distinguished postpartum cases from other forms of mental illnesses. In line with Hippocrates and Trotula, Marce hypothesised that postpartum psychological symptoms occurred during the physiological changes occurring in childbearing women.

In the 20th century, three key lines of thought emerged concerning the description of mental disturbances following childbirth, which have been eloquently summarised by Dr. James Hamilton (psychiatrist and founder of the Marce Society) in his 1962 book, *Postpartum Psychiatric Problems* (122). Strecker and Ebaugh proposed the first theory in 1926 (123). They suggested that depression had no direct link to a woman's pregnancy, delivery, or postpartum changes. Strecker and Ebaugh believed postnatal psychiatric illnesses were indistinct to other forms of psychiatric illness such as dementia, manic-depression and delirium. Their conclusions were to eradicate 'postnatal psychosis' from the psychiatric terminology (123, 124). Gregory Zilboorg proposed a second theory in 1928 and attributed psychiatric illness after childbirth to a woman's pre-pregnancy frigid personality, originally popularised by Sigmund Freud (125-127). Using Freudian Theory, Zilboorg also suggested that the root of psychiatric illnesses after childbirth could be linked to repressed homosexuality, unresolved Oedipal desires or stages of psychosexual development. Although such beliefs have not been followed through to modern-day, Zilboorg did publish first observations of personal or family history of depression in women with postnatal symptoms, a legacy that is found in current research (128). The third and final theory was developed by Kilpatrick and Tiebout in 1926, who suggested that postnatal psychiatric illnesses may be due to a toxic process.

Following the Second World War in the mid-20th century, many women were afraid to seek out help for their psychiatric illness after childbirth as they were anxious that they would be separated from their infant. However, in the 1940s, psychiatric wards in Britain and Australia began to efficaciously incorporate MBUs for mothers suffering from a postnatal psychiatric illness. In the late 20th century, new scientific advances built on the work of earlier physicians and began to refine understandings of postnatal psychiatric illnesses. In 1968, Bruce Pitt was one of the first to draw attention to less severe psychiatric illnesses after childbirth such as postnatal depression. He characterised the depression *"atypical"* as he identified the symptom profile somewhat different to depression outside of the postnatal period. And so, postnatal psychiatric illnesses are not merely of historical importance. Psychiatric illnesses after childbirth are the leading cause of maternal mortality and morbidity are of great public health importance in the 21st century. The following section will continue to discuss a modern Western observation psychiatric illnesses that occur in the postnatal period.

The biomedical model of health and illness

Traditionally, biomedical perspectives dominate the practice of psychiatrists and support psychiatry as a sub-discipline of medical science. The biomedical perspective implies psychiatric illness as a disease with origins that are primarily biological and tends to disregard strong evidence that adverse social circumstances can contribute to the onset of psychological morbidity (129). In a similar way as physical illness, psychopathology is viewed as an entity with distinct pathologies, courses and outcomes. There are known biochemical explanations for the causation of psychiatric illness including biological or chemical activity in the brain (130). In approaching psychiatric illnesses, the medical model involves identifying clinical signs and

symptoms, a diagnosis of the disease and then pharmaceutical management of relevant treatment with the ultimate aim of curing the disease.

Biological underpinnings of postnatal psychiatric illnesses are well established in the literature (10). The Hormonal Theory of psychiatric illnesses after childbirth explains the role of hormones in the origins of women's postnatal psychiatric illness experiences (131). As documented earlier in this chapter under sub-headings *'Risk Factors'* for each type of postnatal psychiatric illness, it is apparent that biology plays a part in women's psychiatry in early motherhood. To provide a brief summary, these include increased levels of progesterone, oestrogen, oxytocin, cortisol, serotonin dysregulation and/or previous history of psychiatric illnesses for mild to moderate psychiatric illnesses. For severe postnatal psychiatric illnesses, biological risk factors include decreased levels of oestrogen and progesterone, hormonal problems and previous history of psychiatric illnesses. However, there has been an upsurge of controversies of Hormonal Theory of postnatal psychiatric illnesses, in that not only hormonal fluctuations are important but there are a number of social and psychological factors that play a large role in the pathogenesis of postnatal psychiatric illness as discussed below (132, 133).

The biopsychosocial model of health and illness

> *"We are now faced with the necessity and the challenge to broaden the approach to disease to include psychosocial without sacrificing the enormous advantages of the biomedical approach"(134) – George Engel (1977).*

In addition to the role of biology and postnatal psychiatric illnesses, non-biomedical factors that come under the categories psychological and social factors are also documented. The

WHO supports the concept that a person's psychiatric illness is shaped by various elements, including social determinants (135). Reported earlier in this chapter were:

- environmental stressors
- poor family and marital relations
- decreased social support
- stressful life events
- unplanned/unwanted pregnancy
- childbirth complications.

Risk factors for developing a severe postnatal psychiatric illness included but were not limited to:

- a mother's age
- marital status
- sleeping problems
- low levels of support
- antipsychotic medication adherence.

Thus, given the multifaceted origins of postnatal psychiatric illnesses, the dominant biomedical model of illness discussed above leaves no room within its framework for the social and psychological dimensions of illness (136). The biopsychosocial model is an interdisciplinary model that sought to acknowledge the patient in the larger context and integrate and recognise biological, psychological and social factors that may help determine why individuals might suffer from an illness (134). This model was proposed by George Engel in 1977, who argued that clinicians should simultaneously attend to the psychological and social factors that

influence biological functioning (136). The biopsychosocial model was offered as a new medical paradigm in three ways (137):

1. *Alongside objective biomedical data, this would offer a worldwide view that includes the subjective experiences of the patient*
2. *A model of causation would be more comprehensive and naturalistic than a simple linear reductionist orientation of medical thinking*
3. *The patient would be accorded more power and act as the protagonist in the doctor-patient relationship* (138).

Engel did not deny that the traditional mainstream biomedical approach had promoted significant developments in medicine, however, he highlighted the narrow reductionist perspective that clinicians follow, which potentially disregards the subjective experiences of the patient. Thus, the biopsychosocial model is more realistic as it considers an individual's lifestyle. The WHO agrees with Engel's view in that it is a central mission to improving well-being:

> *"Health is a positive concept emphasising social and personal resources, as well as physical capabilities"* (134, 139).

In clinical practice, this is a big step towards treating the patient as a person with an individual lifestyle and not simply a patient with a disease. Thus, this model allows the clinician to assess the patient in a holistic manner and consider the context of their illness prior to making a diagnosis. Case studies have shown that clinicians who explicitly focus on the experience of illness from the patient's perspective are able to care better for their patients (140).

The biopsychosocial model is helpful in understanding the health-related experience of a new mother during the postnatal period, as it takes into account the dynamic factors impacting the

mother and child (141). As reported in this chapter, there are numerous factors alongside biomedical properties that can influence the development of postnatal psychiatric illness and also shape individual experiences (141). A recent literature review from the biopsychosocial perspective provided an update on the various factors that can inform the development of health-related issues in the perinatal period (141). As well as biological properties, social and psychological factors are important in influencing an individual's experience in the postnatal period. Social influences included social network factors and social demographics, marital status, stressful life events and social support (141, 142). Psychological factors included heightened stress levels, personal history of mood disorders and previous psychiatric hospitalisation (141). Thus, to optimise maternal and infant health outcomes, greater attention should be given to the multitude of biopsychosocial factors relevant to childbearing women.

Mastrogianni & Bhugra argued that all elements of the biopsychosocial model are influenced by the culture that the individual is born in and exists in (143). The purpose of transcultural psychiatry is to study differences between populations without resorting to the stereotypes of that culture (143). Although the biopsychosocial model has been significant in influencing modern psychiatry, perhaps one of the biggest flaws of the biopsychosocial model is the lack of sensitivity to patients' subjective lived experience of their illnesses. Scholars called for greater emphasis on qualitative conceptualisations of culture, that is informed by hermeneutic rather than positivist epistemologies (144). The next section of this chapter will discuss how patients' lived experience can be informed by cultural influence in psychiatry and the importance of this data.

Individuals' experience of psychiatric illnesses

"Understanding experience is the very bread and butter of psychology" (145).

So far, I have highlighted and discussed the medical and conceptual ways psychiatric illnesses in early motherhood can be understood, however, a mother's subjective understanding and experience of her illness is an important aspect. Research has identified that the transition to motherhood is challenging for many women and this can increase when a woman is struggling with a severe psychiatric illness (146, 147). Patients generally give meaning to their chaotic experiences and these meaning and stories can differ from the clinician's perspective. Clinicians can interpret the behaviour of the patient as pathological or symptomatic of the disease that the patient is suffering and may know what is good for the patient, although arguable, so too can the patients know what is good for them. As a result, psychiatric patients are not only vulnerable but can also be knowledgeable and fully competent. This enables patients to become an 'expert patient' as they are able to take control over their health by understanding and managing their conditions. Expert patients should feel confident and in control of their lives; aim to manage their conditions through effective communication and partnership with healthcare professionals and be realistic about the impact of their illness (148, 149).

Patients with psychiatric illnesses deserve to have their experiences heard rather than their disease reduced to statistics (150). Conrad previously argued that to further our understandings of particular illnesses we need to change our perspective from an "*outsider"* to an *"insider"* perspective:

> *"Outsider perspectives view illness from outside the experience itself, minimizing or ignoring the subjective reality of the sufferer. They see the patient, disease or illness as*

an object or something to be affected. They are often deductive in orientation and adopt medical or social theoretical questions as their central concerns. In contrast an insider's perspective typically focuses directly and explicitly on the subjective experience of living with and in spite of illness. It focuses specifically on the perspectives of people with illness and attempts to examine the illness experience in a more inductive manner" (151).

Therefore, it is important to understand the context of health and illness, the meaning of health, illness and disease and patients' lived experiences. The primary practice of healthcare professionals is to provide competent, individualised care for patients of all ages, cultures, ethnic and religious orientations. To provide this type of care involves an understanding of each person's unique situation and lived experience that evolves from the clinicians' sincere communication with the individual. Clinicians should know the accurate understanding of a patient's true lived experience. This truth will enhance clinician's sensitivity to patient matters and experience, which is a necessary and integral component of effective carrying out the practice role of caregiving. Kleinman and Benson highlight the need for *'Anthropology in the Clinic' (152)*. They believe training clinicians in ethnography is the most optimal way for clinicians to be sensitive to cultural differences and to gain access to what life is like in the patient's *"local world"* (152).

In the literature to date, there have been a handful of studies that have explored women's thoughts, views, feelings and perceptions about severe postnatal psychiatric illnesses (this will be discussed in more detail in chapters 3 and 5). This is surprising for a number of reasons. Firstly, this is a serious illness that can have disabling effects on not only the mother but her family members and significant relationships. Secondly, the nature of delusions and hallucinations are very different from women's everyday experience. Thirdly, a postnatal

psychiatric illness can have serious consequences for the woman who has experienced it. Living through and the importance of living with the illness has previously been reported by women. Although patients are given the same diagnostic label and some of their illnesses experiences can be shared among other patients, some of their experiences can be fuelled by their subjective thoughts, beliefs and behaviours that create a unique experience. As researchers, we need to further understand women's own experiences to underpin the development of care and treatment options. The experience can be fundamentally disempowering and at a time when women transition to motherhood, it is important that women receive the right help and support they need.

Although there is limited research into severe postnatal psychiatric illnesses, recently, there has been an expansion of research that has employed qualitative designs in an attempt to capture mother's experiences of PND. One of the first phenomenological studies that explored the experience of PND was conducted by Beck in 1992. The findings from this study were clustered into 11 themes and women's experiences included a living nightmare, feelings of guilt, obsessive thinking, contemplating harming self and their infant, loneliness, a lack of emotions and all previous interests and fear that their lives would never return back to normal. Between 1990 and 2000, Beck identified four overarching themes that conceptualised PND including the incongruity between expectations and reality of motherhood, spiralling downwards and pervasive loss and making gains. An IPA study by Hall revealed several themes about mothers' experiences of PND (153). Themes offered new understandings of PND experiences and included difficulties disclosing their thoughts and feelings, unrealistic expectations of motherhood, beliefs about being a bad mother and attachment issues (153).

Transcultural qualitative research has also increased and to name a few, research has been conducted in India, China and Taiwan, demonstrating that PND is an international concept that affects mothers from all cultures and countries. Transcultural research has found experiences of PND to differ across cultures. For example, traditional rituals, practices and beliefs are common to many non-Western cultures that accompany the transition to motherhood. These may include, special diets, purification ceremonies and receipts of gifts, *"doing the month"* (confinement period) and traditional medicine. However, the *"protectiveness"* of such rituals has been questioned and in some cases, such rituals and practices do not provide any psychological benefit to the mother. Culturally determined rituals and practices can instead exacerbate PND symptoms and may even contribute to the development and onset (154). Chapters 3 and 5 will focus on mothers' experiences living with a severe postnatal psychiatric illness.

Patient explanatory models

"Suffering, as I have said, is social" – Arthur Kleinman (1997) (155).

A big element to understanding patient experiences is by addressing the patient's unique understanding of their illness, which will inevitably drive patients' self-management. Explanatory models are situated within the context of the individual and so, it is important to understand both the patient's beliefs about their illness and their social context. Patient centeredness is a phenomenon that aims to improve healthcare quality and overall patient outcome and satisfaction (156). Individuals across cultures and ethnic minority backgrounds seem to hold multiple beliefs about causation of illness, which determines where and who they seek help from and their illness experiences. Explanatory models are dependent on the interaction between the individual's illness and the socio-cultural milieu. Illness narratives

contextualise the patient in their world view and attempt to make sense of the patient's illness experiences (157). Recent work on culture and psychopathology is beginning to unpack the interactional process through which social and cultural contexts of an individual shape illness onset, experience, course and outcome.

As part of human functioning and gaining coherence and meaning of life events, people like to share their personal experiences through stories (158). Like traditional writings and literature, stories have structural properties, typically with a start, development and some sense of conclusion (159). Because stories are subjective accounts of the individual and aim to reflect a particular experience, every individual will have a different account of the same event. The approach of a diagnostic label, which would treat PND *"as a real entity that exists independent of perception, language or culture"* does not attend to individual differences and explanatory models of women from different backgrounds (160). Many feminists have criticised this as a reductionist approach and have argued that clinical disorders such as PND are socially constructed (160, 161). When exploring the subjective experiences of mothers through the array and infinite facets of their personal and socio-cultural backgrounds, a woman can give voice to her own experiences.

American psychiatrist and Professor of anthropology and cross-cultural psychiatry at Harvard University, Professor Arthur Kleinman, echoed the importance of the patient's subjective experiences of health and illness (162). Kleinman developed the *Patient Explanatory Model*, which proposed that individuals have varied notions of illness and health, which forms part of the patient's narrative about their reality. He continued to propose that instead of the clinician asking *"Where does it hurt?"*, the clinician should focus on eliciting a response by using prompts

such as *"Why", "When", "How" and "What Next?"* (162, 163). Engaging in patients' explanatory models will provide critical insight into what is most important to the patient and what they believe might help them. In the process of exploring with the patient his or her identity and explanatory model, this ensures improved understanding and informs the successful negotiation of different world views (163). In light of a growing focus on patient-centred care and cultural competence in the medical area, this is useful information for better collaboration between the clinician and patient. Despite the fact that there is a move towards the biopsychosocial model, clinicians' explanatory models are still largely biomedical. Studies have explored explanatory models and found that the patient's belief systems are influenced by their social and cultural milieu and prior experiences (164-168). Explanatory models also affect the type of treatment patients will adhere to as part of their recovery (169).

As well as clinically effective, exploring the subjective experiences is also of import in qualitative health research and are to some degrees, interpretive. This generates knowledge of a particular phenomenon, which can add value to the quantitative research that objectively investigates health-related topics. Kleinman's explanatory model has been applied to postnatal women with psychiatric disorders and mothers' explanatory models have different from the clinical diagnostic criteria (170). Many individuals, especially those from a non-Western culture have shown to have a holistic and complex concept of health and disease. The UK is now a *'superdiverse'* nation and so, applying this model will reveal these complex constructs about causation (171).

A cultural phenomenon in psychiatry

"Puerperal mental illnesses are found in all cultural groups" (172).

Much of the theory and practice of mainstream psychiatry I have discussed thus far, have emerged from Western understandings (173). Although these mono-cultural understandings have been central in the development of frameworks and conceptual tools, they can be problematic and limited when applied to non-Western population cultures and groups. There is literature that emphasises that health and illness are viewed differently across cultures and the identification of a postnatal psychiatric illness may be more complex when working with women from an ethnic minority background (174-176). As the UK is becoming increasingly superdiverse as a nation, this signals a challenge about how best to resond to the various explanatory models around health and illness. The predominant Western approach to understanding mental illness is based on a biomedical perspective that is based on the assumption that dysfunction is similar across diverse populations (177). The cross-cultural literature has revealed significant differences in the manifestation of syndrome across ethnic groups, thereby challenging the universalist position. There appears to be a complex interplay between psycho-physiological function and sociocultural variables which challenges the view that mental illness is best understood through a biomedical view. Using a cross cultural lens in superdiverse settings permits healthcare professionals to look at how cultural factors influence human thoughts, feelngs and behaviours. Although some concepts in mental health may be universal, expanding psychological research has recognised cultural variance in the way individuals view health and illness and the way they seek help (178) Moreover, as noted by Klienman, the biomedical view is unable to explain the sociocultural variation in mental disorder as evidence in the growing body of cross-cultural literature.

The term *culture* was coined by English anthropologist and the founder of cultural anthropology, Sir Edward Burnett Tylor (1871):

> *"that complex whole which includes knowledge, belief, art, law, morals, customs, and any other capabilities and habits acquired by man as a member of society" (179).*

Culture is imperative to psychiatry as it can define normality, deviance and attitudes and understandings towards experiences of emotional distress in many cultural groups. Johnson, Hardt and Kleinman discuss the major ways that patients' cultural background may influence illness beliefs and behaviours (180). They discouraged culture as a *"thing"* and instead defined culture as *"a textured pattern of beliefs and practices"* (180). As individuals grow up in specific cultural settings, they are then provided with a set of guidelines that can become a part of their interpretation of their illness (180). It is understood that culture may influence our thought processes including how we recognise and respond to psychological distress. Hernandez et al. stated that:

> *"Culture influences what gets defined as a problem, how the problem is understood and which solutions to the problem are acceptable" (181).*

For many decades, the role of culture in the expression of psychiatric symptoms was largely neglected and it was not until after World War II that transcultural psychiatry was a distinct discipline (182, 183). In 1977, Kleinman published *'Depression, somatization and the "new cross-cultural psychiatry"* (184). Kleinman argued that explanations of the disease are culturally determined and do not merely construct illness as an experience but also how individuals perceive illness (184). He subsequently encouraged psychiatry to begin with this powerful anthropological insight (183). In the mid-1970s, transcultural psychiatry was established in Britain as a response to increased immigration from the former colonies as well as the immigrants' experiences of racism and discrimination. Subsequently, in the 1980s British

transcultural psychiatrists and the UK Transcultural Psychiatry Society aimed to support equality of mental health irrespective of race, gender or culture and was committed to having a multicultural and multidisciplinary membership (183). Since Kleinman proposed his perspective in psychiatry, there has been a greater appreciation of how cultural concepts, values and beliefs influences the way psychiatric symptoms are expressed, experienced by the individual and also how individuals and families respond to psychiatric distress (185). For example, in 1990 in an edition dedicated to transcultural psychiatry the British Journal of Psychiatry published *'From categories to contexts: a decade of the "new cross-cultural psychiatry"'* (186).

Moreover, since the awareness increased that an individual's perception of aetiology can vary across cultures, this led to the modification as to where they seek help, how they cope, the support from their family members and community, which all form part of patients' lived experiences (173, 183). For example, some cultures may ascribe possession by spirits, the evil eye, black magic to the onset of their illness (187). These explanatory models then place the rectification of the problem within the purview of traditional healers or significant people in the community (187). Therefore, culture can also impact how and at what point of their illness individuals seek treatment from mainstream Western health services. Research has suggested that diverse cultures tend to seek help much later than those from the majority community because of stigma (188).

The stigma around psychiatric illnesses can be higher in some cultural groups and is often a barrier to accessing mental health services (175). In Southeast Asia, shame related reasons have been suggested by Hechanova and Waedle for low access to mental health systems (187).

Firstly, the desire to protect the family repute and dignity. Secondly, individuals may fear that mental health professionals would view them as *"crazy"* and thirdly the individual may feel disinclined to open up to strangers (187). In a systematic review of the prevalence, nature and determinants of postnatal mental health problems among South Asian women who have migrated to high-income countries, cultural factors among this population group were important to women's experiences (189). Women felt stigmatised in their culture and felt embarrassed and fearful of being found an unfit mother, which precluded mothers from seeking help. Moreover, women expressed their anxiety about the gender of the infant, as the desire for a baby boy is an important phenomenon in the patriarchal society of the South Asian culture (190). Therefore, research suggests the plausibility of social and cultural influences on the evolution of postnatal psychiatric illnesses (191). The cultural milieu of the woman can influence the way she conceptualises, experiences and seeks help after childbirth as it is comprised of several shared ideas, values, perspectives, beliefs and perceived causes (192). This data is important to consider when assessing the patient's expression of their illness in the cultural context and this will be discussed in more detail in chapters 2 and 5.

Authors have argued that a cultural approach in addition to a biopsychosocial approach is essential to gain a comprehensive understanding of postnatal psychiatric illnesses (193-195). Although postnatal illnesses are commonly shared by women across cultures, women's experiences and understandings may differ and these issues will be discussed in the following chapters of this thesis in more detail. Transcultural psychiatry has been significant to the clinical and academic work within the field of perinatal mental health. Much of the literature points the need for holistic health services that incorporate the total context in which health and illnesses are experienced (196). A clinician's cultural competency with respect to a

particular patient affects the process of establishing rapport and the quality of assessment. Therefore, such cultural belief systems give a more comprehensive understanding and can have important implications in shaping diagnosis and management (185, 197). This becomes more urgent if the patient and clinician are from different backgrounds (198). Cultural competency in health-care refers to four components developed by Campinha-Bacote (1994):

1. *Cultural awareness*: refers to the process of becoming sensitive to cultural differences
2. *Cultural knowledge*: refers to the involvement of developing an understanding of beliefs, practices and coping styles of specific groups
3. *Cultural skills*: refers to the ability to apply this knowledge in the assessment of patients
4. *Cultural encounter*: refers to the ongoing process of engaging with culturally diverse clients and continuation of developing ones' knowledge and skills (199).

Religiosity, spirituality and supernaturalism in psychiatry

In recent years, there has also been an increased attentiveness to the significance of religion, spirituality and supernaturalism to psychiatry (200). It is important to note that these concepts are intrinsically interrelated. According to definitions outlined in the APA Handbook of Psychology, *Religion and Spirituality (2013)*, religion is defined as:

> *"the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality…an ongoing journey of discovery, conservation, and transformation"* (201).

Spirituality has been defined as:

> *"the search for the sacred"* which includes *"concepts of God and high powers, but also…other aspects of life that are perceived to be manifestations of the divine or imbued with divine-like qualities"* (201).

Religious scepticism in psychiatry first arose from James Morley who believed that psychiatry should be asserted as a scientific subject and should not be related to 'faith healing' in treating psychiatric illness (202). Carl Jung, a Swiss psychiatrist and psychoanalyst believed that religion facilitated emotional stability and contributed to the resolution of mental conflict (203). In his book, *Modern Man in Search of Soul* (1933), he wrote:

> *"Among all my patients…there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook" (203).*

Similarly, Vikrot Frankl, an Austrian psychiatrist and survivor of the concentration camps believed that to survive horrendous traumatic experiences, we have to embrace religion in order to gain meaning and purpose in our lives. Therefore, there have been many theorists that have opposite stances on the benefits and liabilities of religious faith in psychiatry.

Research demonstrates that religion/spirituality can be significant to a patient's explanatory model of their illness and part of their coping mechanism, which can either be positive or negative. A qualitative study by Chiu et al. aimed to investigate how South and East Asian women with serious mental illness make treatment choices in relation to spirituality (204). Their findings revealed that women's process of spiritual choice included three phases: 1) identifying contributing factors 2) exploring spiritual resources and strategies and 3) living with choices. Rima Lamba's qualitative findings demonstrated that women's spiritual beliefs such as a disconnection from God exacerbated feelings of postnatal distress (205). Moreover, Asian communities in the UK have been acknowledged to make greater use of traditional or spiritual healers who offer specific approaches to psychiatric illness and treatment. It has been

suggested that a reason for visiting traditional healers is that *"the healer is part of a community, with shared belief systems and world view, who has an understanding of the rules of that community and whose role is understood and respected by that community"* (206).

In some cultures, including South Asian cultures, health belief systems are more based on supernatural aetiologies (207). Supernatural is the *"belief that mental illness is used by evil spirits and witchcraft…which has been observed in cultures and religions"* (208). British South Asians with psychosis attributed their illness to a supernatural cause, which included black magic and *nazar* (evil eye) (209). In a study that explored explanatory models in schizophrenia between White British group and three ethnic groups, including Bangladeshis, when comparing biological and supernatural causes of illness, those of White British cited biological causes, whereas the Bangladeshis cited supernatural causes more frequently, which included black magic and evil forces (210). Explanatory models have been investigated in Indian women with postnatal psychosis in relation to their understanding and beliefs regarding causes (211). Explanatory models included stressors unique to childbirth, marital stress and supernatural causes, demonstrating that non-biomedical explanatory models are common in women with psychosis after childbirth (211). Names that were related to supernatural and spiritual causes included ghosts, demons, black magic, 'bad breeze', bad fate, evil spirits and evil eye effect. For many Muslim communities, jinn possession as evil spirits were reported to cause their symptoms such as sadness and anxiety after childbirth (212).

In this chapter so far, I have discussed the various perspectives and representations of postnatal psychiatric illnesses. It is important to view psychiatric illnesses from the mother's perspective, given the influence of not only biology but alternative variables such as

psychosocial, cultural, religiosity, spirituality and supernaturality. This is important to consider given that the UK is now characterised by *superdiversity* and many individuals will have their personal subjective model of illnesses. In the UK, females originate from numerous countries and so every mother is different and every mother will have their own unique experience.

Superdiversity in the UK

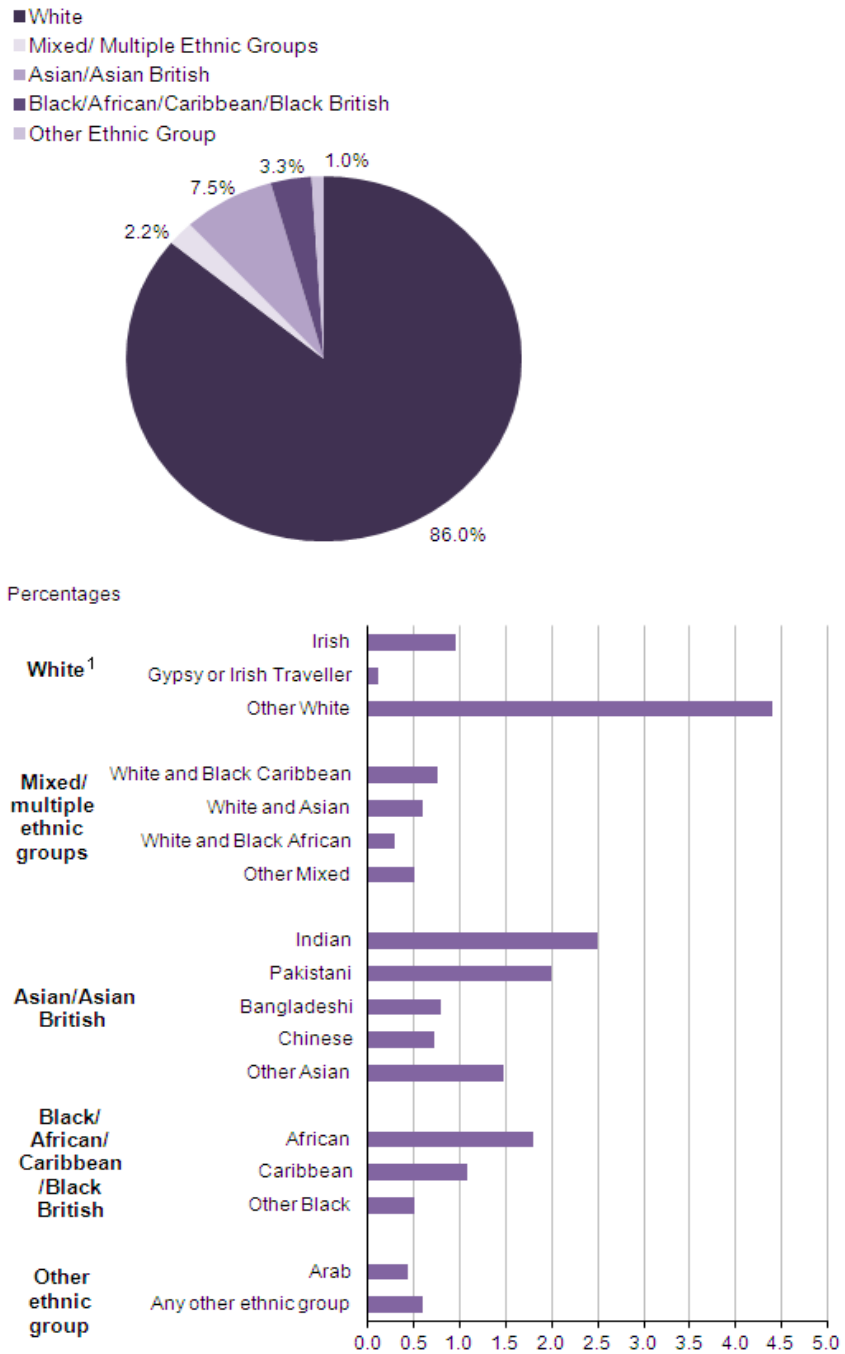
In the 1950s and 1970s, there was a major arrival of people from former British colonies such as Jamaica, Trinidad, India, Pakistan and Bangladesh (213). This influx led to the establishment of large organised communities, religious groups and places of worship. Since the 1990s and 2000s, the UK has continued to change with noticeable growth in migration rates and diversification of countries of origin. The UK comprises of a variety of ethnicities, languages, religious traditions, local identities, cultural values and practices. This has resulted in a contemporary situation of s*uperdiversity* (213).

BME women is an umbrella term used to encompass a range of heterogeneous sub-groups that characterise a multi-cultural and *superdiverse* nation. There is research to suggest that BME women experience significantly higher levels of psychological morbidity during the first year after childbirth (2, 32, 214). The Confidential Enquiry into Maternal Deaths demonstrated that maternal mortality rates were also higher in some ethnic minority groups (215). Nonetheless, it appears that barriers to accessing Specialist Perinatal Mental Health Services are higher for BME women, despite increased vulnerability (2). This may be due to the range of beliefs systems women have, which may impact help-seeking behaviour. According to the 2011 UK Census, women of White ethnicity accounted for the majority group comprising of 86% of the resident population in the UK. 14% of the population is made up of mixed/multiple ethnic groups, Asian/Asian British, Black/African/Caribbean/Black British and other ethnic groups (see Figure 1.). The largest and most prominent group are those with origins in South Asian (India, Pakistan and Bangladesh). The religious diversity in the UK is also well documented. The major religious affiliations of British South Asians are Muslims, Hindus and Sikhs. Findings from a recent scoping review of Perinatal Mental Healthcare for BME women

in England revealed that ‘Asians’ or ‘South Asians’ constituted the largest sub-group accessing Perinatal Mental Health Services (2). It is important for all women from various ethnic backgrounds to receive equal access to care and culturally appropriate care, which is also highlighted and reported in national policy initiates.

Figure 1.

Ethnic groups in England and Wales



*Source: Taken directly from Census – Office for National Statistics

National policy initiatives

A *superdiverse* nation poses long-standing challenges for developing government policy and practice, however, it was the overall aim of the UK to tolerate and respect these new emerging cultures and societies. This was through the development of multicultural policies and the reformation of public services (including health) in order to accommodate culture-based differences of value, language and social practice. This is an ongoing process, including national initiatives within Perinatal Mental Health. The Independent Mental Health Taskforce to the NHS in England (2016) reported the Five Year Forward View Plan for Mental Health (216). Support for new mothers and babies during the postnatal period was reported as a specific theme. Set out in the report, there has been an unprecedented investment of £365 million in Specialist Perinatal Mental Health Services (217). Moreover, there is an ongoing campaign to *'Let's Turn the Map Green'* so that all women can have access to evidence-based treatment (see Figure 2.). The aim is that Perinatal Mental Health Services should meet culturally specific beliefs, needs and values (217). Each individual has their own model of illness, which incorporates illness beliefs and causation. This will determine help-seeking behaviours, adherence to treatment and overall experiences of living through their illness.

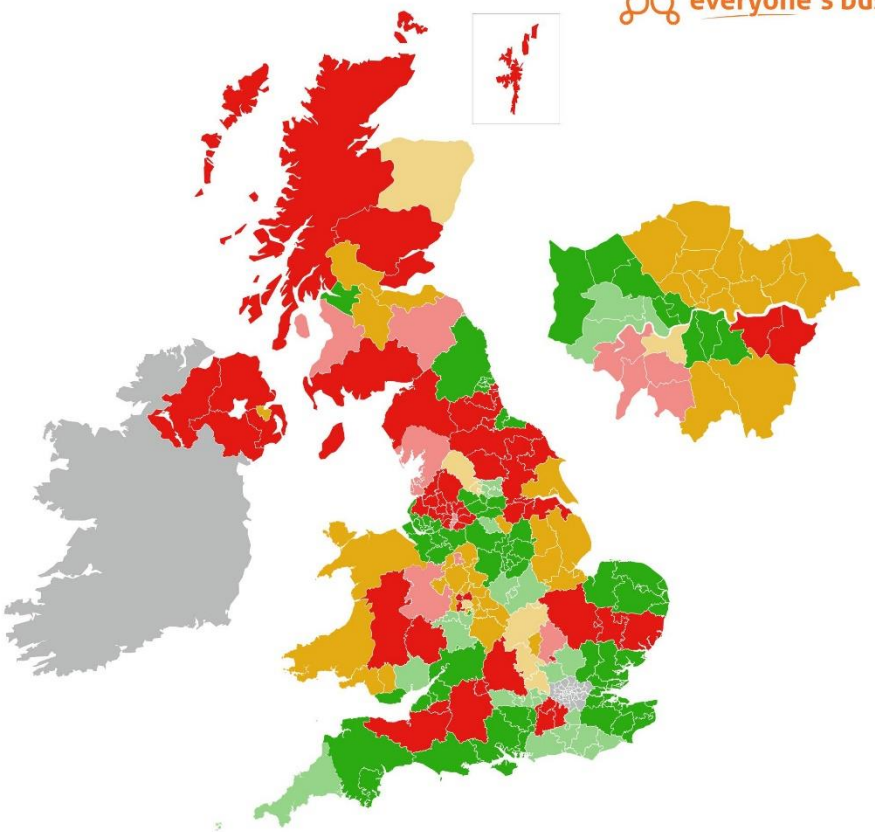
Figure 2.

UK Specialist Community Perinatal Mental Health Teams

2017 DATA
(RELEASED APRIL 2018)

UK Specialist Community Perinatal Mental Health Teams (Provision in 2017)

MATERNAL MENTAL HEALTH
everyone's business



LEVEL	COLOUR	CRITERIA
5		Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 http://bit.ly/2jouvAd
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria http://bit.ly/2AhAVeX
3		Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2		Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1		Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0		No provision

Disclaimer Details in this map and levels of provision have been assessed using the best information available at the time of printing.
Please contact info@everyonesbusiness.org.uk if you suspect any inaccuracy.

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby.

www.maternalmentalhealthalliance.org/campaign

MATERNAL MENTAL HEALTH ALLIANCE
Awareness Education Action

The MMHA Everyone's Business Campaign is hosted by Action on Postpartum Psychosis

APP

*Source: taken directly from Our Campaign | Maternal Mental Health Alliance

improving pathways and access to care has been an important topic part of the UK government, there is evidence to suggest that pathways to care and uptake of healthcare services may differ for ethnic minority populations. It is estimated that 60% of women with a perinatal mental health illness have no access to services and this can be because of inadequate provision of services, shortages of NHS staff, and lengthy waiting times. A recent systematic review and meta synthesis of qualitative studies were identified that explored barriers to accessing mental health services for women with perinatal mental illnesses (97). Qualitative findings included Individual (eg, stigma, poor awareness), organisational (eg, resource inadequacies, service fragmentation), sociocultural (eg, language/cultural barriers) and structural (eg, unclear policy) levels (97).

For patients with a sever psychiatric illness access to and outcomes from mental health services are well known for ethnic minority groups. For example, Halvorsrud and colleagues conducted a systematic review and meta-analysis as part of a national programme to tackle ethnic inequalities (218). Results showed worsening patterns of ethnic inequalities in pathways to psychiatric care, particularly among Black group. Barnett and colleagues explored ethnic variations in compulsory detention under the Mental Health Act and found that BAME groups and migrant groups were at a greater risk of psychiatric detention than majority groups (219). Nonetheless, the use of the Mental Health Act necessitates more use of in-patient beds, and more need for advocacy and quality of standards in assessment and treatment processes. (Bhui) Compulsory admission was also found to be higher in ethnic minority groups in the UK, after challenged of being conventionally admitted for psychiatric conditions (i.e. referral from primary care) (220). Possible explanations for this encompass social stigma associated with psychiatric conditions, and cultural and language barriers to conventional psychiatric

healthcare in ethnic minorities (97, 221). Moreover, patients who do not accept that they have a mental illness may be difficult to engage in interventions and may access services via complex pathways.

Equality and diversity considerations

In addition to all of the above discussed, the UK NICE guidelines also include a section under *Equality and diversity considerations.* This section states that healthcare professionals should be aware of the variations in the presentation of psychiatric illnesses and that they are culturally competent in their discussions with ethnic minority groups, such as South Asians. Moreover, psychological interventions should be tailored to women's individual needs and to ensure that assessments and management plans are culturally competent. This is important to consider in the UK, which has been characterised as *superdiverse* because of the various cultures and ethnicities. This will be discussed in the next section. In Western psychiatry, whilst diagnostically the emphasis is on symptoms, the experience of severe postnatal psychiatric illnesses is a much more diverse and complex phenomenon and each individual lives through it differently and uniquely to their illness beliefs and social and cultural contexts.

Chapter 2

Women's beliefs about the causes of postnatal depression: A systematic review

Abstract

Introduction

Postnatal depression is a major public health concern, which may produce adverse outcomes for the mother, infant, partner and family.

Aim

This aim of this review was to systematically review the qualitative evidence that explores women's beliefs on the causes of postnatal depression.

Methods

A systematic review of the qualitative literature on postnatal depression was undertaken via database and manual searching. Studies were included if they presented descriptive data and discussed postnatal depression occurring among women aged 18 and over. Studies not published in English were excluded as they could not be translated within available resources. Quality appraisal was conducted by two reviewers and analysis was undertaken using Noblit and Hare's meta-ethnography framework.

Results

16 qualitative studies presented seven themes: social difficulties, social-support, culture, biological/physical, obstetric/paediatric, psychological and spirituality.

Conclusion

To our knowledge, this is the first worldwide qualitative systematic review that follows a meta-ethnographic approach exploring women's beliefs about the causes of postnatal depression. Evident from the qualitative data reviewed, the majority of women's beliefs were shaped by social determinants. Existing quantitative findings have generally recognised women's biological makeup, psychosocial and cultural milieu as causal factors in postnatal depression. Therefore, our qualitative findings bring together women's subjective belief systems of causation and existing quantitative findings that have illustrated associations of postnatal depression. This adds to the strengthening of the argument of taking a holistic approach to women's postnatal mental health care through utilising the biopsychosocial model of care, to deliver equitable, accessible and culturally competent mental health services, care and treatment.

Step 1 Introduction

PND is a global mental health concern that affects between 10 and 15% of mothers after childbirth in Western societies (222). Recent epidemiological studies demonstrate higher prevalence rates of PND in developing countries ranging between 13.5 and 30% (223). The effect of PND may be detrimental for the mother, the infant, the partner and family relations (224, 225). Quantitative studies have demonstrated strong correlates of PND including a previous history of mental illness, stressful life events and the role of negative thought processes, low self-esteem, low social support and low income (19, 31, 226). The causes of PND are often described as multifactorial and usually divide into two explanatory frameworks of biological and non-biological theoretical approaches (227). The causal study of PND symptomology is predominantly endorsed by mainstream biomedical concepts in most Western cultures, whereby the onset of the illness is located within the biochemistry of the brain, genetic influences and hormone dysregulation (228).

In recent literature, there has been a recognition that biological factors alongside psychosocial and cultural determinants may influence biological functioning (165, 229). Since the 1980s there has been a rise in the awareness and recognition of the role of stressful life events, social difficulties and social vulnerabilities as well as predisposing existing conditions as factors of causation in psychiatric illnesses (230, 231). Further to understanding psychiatric illnesses through a social perspective, the importance of the patient's own belief systems around causation and its impact on the presentation of symptoms has become an important element of understanding cultural aspects of psychiatric illness (163, 232). The recognition of societal, cultural and individual factors in understanding psychiatric illness enables a shift towards a more collaborative relationship between the patient and the clinician.

Although Britain remains overwhelmingly White, according to the 2011 UK census 14% of the population belong to a BME group. BME groups encompass a variety of heterogeneous subgroups, including recent and settled migrants from many countries and ethnicities. Studies suggest some BME women experience higher levels of psychological morbidity after childbirth (2). What is known is that despite these high rates of community-level PND morbidity, fewer than expected BME women receive diagnosis and treatment (2). There is also evidence to suggest BME communities' lay understanding may differ from the mainstream Western medicalised conceptualisation of PND (2). International migration has become a 21st-century global phenomenon in most high-income nations, including the UK, therefore it is important to understand the nature of the illness across a range of cultures. This understanding will enable the development of culturally-appropriate responsive treatments and service provision. Therefore, the systematic review carried out addresses the objective of synthesising qualitative primary data to gain a worldwide understanding of women's beliefs about the causes of PND. By consolidating this information we will be able to better inform our understanding of how PND manifests across cultures.

Steps 2 -3 Method / design

A systematic review was conducted between February 2016 and June 2016. The key steps in performing a meta-ethnography developed by Noblit and Hare (1988) were adapted to complete a qualitative synthesis (233). See Table 3 for the step-by-step guide.

Table 3.
A step-by-step guide to completing a meta-ethnography

Step1 *Getting started*	To determine a research question that can be informed by qualitative research and to decide a focus of the synthesis. To provide a rationale for conducting the lit review by scoping the literature of interest
Step 2 *Deciding what is relevant to the initial interest*	Defining the focus of the synthesis: to review existing reviews on postnatal depression and find where the gaps in the literature exist. Locating relevant studies: conduct a search in the literature to find potential studies for the review Inclusion decisions: decide on the eligibility criteria for a study to be included in the analysis of the review Quality appraisal of included studies: to critically appraise all included studies to avoid any biases.
Step 3 *Reading the studies*	Becoming familiar with the content and detail of the included studies. Begin to summarise study characteristics and summarise emerging findings.
Step 4 *Determining how the studies are related*	To create a list of themes and determine how they are related. Create a grid or a table to display the concepts or themes across all studies. Themes can then be reduced into categories based on the primary data from the sources.
Step 5 *Translating studies into one another*	Comparing concepts in one account into another. Examine in detail the issue relating to the theme and begin to develop categories.
Step 6 *Synthesising translations*	Link together any key themes, which appeared from author translations and author interpretations.
Step 7 *Expressing the synthesis*	The uptake of the results into policy, programme development and research. The presentation of findings to people who develop new interventions.

Search strategy and eligibility criteria

Electronic databases were searched including Web of ScienceTM Core Collection, PubMed, OVID (PsychInfo, Medline) and CINAHL. Reference lists of included papers were manually searched for additional papers. A search strategy was generated by SPIDER guidelines for qualitative synthesis (234). Search terms included *postnatal depression, postpartum depression, interview, focus group, experience, view, belief and qualitative*. We included a publication if: (a) mothers were interviewed within 12 months after childbirth (b) mothers were recruited during pregnancy, however, data were collected within 12 months after childbirth (c) mothers were screened or diagnosed with PND (d) study design was qualitative (e) study was published in English language (f) study was published from 2000 to 2016.

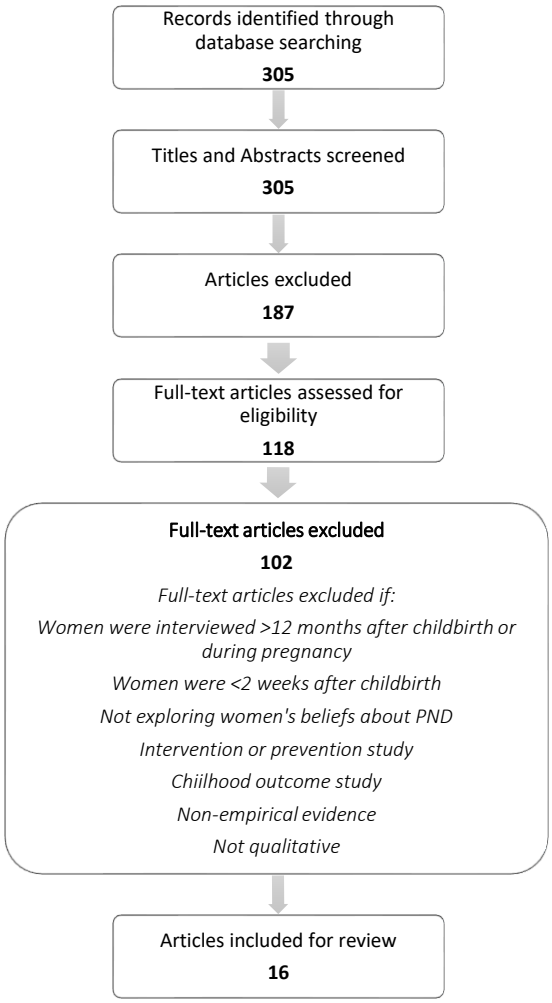
Data extraction and study quality appraisal

I independently extracted data from primary studies, using a standardised data extraction form. Data items included title, author and year of publication, country income group, study design, study aim, sample and setting, a measurement for PND, data collection and analysis method and key findings that discussed perceived causes of PND. The terms causes and contributors were identified in papers as a collective term for 'causation'. When women discussed contributors to the development of PND, we interpreted this as a form of causation. The methodological quality of each primary study was conducted by the second reviewer and I using the Critical Appraisal Skills Programme and the Evaluation Tool for Qualitative Studies checklists (235, 236). A clear definition for PND was included as an additional item on the final quality assessment tool. Because of the paucity of qualitative studies, all studies were included regardless of the quality scoring.

Results

A systematic literature search yielded 305 articles. After screening titles and abstracts (including duplicates), 118 studies were potentially eligible for review. The second reviewer and I examined 118 studies against the inclusion criteria. After accessing and reading 118 papers, 27 papers met the full eligibility criteria. A total of 18 papers were eligible after the removal of duplicates. A third reviewer verified the 18 studies against the excluded papers. An additional two papers were discussed and excluded. Sixteen papers were agreed by all reviewers for inclusion in the qualitative synthesis (see Figure 3).

Figure 3.
Study selection flowchart.



Study characteristics and quality of the evidence

Sixteen studies explored women's beliefs on the causes of PND, which were published between 2002 and 2016. Studies took place in lower middle, upper middle or higher income countries including South Africa, Bangladesh, Canada, Hong Kong, India, Sweden, Taiwan, US and UK. Across included studies the total number of participants accumulated to 443. Sample sizes ranged from 8 to 137 with an average of 27.7 (see Table 4.).

Table 4.

Study characteristics of all included papers

Study (Author, Year) Country Aim	Country income group	Sample description	Setting(s)	Measures of postnatal depression	Methods of data collection	Methods of data analysis	Key findings
A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with Postnatal depression Chan, 2002 Hong Kong Aim: To examine the lived experiences of a group of Hong Kong Chinese women diagnosed with PND and to investigate the factors perceived by the women as contributing to their depression	High income	N = 35 Age range 20-40	Postnatal depression Clinic	Edinburgh Postnatal Depression Scale > 10 Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition diagnosis of minor or major postnatal depression	In-depth semistructured interviews at the clinic or where the patient preferred Approx.1 hour	Collaizzi's phenomenological methodology	Trapped in the situation Uncaring husband Controlling and powerful in-laws
A qualitative study of the postpartum experiences of Chinese women living in England Lam, Wittkowski, Fox, 2012 United Kingdom Aim: To explore the postnatal experiences and the factors that contribute to their thoughts and feelings	High income	N = 8 Age range 24-34	Chinese postnatal centre and community	Edinburgh Postnatal Depression Scale > 10	Interviews with open-ended questions	Grounded Theory	Language and cultural norms Isolation Adjustment Lack of support Great geographical distance to family Status Development of conflict Role of mother-in-law Getting support No specific model for child parenting Different value system
An exploration of illness beliefs in mothers with postnatal depression Patel et al, 2013 United Kingdom Aim: To explore illness beliefs in women with postnatal depression	High income	N = 11 Age range 24-35	Perinatal services	Edinburgh Postnatal Depression Scale > 10	Semi structured face-to-face interviews 45-83 minutes	Grounded Theory	Unmet expectations Identifying stressors in life context Conflict with label Antidepressants: the lesser of the two evils Loss of time Uncertain futures

Being reborn: the recovery process of postpartum depression in Taiwanese women Chen et al, 2006 Taiwan Aim: To understand the psychosocial process by which PPD is alleviated	High income	N = 23 Age range 19-38	Teaching hospitals	Beck Depression Inventory >16	Interviews at 10-12 weeks after childbirth 1.5-2hrs	The constant comparative method	Shattered role identity Feeling trapped and breaking down Struggling for self-integrity Regaining vitality
Causes of women's postpartum depression symptoms: Men's and women's perceptions Habel et al, 2015 Canada Aim: to explore women's and men's perceptions of the causes of women's postnatal depression symptoms and how they differ	High income	N = 30 Mean ages 32.5 years	Two tertiary care hospitals	Edinburgh Postnatal Depression Scale >12	Face-to-face in-depth semi-structured interviews at the home 45-90 minutes	Content analysis	Societal pressure Physical health problems Transition to parenthood Social connectedness and support Personality and past psychological history Child health and temperament Unmet care needs Unmet birth expectations Other life stressors
Culture and postpartum mood problems: Similarities and differences in the experiences of first and second-generation Canadian women Mamisachvili et al, 2016 Canada Aim: To explore differences and similarities in experiences of PPMP between first and second-generation Canadian women and possible role for their cultural beliefs	High income	N = 17	Women's Health Centre	Edinburgh Postnatal Depression Scale > 12	Semi-structured interviews	Qualitative thematic analysis	Relationship with parents/in-laws Internalisation of society's expectations of motherhood Identify issues/relationship with self
First-time mothers' perceptions of motherhood and PND Val, 2003 UK Aim: To explore the experience	High income	N = 14 Age range 17-38	General Practitioners or health visitor caseloads	Edinburgh Postnatal Depression Scale >10	Semi-structured interviews in their own homes 1hr	Constant Comparative Technique	Joy and wonder Responsibility Support Change in life/expectations Postnatal Depression

of first-time mothers considering their view of postnatal depression and to also investigate the significant factors, which contributed to postnatal depression							
"I can't stop worrying about everything" – Experiences of rural Bangladeshi women during the first postpartum months Edhborg et al, 2015 Bangladesh Aim: Qualitative studies are rare – this study aims to describe the experiences and concerns of rural Bangladeshi mothers with postpartum depressive symptoms	Lower middle income	N = 21 Age range 17-45	Two community sub-districts	Edinburgh Postnatal Depression Scale >10	Open narrative interviews at the home 2 hours	Inductive content analysis	Family dynamics Living at the limits of survival Role of the cultural context after childbirth
Listening to mothers: qualitative studies on motherhood and depression from Goa, India Rodrigues et al, 2003 India Aim: To use qualitative methods to investigate the cultural validity of the construct of PND and its social and cultural contexts	Lower middle income	N = 39 Mean age 25.5	The district hospital in North Goa	Edinburgh Postnatal Depression Scale > 11/12	In-depth interviews in the woman's home	Not reported	Overwork Lack of practical support Economic difficulties Poor marital relationships
Perceptions of postnatal depression and health care needs in a South African sample: the "mental" in maternal health care Kathree et al, 2014 Africa Aim: To understand the explanatory models of illness	Upper middle income	N = 10 Age range 21-59	Women attending community health centre postnatal waiting room	Edinburgh Postnatal Depression Scale > 12 Structured Clinical Interview and Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition diagnosis for	In-depth face-to-face interviews, follow-up interviews and observations in the homes	Thematic analysis	Poverty and dependence Interpersonal conflicts (with partners and families) Unwanted pregnancy Social isolation

help b women with maternal depression				major depressive disorder			
Postnatal depression: a qualitative study of the experiences of a group of Hong Kong Chinese women Chan, Levy, 2003 Hong Kong Aim: To describe the experiences of PND in Hong Kong Chinese women and to investigate the factors perceived by the women.	High income	N = 35 Age range 20 – 40	Postnatal depression clinic in a hospital region	Edinburgh Postnatal Depression Scale > 10	In-depth semi structured interviews 60-90 minutes	Collaizzi's phenomenological methodology	Trapped in the situation Uncaring husband Controlling and powerful in-laws Regaining control
Postpartum depression and help-seeking behaviours in immigrant Hispanic women Callister, Beckstrand, Corbett., 2011 United States Aim: to describe perceptions of immigrant Hispanic women experiencing symptoms of PND	High income	N = 20 Mean age 24	Community health clinic in a western state	Postpartum Depression Screening Scale > 60	Audiotaped interviews held in their homes 60mins	Audiotaped interviews were transcribed and translated. Emerging themes were identified	Personal barriers Social barriers Health care delivery barriers
Postpartum depression in the community: A qualitative study from rural South India Savarimuthu et al, 2010 India Aim: This study examined the factors associated with PND	Lower middle income	N = 137 Mean age 23.67	Large villages in the catchment area	Edinburgh Postnatal Depression Scale International Classification of Diseases-10 clinical diagnosis to identify depression	The Short Explanatory Model Interview	Items were enumerated and the broad features identified	Age less than 20 or over 30 years Schooling less than 5 years Thoughts of aborting current pregnancy Unhappy marriage Physical abuse during current pregnancy and after childbirth Husband's use of alcohol Girl child delivered in the absence of living boys and a preference for a boy Low birth weight Family history of depression
Stress in women with postpartum depression: a phenomenological study Leung, Arthur, Martinson., 2004 Hong Kong Aim: to report the lived experiences of	High income	N = 11 Age range 18-45	Recruited from a larger study	Edinburgh Postnatal Depression Scale >13	In-depth interviews in the participants' homes 45mins – 1hr	Colaizzi's method	Living in a metropolitan city under the mixed and sometimes conflicting influences of cultures from the East and the West Parenting competence The expectation experience gap Baby-minder arrangements Childcare demands

postpartum stress among depression Hong Kong Chinese women							Conflict with culture and tradition
"Struggling with life": Narratives from women with signs of postpartum depression Edhborg et al, 2005 Sweden Aim: To explore and describe how Swedish women with signs of postpartum depression experience the first month with their child	High income	N = 22 Age range 20-42	University hospital maternity ward	Edinburgh Postnatal Depression Scale > 9/10	Unstructured interviews in the families' homes 25-60mins	Constant Comparative Methods	Struggling with life Struggling with life related to the self Living up to the image of the "good mother" Struggling with life related to the child Emotional feelings Struggling with life related to the partner Father-child relationship
The experiences of postnatal depression in South Asian mothers living in Great Britain: a qualitative study Wittkowski et al, 2012 United Kingdom Aim: To examine the understanding s of PND in South Asian mothers living in the UK	High income	N = 10 18+	Recruited through health visitors and midwives	Edinburgh Postnatal Depression Scale > 12	Interviews 1-1.5hrs	NVivo Constant Comparative Methods and Grounded Theory	Internalising misery Others will judge me and I feel on my own I talk to my health professional and they don't understand

The methodological quality of studies scoring ranged between 18 and 97%. Methodological flaws were common across studies. Firstly, authors in seven studies did not address or discuss the limitations of the study. Ten studies did not clearly define PND and finally, a lack of information on ethical approval was identified in six studies (see Table 5.).

Table 5.

Study quality results for primary studies

Author	Chan et al.	[redacted]	Patel et al.	Chan et al.	Habel et al.	Mamisachvili et al.	Thurtle.	Edhborg et al.	[redacted]	Kathree et al.	Chen, Levy	[redacted] Callister, Beckstand,	Savarimuthu et al. [28]	Leung, Arthur, Martinson.	Edhborg et al.	Wittkowski et al.
Clear aims/research question	+1	+1	+1	+1	+1	+1	+0.5	+1	+1	+0.5	+1	+1	+1	+1	+1	+1
Design appropriate to answer research question	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1
Setting appropriate for research question	+1	+1	+1	+0.5	+1	+1	+0.5	+1	+1	+1	+1	+1	+1	+1	+1	+1
Recruitment process given	+1	+1	+0.5	+1	+1	+1	+0.5	+0.5	+0.5	+0.5	+1	+1	+0.5	+1	+0.5	+1
Participants appropriate to research question	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1
Ethical approval/informed consent given	+1	-1	+0.5	+1	+1	+1	+0.5	+1	-1	+1	-1	+1	-1	+1	+1	+1
Data collection method adequately described	+1	+0.5	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1
Data sufficiently detailed for research question	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+0.5	+1	+1	+1
Researcher bias addressed	+1	+1	+0.5	+1	+1	+1	+1	+0.5	+0.5	-1	+0.5	+0.5	+0.5	+1	-1	+0.5
Clear descriptions of analytical method	+1	+1	+1	+1	+1	+1	+0.5	+1	+0.5	+0.5	+1	+0.5	+0.5	+1	+1	+1
Clear descriptions of how results derived from analysis	+1	+1	+1	+1	+1	+1	+0.5	+1	+0.5	+0.5	+1	+1	+1	+1	+1	+1
Analysis not biased by researcher	+1	+1	+1	+1	+0.5	+1	-1	+1	+0.5	+1	+0.5	+1	-1	+1	-1	+1
Findings presented in sufficient detail	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+0.5	+1	-1	+1	+1	+1
Findings discussed in context	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1	+1
Implications discussed	+1	+1	+1	+1	+0.5	+0.5	+0.5	+1	+0.5	+1	+1	+1	-1	+1	-1	+1
Limitations of study discussed	+0.5	+0.5	+1	-1	+0.5	+1	+0.5	+0.5	-1	+0.5	+0.5	-1	-1	-1	-1	+1
Definition of postnatal depression	+1	-1	-1	-1	+0.5	+1	-1	-1	-1	-1	+0.5	-1	-1	-1	+0.5	+0.5
Total Score	16.5	12	14.5	12.5	15	16.5	9	13.5	8	10.5	10.5	12	3	13	8	15.5
Percentage (%)	97%	70%	83%	74%	88%	97%	53%	79%	47%	62%	62%	71%	18%	76%	47%	91%

Note: To assess the quality of the included study, all items were accumulated for each study and given a 'total score'. This total score will be divided by the total number of criteria items (18). This was converted to give a percentage (%). For example, if a study had a total score of 16 this would be dived by 17 to give a percentage of 94%. A percentage closer to 100% is considered to have a thorough methodological structure. If criteria items were fully met, a score of +1 was given and items that were partially met were given a score of +0.5. If items were not met, they were given a score of -1 and if items were not applicable a score of zero was given.

Steps 5 – 7 Findings: Women's beliefs about the causes of PND

Key findings extracted from primary studies were tabulated and synthesised into seven themes. Table 6 summarises the following themes and sub-themes that will be discussed: social difficulties were reported in 12 studies, social-support and culture was cited in 10 studies, biological/physical and obstetric/paediatric were both mentioned in nine studies, eight studies found psychological as a cause and only one study reported spirituality as a cause of PND (see Appendix 1. for Step 4 and the summary of findings). As we can see from the themes that have emerged, factors linked to social and cultural aspects of women's lives play a dominant part in the women's belief system on the causes related to their PND.

Table 6.
A summary of main themes and sub-themes

Main theme (number of studies that discussed each theme)	Sub-themes (number of studies that discussed each sub-theme)
Social difficulties (n=12)	Unhappy relationship (n=7) Financial worries and poverty (n=6) Immigration (n=5) Domestic violence and abuse (n=3) Infidelity or polygamous relationships (n=2)
Social – support (n=10)	Lack of support from family relations (n=6) Lack of support from the husband/partner (n=5)
Culture (n=10)	Conflict with parents and parent-in-laws (n=5) Gender preference of the baby (n=4) Postnatal cultural traditions/rituals (n=4) Cultural clash (n=1)
Biological/Physical (n=9)	Physical health changes after childbirth (n=7) Genetic, hormones or biomedical influences (n=3) Breastfeeding (n=3)
Obstetric/Paediatric (n=9)	Child's health, safety and temperament (n=7) Unwanted pregnancy, childbirth complications and fear of childbirth (n=4)
Psychological (n=8)	Expectations versus the reality of motherhood (n=8) History of mental health problems (n=3)
Spirituality (n=1)	Spiritual beliefs (n=1)

Social difficulties

Unhappy relationship

Mothers in seven studies spoke of negative or poor relationships with their husbands for their anger, distress, irritation and disappointment (237-243). Hong Kong Chinese women described the deterioration and the strain of their relationship after the birth of the baby (237). Some South African mothers in one study mentioned complete rejection by the partner as a cause of their PND (240).

Financial worries and poverty

In a study set in a lower-middle-income country, 21 Bangladeshi mothers reported poverty and difficult economic situations (243). Most mothers were reliant on their husbands for financial support as the main source of income in providing food for the infant and family (243). Insufficient financial support in lower middle income and high-income countries led to the worry and stress of not feeding the infant properly and contributed to PND (239, 240, 242-244). Poverty was also informed as a cause by mothers in South Africa, an upper-middle-income country (240). Poverty renders mothers on state support such as Child Support Grant, however this was often described as inadequate. Financial insecurity led to mothers feeling stressed and helpless, which was believed by mothers in triggering their depressive state after childbirth (240).

Immigration

Immigration was disclosed by mothers in five studies as a cause of PND (244-248). Mothers in these studies immigrated to high-income countries including the UK, US and Canada (244-247). Mothers originally from Rwanda and Hong Kong who immigrated to Canada, experienced

isolation and found it challenging to identify with the Canadian culture (247). Chinese speaking mothers who immigrated into the UK were restricted by immigration laws and so, family visits were often problematic (248). This resulted in their isolation, frustration and contributed to a lack of support after childbirth (248). Hispanic mothers living in the US found that they also received a lack of support because of their immigration status (246). The traditional social networks were often compromised because of family separation for immigrant women in this study (246). Most mothers in a UK based study immigrated from India and Pakistan and spoke and read little English (245). Mothers felt extremely isolated from social networks and received little support from both family and mental health services. Language and communication presented barriers to and from services in a Western setting. Mothers reported feeling discriminated against when their illness experiences were perceived to be misinterpreted by healthcare professionals (245).

Domestic violence and abuse

Bangladeshi and South African mothers reported domestic violence after childbirth including getting beaten up by their husbands or having had objects thrown at violently as causes of PND (240, 243). Physical abuse during the antenatal period was also expressed in South Indian mothers as a reason for experiencing PND (242).

Infidelity or polygamous relationships

Bangladeshi and South African mothers in two studies indicated infidelity or polygamous relationships (240, 243). This led to fights and quarrels in the family and was believed as a major cause for their PND (240, 243). Infidelity was perceived with HIV and sexually transmitted diseases and two South African mothers reported their concern about these

transmittable diseases because of the absence of protection during physical intercourse with their partner (240). These feelings of worry, pain and sadness were believed to contribute to PND.

Social – support

Lack of support from family relations

Prevalence rates for PND are higher in South Africa and range between 16.4 and 39% (240). Some South African parent-in-laws failed to accept the new baby into the family. This is because the South African culture demands that a letter should be written to inform the family about the pregnancy and delivery of the baby. As this was not followed by some new mothers, members of the family did not acknowledge the child and consequently did not provide their support (240). 14 mothers in this study cited the lack of family support contributed to the burden of their depression (240). Canadian mothers similarly related their PND symptoms to a lack of family support (244). Women's' needs did not coincide with the actual support received from the partner, family and/or friends (244). A lack of social support was believed and described as a stressor after childbirth that women related to their postnatal mood problems (241, 246, 247). In another study set in Goa, women felt as though they received both practical and emotional support from husbands and mothers, yet there was a desire for more support (239).

Lack of support from the husband/partner

Postnatally depressed mothers across five studies cited uncaring and unsupportive husband/partner as an important source of their unhappiness and isolation (237-239, 245, 249). Mothers felt their husbands did not provide practical support such as, taking care of the

baby and general household duties. Mothers in 3 studies felt that their husbands failed to recognise how they were feeling and could not offer their emotional support (237, 239, 245).

Culture

Conflict with parents and parent-in-laws

In Chinese culture, mothers-in-law were faithful to cultural practices (237, 248-251). New mothers were put on a special diet by their mothers-in-law including meat and ginger, as this was believed to enhance maternal strength and remove excess 'wind' after childbirth (248). This caused inconvenience for new mothers and they felt forced to obey the cultural practice (248). Similarly postnatal diet restrictions were reported as a cause for PND in 8 Chinese mothers (251).

In five studies, mothers-in-law in the Asian culture were reported to dictate parenting-practices that were culturally appropriate (237, 245, 247, 249, 250). Mothers-in-law in Canada believed in formula feeding the child as opposed to breastfeeding (247). This caused conflict between the mother and mother-in-law and 15 mothers described this as problematic and stressful (247). In most Asian cultures, mothers felt that older generations did not comprehend postpartum mood problems and felt they could not express their feelings. The unkind comments, powerful and authoritative behaviour from mother-in-law contributed to interpersonal conflicts and the mother's unhappiness in 3 studies (237, 245, 250).

Gender preference of the baby

In most Chinese and South Asian families, the cultural preference for sons was desired (239, 242, 243, 251). In 3 studies, South Asian mothers mentioned the delivery of a girl in causing

their PND (239, 242, 243). Bangladeshi mothers felt sad and disappointed and often reported the desire for sons (243). In a lower-middle-income country, depressed mothers from India explained the birth of a baby girl as a reason for their distress and were afraid of their in-laws' reaction if a girl was born (239). The Chinese culture similarly prefers the birth of a male, as males will continue the family name into the next generation (251). Although Hong Kong mothers were not affected by the gender of the baby, senior members of the family preferred sons. This hidden pressure for women to give birth to a son caused their unhappiness (251). Mothers in Western cultures did not perceive the gender of the baby as a cause of PND. No study reported Asian women in the west and their preference of they baby as a contributing factor for their PND.

Postnatal cultural traditions/rituals

Postnatal cultural traditions and rituals are practised in some Asian cultures. Chinese traditional practice 'Zuo Yue' or 'Doing the month' requires new mothers to stay indoors one month after childbirth (248, 251). New mothers receive heightened care and are expected to adhere to strict dietary and activity rules to protect both themselves and the infant (248, 251). Mothers felt restricted and isolated from their social network and outside support. Mothers felt forced to accept traditional rituals and reported feelings of stress, low mood or loss (248, 251). Bangladeshi mothers were likewise restricted to stay indoors and follow dietary recommendations, as this was suggested to protect the mother and baby from the *"evil eye"* as they feared something negative would happen to the baby (243). South Asian culturally prescribed practices expect women to move into their parent-in-laws house after marriage (243, 245). South Asian women who immigrated into the UK after marriage, found this transition difficult during motherhood, including adjustments to marriage, motherhood and

the UK Western culture (245). The accumulations of these social adjustments were perceived to cause PND (243, 245).

Cultural clash

Chinese immigrant women who engulf a strong set of cultural values struggled to accept or assimilate into British values (248). These were usually Chinese-speaking women, as they felt they would not be understood by Western culture. The problematic language and communication barriers contributed to their conflict, isolation and PND (248).

Biological/Physical

Physical health changes after childbirth

An unexpected change Taiwanese mothers experienced during the postnatal period involved physical exhaustion, which was perceived to contribute to PND symptoms (250). In a study set in India, mothers reported the demanding nature of motherhood, which led to physical tiredness and was perceived to contribute to their PND (239). Canadian women similarly reported physical health problems such as lack of sleep and fatigue because of infant care demands (244).

South Asian mothers in three studies described health-related issues as causes of their PND (239, 242, 243). Mothers from Bangladesh attributed a loss of blood and deficiency of vitamins and calcium during childbirth, which stemmed weakness and lack of physical strength (243). Other physical health problems included stomach pains, chest pains, headache, dizziness, low or high blood pressure, jaundice, urinary problems, gastric problems, tumour, trouble in mobilisation. Mothers from Goa described health problems such as lower backache, heavy

menstrual flow, stomach-ache, body ache and cold (239). Women also reported health problems after childbirth from Rural South India (242).

Some mothers reported changes in their physical appearance as perceived causes of PND, for example, weight gain or loss after childbirth (238, 241, 243). This change affected mothers' psychological well-being, as they were not able to emotionally identify with themselves and felt a loss of their previous physical identity. Mothers were surprised and confused, which negatively affected their psychological well-being (238).

Genetic, hormones or biomedical influences

Biomedical explanations were reported by mothers in 3 studies from high-income Western countries (241, 244, 252). Mothers reported hormonal fluctuations after childbirth that triggered PND symptoms (244, 252). Mothers living in the UK reported the influence of hormones, genetics, brain factors such as confusion, memory difficulties and some even suggested pathology in the brain (241). One mother endorsed a purely medical model in suggesting PND as a chronic mental health difficulty. In contrary, some mothers believed their depressive symptoms were related to their feelings and emotions (241).

Breastfeeding

Not being able to breastfeed was perceived to cause distress for mothers, as they fell short of the societal expectations to provide milk for the infant (244, 251). Eleven Hong Kong Chinese mothers reported breastfeeding difficulties as a cause of their PND (251). Some mothers were hesitant about the amount of milk the baby was taking in (251). Moreover, mothers felt stressed when they had prepared to breastfeed but had to unexpectedly learn how to bottle-

feed their baby (251). In a study that explored Swedish women's experiences of PND, mothers expressed their inability to breastfeed and labelled themselves as *"bad mothers"* (238). Mothers who could not produce milk felt guilty in not fulfilling the expected responsibilities of motherhood, causing them stress (238).

Obstetric/Paediatric

Child's health, safety and temperament

Caring for a child who is either unwell, sick, crying more, eating problems or experiencing weight loss proved great stress for mothers (242-244, 251). This was challenging for new mothers and was perceived as contributing to the onset of depressive symptoms in early motherhood. Thurtle found that the arrival, priority and the demands of the baby were the biggest change in first-time mothers living in the UK (252). Hong Kong Chinese mothers were concerned about the health and safety of the child (248). Mothers became stressed because of the practical demands of the infant and the lack of knowledge on how to care for their infant. Some mothers felt incompetent when performing basic skills in caring for their baby, for example bottle-feeding and changing diapers. Mothers in these two studies were frustrated and felt a sense of failure during motherhood as they could not fully provide for their infant (248, 252). Swedish mothers felt unprepared and feared to look after the child alone, which prompted feelings of anxiety (238).

Unwanted pregnancy, childbirth complications and fear of childbirth

Unplanned and unwanted pregnancies were highlighted as significant stressors for mothers from South Africa and contributed to PND symptoms (240). Bangladeshi mothers in one study were insecure they would fall pregnant when their husbands did not agree to birth control

(243). Reasons for unwanted pregnancy included a lack of support from the partner and the inability to support the child in two lower-middle and upper-middle-income countries (240, 243).

Mothers in Bangladesh were insecure and feared their own death, their child's death or childbirth obstetric complications (243). Some women experienced complications during labour, causing poor health conditions that contributed to their depressive symptoms (243). Unexpected obstetric complications, such as traumatic pregnancies and traumatic births were experienced in UK mothers who were depressed following childbirth (241). This also caused incongruence in their experiences and expectations of early motherhood experiences and so contributed to PND symptoms. A group of women from urban centres of the province of Quebec in Canada also experienced unmet birth expectations (244). For example, one mother had an emergency C-section, which was perceived to have contributed to the development of PND symptoms.

Psychological

Expectations versus the reality of motherhood

For mothers in seven studies, the transition to motherhood was not as they expected and was perceived to cause PND (239, 241, 244, 247, 250-252). Taiwanese mothers described the transition as a *"kind of survival training"* because of the unbearable postnatal changes (250). Mothers also experienced a loss of independence, identity and previous lifestyle during this transition (238, 241, 247). When mothers experienced this unexpected conflict between the picture and reality of motherhood, feelings of frustration, loss and confusion were reported (251, 252). Mothers also experienced complications during childbirth, emotional changes and

poor physical health during the postnatal period. This was not coherent with their idealised expectations of motherhood (241). At first, mothers denied all difficulties by attributing their experiences to the baby blues, hormones, exhaustion or a passing phase (241).

History of mental health problems

In two high-income countries, mothers who previously experienced depressive symptoms or other types of mental health problems felt susceptible to developing PND (241, 244). Mothers also reported their current episode of PND would make them more likely to experience future episodes of PND (241). Mothers in rural South India reported a family history of PND, thus felt vulnerable to developing PND (242).

Spirituality

Spiritual beliefs

Spiritual beliefs were only reported in one study as a perceived cause for PND. A group of new mothers from rural India explained magico-spiritual beliefs as reasons for their PND symptoms (242). These beliefs included black magic, karma, punishment by God and the evil spirit. These beliefs were also perceived as causes for other health-related problems in the postnatal period (242).

Discussion

To our knowledge, this is the first comprehensive systematic review that follows a structured approach in synthesising primary data from the small body of qualitative research that understands women's beliefs about the causes of PND. Following a meta-ethnography approach, seven themes emerged from primary studies: social difficulties, social-support, culture, biological/physical, obstetric/paediatric, psychological and spirituality. The qualitative synthesis of 16 primary studies demonstrate the multi-dimensional responses that comprise predominantly within non-biological paradigms. While PND symptomology can be universally identified via clinical assessment, women's understanding and beliefs are shaped by their subjective experiences. This information is useful when service users in Western settings such as the UK come from diverse countries and ethnicities. Datum discussing subjective experiences addresses explanations for health differences across ethnic minority groups that aims to reduce the ethnic inequalities in health and illness. Therefore the discrepancy between the clinician's biomedical lens and the patient's interpretation of illness is an important one. Also of importance is the discrepancy between societal and cultural constructions of motherhood being a joyful time and the findings of our review that some women with PND report this as a period of emotional, physical and psychological maladjustment. Our qualitative findings suggest several unique challenges women experienced during the transition to motherhood including physical health changes, increased body image dissatisfaction, difficulties coping with the demands and care of the infant and a loss of previous independent lifestyle. Motherhood has been reported as a major developmental life event and our qualitative findings illuminate the complexities of women's subjective psychological experiences, which can be an important part of a woman's causal belief system of PND (253).

Consistent with previous literature on social determinants of mental health, the majority of women included in this systematic review reported causes that were alternative to the biomedical explanation (28, 168). Evident from the qualitative literature reviewed, the various non-biological factors included intimate partner violence, social ostracisation for giving birth to a girl, lack of financial autonomy, restrictions on liberty imposed by postnatal traditional practices/rituals and unwanted or unplanned pregnancy. In line with previous literature, these findings suggest that the origins of much of the suffering are particular to women; the discrimination faced, the particular social stressors, women's socio-economic status and the expectations faced by women, can be traced to the positions women occupy in society and are connected to culture within those societies (254). Therefore, assessing and diagnosing PND should include an understanding of the social and cultural contexts of a woman's life. Focusing a lens on a woman's social and cultural circumstances during the postnatal period provides an opportunity for understanding the aetiology of psychiatric illness.

The study of female biology and PND is fairly established in previous literature (255, 256). However, our systematic review qualitative findings revealed that beliefs about causes of PND related to a Western biomedical concept were cited less frequently from the women's perspective. These included physical health changes after childbirth, genetics, hormones or biological influences. When examining the sample characteristics of women included in these few studies, women were predominantly from high-income Western cultures, where the medical model of illness dominates. In contrast, when taking a comprehensive overview and considering the complete qualitative data reviewed, the findings demonstrate the diversity of social and culturally linked causal beliefs of PND. The majority of studies found in the qualitative systematic review support the notion that non-Western and Caucasian women

differ in their beliefs about the origins of depression after childbirth, which may impact preferences and adherence to treatment as demonstrated in previous literature (257). The heterogeneity of women's conceptualisations of PND may be ill-suited to a Western biological paradigm and so evidence-based treatments originally developed in Western countries may not be applicable for non-Western population groups, thus may require review. Different treatment options employ different aetiologies of PND, with psychotherapies and social interventions tending towards non-biological conceptions and pharmacotherapy towards biological explanations. Therefore, in clinical practice it is imperative to examine patient's subjective understanding to their aetiology using a broader approach also incorporating their social and cultural contexts, such as the biopsychosocial model of care (134). Within superdiverse high-income nations, there is an importance in recognising that cultural competency and cultural relativism are essential to successfully manage and treat patients experiencing postnatal mental illness from various cultural and minority ethnic backgrounds, otherwise healthcare professionals can easily fall prey to errors of diagnosis and inappropriate management and care (134). Cultural competency is now a core requirement for mental health professionals working with culturall diverse patient groups. Health care professionals should, therefore, view and make sense of the patient's experiences, beliefs and values from the patient's own culture, which may not be regarded by the cultural criteria of other existing social groups (258). This will help health care professionals remain culturally sensitive and concordant to the patient's understandings that are central to their psychopathological experiences (258, 259). Therefore, this representative study of biological, psychosocial, social and cultural matrix to understanding PND provides evidence that there is a need for multi-disciplinary clinical teams to devise culturally and socially appropriate care and management plans.

Limitations and strengths

Firstly, the methodological quality across studies presented inconsistencies, thus findings and implications for clinical practice can only be recommended. Third, only one author extracted data, which may have influenced some bias. Nonetheless, we used a systematic and rigorous methodology to search for published studies that explored perceived causes of PND and two reviewers independently critically appraised the evidence.

Limitations

The majority of studies had small samples sizes, cultural heterogeneity thus there is a lack of generalisability of findings. In addition, only few papers were from higher-income countries similar to the UK, which may limit the findings for a UK audience. Moreover, although all studies used a validated screening tool to detect PND symptoms, 14 studies did not clinically diagnose mothers with PND. We only included studies published in the English language. Studies published in other languages may have contained useful information, however could not be achieved for this review as a result of limited resources.

Implications for clinical practice and future research

Given the range of studies included in our review, further high-quality qualitative studies are needed that explore BME women's experiences of PND. This will help facilitate the development of an intervention. For example, to enable postnatal women to deal with the discrepancy between the antenatal expectation and postnatal realities, consideration should be given to developing an educational intervention for women to address this need by both health care professionals and postnatal women with lived experience. Furthermore, qualitative findings highlighted the importance of soceioeconomic factors that contribute to women's

mental illnesses during the postnatal period. Therefore, there is a need for health care professionals to be aware of the patient's subjective experiences and understandings of PND in BME communities where a biomedical explanation of illness may not be present. Using the biopsychosocial model of care enables a holistic and patient-centred care approach to treatment.

Review Update

The searches for this syetamtic review were updated from June 2016 to December 2020. The same methods were followed and search terms included *postnatal depression, postpartum depression, interview, focus group, experience, view, belief and qualitative*. Web of Science Core Collection identified 158 potentially eligible papers. After screening titles and abstracts, 12 papers appeared eligible for review. The 12 papers were accessed and read in full and 7 papers were excluded. An additional 4 papers were identified and met the criteria for review (260-263). See table 7 for a summary of study characteristics and table 8 for study quality results.

Table 7.

Study characteristics of included papers (review update)

Study (Author, Year) Country Aim	Country income group	Sample description	Setting(s)	Measures of postnatal depression	Methods of data collection	Methods of data analysis	Key findings
"Pain in my heart": Understanding perinatal depression among women living with HIV in Malawi. LeMasters et al, 2020, Malawi Aim: To examine experiences of PND among women living with HIV (WLWH) in Malawi.	Low income	N = 24 Age mean 27	Urban and rural ANc clinics	Edinburgh Postnatal Depression Scale > 10	Semistructured interviews	Thematic and narrative analysis	HIV diagnosis and stigma Pregnancy issues Marital issues
Mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth: a qualitative study Johansson, Benderix & Svensson, 2020, Sweden Aim: The study aims are to explore the lived experiences of mothers and fathers of postpartum depression and parental stress after childbirth.	High income	N = 15 Age range 25 - 43	Not reported	Edinburgh Postnatal Depression Scale > 10	Qualitative interviews	Interpretative Phenomenological Analysis	Problems during pregnancy Traumatic delivery
Passing through difficult times": Perceptions of perinatal depression and treatment needs in Malawi-A qualitative study to inform the development of a culturally sensitive intervention Ng'oma et al, 2019, Malawi	Low-income	N = 22 Age range 25 - 43	Clinics in 1 rural and 1 urban health care setting in Lilongwe District, Malawi	Chichewa version of the Edinburgh Postnatal Depression Scale	In-depth interviews	Descriptive exploratory design	Financial difficulties Relationship problems (polygamy, lack of support, neglect, and infidelity) Traumatic events (intimate partner violence and loss) Fear of birth outcomes

Aim: to explore the perceptions of perinatal women and key maternal care health workers about perinatal depression and the health service needs required to inform development of a culturally sensitive and acceptable psychosocial intervention.							
Chinese American women's experiences with postpartum depressive symptoms and mental health help-seeking behaviors Ta Park et al, 2019, USA Aim: The objective of this study was to explore the perspectives of postpartum depression (PPD) and mental health help-seeking behaviors among Chinese American women.		N = 15 Age range 29 - 39	Referrals from community partners, and word of mouth.	Edinburgh Postnatal Depression Scale > 10	Qualitative interviews	Content analysis	Having your life change when you become a new parent Lack of social support Hormonal changes Inability to breastfeed A sign weakness, caused by another illness, and is all in the head or self-infl icted.

Table 8.

Study quality results for primary studies (review update)

Author	LeMasters et al.	Svensson Benderix Johansson	Ng'oma et al.	Park et al.
Clear aims/research question	1	1	1	1
Design appropriate to answer research question	1	1	1	1
Setting appropriate for research question	1	-1	1	1
Recruitment process given	1	1	1	0.5
Participants appropriate to research question	1	1	1	1
Ethical approval/informed consent given	1	1	1	-1
Data collection method adequately described	1	1	1	0.5
Data sufficiently detailed for research question	1	1	1	1
Researcher bias addressed	-1	1	1	-1
Clear descriptions of analytical method	1	1	1	0.5
Clear descriptions of how results derived from analysis	1	1	1	1
Analysis not biased by researcher	1	1	1	0.5
Findings presented in sufficient detail	1	1	1	1
Findings discussed in context	1	1	1	1
Implications discussed	1	1	1	0.5
Limitations of study discussed	1	1	1	-1
Definition of postnatal depression	-1	-1	1	1
Total Score	13	13	17	8.5
Percentage (%)	76 %	76 %	100 %	50 %

Note: To assess the quality of the included study, all items were accumulated for each study and given a 'total score'. This total score will be divided by the total number of criteria items (18). This was converted to give a percentage (%). For example, if a study had a total score of 16 this would be dived by 17 to give a percentage of 94%. A percentage closer to 100% is considered to have a thorough methodological structure. If criteria items were fully met, a score of +1 was given and items that were partially met were given a score of +0.5. If items were not met, they were given a score of -1 and if items were not applicable a score of zero was given.

Updated findings: Women's beliefs about the causes of PND

Most women in a study conducted in Malawi found that psychological and social challenges were a primary cause of their PND (262). There included life struggles, relationshoip problems, fear of pregnancy outcome and traumatic events. For almost all women, llife struggles included poverty, struggling to meet daily needs, having no means of earing a living, having no food and poor living conditions. Because of these struggles, women has persistent thoughts about their problems and some expressed a wish to die of commit suicide. Moreover, some women in this study did not feel care for/loved by their spouses and felt inadequate and/or complete lack of support (262). Causes of depression also included indifelity and unfaithfulness, abandonment and conflicts. Most women in this study also expressed worry and fears regarding birth outcomes. For example, witchcraft and ancestral beliefs of having mixed blood if one has had more than one sexual relationship was a fear among women who thought they would have complications during delivery due to such beliefs. Previous traumatic experiences such as loss of previous pregnancy or baby and forms of various abuse from partners were also identified as contributing to women's PND (262). Similarly, Swedish mothers revealed that they had become depression almost immediately after childbirth. Causes of PND were due to miscarriages before having a child, a fear over losing the baby during pregnancy, complications during pregnancy and traumatic delivery (for example, acute caesarean section and multiple miscariages) (261).

Some Chinese American women reported that their depression after giving birth was caused by experiencing life change when you become a new parent, a lack of social support, hormonal changes and the inability to breastfeed (263). Mothers in a study that aimed to explore PND

among women living with HIV in Malawi felt that their HIV diagnosis, especially when it was unexpected was a key contributor to their developing PND (260).

A total of four studies satisfied the inclusion criteria for this review update that aims to explore women's beliefs about the causes of PND. This review reinforced findings in the previous review with respect to themes such as social difficulties, social support, obstetric/paediatric, biological/physical and spirituality. These studies indicate that the origins of PND vary across women and some explanations go against the biomedical perspective that posists that mental disorders are brain diseases that emphasises pharmacological treatment. This further echos that healthcare professionals should take a holistic approach when assessing and understanding why new mothers may be experiencing PND.

Chapter 3

Women's experiences of severe postnatal psychiatric illnesses: A systematic review

The systematic review protocol enclosed in this chapter has been published:

Sihre HK, Simons AM, Gill P, Lindenmeyer A, Fazil Q. Women's experiences of severe postnatal psychiatric illness: a systematic review protocol. Systematic reviews. 2019 Dec;8(1):173.

Study protocol

See the following page.

Sihre *et al. Systematic Reviews* (2019) 8:173
https://doi.org/10.1186/s13643-019-1085-6

Systematic Reviews

PROTOCOL Open Access

Women's experiences of severe postnatal psychiatric illness: a systematic review protocol

Harpreet Kaur Sihre[1*], Anne-Marie Simons[2], Paramjit Gill[3], Antje Lindenmeyer[1] and Qulsom Fazil[1]

Abstract

Background: Super diversity has become a twenty-first-century phenomena in the UK. The Five Year Forward View Plan for Mental Health commits to improving access to Perinatal Mental Health services for all new mothers. Existing research indicates various postnatal mental illness aetiologies, traditional practices and beliefs, which are important to explore during medical consultation to achieve a collaborative relationship between the patient and clinician. The study of severe postnatal psychiatric illnesses is well established in the quantitative literature; however, the subjective experiences of mothers with severe psychiatric illnesses after childbirth have been given little attention. The aim of this systematic review is to synthesise the small body of qualitative findings, which will achieve a deeper understanding of mothers' experiences and understandings. This integration of qualitative data is invaluable in facilitating culturally competent strategies in Western settings and informing future research.

Methods/design: This protocol proposes a systematic review of qualitative literature of severe postnatal psychiatric illnesses, using a meta-ethnography approach following the PRISMA-P guidelines. A comprehensive search strategy will be developed to undertake a systematic search via online databases to identify eligible articles. Studies will be considered for eligibility if they include mothers aged 18 and over who have been diagnosed with a severe psychiatric illness during the postnatal period; present primary data on women's illness experiences; use qualitative methods. Titles and abstracts will be screened by the primary reviewer to identify potential papers. Two independent reviewers will access and read texts in full and agree on the final list of included studies. Discrepancies will be resolved via consultation with a third independent reviewer. The final list of included studies for review will be methodologically appraised by two independent reviewers using the Critical Appraisal Skills Programme. This systematic review protocol has been registered with the International Prospective Register of Systematic Reviews (PROSPERO): CRD42018093674.

Discussion: To date, no systematic review following a meta-ethnographic approach on qualitative explorations of mothers worldwide diagnosed with severe postnatal psychiatric illnesses has been conducted. An amalgamation of this information enables a deeper understanding of how severe postnatal psychiatric illnesses manifests across cultures. This information is useful when devising culturally competent care.

Systematic review registration: CRD42018093674

Keywords: Systematic review, Meta-ethnography, Severe postnatal psychiatric illness, Perinatal Mental Health Services, Qualitative research, Protocol

* Correspondence: HKS449@student.bham.ac.uk
[1]Institute of Applied Health Research, University of Birmingham, Birmingham, Edgbaston B15 2TT, UK
Full list of author information is available at the end of the article

© The Author(s). 2019 **Open Access** This article is distributed under the terms of the Creative Commons Attribution 4.0 International License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license, and indicate if changes were made. The Creative Commons Public Domain Dedication waiver (http://creativecommons.org/publicdomain/zero/1.0/) applies to the data made available in this article, unless otherwise stated.

Background

A woman's transition to motherhood has been reported as a major life event involving challenges in the psychological, social and biological spheres [1]. The postnatal period is defined up to a year after childbirth and is considered to be a time of increased susceptibility to psychiatric illnesses for all new mothers across all cultures [2]. Since the 1980s, there has been an upsurge of clinical and academic research to recognise symptomology, prevalence, prognosis, differential diagnosis, and management strategies to prevent adverse outcomes for mother and baby [3]. It is documented that 0.2% of new mothers will experience postnatal psychosis and 0.2% will experience a serious/complex disorder after childbirth such as psychotic depression, schizophrenia, bipolar disorder, and schizoaffective disorder [4, 5]. Previous systematic review findings have confirmed low global incidence of perinatal psychosis from 0.89 to 2.6 in 1000 women, aligning with the commonly reported prevalence among the general population [6]. Although relatively low, this morbidity is significant from a global health perspective because of the long-standing deleterious consequences that go beyond the mother. The long- and short-term adverse outcomes of a mothers' severe postnatal psychiatric illness can impact the infant, the partner, and the family relationships [2]. In rare cases, a severe postnatal psychiatric illness can lead to maternal and/or infant mortality [7]. The strongest and most established risk factor for susceptibility for severe postnatal psychiatric illnesses is a history of bipolar disorder or previous severe postpartum episodes [8, 9]. Other risk factors identified include obstetric factors, changes in medication, psychological factors, hormonal factors, immunological factors, sleep deprivation, and genetics factors [7].

A severe postnatal psychiatric illness is considered a psychiatric emergency requiring imminent medical attention and referral to secondary or tertiary care services, such as Perinatal Mental Health services [10]. Despite limited data on intervention programmes, existing reviews have examined admission data, outcomes for mothers and programmes and interventions in Mother and Baby units [11]. Findings conclude that this is a favourable environment for interventions and programmes leading to positive outcomes for postnatal mothers with severe psychiatric illnesses [11]. Additionally, previous systematic reviews have examined the efficacy of interventions to prevent (e.g. lithium) and treat (e.g. electroconvulsive therapy) postnatal psychosis [12]. Nonetheless, due to methodological limitations among included studies reviewed, extensive evidence-based recommendations could not be strongly inferred. Although the quantitative and scientific data is pivotal for clinical and cost-effectiveness, it is equally important that preventative and treatment strategies are implemented appropriately and culturally, meeting the subjective needs and experiences of patients and improve better access to care. The National Institute for Health and Care Excellence (NICE) guidelines highlights the importance of understanding illness from the patient's perspective. We conducted a scoping search of the literature and identified several qualitative papers that reported women's subjective experiences and understandings of severe postnatal psychiatric illness. Although studies are sparse, the existing qualitative data reports descriptions of illness experiences and author interpretations. This data is appropriate and informative for a meta-ethnography study to provide a higher level of analysis of the phenomena being researched and re-interpretations of meaning across studies [13]. This method allows a rigorous process for critical examination of several accounts to derive substantive interpretations and combine these elements to form a new whole.

Previous studies suggest that ethnicity and culture may influence a patient's subjective illness beliefs and perceptions of postnatal psychiatric illnesses and appropriate help-seeking behaviours that go against the biological model of illness [14]. Additionally, studies have recognised non-biological determinants such as psychological, psychosocial and cultural factors that influence the evolution of psychopathology after childbirth, and so it is important to explore the intricacies and myriad of aetiology in the context of the patient's cultural and social milieu [14]. Therefore, understanding conceptualisations of psychiatric illness through a cultural and social lens is invaluable in reaching collaborative patient-centred diagnoses and management plans enabling the development of culturally appropriate treatment. This will also help reduce barriers to accessing care and treatment and encourage all women across cultures to engage with services, which has been prioritised in developing UK policy such as the Five Year Forward View Plan for Mental Health in an era of super diversity [15]. In the UK, females originate from a range of countries and ethnicities, which include heterogeneous cultures, religions and languages. With higher fertility rates among this super diverse cohort, they are likely to be the main users of Maternity and Mental Health services [16]. Experiences of mental health differ across different cultural contexts, also affecting how and where treatment is sought. Therefore, it is important to consider how Perinatal Mental Health care providers can develop appropriate services to meet the needs of ethnic groups through qualitative research understanding their subjective experiences and understandings [17]. To our knowledge, a worldwide comprehensive synthesis of new mothers' experiences and understandings of severe postnatal psychiatric illnesses remains absent. The aim of the systematic review is to explore postnatal mothers'

experiences of severe psychiatric illnesses and enable a deeper understanding by extending the interpretative possibilities offered by the small body of literature, using a meta-ethnographic approach. The qualitative review synthesis is to go beyond what is currently offered in the literature and offer new in-depth understandings, insights and directions for future research. This information is an important component in an area of developing evidence-informed government policy and practice in Perinatal Mental Health.

Methods/design

This systematic review protocol has been registered with the International Prospective Register of Systematic Reviews (PROSPERO): CRD42018093674. This systematic review protocol was developed using the Preferred Reporting Items for Systematic review and Meta-Analysis Protocols 2015 checklist (PRISMA-P) (see Additional file 1) [18]. However, it is important to note that not all items on the PRISMA-P checklist will apply, given the qualitative nature of the study design. When we synthesise and write-up the findings of the final review report, we will adhere to the enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) guidelines [19].

Study design

Our review will aim to use a meta-ethnography developed by Noblit and Hare (1988) to search, interpret and synthesise the phenomena under investigation [20]. This has been recognised as the most developed and structured method used to synthesise qualitative findings that goes beyond a traditional narrative literature review, offering new interpretation, insights and in-depth meaning of primary data. The seven-phase approach of meta-ethnography includes (1) getting started, (2) deciding what is relevant to the initial interest, (3) reading the studies, (4) determining how the studies are related, (5) translating the studies into one another, (6) synthesising translations, and (7) expressing the synthesis.

Phase 1: Study aim

Our systematic review using meta-ethnography will aim to provide a worldwide coherent and comprehensive transcultural approach to understand women's experiences of their psychiatric illnesses after childbirth, including the psychosocial and cultural contributions to the aetiology of illness.

Phase 2: Search and selection strategy

Study eligibility criteria The SPIDER (Sample; Phenomenon of Interest; Design; Evaluation; Research type) criterion for qualitative research will be used in lieu of PICO (Participant; Intervention; Comparison; Outcome), which are more specific to develop eligibility criteria for qualitative research studies [21].

Sample This review will include studies describing the experiences of mothers aged 18 years or above. Mothers can be interviewed during the postnatal period or retrospectively. For the proposed systematic review, the postnatal period is defined as up to a year after childbirth. Recall around childbirth and traumatic life events, such as psychotic illness is generally reported to be excellent [22]. Therefore, mothers do not have to be in the postnatal period when participating in studies.

Phenomenon of interest For the purpose of this systematic review, studies will only be included if they include mothers who have been diagnosed with a severe psychiatric illness during the postnatal period.

Design Studies will only be included if they use qualitative methods such as interviews, focus groups as methods of primary data collection.

Evaluation Studies that present primary data on new mothers' experiences and understandings of severe postnatal psychiatric illness using qualitative methods of data collection.

Research type Qualitative studies only will be included in this review. Although there may be mixed methods studies available, the data offered from the qualitative component is not in-depth for a meta-ethnography study.

Study characteristics No demographic or geographic restriction will be placed on sample participants or study setting, as it is good practice to be as inclusive as possible. Because of limited resources, results will be restricted to English language publications. Studies published from 2000 to 2018 will be considered to include recent literature.

Information sources Peer-reviewed published articles across the following databases:

- CINAHL
- EMBASE
- OVID (PsychInfo, MEDLINE)
- PubMed
- Web of Science Core Collection

The reference list of all relevant articles will be hand searched by the primary reviewer for any additional papers that may meet eligibility for the review.

Search strategy A reference librarian will be consulted with regards to the design of the search strategy, which will be developed using the SPIDER guidelines for qualitative research. Search terms will incorporate medical subject headings (MeSH), text words and/or keywords (see Table 1). The initial search strategy will be designed for Web of Science Core Collection and adapted to suit individual databases (see Additional file 2).

Selection process A flow diagram following the PRISMA guidelines will be used in reporting the selection process and all results. Studies will be recorded and managed using data management software such as Endnote. The predetermined search terms will be entered manually across all online database and combined with Boolean terms "and" or "or". The primary reviewer will run the initial searches across all online databases to identify empirical articles in the field. All titles and abstracts will be screened by the primary reviewer against the eligibility criteria and any potential papers for inclusion will be marked and imported into Endnote. Two independent reviewers will conduct a full-text review of provisionally included studies. Studies will be included or excluded with reason against the predetermined eligibility criteria. Any discrepancies will be resolved through consultation of a third reviewer. If multiple papers are found that describe the same data set, we will include the paper that describes the most comprehensive findings. All reviewers will agree on the final list of included papers.

Quality assessment of included studies Two independent reviewers will critically appraise the final list of included studies using the Critical Appraisal Skills Programme tool [23]. Discussion will be used to resolve discrepancies and potential intervention of a third reviewer to reach consensus. Poor quality studies will be excluded from review to ensure the validity of study findings and trustworthiness of clinical implications. A 'good' study will include sufficient original data or at least some interpretive analysis for a meta-ethnography.

Phases 3–7: Synthesis of findings

Meta-ethnography offers rigorous synthesising of qualitative research offering a range of depth of meanings, experiences and perspectives of participants across varied contexts. The studies included for review will be read and re-read by an independent reviewer. Reading studies repetitively is central to meta-ethnography as it allows the reviewer to familiarise themselves with the data that will be used for analysis. Items will be extracted and documented in a standardised Microsoft Excel spreadsheet. Data items will include, but not be limited to

- Study title
- Author(s)
- Year of publication
- Country and country income group
- Study design
- Study aim(s)
- Sample and sampling method (including age range)
- Sample characteristics (including ethnicity)
- Setting(s)
- Measurement(s) used for the diagnosis of severe postnatal psychiatric illness
- Data collection and data analysis method(s)
- Key findings (first-order constructs, including any mentions of culture, religion, traditions or postnatal practices).

Meta-ethnographies are often described in terms of first-order, second-order and third-order constructs. First-order constructs reflect the descriptive narratives of the participants reported in the primary studies that relates to our main research inquiry. Any information that falls outside the remit of our research inquiry will not be included to remain close to the phenomena of interest. Although first-order concepts will come from the

Table 1 Search terms

SPIDER heading	Search terms for Web of Science Core Collection
Sample: mothers	"female" OR "females" OR "mum" OR "mums" OR "mother" OR "mothers" OR "women" OR "woman" OR "new mothers" AND
Phenomenon of interest: severe psychiatric illness after childbirth	"postnatal" OR "postpartum" OR "puerperal" OR "perinatal" OR "childbirth" OR "after birth" OR "post-delivery" OR "post neonatal" OR "peripartum" OR "motherhood" OR "after childbirth" AND "psychosis" OR "schizophrenia" OR "bipolar disorder" OR "mania" OR "psychotic episode" OR "severe depression" OR "schizoaffective" OR "mood disorder" AND
Design: qualitative research	"qualitative research" OR "qualitative study" OR "interviews" OR "surveys" OR "focus groups" OR "grounded theory" OR "ethnography" OR "phenomenology" OR "content analysis" OR "thematic analysis" OR "observation" OR "narrative" OR "stories" AND
Evaluation:	"experience" OR "lived experience" OR "attitude" OR "belief" OR "understanding" OR "perceptions" OR "knowledge" OR "view" OR "feeling" OR "opinion" AND
Research type: qualitative or mixed methods	"qualitative research" OR "qualitative analysis" OR "qualitative mixed methods"

results section of the paper, when reading and re-reading the studies, if we find original data being discussed in the discussion section of an article, this will also be included as first-order concepts. Second-order constructs are authors' explanations and interpretations of the data extracts/key concepts, which are usually found in the discussion section of an article. The third-order construct is a synthesis of both the first and second order constructs conducted by the reviewer and team, which begins the development of the line of argument [20]. The next stage of analysis and synthesis involves a translational process to continue the formation of the line of argument across papers. Concepts from each paper will be compared to check for similarities (reciprocal translation) and different accounts between studies will also be highlighted (refutational translation). This will form conceptual categories that reflect the original data from the included papers. The reviewers will be able to make sense of the studies as a whole rather than in isolation, which will determine a reciprocal or refutational synthesis from which a line of argument can be shaped. The primary reviewer will be conducting the analysis with discussion with the second reviewer and academic supervisors to triangulate second and third order concepts (co-authors). Triangulation is a strategy used in the qualitative analysis that allows several perspectives to reach consensus in the themes generated, increasing the validity and convincibility of the overall review findings [24]. Face-to-face and telephone discussions with a second reviewer and academic supervisors will facilitate the translation process and assist with the conceptual innovation. Peer debriefing will add rigour to the analysis and synthesis process adding trustworthiness to the study results.

The data will be managed using Microsoft word documents. First-order, second-order and third-order concepts will be tabulated. A column will be given for each study. Similarities and differences between concepts will be highlighted and colour coordinated. The synthesis will be presented in textual format with the use of a visual diagrams and tables.

The first author has previous experience in conducting a qualitative systematic review using meta-ethnography, which aimed to explore women's beliefs about the causes of postnatal depression (under review). Academic supervisors who will be involved in the translational process are also experienced in conducting meta-ethnographies and qualitative research. The first author is currently completing a Ph.D. using Interpretative Phenomenological Analyses and so has experience in using complex methods for analysing qualitative data.

Discussion

A worldwide comprehensive synthesis of qualitative primary data on mothers' experiences of severe psychiatric illness after childbirth is deficient in the current literature. Our proposed review will enable a deeper understanding and interpretation of new mothers' experiences, which is vital in informing a patient-centred care approach within a super diverse setting. The failure of providing culturally competent health care services may have a negative impact on health care interactions and outcomes.

Limitations and strengths

Because of limited resources, the review will only include studies in the English language. Studies published in other languages may contain useful information for the review, which may prove invaluable given the international focus of this review. Furthermore, studies in non-English languages may provide various conceptualisations of postnatal psychiatric illnesses from a cultural angle, which may prove invaluable given the international focus of this review.

The major strength of this review will be the use of a systematic and transparent approach, employing validated and recommended tools. The quality of the review will be strengthened by the involvement of multiple reviewers for validation of study selection and critical appraisal. The inclusion of a second reviewer and academic supervisors to triangulate concepts, interpretations and overall review findings will make sure the findings are robust, comprehensive and well-developed ensuring the credibility and validity of the synthesis and findings. We will only include studies with a strong critical appraisal score, thus adding to the trustworthiness of review findings and clinical implications.

Additional files

Additional file 1: Preferred Reporting Items for Systematic review and Meta-Analysis Protocols 2015 checklist (PRISMA-P). (DOCX 29 kb)

Additional file 2: Search strategy. Web of Science Core Collection. (DOCX 155 kb)

Abbreviations

CASP: Critical Appraisal Skills Programme; CINAHL: The Cumulative Index to Nursing and Allied Health Literature; PND: Postnatal depression; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses; PROSPERO: International prospective register of systematic reviews; SPIDER: Sample, Phenomenon of Interest, Design, Evaluation, Research type; UK: United Kingdom

Authors' contributions

HKS is a doctoral researcher who designed the protocol, drafted the manuscript and will be the first reviewer of the systematic review. QF provided supervision and guidance in preparing the manuscript. A-MS will be the second reviewer and will read provisionally marked papers for inclusion and critically appraise all included studies alongside HKS. All authors read and approved the final manuscript.

Funding

No funding was received for this study.

Availability of data and materials
Not applicable.

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Author details
[1]Institute of Applied Health Research, University of Birmingham, Birmingham, Edgbaston B15 2TT, UK. [2]Birmingham and Solihull Mental Health Foundation Trust, The Barberry, Birmingham, UK. [3]Warwick Medical School, University of Warwick, Coventry, UK.

Received: 23 July 2018 Accepted: 2 July 2019
Published online: 17 July 2019

References

1. Ball JA. Postnatal care and adjustment to motherhood. Midwives, research and childbirth. Boston: Springer; 1989. p. 154-75.
2. O'Hara MW, Wisner KL. Perinatal mental illness: definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2014;28(1):3–12.
3. Sit D, Rothschild AJ, Wisner KL. A review of postpartum psychosis. J Women's Health. 2006;15(4):352–68.
4. Paschetta E, Berrisford G, Coccia F, Whitmore J, Wood AG, Pretlove S, et al. Perinatal psychiatric disorders: an overview. Am J Obstet Gynecol. 2014;210(6):501–9. e6.
5. Health Nif, Excellence C. Antenatal and postnatal mental health: clinical management and service guidance: National Institute for Health and Clinical Excellence; 2007.
6. VanderKruik R, Barreix M, Chou D, Allen T, Say L, Cohen LS. The global prevalence of postpartum psychosis: a systematic review. BMC Psychiatry. 2017;17(1):272.
7. Jones I, Chandra PS, Dazzan P, Howard LM. Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. Lancet. 2014;384(9956):1789–99.
8. Chaudron LH, Pies RW. The relationship between postpartum psychosis and bipolar disorder: a review. J Clin Psychiatry. 2003;64(11):1284–92.
9. Wesseloo R, Kamperman AM, Munk-Olsen T, Pop VJ, Kushner SA, Bergink V. Risk of postpartum relapse in bipolar disorder and postpartum psychosis: a systematic review and meta-analysis. Am J Psychiatry. 2015;173(2):117–27.
10. Gale S, Harlow B. Postpartum mood disorders: a review of clinical and epidemiological factors. J Psychosom Obstet Gynecol. 2003;24(4):257–66.
11. Connellan K, Bartholomaeus C, Due C, Riggs DW. A systematic review of research on psychiatric mother-baby units. Arch Women's Mental Health. 2017;20(3):373–88.
12. Doucet S, Jones I, Letourneau N, Dennis C-L, Blackmore ER. Interventions for the prevention and treatment of postpartum psychosis: a systematic review. Arch Women's Mental Health. 2011;14(2):89–98.
13. Atkins S, Lewin S, Smith H, Engel M, Fretheim A, Volmink J. Conducting a meta-ethnography of qualitative literature: lessons learnt. BMC Med Res Methodol. 2008;8(1):21.
14. Edge D. Perinatal mental health care for black and minority ethnic (BME) women: a scoping review of provision in England. Ethn Inequalities Health Soc Care. 2010;3(3):24–32.
15. England N. Five year forward view. 2014. 2016.
16. Latif Z. The maternal mental health of migrant women. London: Race Equality Foundation; 2014. Report No.: 31.
17. Phillimore J. Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. Ethnic Racial Stud. 2015;38(4):568–82.
18. Moher D, Liberati A, Tetzlaff J, Altman DG, Group P. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6(7):e1000097.
19. Tong A, Flemming K, McInnes E, Oliver S, Craig J. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. BMC Med Res Methodol. 2012;12(1):181.
20. Noblit GW, Hare RD, Hare R. Meta-ethnography: synthesizing qualitative studies: sage; 1988.
21. Cooke A, Smith D, Booth A. Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qual Health Res. 2012;22(10):1435–43.
22. Brockington I. Motherhood and Mental Health: Oxford University Press; 1998.
23. CASP U. Critical appraisal skills programme: making sense of evidence. See: www casp-ulr net (Accessed: 21 Dec 2014). 2013.
24. Jonsen K, Jehn KA. Using triangulation to validate themes in qualitative studies. Qualitative Research in Organizations and Management: An International Journal. 2009;4(2):123-150.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Ready to submit your research? Choose BMC and benefit from:

- fast, convenient online submission
- thorough peer review by experienced researchers in your field
- rapid publication on acceptance
- support for research data, including large and complex data types
- gold Open Access which fosters wider collaboration and increased citations
- maximum visibility for your research: over 100M website views per year

At BMC, research is always in progress.

Learn more biomedcentral.com/submissions

BMC

Step 1 Introduction

As discussed in chapter 1, the year after childbirth (the postnatal period) is associated with high risks of psychiatric illnesses for all new mothers across cultures including severe psychiatric illness (81). Severe postnatal psychiatric illnesses have been recognised as a leading cause of maternal deaths (120). It is well established that 0.2% of new mothers will experience postnatal psychosis aligning with a previous review that aimed to obtain a global estimate of puerperal psychosis prevalence (82). A further 0.2% of new mothers will experience a serious/complex disorder after childbirth such as psychosis, severe depression, schizophrenia and bipolar disorder (16). Rare but devastating outcomes of psychiatric illnesses include attempted suicide, suicide and infanticide, therefore it is imperative to recognise, diagnose and treat appropriately (8, 264).

There has been an expansion of quantitative reviews on severe postnatal psychiatric illnesses on the study of epidemiology. A quantitative review of postpartum psychosis provided an overview of clinical features, prognosis, differential diagnosis and evaluation and treatment (8, 81). The link between bipolar disorder and postpartum psychosis has been explored in previous quantitative reviews and is well recognised in the literature (8). Mother-infant interactions in mothers with severe postnatal psychiatric illnesses have also been examined and findings have demonstrated that interactions and attachment types can be insecure and poor (265, 266). Furthermore, the efficacy of interventions which may be effective strategies to prevent (e.g. lithium) and treat (e.g. electroconvulsive therapy) postnatal psychosis has been examined, however authors concluded that well-designed prospective studies are necessary to determine the efficacy of preventative and treatment strategies (267). In sum, evidence-based practices are an important feature of many areas of social sciences and so quantitative research and

outcomes play a significant role. In recent years, there has been a growing awareness of the importance of qualitative research and patient subjective experiences. Only one systematic review and meta-synthesis of 23 qualitative studies were identified that aimed to explore mothers with severe mental illness and their experiences of motherhood and experiences of services (268). Authors developed four themes: discomfort, stigma, need for education and integration of services and concluded that an understanding of women's experiences of pregnancy and motherhood living with severe mental illness can inform the development and provision to ensure the needs of women and their families are met (268).

As previously discussed in chapter 1, the UK can now be characterised by *superdiversity*, which can have many challenges for both policy and practice. Nonetheless, recent government reports have been framed by a particular understanding of multi-cultural diversity. Ensuring service users' views and choices are respected and ensuring patients are viewed and treated as rounded individuals has been recommended in the Final Report of the Independent Review of the Mental Health Act 1983 published in December 2018 from the Department of Health and Social Care. NHS England are committed to fulling the ambition reported in the Five Year Forward View for Mental Health so that by 2020/21, there will be increased access to perinatal mental health support for all women (216). Although patients may share a similar diagnosis, their subjective understanding and experiences may be highly personal and they may develop unique patterns of beliefs about their condition shaped by their social and cultural contexts. In the UK females originate from a range of countries and ethnicities, which include heterogeneous cultures, religions and languages. With increased fertility rates among this super diverse cohort, they are likely to be the main users of Maternity and Mental Health Services (269). The literature suggests that an individual's cultural and social context may

influence their subjective illness perceptions of postnatal psychiatric illnesses and appropriate help-seeking behaviours that go against conventional medicine (2). Qualitative research methods encompass and uncover identity of illness, causal beliefs and beliefs coping strategies that are needed to determine assessment, diagnosis and coordination and integration of care. Furthermore, studies have recognised non-biological determinants that influence the evolution of psychopathology after childbirth such as psychological, psychosocial and cultural factors. Therefore, it is important to explore the intricacies of aetiology in the context of the patient's cultural and social milieu.

This research highlights the subjective experiences of women who have been diagnosed with a severe psychiatric illness within the year after childbirth. This information is important to deepen the current understanding of new mothers' experiences of severe psychiatric illnesses after childbirth about how this illness manifests across cultures. Findings will also help to identify and develop futures areas of research. The past decade has witnessed several publications of qualitative studies on women's experiences of severe psychiatric illnesses, which allows for a rich and in-depth understanding of the phenomena contributing to patient-centred care. Drawing on nine qualitative studies, this review aimed to develop a deeper understanding and explore women's experiences of severe postnatal psychiatric illnesses. These findings will demonstrate the value of sociological enquiry in this area, challenging the need for more in-depth descriptive research.

Steps 2 – 3 Method / design

The protocol presented at the start of this chapter offers a full account of the methods used. A summary of the methods is presented below.

Aim

My aim was to identify all published qualitative literature exploring how women experience and understand severe psychiatric illness within the year after childbirth. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement for Performing and reporting systematic reviews was followed where relevant. Noblit and Hare's key steps in performing a meta-ethnography were adapted to complete this review (see Table 3.) (233).

Search strategy and eligibility criteria

The electronic databases Web of Science Core Collection, Scopus, CINAHL, Ovid (Psych Info, Medline) were manually searched. The search terms were generated using the SPIDER guidelines for qualitative synthesis which deemed likely to capture women's perspectives. See Table 7 for search terms. The predetermined search terms were combined with either *"and"* or *"or"*. The primary reviewer ran the initial searches across all databases to identify empirical articles in the field for review. I provisionally included an article if:

- Mothers were aged 18 years or above
- Mothers were interviewed during the postnatal period or retrospectively
- Mothers diagnosed with a severe psychiatric illness after childbirth
- Studies that presented primary data on experiences and understandings
- The study design was qualitative
- Studies were presented in the English language
- Studies were published between 2000 and 2018.

There were no geographic or demographic restrictions, as it is was my aim to conduct a worldwide comprehensive review. Unpublished studies were not considered. Studies that included more than just the mothers perspective were considered, however for the analyses, just the mother's experiences were analysed to keep within the remit of the research question.

Table 9.
Search terms

SPIDER heading	Search terms
Sample: mothers	*"female" OR "females" OR "mum" OR "mums" OR "mother" OR "mothers" OR "women" OR "woman" OR "new mothers" AND*
Phenomenon of Interest: severe mental illness after childbirth	*"postnatal" OR "postpartum" OR "puerperal" OR "perinatal" OR "childbirth" OR "after birth" OR "post-delivery" OR "postneonatal" OR "peripartum" OR "motherhood" OR "after childbirth"* *AND* *"psychosis" OR "schizophrenia" OR "bipolar disorder" OR "mania" OR "psychotic episode" OR "severe depression" OR "schizoaffective" OR "mood disorder" AND*
Design: qualitative research	*"qualitative research" OR "qualitative study" OR "interviews" OR "surveys" OR "focus groups" OR "grounded theory" OR "ethnography" OR "phenomenology" OR "content analysis" OR "thematic analysis" OR "observation" OR "narrative" OR "stories" AND*
Evaluation:	*"experience" OR "lived experience" OR "attitude" OR "belief" OR "understanding" OR "perceptions" OR "knowledge" OR "view" OR "feeling" OR "opinion" AND*
Research type: qualitative or mixed methods	*"qualitative research" OR "qualitative analysis" OR "qualitative mixed methods"*

Selection process

After running the preliminary searches across all databases, I identified all of the titles and abstracts of all citations for appropriateness following predetermined eligibility criteria (as per protocol). Potential papers for review were marked and imported into Endnote. I and the second reviewer (Dr Simons) accessed and read in full the marked papers. Papers were included or excluded against the eligibility criteria and any discrepancies were resolved. All final papers were agreed for review.

Quality assessment

Dr Simons and I used the CASP tool to evaluate the methodological soundness of the final included papers. Decisions were compared via discussion.

Data extraction

A Microsoft Excel spreadsheet was created to document data extracted from studies, and where available items such as study title, authors, year of publication, country, country income group, study design and aims, ethical approvals, recruitment and description of sample, type and measurement of severe postnatal psychiatric illness, data collection and analysis methods, key findings, study conclusion, clinical implications and limitations.

Data analyses

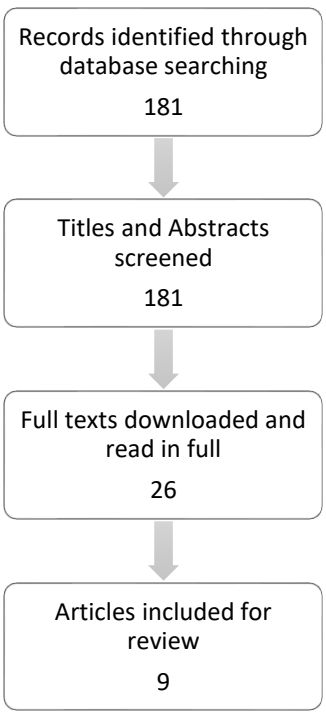
Phases 3 to 6 outlines the principles of meta-ethnography guiding the synthesis and analysis. Studies were read and re-read and any main themes, ideas, metaphors, concepts and quotes from women were identified and labelled as first-order constructs. A second column termed second-order constructs was developed, which included the authors' original interpretations

of the first-order constructs. The final column included third-order constructs. Through a process of reciprocal translation and refutation investigation between studies, this represented the my integrated interpretations to gain a deeper understanding of the phenomena being reviewed.

Results

A systematic search of four academic databases resulted in 181 hits. I assessed the titles and abstracts of all papers for inclusion and identified 26 potential papers for review. All 26 papers were downloaded and read in full by Dr Simons and I and we reached consensus and identified nine studies meriting inclusion for review (See Figure 4). It is possible that I may have missed some relevant studies, for example, book chapters PhD theses and grey literature. However, most studies included cited each other suggesting that we managed to find the majority of studies relevant to the research inquiry.

Figure 4.
Study selection flowchart



Study characteristics and quality of the evidence

Nine studies published between 2005 and 2015 were included that explored women's experiences of living with a severe postnatal psychiatric illness:

1. Barr & Beck. Infanticide secrets: Qualitative study on postpartum depression
2. Doucet et al. Support needs of mothers who experience postpartum psychosis and their partners
3. Edwards & Timmons. A qualitative study of stigma among women suffering postnatal illness
4. Engqvist et al. Experiences of the first days of postpartum psychosis: An interview study with women and next of kin in Sweden
5. Glover et al. Puerperal psychosis – a qualitative study of women's experiences
6. Heron et al. Information and support needs during recovery from postpartum psychosis
7. McGrath et al. The process of recovery in women who experiences psychosis following childbirth
8. Robertson & Lyons. Living with puerperal psychosis: A qualitative analysis
9. Wyatt et al. Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others

A sum of 78 participants were included across all studies. Studies took place in high-income countries such as Australia (n=1), Canada (n=1), United Kingdom (n=5) and Sweden (n=1). One study did not mention the country setting. All but one study mentioned ethical approvals granted for the study. Diagnoses ranged from severe postpartum depression, postpartum psychosis, puerperal psychosis and depressive psychosis. All women were interviewed face-to-face about their experiences. Where reported, all women were Australian, American, White British or White European.

Table 10.

A summary of the study characteristics.

Study title Author(s) Year Country Country income group Aim(s)	Ethics	Recruited from & Description of sample	Severe postnatal mental illness	Data Collection & Analysis	Key Findings
1.Infanticide secrets: qualitative study on postpartum depression Jennieffer A. Barr Cheryl T. Beck Dec 2008 Australia High-income group To explore thoughts of infanticide that did not lead to the act among mothers with postpartum depression Examining the characteristics of infanticidal thoughts experiences by women with postpartum depression	Ethical approval was obtained from Queensland University of Technology in Brisbane, Australia	A single recruiting site, a common support group Snowballing technique N = 15 mothers Age range: 20-34 years	Identified by a psychiatrist or psychologist being depressed with postpartum onset Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision	In-depth interviews Audiotaped and transcribed verbatim Data analysed using Thematic analysis Data collection continued until saturation was achieved	Six themes were identified: Imagine acts of infanticide The experience of horror Distorted sense of responsibility Consuming negativity Keeping secrets Managing the crisis
2.Support needs of mothers who experience postpartum psychosis and their partners Shelley Doucet Nicole Letourneau Emma Robertson Blackmore March-April 2012 Canada High-income group To explore the perceived support needs and preferences of women with postpartum psychosis	Ethics approval was obtained All participants provided written informed consent	Participants recruited from Canada and the United States through a variety of community and hospital agencies that provide services for mothers in the postpartum period Purposive sample N = 9 mothers	Mothers with manic or affective psychotic symptoms within four weeks of delivery Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision A diagnosis of postpartum psychosis by a physician	One-to-one, in-depth, semi-structured interviews Interviews placed over the telephone, or in person, mutually agreed-upon setting Interviews ranged from 45-120 minutes Audiotaped and transcribed verbatim Data analysed using Thematic analysis	Support needs Support preferences Availability and accessibility to support Barriers to support
3.A qualitative study of stigma among women suffering postnatal illness Elizabeth Edwards Stephen Timmons October 2005 United Kingdom High-income group	Study clearance was achieved from the Local Research Ethics Committee Written consent was received from the participants	Participants who had been patients on the mother and baby unit, an in-patient service, NHS hospital. Purposive sampling N = 6	All women had been diagnosed with severe postnatal mental illness by a consultant psychiatrist Three had puerperal psychosis, two of severe postnatal depression and one of depressive psychosis	Semi-structured interviews Interviews took place at women's homes and one in the mother and baby unit Interviews were 60 – 90 minutes	Stigma was perceived to exist from others Access to mental health services Feel a "bad mother" Labels/diagnosis

To explore and gain an understanding of a mother's experiences, feelings and emotions in relation to stigma and the woman's perception of herself as a mother				Tapes were transcribed verbatim Data analysed using Bryman and Burges (1994) data display and Mathers et al (1998)	
4.Experiences of the First Days of Postpartum Psychosis: An interview Study with Women Next of Kin in Sweden Inger Engqvist Kerstin Nilsson January 2013 Sweden High-income group To explore descriptions of the first days of postpartum psychosis from different perspectives, namely of the women and the of kin	Approval for this research was obtained from the University of Gothenburg Ethical Committee Fundamental ethical demands regarding the individuals such as informed consent, confidentiality, and right use of the findings, were followed.	Participants recruited via a local radio station, a network of women in a Swedish patients association, mental health journal N = 7 women Age range: 29-60 years	All mothers had experienced postpartum psychosis and the women considered themselves to be fully recovered	Face-to-face interviews were conducted either at the home or a local library The interviews were recorded and lasted 45-90 minutes Interviews were transcribed verbatim The data were analysed by means of Content Analysis	Loss of Sleep Being in an Unreal World From wanting the baby to not wanting the baby Infanticidal ideation Suicidal ideation – a complete darkness Shades of black with a ray of light
5.Puerperal psychosis – a qualitative study of women's experiences Lesley Glover Julie Jomeen Tracy Urquhart Colin R. Martin February 2014 United Kingdom High-income group This study aimed to gain further insight into women's individual experiences of puerperal psychosis and the context in which they make sense of it	Ethical approval was sought and gained from the Local Research Ethics Committee	Women recruited via a local specialist psychiatry services for mothers and babies in the North of England. N = 7 Age range: 25-45	All mothers had been diagnosed with puerperal psychosis in the previous 10 years	A semi-structured audio-taped interview The interviews lasted approximately 1 hour and were transcribed verbatim Data analysis using an inductive thematic analysis	The path to puerperal psychosis Unspeakable thoughts and unacceptable self 'Snap out of it' Perceived causes
6.Information and support needs during recovery from postpartum psychosis Jessica Heron Naomi Gilbert Clare Dolman Sonal Shah Ines Beare Sarah Dearden Nicola Muckelroy Ian Jones Jonathan Ives October 2011 United Kingdom High-income group	R&D approval was gained from the Birmingham and Solihull Mental Health Foundation Trust	Participants were recruited through Action on Postpartum Psychosis N = 5	Women have experience of postpartum psychosis	One-to-one semi-structured interviews The interviews ranged from 19 – 45minutes Interviews were audio-recorded and transcribed Data analysed using a grounded analytic induction approach	Unmet expectations Ruminating and rationalising Social recovery Medical support Information needs Family functioning Giving recovery time

The study aims to explore women's experiences of the process of recovery and their beliefs about the services needed to support recovery					
7.The process of recovery in women who experience psychosis following childbirth Laura McGrath Sarah Peters Angelika Wieck Anja Wittkowski November 2013 United Kingdom High-income group The aim was to develop a theoretical understanding of recovery from psychosis following childbirth	Ethical approval was obtained from the University of Manchester's Research Governance Department, the local Research Ethics Committee and the relevant NHS Trust Research and Development Department	Women were recruited from a Mother and Baby Unit in Northwest England and by advertisements placed on website forums and newsletters N = 12 Age ranged: 26-45	Women with experience of severe postnatal illness, including puerperal psychosis and postpartum depression with psychotic features	Interviews were semi-structured Interviews were audio-recorded and ranged from 37 – 110 minutes Interviews were face-to-face or over the telephone The constant comparison method was used to construct theory directly from the data	The process of recovery Immobilisation Recognising recovery Accepting loss Using experience positively Maintaining recovery versus recurrence Evolving an understanding Initial understanding Later understanding Strategies for recovery Crisis management Strategies to conceal illness Sharing experience Seeking support Sociocultural context
8. Living with puerperal psychosis: A qualitative analysis Emma Robertson Antonia Lyons December 2003 Not mentioned To explore women's experiences of puerperal psychosis, and to gain some understandings about living with that experience following the illness	Not mentioned	Women who were treated in both specialist mother and baby units and on general psychiatric wards, as well as women treated at home N = 10 Age range: 28-44	Women who had been diagnosed with puerperal psychosis within the last 10 years Defined as a manic or psychotic episode according to DSM-IV criteria	Semi-structured interview in the participants' own homes and ranged between 40-90 minutes Interviews were taped and transcribed verbatim Data analysed using Grounded Theory approach	A separate form of mental illness Loss Relationship and social roles Living with emotions Regaining and changing self

9. Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others Caroline Wyatt Craig Murray Jenny Davies Julie Jomen April 2015 United Kingdom Explores the meaning ascribed to relationships by mothers who have experienced postpartum psychosis and their significant others	Approval was granted by a NHS Research Ethics Committee and the Research Directorates of NHS services	Women recruited by professionals identifying potential participants, online recruitment and GPs. N = 7 Age range: 28-33	Women who had received a diagnosis of postpartum psychosis	Semi-structured interviews were conducted in participants' homes or local buildings All interviews were digitally audio-recorded and transcribed verbatim and lasted between 60-85 minutes IPA was used for the analysis of data	

All papers were scored as either *"good"* or *"very good"* using the CASP tool. See Table 9 for the study scoring.

Table 11.
Study quality results for primary studies

	Study								
CASP items	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell
Has the relationship between researcher participants been adequately considered?	No	No	Yes	No	No	No	Yes	No	Yes
Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes
Was the data analysis sufficiently rigorous?	Yes	No	Yes	Can't tell	Can't tell	Can't tell	Can't tell	Yes	Can't tell
Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How valuable is the research?	Valuable	Somewhat valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Somewhat valuable	Valuable
Overall score	**Very Good**	**Good**	**Very Good**	**Very Good**	**Very Good**	**Very Good**	**Very Good**	**Good**	**Very Good**

Steps 5 – 7 Findings: Women's experiences of severe postnatal psychiatric illnesses

The nine included papers in this meta-ethnographic qualitative synthesis represent women's experiences of severe postnatal psychiatric illness from over 78 women in 4 Western countries. Five themes were developed using the women's narratives and my interpretations from primary studies through the process of reciprocal translation and reputational investigation, although most concepts generated were consistent across studies (See Appendix 2. for Step 4 and a summary of the findings). The meta-ethnography revealed five major themes; 1) Experiences of illness 2) Illness explanatory models 3) Social difficulties 4) Unmet expectations 5) Consequences of illness.

Experiences of illness

Isolation

The isolation mothers felt when experiencing severe psychiatric symptoms after childbirth was highlighted in four studies (98, 270-272). Mothers expressed feeling *"abandoned and excluded"* and felt they were living in a negative place on their own where there were no other fellowship: *"It was as if I was living on a globe or sphere, and the other world was gone for me. It was like there was a difference between my world and everyone else's world. I was living on my own. A black world and very negative"* (270). Mothers also feared being abandoned or were apprehensive that their partner would leave them completely (272). Some mothers were also scared by their feelings of loneliness (98). Women felt their psychosis was a separate form of mental illness, which exacerbated their feelings of isolation (98). However, when women identified with other women going through a similar illness, this was reported to relieve their isolation: *"I ended up talking to a friend who had…hallucinations and mania…which made me feel a bit more normal"* (98).

Suicidal and infanticidal thoughts

Experiences of women diagnosed with severe postnatal depression/postpartum psychosis described recurring thoughts of suicide and infanticide and often became shocked and horrified by their thoughts (270, 273). Some mothers discussed their fear of opportunistic harm, for example, harming the baby when they could not stop them from crying or drowning the baby during bath time (273). A woman portrayed images of her dead baby like a cloud from the darkness around her: *"They came like clouds out of this blackness…pictures of when he was dead…they just came to me in a way, as well as the desire for him not to be there"* (270). Moreover, a mother felt the need to not only save her baby but all of her children from the evil world: *"I would give them something to eat so they would die, or I might strangle them. Killing them in a way that would not scare them"* (270). Other thoughts of infanticide described by mothers included throwing the baby off the balcony, dropping the baby onto the cement, seeing the baby going into the microwave and pushing the baby underwater. Women reflected their anger towards the babies and one woman described contemplating suffocating her infant with a teddy bear as a grave consequence of her frustration: *"You are so angry it's like a rage, it's all consuming, like a fury, like a volcano, you know, when it erupts. You feel like the lava as it starts at your feet and flows through your veins, rushing and you can't stop it"* (273). A distorted sense of responsibility towards the baby occurred when mothers attempted suicide and planned to take their infant with them as they would be deprived without a mother: *"It also wasn't fair on him not to have a mother. And so, to take him with me was the only option"* (273). Some said their baby did not stop them from contemplating suicide and others reported the baby was no longer a part of their thoughts (270, 273). A woman reported that she could not tolerate the suffering anymore and as a result cut themselves or overdosed on tablets (270,

273). A mother felt worthless and could not cope with the severity of her symptoms and believed death was a better choice (270).

An unreal situation

When experiencing symptoms of postpartum psychosis, some mothers could not comprehend the situation and felt it was unreal (270, 271, 274). Women experienced confusion, disorientation and poor judgement and in some cases memory loss (275). A woman described her chaotic experience with postpartum psychosis as *"horribly unusual and unreal"* (270). Another woman symbolised her experience of postpartum psychosis like falling into a tumble dryer, where everything just rolled around without making sense (270). A mother also used the term *"messy"* to describe her experiences of disappeared into a state of psychosis: *"It was just messy…then it all became just a mess…there was such a sense of unreality that I must be dead"* (270).

Exhaustion

Exhaustion was commonly experienced by some women living with a severe psychiatric illness after childbirth. Some mothers anticipated the possibility of tiredness when experiencing postpartum psychosis, however, some mothers did not expect sleeping problems to occur (270, 271, 274). Mothers spoke of their incapability to physically sleep when experiencing postpartum psychosis: *"I was so wound up. I couldn't relax…then it was full speed ahead at night"* (270). Similarly, some mothers felt fatigued however were unable to sleep after traumatic labour (5). One mother discussed feeling restless and felt anxious to sleep as she feared her baby would die (270).

Delusions

Many women described their frightening, horrifying and distressing postnatal thoughts (98, 270, 273, 274, 276). For some women, the nature of their thoughts was often in relation to the baby: *"At one point I thought the baby was the devil and by feeding her she was sucking my life blood away"* (274). A mother described her great fear of her child and believed her baby would eat her: *"I was afraid that she would eat me. It was like a dream…I was so afraid of her"* (270). Furthermore, women were also alarmed by their thoughts and felt a sense of detachment from reality: *"It was so scary, I just woke up and thought that someone had taken my brain out and I was trying to explain it to [HUSBAND] that someone had sawn off my head to get my brain and put someone else's in and I didn't know anymore"* (274). Additionally, mothers illustrated the image of a clock as part of their psychosis and delusional thoughts, as enlarged and dangerous that towered above them: *"The clock is one of those awful memories for me…Those bright black and white figures. The clock towered above me. The minutes passed slowly. The clock to me is one of those horrible memories"* (270). One woman believed she was a victim of conspiracy perpetrated by strangers and people that she knew (270).

Illness Explanatory Models

Biological

Women's understandings of what caused their severe psychiatric illness after childbirth varied from biomedical to non-biomedical explanations. The majority of women across studies held a biomedical model of illness (98, 270, 274, 275, 277). A mother diagnosed with postpartum psychosis felt that something had left her brain and believed a drink would help restore her loss and her mental capacity (270). Women felt that their psychosis episode was caused by biological factors related to the childbirth: *"They told me that I was unlucky that it was some*

sort of chemical imbalance in the brain caused by pregnancy" (271). However, although some women's beliefs were incorporated by biological factors such as hormones, chemicals and genetics, they were not restricted by it (277). Mothers discussed their experience as a result of multiple factors leading to a *"perfect storm"* or *"domino effects"* (277). One woman believed she was biologically vulnerable to psychosis, however other factors such as sleep deprivation triggered her psychosis following childbirth: *"My brain doesn't fit well with the birth process but then the sleep deprivation might have been the thing that, the switch that…the fuse that blew"* (277).

Childbirth experiences

Negative childbirth experiences were also highlighted by women as a cause of their severe psychiatric illness (98, 270, 274). Although most women felt their childbirth was normal, some women had difficulties giving birth and in some cases ended up having a caesarean section (270). Additionally, women described their negative childbirth experiences as difficult, traumatic and distressing (274). Mothers in two studies highlighted their prolonged deliveries in influencing their path to psychosis: "*I was 36 weeks. I went into labour and that was quite traumatic because the labour lasted about 72 hours and I was so exhausted afterwards"* (270, 274). Furthermore, although women viewed childbirth as the precipitator of their illness, their beliefs were multifactorial and included hormonal changes, trauma during labour or childbirth or feelings of stress leading up to the birth (98).

Antenatal experiences

Women's adverse antenatal experiences were also perceived as contributing to the onset of illness after childbirth (270, 274). A woman experienced bereavement whilst pregnant and

believed this contributed to her pregnancy difficulties and subsequent severe postnatal illness (270). Other women reported unwanted pregnancies as a cause of their postnatal illness as they were not looking forward to the birth: *"I regretted it all the time, all the time, all the time – THAT I HAD THIS BABY! I would have done anything to undo it…I would have avoided everything that was so difficult; all the sleeplessness and all this horror"* (270). Similarly, one woman could not see herself as her infant's mother: "*He was not my child…the word mother was a dirty word to me"* (270). Unforeseen pregnancies were also reported by women, which was disruptive to work, relationships and life in general: *"Well the baby wasn't really planned…my career was going really well…then we had to buy a house with a mortgage and everything"* (274).

Psychological problems during pregnancy were also reported by women (274). Anxieties were described during women's pregnancies that were linked to their puerperal psychosis (274). A woman was told that she would never be able to have children due to gynaecological problems, thus when she fell unexpectedly pregnant this led to worries about the well-being of the baby: *"it was ectopic…if I had any previous problems I would not have known it was ectopic and that could have been life threatening. Eventually when I got pregnant again, I was petrified"* (274). As well as high levels of worry, women's antenatal depression was identified as cause of their postnatal illness: *"I was depressed in the pregnancy…it was not easy pregnancy"* (274). Additional stress induced by antenatal care was also reported to contribute to women's postnatal experiences: *"the biggest problem with antenatal care is everything is geared to your physical well-being rather than your mental and no one ever asks you how you're feeling emotionally…it is a big change and a lot of is was stress and circumstances"* (274).

Spirituality

Some mothers diagnosed with psychosis following childbirth instead favoured a spiritual understanding of their aetiology, however, this was only mentioned in one study (277).

Social Difficulties

Practical and emotional support

Mothers who experienced postpartum psychosis felt unsupported and desired different types of support including instrumental, informational, emotional and affirmational support (271, 275). Instrumental and information support were discussed in relation to generic parenting needs and caring for their infants during the night or during a manic state or from side effects from medication (275). Women's own physical needs were also described as something they needed help with (275). Furthermore, the lack of support from husbands was cited in 2 studies (98, 275). Mothers felt that if their families were more understanding about their severe psychiatric illness, they would have received more support: *"If my husband had a support group for new fathers to deal with a psychotic…it would have changed everything. He would have been far more compassionate"* (275). Mothers felt that their usual source of support was often dismissive of the situation: *"you've only had a baby, what's wrong with you, why you acting like that?"* (274). Some mothers felt this general consensus of being able to snap out of it was the most unsupportive element of their illness and played a big part in impacting their illness (274). However, others did feel supported and highlighted the importance of their relationships as providing security: *"I felt resentment, I felt angry but most of all I think I just felt supported"* (272). Mothers also felt they had access to available support from mothers' partner and immediate families (275).

Relationship difficulties

Women's postnatal illnesses were also reported to impact relationships with family and friends (98, 272, 277). Some mothers discussed that their severe postnatal illness put a strain on their relationship, including their spouses or resulted in relationship breakdown (98, 277). Some mothers felt their partners did not respond in an empathetic way, causing ruptures, which could not always be repaired (272). Physical intimacy difficulties were also experienced by mothers and their partners: *"it's probably affected our sex life…not irreversibly but erm, it took a while when I came home from hospital to have a normal relation again in that way"* (272). Women described a dichotomy between caring for their child and their husband: *"my focus was on looking after [daughter], but I wasn't actually taking much notice that my relationship was sort of drifting apart"* (98). Furthermore, women's relationships with their friends were also deeply affected, however mothers felt again this was due to a lack of understanding (98). In contrast, some women felt their experiences of postpartum psychosis was linked to positive changes in their relationship: *"fortunately it only changed for the better"* (272).

Unmet Expectations

Expectation to uphold a social role

Mothers felt they were falling short of the role of the mother constructed by society (272, 274, 277). Mothers felt devastated because they were incapable to meet the role of new mothers imposed by society because of their psychosis following delivery: *"…it felt like I was – it felt like I'd failed I suppose"* (277). Also, mothers felt there was an expectation imposed by society about the absence of mental illness during motherhood, which was usually perceived from the mother-in-law (274). Mothers reported the added pressure to be seen doing everything correctly and not letting people down, despite suffering from puerperal psychosis (98, 272).

Unmet expectations for self

Mothers had an expectation that motherhood would be a joyful and happy period, however, mothers in four studies described a mismatch between their expectations and experiences of motherhood (270-272, 277). Instead of describing a sense of joy at birth, some mothers felt as if they were in a vacuum and did not understand what was going on around them (270). Women described the joy was replaced by a traumatic experience (271). Some mothers never heard of psychosis following childbirth and had no idea it was possible to develop mania or psychosis: *"It was a shock and at the time that you were expecting to be such a wonderful time"* (271). Some mothers felt overwhelmed by the psychological enormity of the event: *"Worst thing was the whole, sort of, psychological impact of it"* (271).

Consequences of illness

Stigma

The effect of stigma was cited by mothers in 3 studies, which prevented them from speaking openly about their severe psychiatric illness after childbirth (98, 272, 274). Internalised stigma was described by mothers who admitted to feeling ashamed of their severe depression after childbirth and felt unable to disclose or communicate their feelings to family members or health care professionals (274). Similarly, mothers concealed their severe psychiatric illness, however, their stigma derived from others' perceptions of them: *"I just didn't want people to know I had a mental illness, I would have preferred them to think I was in hospital for a physical illness, definitely"* (276). Mothers felt less stigmatised from their illness after they recovered and felt they were able to disclose their feelings (276). Most women who did choose to disclose their illness received support and understanding from others (276). Some women desired to reduce their stigma, however also believed that stigma would remain to some extent (277).

Guilt

The sub-theme of guilt was experienced by women in 4 of the studies examined (98, 270, 271, 277). One woman experienced deep feelings of guilt because of her thoughts of not wanting her baby: *"She wished fervently that should could put him back into her womb and continue living as before"* (270). Mothers who did want their baby and developed postpartum psychosis felt guilty for not providing for the baby during the initial stages of motherhood: "*I feel like I wasn't there to look after my baby in the first weeks of his life…All these feelings of guilt because you missed out, or not being there, for your new born baby, and guilty"* (98, 271). Feelings of guilt were also expressed when mothers were unable to fully partake in caring and bonding with their baby (277).

Unable to cope as a mother

Mothers in 4 studies discussed the negative implications of their mothering role when living with a severe psychiatric illness after childbirth (98, 271, 276, 277). Mothers felt they could not always complete basic tasks including feeding, bathing and changing the baby (276). Low self-esteem and decreased confidence were experienced by mothers in relation to their mothering skills when experiencing symptoms of postpartum psychosis (271). A sense of failure was spoken by mothers living with a psychotic illness as they felt could not fulfil the role of a mother during the first few weeks of their infant's lives: *"I get quite bitter about the fact that I couldn't do it"* (98, 271, 277). Failure was also mentioned when women experienced difficulties associated with breastfeeding (277). Furthermore, women felt they could not emotionally provide for their infant and described a lack of love or maternal instinct (270, 276). Although some mothers expressed no desire to touch, kiss or embrace their child, one mother stated she deeply loved her baby (270).

Loss

Loss was mentioned by several mothers across five studies in relation to loss of motherhood, loss of identity and infant loss as a consequence of their severe psychiatric illness after childbirth (98, 271, 273, 276, 277). Mothers in two studies feared that they would be judged as inappropriate mothers as they were unable to care for their baby and as a result, their baby would be removed from their care (273, 276). Mothers experienced a loss of the mothering role and the first few months of their child's life they had prepared for as a consequence of their illness after childbirth (98, 271). The loss was also highlighted in reference to women's identity issues (98, 271, 277). Women reported feeling shocked and bewildered living with symptoms of postpartum psychosis, which was not consistent with their normal sense of self (271). Women felt the event challenged their personal identity and associated with a loss dignity and independence: *"Your whole being, how you see yourself, the kind of person you are, and your whole sense of identity is completely devastated really, because you will have behaved in ways that shock you completely"* (271). Mothers also felt a loss of their sense of self as they moved towards the role of a mentally ill person (277). Their shame and fear of stigma were shaped by society's socially constructed stereotype of a mentally ill person, which was incongruent with their identities (277). Similarly, mothers also felt their puerperal psychosis meant they had lost their minds, identity and personality: *"I didn't have a characteristics left of me at all"* (98). Mothers perceived to differ from their normal character when experiencing postpartum psychosis: *"I was not behaving like myself. I was getting excited over like food…and very direct"* (272). Mothers were totally confused and felt fearful of their personality change as they could not recognise themselves during this time of total darkness (270).

Impact on child

Women also felt that because of their diagnosis, this would have potentially adverse consequences for their infant (98, 277). Mothers were worried it would impact their child's emotional and intellectual development: *"I was terribly worried when I was in hospital that it would affect her for the rest of her life"* (98, 277).

Confidence and positivity

For some mothers, their overall experience of living with a severe postnatal psychiatric illness had a positive effect (98, 272). Some mothers became more confident after this life-changing experience: *"I'm not really scared of anything anymore…apart from something terminal…I've had the most scary thing".* Others felt less alienated when they were in contact with other women experiencing similar postnatal symptoms (276). Women's attitudes towards mental health altered and they became more compassionate and empathetic towards others and felt the need to become more open about mental illness: *"now we all know somebody affected by cancer, mental health should be like that"* (276). Additionally, receiving a diagnostic label was reported to contribute positively to their experiences and understanding as it challenged the feeling that they were *"going mad"* and found it reassuring (276, 277). Women felt they were able to evolve their understandings, which allowed them to overcome the fear of stigma, shame and hopelessness (277).

Discussion

This is the first comprehensive systematic review that explores the small body of qualitative literature on mothers' experiences of severe postnatal psychiatric illnesses. This review found that most women living with a severe postnatal psychiatric illness shared similar postnatal experiences, despite the heterogeneity across studies. The 5 themes developed here help to better understand the experiences of these women; 1) Experiences of illness 2) Consequences of illness 3) Illness explanatory models 4) Social difficulties 5) Unmet expectations.

Women's subjective experiences

The findings of this systematic review indicate that women's subjective experiences of living with a severe psychiatric after childbirth was lonely, isolated and exhausting. Some women experienced delusional thoughts that were mostly related to their baby and some women had thoughts of suicide and infanticide. Women's delusions were often frightening and there are consistent findings related to the baby being the *"devil"* (264, 278). Chandra et al. examined delusions related to the infant in women with postnatal psychotic disorders (264). Mothers who experienced delusions believed that the baby was a devil or ill-fated, and as a result mothers were most likely to have significant abusive incidents towards their baby (264). These findings are also similar to the findings in a narrative review that looks at women's experiences of postnatal anxiety disorders (279). Women often felt intrusive thoughts in harming the baby, intentionally or accidentally (279). Findings from a study of 'middle-class' UK women also revealed mothers' infant-related intentional harm, rather than accidental (280). Moreover, many women in this systematic review described that living with a severe postnatal psychiatric illness felt *"unreal"*. These findings strongly resonate with the literature on experiences of severe psychiatric illnesses at other times. *"The loss of censual reality"* was a theme identified

in a meta-synthesis of inductive qualitative studies that explored the experience of psychosis (281). Participants felt they were in a different reality, similar to the women in our review findings (281).

Women's explanatory models of illness

Our findings suggested that mothers had multi-layered responses, which gives rise to a better understanding of their illness. The biomedical aetiology of illness appeared to be the dominant belief system when mothers discussed the causes of their illness. These included chemical imbalances in the brain, hormones, genetics and biological vulnerabilities; these are explanations which are predominantly accepted in psychiatry. In contrast to this, I found that mothers also appeared to construct illness models, which did not always align with the mainstream biomedical paradigm, including negative antenatal and childbirth experiences and spirituality. Supporting the quantitative literature, Bel and Anderson conducted a systematic review that suggested the link between negative birthing experiences and postnatal depression (282). Authors recommended support, trust, respect and privacy in promoting women's confidence and positive birthing experiences (282). Spirituality was reported in one study only as contributing to symptomology in my review, which goes against the literature demonstrating the positive effects of spirituality when experiencing and recovering from severe mental illnesses. Spiritual practices, such as praying to God and faith, has been demonstrated as an important factor for postnatal women across cultures (283). For example, mothers with PND felt that spirituality provided a source of strength and support (283).

Women's losses

Most women in the included papers described aspects of both adverse and positive consequences of living with severe postnatal psychiatric illnesses. Mothers spoke of negative experiences such as identity loss, stigma, feeling unable to cope as a mother, subsequent feelings of guilt, impact on the child. The transition related to motherhood entails adjustments in women's roles and identity; however, under the influence of severe postnatal psychiatric symptoms these changes can be understood as losses, which was identified as a prominent sub-theme. The impact of severe postnatal psychiatric illness in relation to women's expectations of motherhood was important. Although the transition to motherhood is usually depicted as a positive experience in a woman's life, it is also a time of enormous physical and psychological changes which may leave women in a vulnerable state. Identifying factors that may influence the quality of the transition is important to understand, such as living with severe postnatal psychiatric illness. A severe postnatal psychiatric illness is a crippling disorder that erodes away at the joy and happiness of new mothers, affecting the concept that society has on new mothers and also the expectation that new mothers have on motherhood. A sub-theme that emerged from this review is the women's expectations of the postnatal period were often unmet, which led them feeling inadequate as a new mother and often left mothers feeling guilty. The chasm between expectations and realities of motherhood echoes previous research on mothers with psychiatric illnesses (284).

Furthermore, this review's findings support previous literature stressing that mothers were also influenced by the expectation of motherhood created by wider society, often leaving them feeling pressurised and incapable when they could not adhere to their new gendered role and responsibility of motherhood. Societal constructions reflect unrealistic expectations that could

cause difficulties in women's postnatal adjustments when diagnosed with a severe psychiatric illness.

Strengths and Limitations

Firstly, similar to the qualitative systematic review in chapter 2, a limitation of this systematic review was that it only considered and included qualitative studies. Therefore because of the typical small sample sizes and the nature of qualitative research, the findings should be taken with caution and there is limited generlisability of the findings. Moreover, the papers included in the systematic review did not include a mix of women from various ethnic backgrounds. This may have revealed how women experience psychiatric illnesses after childbirth across cultures and the various conceptualisatoins as evident in chapter 2 when exploring depression in the postnatal period.

A major strength of this systematic review is that it is the first comprehensive study to review all of the existing papers on women's experiences of a severe postnatal psychiatric illness. This is important in an era where the government has prioritised imporovements in Perinatal Mental Health, and so a deepened understanding of women's subjective illnesses will be a useful source of information.

In the UK, ethnic minority groups have a higher burden of perinatal psychiatric illnesses when compared to the majority white population (285). The systematic review found no study that was conducted on ethnic minority groups. It is important to explore the experiences of women from ethnic minority groups to address the postnatal needs of these women. Previous literature has demonstrated that women's belief systems and experiences can be shaped by social, cultural and religious factors. And so, given that the South Asian population are the largest facing population group in Perinatal Mental Health Services (as reported in chapter 1), the next chapter will present the methodology and methods to the empirical study of this thesis, the first study in the UK that aims to explore:

- *South Asian women's experiences of a severe postnatal psychiatric illness and*
- *South Asian women's experiences of Perinatal Mental Health Services, in the UK.*

Chapter 4

Methodology & Methods

My IPA study protocol enclosed in this chapter has been published:

Sihre HK, Gill P, Lindenmeyer A, McGuiness M, Berrisford G, Jankovic J, Patel M, Lewin J, Fazil Q. Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: a qualitative study protocol. BMJ open. 2019 Aug 1;9(8):e025928.

Study protocol

See the following page.

BMJ Open

Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: a qualitative study protocol

Harpreet Kaur Sihre,[1] Paramjit Gill,[2] Antje Lindenmeyer,[3] Mary McGuiness,[4] Giles Berrisford,[4] Jelena Jankovic,[4] Minaxi Patel,[5] Jona Lewin,[5] Qulsom Fazil[3]

To cite: Sihre HK, Gill P, Lindenmeyer A, *et al*. Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: a qualitative study protocol. *BMJ Open* 2019;**9**:e025928. doi:10.1136/bmjopen-2018-025928

► Prepublication history for this paper is available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2018-025928).

Received 08 August 2018
Revised 03 July 2019
Accepted 05 July 2019

Check for updates

© Author(s) (or their employer(s)) 2019. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

For numbered affiliations see end of article.

Correspondence to
Harpreet Kaur Sihre;
hks449@student.bham.ac.uk

ABSTRACT

Introduction The South Asian population is the UK's largest and fastest growing minority ethnic group. There is evidence to suggest the lay understanding of postnatal psychiatric illnesses of this group may fall outside the purview of Western biomedical perspectives. Alternative explanations include psychosocial, cultural and spiritual factors. Approaching psychiatric illnesses through a social perspective includes gaining insight to the patient's subjective experiences and understandings via qualitative inquiry. The objectives of this qualitative study are to explore South Asian women's narrative of living with a severe postnatal psychiatric illness and experiences of Perinatal Mental Health Services, care and support.

Methods and analysis Data collection is ongoing and will continue until 31 December 2018. Participants will be identified and recruited from Perinatal Mental Health Services in Birmingham and London. Eligible participants will be English speaking South Asian females aged 18 years or above with the capacity to give written informed consent. Participants are clinically diagnosed with a severe postnatal psychiatric illness. This qualitative study uses individual in-depth face-to-face interviews that aim to last 1 hour. Interviews will be audio recorded with participants' permission. Interview audio recordings will be transcribed verbatim and analysed using interpretative phenomenological analysis (IPA). The primary goal of IPA is for the researcher to closely study and interpret how individuals make sense of their life experiences in a particular context by drawing on the fundamental principles of phenomenology, hermeneutics and idiography.

Ethics and dissemination The University of Birmingham, the South Birmingham Research Ethics Committee and the Health Research Authority have approved this study (approvals date: 18-12-2017 ref: 17/WM/0350). Local capability and capacity have been confirmed from Trust Research and Development departments. The researchers plan to publish the results from this study in journals and present findings at academic conferences.

Strengths and limitations of this study

- ► First interpretative phenomenological analysis (IPA) study to investigate South Asian women's lived experiences of severe postnatal psychiatric illness, living in the UK.
- ► The purpose of using IPA is to understand and interpret the subjective meaning of a social phenomenon. Lived experiences takes into account the social and cultural milieu of the individual lives.
- ► Results will inform the development of culturally competent care.
- ► Limitations: a small selective sample means findings will not be generlisable.
- ► Excluding non-English speaking South Asian women will not highlight the different experiences are likely to have in comparison of English speaking South Asian women.

SEVERE POSTNATAL PSYCHIATRIC ILLNESSES

Postnatal psychiatric illnesses occur within the year after childbirth and are one of the leading cause of maternal morbidity in the UK.[1–3] Postnatal depression (PND) is a non-psychotic depressive disorder that occurs in ~10% of new mothers in high-income countries, with increased estimates in lower-middle-income countries.[4 5] Postnatal psychosis the most severe type of illness, documented to impact 2 in every 1000 deliveries.[6] A further 2 per 1000 new mothers will suffer from another form of severe psychological state including severe depression, schizophrenia and bipolar disorder.[1] Although the incidence is small, the impact can be devastating for the mother, the infant, the partner and the family.[7 8] It is documented that women with a history of bipolar disorder or a postnatal psychotic episode are at an elevated risk for postnatal relapse.[8 9] Furthermore,

BMJ Open: first published as 10.1136/bmjopen-2018-025928 on 1 August 2019. Downloaded from http://bmjopen.bmj.com/ on August 28, 2019 at Barnes Library Medical School. Protected by copyright.

changes in medication in women with pre-existing severe psychiatric illnesses may be at a higher risk for postnatal relapse.[10] Symptom onset of severe illnesses can occur rapidly and unexpectedly during the early days or weeks following childbirth.

Postnatal psychosis

The clinical features of postnatal psychosis can be dramatic and include mania, psychotic thoughts and severe depressive symptoms.[11 12] Women may feel excited or elated, the inability or not needing to sleep.[12 13] Women may also develop paranoia and bewilderment.[1] Frequent obsession thoughts of infanticide may be present, which often centre on the baby resulting in impulses to harm the baby or oneself as a command of auditory hallucinations.[14]

Severe depression

Severe depression is presented by feelings of guilt, psychomotor slowing and agitation, high level of cognitive disorders, anxiousness and feelings of hopelessness, hyprochronidria and somatic symptoms.[15] A small number of women with severe depression are likely to develop psychotic symptoms including hearing voices and have unusual beliefs. Neonaticide is rare in mothers with severe depression; however, women with thoughts of harming their infants are more likely to act on them.[16 17]

Schizophrenia

Symptoms of postnatal schizophrenia can be debilitating and include social withdrawal, cognitive disorganisation, misinterpretation of reality, hallucinations, seeing things that others cannot seeing. Cognitive symptoms include, difficulty in focusing attention, memory problems and difficulty maintaining conversation.[18] It should be noteworthy that schizophrenia may arise prior to conception or during pregnancy and symptoms may continue into the postnatal period.[19]

Postnatal bipolar disorder

Bipolar disorder is typically characterised by a wide range of mood changes carrying between manic episodes, hypomania or episodes of depression.[20] Postpartum psychosis may be the first presentation of bipolar disorder.[19]

Specialist Perinatal Mental Health Services

Women experiencing severe postnatal psychiatric illnesses typically require hospitalisation and treatment via Specialist Perinatal Mental Health Services.[1 21] Specialist Perinatal Mental Health Services are for women experiencing a severe and enduring types of psychiatric illness after childbirth. These include Specialist Community Perinatal Mental Health Teams and Mother and Baby Units (MBU). Secondary care consists of Specialist Community Perinatal Mental Health Teams on referral by a primary care physician, who offer specialist biopsychosocial assessments and care plans. A MBU is a specialist inpatient psychiatric tertiary care service with several beds for joint admission of a very severely ill mother and her baby. The Independent Mental Health Taskforce to the NHS in England (2016) reported the Five-Year Forward View Plan for Mental Health.[22] Support for new mothers and babies during the postnatal period was reported as a specific theme. As set out in the report, there has been unprecedented investment into Specialist Perinatal Mental Health Services. £365 million is being invested in Specialist Perinatal Mental Health Services, so that all women across the region can have access to evidence-based treatment.[23]

Historically, psychiatry was considered a biomedical concept, in isolation of social and cultural determinants.[24] However, recent findings suggest the understandings and causes of postnatal psychiatric illness are multifactorial and are viewed through a psychosocial, sociocultural and religious/spiritual lens.[25] Although there are many existing theoretical concepts that aim to understand postnatal psychiatric illness, recently, light has been given to the patient perspective in order to understand and conceptualise their illness experiences. However, the literature surrounding women's understandings and experiences of their psychiatric illness after childbirth remains underdeveloped. Exploring the social origins of illness via the subjective belief system of the patient and their experiences of illness is also clinically relevant for assessment, diagnosis and management.[26 27] A small body of qualitative studies have explored the cause and consequence, women's experiences of their illness, women's experiences of treatment and support and recovery needs, experience in relation to the stigmatisation of their postnatal psychiatric illness.[7 8 12 28–30] However, the majority of these studies were conducted in Western Europe, thus limiting cross-cultural generlisability of findings. Studies that use samples from the 'general population' often exclude non-Western population groups and do not capture the variety of conceptualisations of illness from different cultural groups.

Super diversity has become a 21st century phenomena in the UK. A super diverse nation is characterised by individuals who originate from a range of countries and ethnicities, which include heterogeneous cultures, religions and languages.[31] The South Asian population are the largest and fastest growing minority ethnic group.[32] The 2011 UK Census identifies Indian, Pakistani and Bangladeshi ethnicities within the South Asian ethnic group and for the sake of brevity, 'South Asian' will be used throughout this protocol.[33] Individuals with South Asian origins often share similarities in relation to their cultural beliefs, norms and values.[34] Although the prevalence rates of severe postnatal psychiatric illnesses in the South Asian population is under-researched, there are quantitative data to suggest that South Asian women are more susceptible to developing postnatal psychiatric illness than their White counterparts.[35 36] Previous literature on South Asian populations has predominantly focused on PND and identified determinants including husband/marital relationship problems, conflict with in-laws, dissatisfaction with infant's gender, financial difficulties, lack of social support, culturally specific

BMJ Open: first published as 10.1136/bmjopen-2018-025928 on 1 August 2019. Downloaded from http://bmjopen.bmj.com/ on August 28, 2019 at Barnes Library Medical School. Protected by copyright.

postpartum rituals and language and communication barrier.[37 38] Although some factors associated with PND overlap Western conceptualisations, some differences in ethnicity, culture and society pervade through South Asian women and recognised as significant risk factors for developing PND. Only one study was identified in India that investigates severe postpartum psychiatric illnesses in South Asian women.[39] Almost the majority of women in this study reported infanticide ideas and behaviours, separation from the infant and psychotic ideas towards the infant.[39] Thoughts of infanticide were associated with the birth of a female, a concept that was not present among Western population groups.[39]

Although there is considerable heterogeneity within and between the South Asian populations, cultural similarities contribute to common challenges when South Asian populations are seen in primary and secondary healthcare settings. We know that cultural and religious beliefs often contribute towards the understanding of mental illness and so investigating associations in specific ethnic groups is important in promoting equalities in mental healthcare provision. This information is crucial to understand how culture, religious and social context contributes to severe mental illness. For example, Hussain and Cochrane investigated beliefs on causes and cures in clinically depressed South Asian women living in Birmingham.[40] This study concluded that cultural and religious beliefs exert an influence in South Asian women's beliefs about the understanding, causes and cures of their mental illness and were central to these women's experiences of depression.[40] Culture and religion beliefs can be fluid and can structure the way a person defines illness and how or where treatment is sought that may influence the management of illness. To our knowledge, no study has explored experiences of severe postnatal psychiatric illnesses in South Asian women residing in the UK. Therefore, the overall goal of this research study is to provide a deeper understanding of the lived experiences of South Asian women diagnosed with a severe postnatal psychiatric illness.

Research objectives

1. To explore South Asian women's experiences of living with a severe postnatal psychiatric illness.
2. To explore South Asian women's experiences of Perinatal Mental Health Services, care and support.

METHODS AND ANALYSIS

Study design

Qualitative methods using interpretative phenomenological analysis (IPA) is appropriate for this study. IPA is a methodological framework in qualitative research that focuses on exploring in-depth how individuals make sense of their lived experiences, including how they experience living through events and what meaning they attribute to a given phenomenon.[41] IPA is invaluable when discussing emotional and sensitive topics, such as psychiatric illnesses. IPA enables the participant to retrospectively provide a full detailed account of their experiences with the researcher remaining strongly empathetic and highly attuned to their personal accounts. As we are interested in lived experiences, IPA allows a micro reading of the participant's accounts, leading to deeper understandings of the phenomena. With theoretical origins in phenomenology, hermeneutics and ideography, IPA allows the researcher to rigorously explore and interpret how a specific experience may affect a person in the context of their lives in a under-developed research area.[41]

Patient and public involvement

The researcher approached patients on the MBU and asked if they were interested to provide their views and opinions about the research study through an informal consultation. A South Asian patient agreed to give their views and opinions. The patient was presented with a brief overview of the research protocol. The patient was asked to provide their views about the appropriateness of the research methods in obtaining information about experiences of postnatal psychiatric illness.

The patient was also shown the research materials and asked to provide their views, feedback and any other comments on how they could be improved. Research materials included letter of invitation to participant, participant information sheet, participant consent form, interview schedule and letter to GP. Changes to the research materials were implemented based on the patient's comments. For example, the patient commented that some terms used as part of the interview schedule might not be understood. These terms were rephrased with the patient in a way that would be understandable.

Sampling strategy

A non-probabilistic, purposive sampling strategy is appropriate for IPA studies. The participants will be purposely selected as they have 'lived experience' about the phenomena being explored. Therefore, due to the deliberate choice of participants, the data drawn will contribute to a better understanding about a particular group and the phenomena under investigation.[42] The demographic population of interest purposively recruited for this study are women from a South Asian population (Bangladeshi, Indian and Pakistani), any generation. This group also includes major religious groups including Muslims, Hindus and Sikhs.

Eligibility criteria

English speaking South Asian new mothers who have been diagnosed with a severe postnatal psychiatric and currently presenting or presented within a year at Perinatal Mental Health Services will be considered for this study. The participant may be eligible for the study if the following criteria apply:

1. Willing and capacity to give informed consent for participation in the study. Prior to informed consent, capacity for participants to potentially partake in the

BMJ Open: first published as 10.1136/bmjopen-2018-025928 on 1 August 2019. Downloaded from http://bmjopen.bmj.com/ on August 28, 2019 at Barnes Library Medical School. Protected by copyright.

study will be determined by a member of their clinical care team.
2. South Asian female (Indian/Bangladeshi/Pakistani)
3. Clinically diagnosed with a severe postnatal psychiatric illness by a perinatal psychiatrist and is/has received care from Perinatal Mental Health Services (this includes specialist community perinatal mental health teams and MBUs).
4. Women must be at 3 months' discharge before interview takes place (only applies for in-patients).
5. Their illness is an extension from pregnancy or as a new episode within the year after childbirth.
6. 18 years of age or above.
7. Able to speak sufficient English to take part. We will not be including women non-English speaking women due to lack of resources.

Participant identification and recruitment

All participants will be identified and recruited from two Perinatal Mental Health Services in Birmingham and London. The multidisciplinary clinical care team (MDT) will be responsible for identifying all potential participants and initial approach. The MDT team comprise of perinatal psychiatrists, clinical psychologists, clinical nurse specialists, nursing staff, occupational therapists, perinatal psychiatric nurses and administrative staff. If potential participants preliminary express an interest to partake and agree for their details to be given to the researcher, the researcher will continue with recruitment. Participants will have the option for the interview to take place at their home, the NHS Trust, the university or a preferred quiet location. A participant information sheet will be administered to the participant prior to the interview. An opportunity to ask questions will be given to the potential participant.

Potential participants are being contacted through the following routes:
1. A telephone call.
2. Inpatients identified on the MBU who fit eligibility will be approached at discharge.
3. A letter of invitation to participants discharged up to a year.

Sample size

There is no necessary correct number of participants for an IPA qualitative study.[41] The primary concern of IPA research is to elicit rich and detailed accounts of a specific inquiry and maintain and manage the in-depth analysis of key individuals.[41] IPA study sample sizes are typically small so that the amount of data collected will not be overwhelming. We will not aim to reach data saturation sampling. We will stop recruitment of participants and data collection when we trust we have sufficient data and participants to conduct an IPA analysis. Due to the small patient cohort, we envisage to recruit between five and eight participants for this research study.

Data collection

Demographic characteristics will be collected prior to the interview. Data will be collected using qualitative semistructured, face-to-face interviews by the first author. HKS has received formal training in qualitative research methods. An interview schedule has been developed from a literature review and in relation to the research questions, which includes understanding of the illness, lived experiences, illness beliefs, perceived causes and experiences of treatment and care. The interview schedule includes the following topics:
1. Diagnostic history.
2. Understanding of the illness.
3. Illness beliefs and perceived causes.
4. Lived experiences of a severe postnatal psychiatric illness.
5. The journeys, pathways and process of referral and admission.
6. Experiences of Perinatal Mental Health Services and support networks

The interview schedule includes a range of open-ended questions to encourage the interviewee to talk in detail about their experiences, which allows the interviewee to set the parameter. The duration of the interview aims to last ~1 hour. With participants' permission, interviews will be recorded on a digital voice recorder and supplemented by additional field notes. Interviewees will be provided with choice of where to be interviewed including their homes, the trust, the university or a convenient location.

DATA ANALYSIS

Each interview will be transcribed verbatim before the analysis. The interview transcripts will serve as the raw data to be analysed following the principles of IPA.[41] The principles of IPA include phenomenology, hermeneutics and idiography.[43] Phenomenology, influenced by Husserl[44], is the study of consciousness through in-depth descriptions of a lived experience. Hermeneutics is the theory of interpretation of the lived experience, developed primarily by Heidegger.[45] Idiography then focuses on the particular experience of the individual and their specific context. Participant names will be replaced by an ID number to ensure their anonymity. Initially, IPA involves close readings of transcripts where initial thoughts, observations and responses to the text will be noted in relation to the research objective. The researcher will try to step into the participant's shoes as deeply as possible. To ensure reflexivity as a method of validity, as part of the process of IPA, the first author will deliberately put to aside (bracket) their own experiences, values, preconceptions and beliefs during the initial stages of analysis, which may influence the interpretation of the participant's responses.[46] Distinctive phrases and emotional responses will also be highlighted at this initial stage of analysis. Second, the researcher will work more closely with the detailed notes that have been developed from the initial readings. Using these comprehensive notes, the researcher will aim

BMJ Open: first published as 10.1136/bmjopen-2018-025928 on 1 August 2019. Downloaded from http://bmjopen.bmj.com/ on August 28, 2019 at Barnes Library Medical School. Protected by copyright.

to formulate concise phrases through a psychological lends that capture an interpretation and understanding of the participant's experiences, thoughts and emotions. The next stage involves seeking connexions between emerging themes and grouping them together according to conceptual and theoretical similarities. Each theme or cluster will be given a descriptive label. This process will be repeated for each transcript and patterns will be established between individual cases on a master table. These may include convergences or divergences between themes that developed from each transcript. The themes identified in the final master table will be transformed into a narrative account exemplified by verbatim quotes from the original scripts. The analysis will be managed with software assistance Nvivo.

Ethics and dissemination

Benefits to participants

Living with a severe mental illness is often said to decrease self-esteem and confidence, as it is still viewed as a taboo subject in the South Asian culture. By reflecting on their mental illness, participants will be able to fully explore their illness any may also gain a new perspective. This sense of self-awareness and self-exploration may be empowering for the participant. The data collected may be shared with others through presentations, publications and conferences. To be able to understand and increase an awareness of their illness may also help other South Asian women to accept and understand their illness.

Participant withdrawal

Participants will have the right to withdraw before or during the interview; however, a cut-off point of 2 weeks after the interview will be added to the withdrawal of data.

Deception

Participants will not be deceived in any way about study objectives. All information regarding the study will be provided verbally and in writing prior to the interview.

Consent

Eligible participants must have the full capacity to provide informed consent for themselves. Verbal and written informed consent is obtained from all those who are directly involved in the research, after they have been informed about the following issues: the purpose of the study, the types of data and methods of data collection, confidentiality and anonymity conditions associated with the data, time commitment expected from participants, the right to decline information, the opportunity to withdraw at any time during the interview, details of any risks, any plans for debriefing, how the data will be used, benefits of the research and how the results of research can be made available to participants. At least 24 hours is given to potential participants to absorb and to consider the information provided on the participant information sheet. An opportunity to ask any relevant questions is given before they provide consent.

Confidentiality

Data obtained from the participant will be kept confidential. Participants will remain anonymous and their names will be replaced by an ID number during transcription and analysis. When disseminating findings from the research study, direct quotes from respondents may be used as an example and will remain anonymous.

Psychological discomfort and distress

We envisage that recalling a distressful or traumatic event may cause some discomfort and suffering for the participant. If at any point the participant feels discomforted, distressed or upset during the interview, they will be given the option to pause the interview and continue at a time they feel more comfortable. If they feel they no longer wish to participate, they will have the opportunity and right to withdraw. The researcher will have a file of support services that they can provide to the participant during the interview. Furthermore, the researcher will use their own judgement to terminate the interview if the participant seems too ill to partake on initial meeting. If during the interview the participant mentions current thoughts of harm or suicide to self and/or others, relapse, malpractice or abuse, this information will be disclosed to the clinical team for the safety of the participant. This information will be disclosed to protect the health and safety of the mother, baby and any household members. Disclosure of the above mentioned information will be discussed during the consent process and is clearly mentioned on the participation information sheet,

Storage of personal data

Manual files such as informed consent sheets will contain personal information. These manual files will be kept in a secure filing cabinet at the university that has been allocated to the researcher for the duration of the study, who will only have access. Any data collected from the interview that was recorded on the dictaphone will be transferred onto the researcher's secure university account. Data will be stored anonymously and archived on the University's Research Data Archive for 10 years.

DISSEMINATION

The researchers will prepare manuscripts and publish the results from this study in relevant peer-reviewed journals and present findings via poster presentations and oral presentations at appropriate academic and non-scientific conferences.

Author affiliations
[1]Institute of Applied Health Research, University of Birmingham, Birmingham, UK
[2]Social Science and Systems in Health, University of Warwick, Warwick, UK
[3]Institute of Applied Health Research, University of Birmingham, Birmingham, UK
[4]Perinatal Mental Health services, Birmingham and Solihull Mental Health Foundation Trust, Birmingham, UK
[5]Coombe Wood Perinatal Service, Central and North West London Foundation Trust, London, UK

Acknowledgements We sincerely thank the clinical team at Birmingham and Solihull Mental Health Foundation Trust Perinatal Mental Health Services

BMJ Open: first published as 10.1136/bmjopen-2018-025928 on 1 August 2019. Downloaded from http://bmjopen.bmj.com/ on August 28, 2019 at Barnes Library Medical School. Protected by copyright.

and Central and North West London Perinatal Mental Health Services for their collaboration and support for the study. We would also like to sincerely thank our patient advisor who provided insightful and invaluable comments to research materials.

Contributors HKS, QF, PG, AL, MM and GB conceptualised the study. HKS wrote the manuscript. QF, AL, PG, MM, GB, JJ, MP and JL participated in revising and approving the final manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

REFERENCES

1. Paschetta E, Berrisford G, Coccia F, *et al*. Perinatal psychiatric disorders: an overview. *Am J Obstet Gynecol* 2014;210:501–9.
2. Oates M. Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *Br Med Bull* 2003;67:219–29.
3. Knight M. The findings of the MBRRACE-UK confidential enquiry into maternal deaths and morbidity. *Obstetrics, Gynaecology & Reproductive Medicine* 2019;29:21–3.
4. Howard LM, Molyneaux E, Dennis C-L, *et al*. Non-psychotic mental disorders in the perinatal period. *The Lancet* 2014;384:1775–88.
5. Fisher J, Cabral de Mello M, Patel V, *et al*. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. *Bull World Health Organ* 2012;90:139–49.
6. Gale S, Harlow BL. Postpartum mood disorders: a review of clinical and epidemiological factors. *J Psychosom Obstet Gynaecol* 2003;24:257–66.
7. Doucet S, Letourneau N, Blackmore ER. Support needs of mothers who experience postpartum psychosis and their partners. *J Obstet Gynecol Neonatal Nurs* 2012;41:236–45.
8. Glover L, Jomeen J, Urquhart T, *et al*. Puerperal psychosis – a qualitative study of women's experiences. *J Reprod Infant Psychol* 2014;32:254–69.
9. Wesseloo R, Kamperman AM, Munk-Olsen T, *et al*. Risk of postpartum relapse in bipolar disorder and postpartum psychosis: a systematic review and meta-analysis. *American Journal of Psychiatry* 2016;173:117–27.
10. Taylor CL, Stewart RJ, Howard LM. Relapse in the first three months postpartum in women with history of serious mental illness. *Schizophr Res* 2019;204:46–54.
11. Kendell RE, Chalmers JC, Platz C. Epidemiology of puerperal psychoses. *Br J Psychiatry* 1987;150:662–73.
12. Heron J, McGuinness M, Blackmore ER, *et al*. Early postpartum symptoms in puerperal psychosis. *BJOG: Int J O & G* 2008;115:348–53.
13. Essali A, Alabed S, Guul A, *et al*. Preventive interventions for postnatal psychosis. *Cochrane Database of Systematic Reviews* 2013;7.
14. Sit D, Rothschild AJ, Wisner KL. A review of postpartum psychosis. *Journal of Women's Health* 2006;15:352–68.
15. Zdanowicz A, Wierzbinski P, depression P. Psychiatria i psychologia kliniczna-journal of psychiatry and clinical psychology 2017;17:115–9.
16. Donahue Jennings K, Ross S, Popper S, *et al*. Thoughts of harming infants in depressed and nondepressed mothers. *J Affect Disord* 1999;54:21–8.
17. Miller LJ. *Postpartum mood disorders*. American Psychiatric Association, 1999.
18. Seeman MV. Schizophrenia during pregnancy and the postpartum period. *Current Clinical Practice: Psychiatric Disorders in Pregnancy and the Postpartum: Principles and Treatment* 2006:139–52.
19. Jones I, Chandra PS, Dazzan P, *et al*. Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *The Lancet* 2014;384:1789–99.
20. Rusner M, Berg M, Begley C. Bipolar disorder in pregnancy and childbirth: a systematic review of outcomes. *BMC Pregnancy Childbirth* 2016;16:331.
21. Kissane D, Ball JRB. Postnatal depression and psychosis — a mother and baby unit in a general Hospital. *Aust N Z J Obstet Gynaecol* 1988;28:208–12.
22. England N. Five year forward view. 2014 2016.
23. NHS England NI. *National collaborating centre for mental health, National collaborating centre for mental. The*. England: Perinatal Mental Health Care Pathways. NHS, 2018.
24. Engel G. The need for a new medical model: a challenge for biomedicine. *Science* 1977;196:129–36.
25. Tovino SA. Scientific understandings of postpartum illness: improving health law and policy. *Harv JL & Gender* 2010;33.
26. Allen J, Balfour R, Bell R, *et al*. Social determinants of mental health. *International Review of Psychiatry* 2014;26:392–407.
27. Carod-Artal FJ. *Social determinants of mental health*. Global Mental Health: Springer, 2017: 33–46.
28. Robertson E, Lyons A. Living with puerperal psychosis: a qualitative analysis. *Psychol Psychother* 2003;76:411–31.
29. Engqvist I, Ferszt G, Åhlin A, *et al*. Women's experience of postpartum psychotic episodes—analyses of narratives from the Internet. *Arch Psychiatr Nurs* 2011;25:376–87.
30. Heron J, Gilbert N, Dolman C, *et al*. Information and support needs during recovery from postpartum psychosis. *Arch Womens Ment Health* 2012;15:155–65.
31. Phillimore J. Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethn Racial Stud* 2015;38:568–82.
32. Vertovec S. Super-diversity and its implications. *Ethn Racial Stud* 2007;30:1024–54.
33. Bradford-ONS S. *Ethnicity and national identity in England and Wales 2011*, 2012.
34. Ahmad F, Shik A, Vanza R, *et al*. Voices of South Asian women: immigration and mental health. *Women Health* 2005;40:113–30.
35. Onozawa K, Kumar RC, Adams D, *et al*. High EPDS scores in women from ethnic minorities living in London. *Arch Womens Ment Health* 2003;6:s51–5.
36. Edge D. Perinatal mental health care for black and minority ethnic (BME) women: a scoping review of provision in England. *Ethnicity and Inequalities in Health and Social Care* 2010;3:24–32.
37. Nilaweera I, Doran F, Fisher J, Prevalence FJ. Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: a systematic review of the evidence. *J Affect Disord* 2014;166:213–26.
38. Wittkowski A, Zumla A, Glendenning S, *et al*. The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. *J Reprod Infant Psychol* 2011;29:480–92.
39. Chandra PS, Venkatasubramanian G, Thomas T. Infanticidal ideas and infanticidal behavior in Indian women with severe postpartum psychiatric disorders. *J Nerv Ment Dis* 2002;190:457–61.
40. Hussain FA, Cochrane R. Depression in South Asian women: Asian women's beliefs on causes and cures. *Ment Health Relig Cult* 2002;5:285–311.
41. Pietkiewicz I, Smith JA. A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal* 2014;20:7–14.
42. Etikan I, Musa SA, Alkassim RS. Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics* 2016;5:1–4.
43. J Charlick S, Pincombe J, McKellar L, *et al*. Making sense of participant experiences: interpretative phenomenological analysis in midwifery research. *International Journal of Doctoral Studies* 2016;11:205–16.
44. Husserl E. Phenomenology. *Encyclopaedia Britannica* 1927;14:699–702.
45. Heidegger M. *Being and time. 1927. Trans. John Macquarrie and Edward Robinson*. New York: Harper, 1962.
46. Chan ZC, Y-l F, W-t C. Bracketing in phenomenology: only undertaken in the data collection and analysis process. *The qualitative report* 2013;18:1–9.

BMJ Open: first published as 10.1136/bmjopen-2018-025928 on 1 August 2019. Downloaded from http://bmjopen.bmj.com/ on August 28, 2019 at Barnes Library Medical School. Protected by copyright.

Methodology

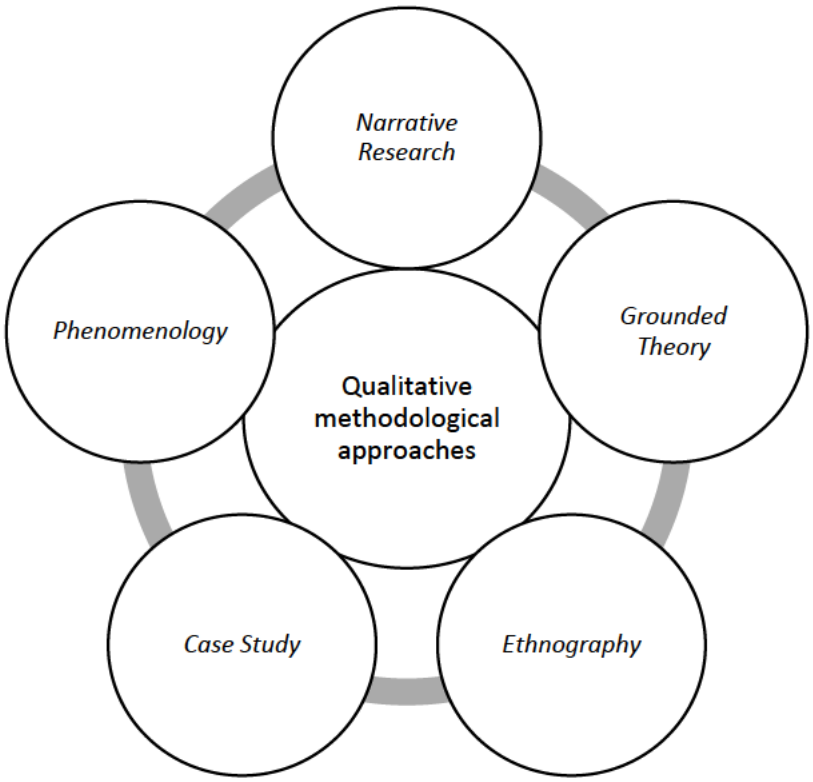
"any understanding of madness which overlooks subjective experience will inevitably provide an incomplete and, ultimately, inadequate conceptualization of the experience" (286).

Geekie & Read, 2009

Qualitative methodological approaches

Leedy and Ormrod defined methodology as *"the general approach the researcher takes in carrying out the research project"* (287). Each research approach constitutes a comprehensive methodological framework including theoretical underpinnings behind it and guidelines for a research design. According to John W. Creswell and Cheryl N. Poth, there are five main approaches in qualitative research, which are illustrated in Figure 5 (288).

Figure 5.
Five main approaches in qualitative research



Narrative Research

An important part of being human involves narrative stories to ourselves and to others, which in research provides an option to explore person experiences (289). In contemporary social sciences, Narrative Research has become a widespread field. A narrative is broadly defined as *"a set of signs, which may involve writing, verbal or other sounds, or visual, acted, built or made elements that similarly convey meaning"* (290). Narrative Research, also known as narrative inquiry, involves working with narrative materials of all kinds. The narrative can sometimes or exist or elicit as part of the research. Typically focusing on a single person, the researcher typically gathers data through the collection of stories and discusses the meaning of those stories. These stories are usually told and presented in a chronological way with a distinct beginning, middle and an end. Although narrative research would have been useful for the current research project, telling stories and experiences of severe postnatal psychiatric illnesses are very different entities. Traditionally, stories have a clear conclusion, however many experiences of a complex illness do not. Instead, it involves a continuing description of the experience, thus IPA is better suited when exploring the continuation of an individual's experience.

Grounded Theory

The development of Grounded Theory was by two sociologists, Barney Glaser and Anselm Strauss (1967) and is rooted in sociology. Grounded Theory methodology explicitly involves *"generating theory and doing social research [as] two parts of the same process"* (291). The key point in Grounded Theory is that it is an inductive method in that the construction of theory is *grounded* in the data of participants who have experienced the phenomena under investigation (292, 293). The researcher begins with a comprehensive inquiry, which ultimately

leads up to a theory that explains observations. Therefore, all conclusions or theories must be explicitly demonstrable in the data. A Grounded Theory project is often entirely led by the data, as opposed to, like Interpretative Phenomenlogical Analysis (IPA), an agenda or questions that are laid out from the beginning. Moreover, my aim is not to build theory as the focus is on lived experiences.

Ethnography

Ethnography came from cultural anthropology in the early 20th century. Through extended times of observation, the aim of ethnography is to examine shared behaviour, language and beliefs within a cultural group, to provide rich, holistic insights into people's view and actions as well as the location they inhibit (293, 294). This data is then described and interpreted by the researcher (293). Sharing similar qualities with IPA with an aim to get inside the experiences of how people see the world, IPA seemed to be more ethical in that it also intends to 'get inside' the subjective experiences, however in a way that seemed more appropriate then constant observations with new mothers and their newborns. Also, as the majority of the women were in recovery or recovered, for ethical reasons (such as the capacity to provide informed consent for themselves), their experiences were a retrospective account of their illness.

Case Study

A case is described as *"an event, an entity, an individual or even a unit of analysis".* A case study is an idiographic approach in that it allows the researcher to examine the individual in as much rich detail as possible. Case studies were originally and frequently used by Sigmund Freud, as he investigated the private lives of his patients, in an attempt to both understand and help

them overcome their illness (295). Although a large part of the IPA commitment is to treat each participant as a 'case' and remain central to the social and cultural contexts of the participants' lives. I was also interested to look out for convergences and divergences between cases, therefore for the purpose of our study a single case study was not appropriate.

Phenomenology

A case study reports the life of a single individual, however, the phenomenological approach aims to develop a comprehensive, truthful, clearly articulated account and understanding of a particular human experience/phenomenon for several individuals. Phenomenologists aim to describe what all participants have in common as they *share* a particular experience. Creswell points out the essence of a phenomenological approach:

> *"the central underlying meaning of the experience and emphasize the intentionality of consciousness where experiences contain both outward appearance and inward consciousness based on the memory, memory, and meaning" (296).*

The fundamental purpose of phenomenology is to identify a phenomenon, be it, insomnia, depression, anger or being left out, and to reduce individual experience with a phenomenon to a description of the universal essence. As Max van Manen refers to in his book *Researching Lived Experience* (1990), this is a *"grasp of the very nature of the thing"* (288, 297). Edmund Husserl established the discipline of phenomenology, now known as *descriptive phenomenology*. Experiences are described in real-world contexts and setting and the researcher's perceptions are set aside and *bracketed* in order to enter into the world view of the participant. Martin Heidegger developed *interpretive phenomenology* using hermeneutics (298). Building on the work of Husserl and Heidegger, different approaches and applications of

phenomenology to research have been developed. Phenomenology gives rise to IPA, which is discussed in the next section.

Interpretative Phenomenological Analysis

IPA is a contemporary qualitative methodology, pioneered in the UK by Professor Johnathan Smith, Professor Paul Flowers and Dr Michael Larkin (299). IPA commits to phenomenology and hermeneutics with the primary objective of investigating how individuals make sense of their experiences (300). Since IPA's first articulation in the UK, it is now one of the best established qualitative approaches in UK psychology (301). Although IPA is a newly established approach in qualitative methodology, its philosophical underpinnings in phenomenology and hermeneutics date back to the early 1920s (see below). As well as traditions in phenomenology and hermeneutics, IPA has also been characterised as being *"idiographic, inductive and interrogative"* (302).

The relevance of IPA to health and illness

The vast majority of published IPA work is in the field of health psychology. With a move away from a biomedical model of disease and illness (as discussed in chapter 1), there has been a growing appreciation of the constructed nature of illness from the patients' perspective, which is even more invaluable in a superdiverse setting (303). This thesis reports the first study that explored South Asian women's lived experience of a postnatal psychiatric illness in the UK, therefore, I chose this methodology to provide detailed examinations of their personal lived experiences. The importance of acknowledging the patient's understanding, their subjective interpretations of their experiences and the meanings they assign to them have been recognised by healthcare professionals (303). Therefore, in academic research, the IPA

approach enables researchers to explore these subjective experiences and helps us to understand the way they make sense of their experiences. Since its inception, there has been a corpus of studies utilising IPA. Recently published research using IPA to explore health-related topics include exploring the lived experiences of deep brain stimulation in Parkinson's disease; chronic depression; living with ileostomy; the lived experience of pain (304-307). In recent years, IPA has broadened its application to many different trajectories outside its "home" of health research, including education, management and the humanities (308). The most important authors of the phenomenological movement were Franz Brentano, Edmund Husserl, and Martin Heidegger and this will be discussed next.

The Theoretical Underpinnings of Phenomenological Research

Franz Brentano & Edmund Husserl's Phenomenology

We should "go back to the things themselves".

Husserl, (1982)

Phenomenology is a philosophical approach to studying how people make sense of their experience (299). The word phenomenology originates from the Greek 'phainomenon' meaning appearances. The basic approach of phenomenology was first developed in the early work of German psychologist and philosopher, Franz Brentano. In his famous book *Psychologie vom empirischen Standpunkte* (1874) Brentano was proposing a form of descriptive psychology which would concentrate on illuminating the nature of inner self-aware acts of cognition, which would distinguish between the mental and the non-mental (309). Brentano thought that all and only psychological states exhibit intentionality. In philosophy, intentionality is the power of minds and mental states to be about, to represent or to stand for things, properties

and states of affairs. Therefore to say if an individual's mental state has intentionality is to say that they are mental representations or they contain contents.

For Edmund Husserl, Brentano's student, phenomenology involved meticulous examination of human experience (310). The founding principle of phenomenology is that experience should be observed in the exact way that it appears and in its own terms (299). Husserl was interested in finding a means by which someone might come to accurately know their personal unique experiences of a given phenomenon and would do with depth and precision. This may allow them to identify the essential qualities of their experience and fathom the timeless reality that underlies it.

The *"thing"* Husserl famously refers to is the experiential content of consciousness. He refers to the numerous obstacles that can interfere in its pursuit and suggested that we should focus on each and every particular thing, in its own right. Husserl's phenomenology involved stepping out of our natural attitude (our everyday experiences), to allow the study of that everyday experience. In our everyday life, we are actively engaged in the activities in the world and our taken for granted experiences. Therefore, to become phenomenological, we need to disengage from the activity and focus to the taken for granted activities of the world (299). Once we stop to self-consciously reflect on any of the thinking, seeing and remembering, we are being phenomenological. If this could be done, Husserl reasoned that these essential features of experience would transcend the particular circumstances of their appearance and possibly illuminate a given experience for other people experiencing the phenomena too(299).

For Husserl, phenomenological enquiry focuses on that which is experienced in the consciousness of the individual. In phenomenological language, experience or consciousness is always consciousness of *something*. That *something*, the object of which we are conscious, may have been stimulated by a real object in the world, or through an act of memory or imagination. To identify the fundamental structures and features of human experience, Husserl developed a *'phenomenological method'*, to successfully achieve a phenomenological outlook. Firstly, rather than describing the phenomena according to a predetermined categorical system, conceptual and scientific criteria, according to Husserl we need to 'bracket' our preconceptions, beliefs, values and all knowledge to allow the phenomena to speak for itself and to get at the content of consciousness. This process formed part of what he described an *'eidetic reduction'* approach, which involved a procedure to get at the essential meaning – the set of invariant properties lying underneath the subjective perception of individual expressions. Therefore, the *'eidetic reduction'* approach identifies the fundamental features of the phenomena or experiences that make them unique or distinguishable from others. Each reduction offers a different lens or prism, a different way of thinking and reasoning about the phenomena. This is intended to lead the inquirer away from the distraction and misdirection of their own experiences and assumptions, and back towards the essence of their experience of a given phenomenon (299).

Since IPA is largely phenomenological, it has been criticised for being a simple descriptive methodology and consequently and IPA study is *"easy to do badly and difficult to do well"* (311). Although the centrality is on the participant's perspective, there is also emphasis on the researcher's interpretation of the text (312). As a result IPA seeks to *"give voice"* than to simply make sense of the initial description (310).

Martin Heidegger's Hermeneutics

"the question of the meaning of Being" (313).

Heidegger, 1927

Martin Heidegger was the driving force of hermeneutic phenomenology(299). Husserl's thought was further developed by Heidegger into existential philosophy and hermeneutics. Hermeneutics was concerned with the need to comprehend the mindset of a person and language, which mediates their experiences in the world. Heidegger differed from Husserl in that the phenomena need to be interpretative rather than merely descriptive. The goal of the hermeneutic phenomenology is to understand the essence of the lived experience of the human way of *being* in the world (299).

Although never completely possible, IPA researchers aim to understand what it is like to stand in the shoes of the participant and through interpretative activity make meaning comprehendible by translating it and making sense of the participant's world. The IPA study is a dynamic process whereby the active role of the researcher will influence the extent to which they get access to the participant's experiences and cognitions, through interpretative activity. The analytical process of IPA is usually described in terms of a *double hermeneutics* (299, 314). Firstly, the participants make meaning of their world and secondly, the researcher tries to make sense of their world (299). In sum, IPA researchers aim to understand what an experience is like from the participant's insider perspective but at the same time try to formulate critical questions referring to the material (299). For example, *What is the person trying to achieve here? Is there anything meaningful being said here? Do I have a sense of something that the participant is less aware of?* This makes the analysis richer and more comprehensive. The

significance of the double hermeneutic is central to IPA and acknowledges that both the participant and the researcher can view the same phenomena from different angles (310).

Heidegger's believed that the researcher should bring their own knowledge, understanding, history, insights and bases to the research process. The researcher's personal and intuitive knowledge is valued in the interpretative approach and is regarded as an asset rather than something that needs to be bracketed. Interpretative phenomenology is a partnership of participant and researcher working to understand the essence of a phenomenon. As Smith et al. propose, it is sometimes necessary to disagree with the surface of the meaning of the participant's account, to agree with the deeper meaning observed via the researcher's theoretical knowledge (299).

The ontological and epistemological positioning of IPA

> *"If people have multiple identities and deal with multiple realities, why should we expect them to be ontological purists?"* (315).
>
> *Weick, 1995*

IPA is committed to the examination of how people make sense of their major life experiences (299). At the heart of IPA's epistemology lies the assumption that experience is accessed via interpretation (300). Interpretation enables the complicated process of gaining access to and making sense of the participant's world, whereby there is no objective reality or objective truth (300, 316). Therefore IPA assumes an interpretative (hermeneutic) research paradigm, as the researcher plays an integral part to uncover the dynamic meaning and the reality of people's experiences (317). IPA is not viewed as objective, nor is it a methodological approach that lies at the positivist end of the ontological spectrum. It does not search for facts or even to seek

the absolute truth, but to recognise the person's personal experience and the meaning they assign to it and importantly, the interpretation which the researcher's makes. Larkin and Thompson outline IPA's epistemological assumptions:

- *An understanding of the world requires an understanding of experience*
- *IPA researchers elicit and engage with the personal accounts of other people who are 'always-already' immersed in a linguistic, relational, cultural and physical world*
- *We, therefore, need to take an idiographic approach to our work, in order to facilitate a detailed focus on the particular (318).*

Heidegger's double hermeneutics highlights how I understand experience and existence in mothers with severe postnatal psychiatric illnesses. In comparison to a positivist approach in that, there is one lived world, every mother has their own reality and experience of their unique world. In relation to the research question, by exploring the lived experience of mothers, each mother constructs her own ontological position. The theoretical framework is congruent with my own world as I believe that there are multiple realities and each person's reality is a unique experience. To understand women's experience, I also believe it is helpful for the researcher to have some insider knowledge of the phenomena. My experience will not mirror the experience of the participants, but it will contribute to the interpretation.

Objectivity and subjectivity

Objectivity and subjectivity are key concepts in research and can govern the conduct and outcome of research findings. The definition of Objectivity is *"the ability to consider or represent facts, information etc. without being influenced by personal feelings or opinions…"* It aims to disclose facts about the world, independently of the researcher, suggesting that the truth is not purely socially constructed and that the same conclusion could be drawn

irrespective of who is conducting the research project. And so, objectivity in research takes a positivist reductionist paradigm in that it seeks to make generalisable statements from observational or experimental data. Taking an ontological and epistemological standpoint, objectivity implies that there is a single reality or truth in the world, which can be measured using valid and trustworthy tools. In general, natural sciences encompass the exploration non-human materials, such as the orbit of planets or how cells divide and/or reproduce. In this way, objective natural sciences do not take an inward approach of the phenomena and instead involves looking into a system from the outside. Most measures of objectivity can, however, be troubling when studying human behaviour. The crux of the problem is that scientists do not enter the sphere or world-view of humanity.

Social sciences research involves the observation and interpretation of human behaviour and social relations, which requires an inward approach in the conduct and analysis of research. Subjectivity is based on constructivist epistemology and explores what appears to be socially constructed from the perspectives of the people involved. Unlike the distance between the researcher and research in an objective approach, subjectivity views the relationship between the knower and the known as inextricably connected, therefore the research is supposed to develop a close rapport with the subjects being studies (319). Taking this approach allows the researcher to gain access to the subjective understanding of the individual and explore the multiple realities of a given phenomenon, as opposed to a single truth or universal fact. Therefore, the antonym of objectivity, subjectivity, is defined as *"the quality or condition of being based on subjective consciousness [or] experience [and] the fact or existing in the mind only"*. The current piece of qualitative research aims to create first hand, experiential accounts of what it is like living with a severe postnatal psychiatric illness for South Asian women and

also experiences of Perinatal Mental Health services, in the UK. The importance of subjectivity honours the underpinnings of our research inquiry.

Characteristics of IPA

> *"all human knowledge is inevitably idiographic – all that is is experienced once" (320).*
>
> *Salvatore & Valsiner, 2010*

Experience

Lived experience is the essential feature that IPA addresses (301). Experience is a complex phenomenon and IPA aims to attend to aspects of experience that matters most to people. Attending to different things that matter to people means distinguishing between different parts of the experience and making decisions about which parts of the whole experience to focus on.

Irrespective of the phenomena being studied, IPA attends to all aspects of the lived experience, from the individual's wishes, desires, feelings, motivations and belief systems. Understanding the first-person life world requires doing so from the perspective of the person experiencing it and so, the participant is treated as the experiential expert in the phenomenon of interest.

Idiographic

IPA emphasises in studying people idiographically. This term refers to an in-depth exploration of single cases and examining individual perspectives of study participants, whilst foregrounding their unique contexts. Prior to producing any generic statements, the fundamental principle behind idiography is to explore every single case (321). Therefore, taking this idiographic approach, researchers tend to focus on the particular rather than the universal

thus, the analysis can entail specific statements about study participants because the analysis is based upon a detailed case exploration (302). Moreover, this enables the reader to learn a great deal about the person and their circumstances and also their responses and experiences to a particular situation, which allows the reader to engage in their life world (302, 311). Only when this has been achieved can a cross-case analysis be attempted and interrogate for convergence and divergence (321).

Inductive

Analytic induction is a technique for attempting to develop theoretical accounts from a set of cases (322). IPA is a flexible methodology in that the procedures of IPA allows the researcher to explore unanticipated themes to emerge from the data during the analysis. In IPA, broad research questions are developed to explore a phenomenon of interest, as opposed to attempting to refute a predetermined hypothesis. Therefore, this develops the inductive practice of IPA, which has commonly been recognised as a longstanding hallmark of most qualitative research methodologies. IPA researchers accept that personal stories rise from the individual and that the retelling of stories is an act of reconstruction, therefore it is inductive as theory arises from the exploration of the lived experience as opposed to a study driven by pre-determined theoretical perspectives (323). This also marks IPA an iterative procedure as it involves a close-nit relation between the researcher and the text and allows the data to foreground overall discussion of the study. This includes the researcher to actively engage in a to and fro circular process by participating, observing, writing, reflecting, listening, more like a voyage of discovery than a pragmatic linear analysis. According to Biggerstaff and Thompson the iterative process in IPA follows through the following stages in healthcare research:

- *Stage 1: first encounter with the text*
- *Stage 2: preliminary themes identified*
- *Stage 3: grouping themes together as clusters*
- *Stage 4: tabulating themes in a summary table* (312).

Interrogative

IPA involves the researcher to be interrogative at two stages:

- *Trying to make sense of the participant's world, and*
- *The discussion of the findings with extant literature.*

First of all, IPA is concerned with, trying to make sense of the participant's world view, and so on a methodological level the researcher typically requires to be interrogative of the data. As well as taking an initial descriptive phenomenological reading of the text, at a more critical hermeneutic level, IPA analysis can involve questioning the data to produce an interrogative account (310, 324). For example, *what is the person trying to realise here? Is something appearing that was not anticipated? Do I have some sense of what is going on here that the participants themselves are less aware of?* Secondly, through the interrogation of or enlightenment with existent literature, another key principle of IPA is to make a contribution to the academic literature.

Methods

This research followed the methods proposed outlined by Smith, Flowers and Larkin and will be discussed in detail below (299).

Research design

"The most basic definition of qualitative research is that it uses words as data" (325).

Braun & Clarke, 2013

Although the nature of qualitative research is underpinned by several paradigms, it can be difficult to define, however, Strauss and Corbin offer the definition: *"By the term "qualitative research" we mean any type of research that produces findings not arrives at by statistical procedures or other means of quantification"* (326).

To explore the subjective realities of South Asian women diagnosed with a severe postnatal psychiatric illness, this study adopted a qualitative, phenomenological, hermeneutic and idiographic design using semi-structured face-to-face interviews. It captures the complexities that characterise the real world of the individual and allows researchers to make sense of their world. Recently published in The Lancet Psychiatry, Virginia Braun and Victoria Clarke (2019) discuss novel insights into patients' lifeworld: the value of qualitative research (327). Quantitative methods have often been criticised as they do not intend to take healthcare professionals to the *"heart of the patient's lived experience"* (312). In light of Geekie and Read's quote at the start of this chapter, it is apparent that the 'lived world' is not accessible through any measures that fail to access the subjective account of the individual. Firstly, in line with phenomenology, the most central feature of qualitative research is that it is interested in and

prioritises *meaning* from the data. Secondly, in line with double hermeneutics, qualitative research interprets meaning in some way by categorising a framework around it. Therefore, qualitative research does not aim to provide one single answer and it is generally recognised that there are several ways of producing meaning from qualitative data. And thirdly, another key tenet of qualitative research in line with IPA is that information always comes from somewhere. Information is produced in particular contexts, by participants who are located within that particular context and so involved contextualised analysis.

Justification for the empirical study

The South Asian population are the largest ethnic minority group residing in the UK. Although prevalence rates of severe postnatal psychiatric illnesses in the South Asian population is under-researched, there is quantitative research to suggest that South Asian women are more susceptible to developing a psychiatric illness after childbirth, when compared to their White counterparts (2, 245). Historically, psychiatry was considered a biomedical concept. However many South Asians have a holistic conceptualisation of their psychiatric illness, which is imperative to consider in a clinical setting (169). Although there is considerable heterogeneity within and between the South Asian populations, similarities contribute to common challenges when South Asian populations are seen in primary and secondary health care settings. We know that non-biomedical beliefs often contribute towards the understanding of mental illness thus investigating associations in specific ethnic groups is important in promoting equalities in mental health care provision.

Research indicates that the phenomenon of depression is higher among new mothers from ethnic minority groups, including the South Asian ethnic group of 19% (32). A systematic review

reported that a significant number of women born in the South Asian region who migrate to high-income countries experience postnatal psychiatric problems (189). Therefore, it is imperative for clinicians to understand and support the mental health of women from diverse religious and cultural backgrounds (189). A recent narrative review identified factors in relation to PND that is unique to the South Asian culture. These included a poor relationship with the mother-in-law, disappointment with sex/gender of the baby and have never had a son (328). Chapter 2 in this thesis reports findings from a comprehensive qualitative systematic review that explores the experience of PND in South Asian mothers living in Great Britain (245). Although some experiences of PND overlap with Western concepts, some differences pervade through the experiences of South Asian women. The experience was very dynamic and influenced ethnic, societal, cultural, religious and domestic factors.

The NICE guidelines recommend that British ethnicity minority women should be provided with culturally sensitive information and treatment during the postnatal period (16). A recent qualitative nested study aimed to test the feasibility and acceptability of a culturally adapted intervention (Positive Health Programme) for PND in British South Asian women (329). Mothers in this study reported a positive change in their attitudes, behaviour and increased self-confidence. Masood et al. concluded that culturally sensitive interventions may lead to better health outcomes and overall satisfaction (329). There is an ongoing national scale research study (ROSHNI-2) funded by the National Institute for Health Research to address the rise in British South Asian women who experience PND. Researchers aim to evaluate the clinical and cost-effectiveness of a culturally adapted group psychological intervention in primary care for British South Asian women with PND (compared to treatment as usual). It is anticipated that this trial will make recommendations for policy makers, provide an insight into the

importance of culturally adaptation of existing technologies and to inform the next update of the NICE PND guidelines.

The existing literature predominantly focuses on South Asian women and PND. This prompted my curiosity to investigate and review the literature on severe postnatal psychiatric illnesses. Chapter 3 is a comprehensive qualitative systematic review that explores women's experience of severe postnatal psychiatric illnesses. Findings revealed no existing study on South Asian women residing in the UK and their experiences of severe postnatal psychiatric illness, therefore this was an opportunity to create a holistic account of their lived experiences. My findings would then be discussed in light of the existing literature and theoretical concepts. Furthermore, as women are patients receiving specialist care, we were also interested to explore experiences of Perinatal Mental Health Services.

There is existing literature on PND in South Asian women, however, to my knowledge, no study using qualitative methods has explored the *"reality"* of experiences of severe postnatal psychiatric illnesses in UK South Asian women, using philosophical phenomenology as a guide. Therefore, the overall goal of this research study is to provide a deep understanding of the lived experiences of South Asian women diagnosed with a severe postnatal psychiatric illness.

For the purpose of this study and research questions, I felt that IPA was appropriate and best suited the research that was to be undertaken. With Husserl's phenomenology, I would obtain a certain outlook when approaching the research and the interviews. Interview questions would be developed in a way that mothers can openly and fully talk about their experiences, thus being able to gain a descriptive exploration of the mother's experiences. Hermeneutics

will allow for meaning to be created between myself and the mothers. The dimension of hermeneutics will give richer accounts of mother's experiences, as opposed to purely a descriptive approach.

The research question(s)

For studies using IPA, research questions focus on experiences and understandings of a particular phenomenon and generally person-orientated (299). Research questions are usually grounded in an epistemological position, in that the data will be able to tell the researcher about people's direction and orientation towards the world (299). IPA studies aim to elicit the lived experiences of a phenomenon, and so do not look to develop a theoretical understanding, causal relationships or explanations (299). Therefore, my research questions have broad elements and their wording hoped to capture a deepened understanding of what it is like for South Asian women to live with a severe postnatal psychiatric illness:

1. *What are the lived experiences of South Asian women with severe postnatal psychiatric illnesses living in the UK?*
2. *What are South Asian women's experiences of Perinatal Mental Health Services?*

Research objectives

1. *To explore South Asian women's experiences of living with a severe postnatal psychiatric illness, including:*
    - How women first learnt about their illness
    - Women's understandings of their illness
    - How women feel about their illness
    - What women believe their illness is
    - What women believed caused their illness
    - The lived experiences of their illness

2. *To explore South Asian women's experiences of Perinatal Mental Health Services, care and support for your severe postnatal psychiatric illness, including:*

- The journeys, pathways and process of referral and admission to Perinatal Mental Health Services
- Women's experiences of Perinatal Mental Health Services and the treatment they received
- Women's experiences of accessibility and barriers to support
- The support networks from family and friends women received outside of Perinatal Mental Health Services

Patient and public involvement

Patient public involvement (PPI) is internationally recognised as important to improve the way research is prioritised, commissioned, undertaken, communicated and used. Active involvement of patient/the public can bring their unique and new perspectives to a research project that can lead to greater quality of research and has become a requirement for most publically funded projects in the UK (330, 331). The impact of PPI has been investigated in the literature. Brett et al. conducted a systematic review of PPI in health and social care (330). Benefits were identified as enhanced quality and appropriateness of research, user-friendly information, questionnaires and interview schedules, appropriate recruitment strategies, consumer-focused interpretation of data and enhanced implementation and dissemination of study findings. A recent research paper has demonstrated a positive impact on researchers, including their knowledge and skills, values and attitudes (332). There are different levels of PPI, which include:

- Low-level involvement called *informed*, *consulted* or *participation*, which consists of researchers asking for views to inform research decision making
- Medium-level involvement called *involved*, *collaboration* or *co-production*, which has a focus on equity between the PPI participant and the researcher and comprises an ongoing relationship
- High-level involvement called *influential*, *control* or *service user-led*, which consists of people with the lived experience having the dominant voice and even, deliver and manage the research themselves (333).

After liaising with members of staff at the Birmingham and Solihull Mental Health Foundation Trust (including lead for service user, carer and public engagement), confirmation was received to approach patients on the MBU. I approached patients on the MBU and asked if they were interested to provide their views and opinions about the research study through an informal chat. A South Asian patient verbally agreed to give their views and opinions. The patient was presented with a brief overview of the research protocol. The patient was asked to provide their views about the appropriateness of the research methods in obtaining information about experiences of postnatal psychiatric illness. The patient was also shown the research materials and asked to provide their views, feedback and any other comments on how they could be improved. Research materials included the letter of invitation to the participant, participant information sheet, participant consent form, interview schedule and letter to GP. Amendments to the research materials were implemented based on the patient's comments. For example, the patient commented that some terms used as part of the interview schedule might not be understood. These terms were re-phrased with the patient in a way that would be understandable. The patient questioned the meaning of *"illness explanatory model"* and mentioned this was a term she had never heard of. This was modified to *"understanding of illness, illness beliefs and causes of illness".*

Peer review & external review

The study protocol was presented to the multi-disciplinary team at The Barberry, Birmingham and Solihull Mental Health Foundation Trust. Expert advice from clinicians including Dr Giles Berrisford, Consultant Clinical Psychiatrist and Dr Mary McGuinness, Consultant Clinical Psychologist who have vast experience in perinatal research was received and implemented in the final protocol and research materials.

Professor Kalamdeep Bhui has reviewed the study. Professor Kamaldeep Bhui, BSc (Pharmacol), MBBS, MSc (Epid), MSc (Mental Health Studies), MD (Res), FRCPsych, Dipl. Clin.Psychotherapy. Dip. LSHTM is Professor of Cultural Psychiatry and Epidemiology at the Wolfson Institute of Preventive Medicine, part of Queen Mary's medical school, and honorary Consultant with East London NHS Foundation Trust.

Ethical approvals

For this research project, I had to gain:

- Research Governance approvals at the University of Birmingham
- NHS Health Research Authority approvals
- NHS Research Ethics Committee approvals
- Confirmation of Capacity and Capability at the participating NHS Trusts.

The University of Birmingham Research Governance team authorised Sponsorship for this study and issued Insurance and Indemnity Liability documents supporting their Sponsorship for the study (see Appendices 3 - 8). The South Birmingham Research Ethics Committee and the Health Research Authority have approved this study (approvals date: 18-12-2017 ref: 17/WM/0350) (See Appendices 9 and 10) Local capability and capacity have been confirmed from Trust Research and Development departments (See Appendices 11 and 12). Moreover, in order to conduct the study, I required a Research Passport (see Appendix 13) that was issued via the University of Birmingham. For this, I completed the application form, Clinical Clearance and DBS Enhanced Certificate (see Appendices 14 and 15).

Study setting

This was a multi-centre study including NHS organisations in England. The purpose of multi-centre study is to protect and minimise the risk of identification of the trust and the patient cohort. The study participants were recruited from two Perinatal Mental Health Services including, The Barberry, Birmingham and Solihull Mental Health NHS Foundation Trust and Coombe Wood Perinatal Mental Health Services, Central and North West London NHS Foundation Trust. Women who have been referred to specialist secondary/tertiary care services and who are suffering from psychiatric illnesses associated with pregnancy and childbirth are provided with care and treatment at these specialist services. The women are new mothers who are experiencing a severe and enduring mental illness in the perinatal period. Therefore the research setting was appropriate for the research aims, as this study aimed to explore the experiences of women who suffered with a postnatal psychiatric illness.

Sampling strategy and sample size

As this research was a qualitative study, there was no need for a scientific power calculation to determine sample size. Although there are no stringent rules for qualitative sample sizes, IPA studies tend to use smaller sizes so that the data collected is not overwhelming for the researcher (299). Smith and Osborn noted that sample size depends on a number of factors and there is no 'right' sample size (314). As an idiographic method, small sample sizes are the norm in IPA studies as large datasets have the potential to lose meaning. IPA samples tend to be purposively selected (rather than through probability methods) and broadly homogenous as a small sample size of five and 10 can provide sufficient perspective on the phenomena under inquiry (302). For a student project using IPA, Smith et al. (2009) recommended that between three and six participants are a reasonable sample size to provide sufficient cases for

the development of meaningful points (299). Moreover, for an IPA study our aim was not to reach saturation.

Eligibility criteria

Participants were eligible for the study if the following criteria applied:

- Women had the will and capacity to give informed consent for participation in the study. Prior to informed consent, capacity for participants to potentially partake in the study were determined by a member of their clinical care team
- Women were South Asian female (Indian/Bangladeshi/Pakistani)
- Women were clinically diagnosed with a severe postnatal psychiatric illness by a perinatal psychiatrist and had received care from Perinatal Mental Health Services (this includes specialist community Perinatal Mental Health teams and MBUs)
- Women had to be at least three months post-discharge before the interview took place (only applied for in-patients due to the severity of their illness)
- Women's illness has an extension from pregnancy or a new episode within the year after childbirth
- Women were 18 years of age or above
- Women were able to speak sufficient English to take part. We did not include non-English speaking women, because of a lack of resources.

Participant identification and recruitment

All women who were part of the study were identified and recruited from two Perinatal Mental Health Services in Birmingham and London. Participants were recruited up to a year after childbirth. A challenging factor to patient identification was that I do not have involvement within NHS Perinatal Mental Health Services, and so I did not have access to patient information. Therefore, the MDT team who comprise of perinatal psychiatrists, clinical psychologists, clinical nurse specialists, nursing staff, occupational therapists, perinatal

psychiatric nurses and administrative staff were responsible for identifying patients. The study was also advertised on the MBUs so patients could approach a member of the team if they were interested to take part (see Appendix 16). In discussion with local collaborators it was agreed that once patients were identified, they contacted through the following identification strategies by a member of the MDT team:

- A telephone call to potential participants was made by a member of the clinical team and a script was provided to the member of the clinical team (see appendix 17). The potential participant identified by a member of the clinical team was either an outpatient or discharged from the services. During the initial telephone call, the clinician advised the potential participant about a *"health research"* study and invited them to partake. If the potential participant expressed an initial interest, they were asked to provide verbal consent for their contact details to be referred to the researcher. They were then informed that the researcher would be in contact. They were given options for the researcher to contact them i.e. contact via post, email, telephone or in-person.

- Or, inpatients identified on the Mother and Baby unit who fit eligibility were approached at discharge by a member of the clinical team. If patients expressed an initial interest they were given the *Letter of Invitation to Participant* (See Appendix 18) and *Consent to Contact Form* (see Appendix 19) at discharge. The *Consent to Contact Form* was completed by the potential participant and forwarded to the researcher by the member of the clinical team.

- Or, a member of the clinical team approached potential participants identified at outpatient appointments. The *Letter of Invitation to Participant* and *Consent to Contact Form* was given directly to the potential participant. The *Consent to Contact Form* was completed by the potential participant and forwarded to the researcher by the member of the clinical team.

- Or, a *Letter of Invitation to Participant (Sent in the Post)* (see appendix 20) was posted to potential participants who have been discharged from the services, however, are still within the postnatal period. The potential participant telephoned contact a member of the clinical team if they expressed a wish to be involved in the study. This contact number was provided on the *Letter of Invitation to Participant (Sent in the Post)*. The potential participant provided verbal consent for their contact details to be referred to the researcher.

If potential participants' preliminary expressed their interest to partake and agreed for their preferred contact details to be given to the researcher by providing their Consent to Contact, I continued with the recruitment procedure. Once I received the contact details of the potential participants from the member of the clinical team, I contacted participants via their preferred method. All women gave permission for me to contact them via telephone. I contacted the women and confirmed their potential eligibility by asking them the following questions prior to proceeding with recruitment:

- *"Are you South Asian?"*
- *"Are you 18 years or above?"*
- *"Did you/have you had/have a diagnosis of a severe psychiatric illness after childbirth?"*
- *"Are/did you received/receiving care from Perinatal Mental Health services?"*
- *"Are you still in the postnatal period?"*

Once I confirmed their eligibility, the conversation developed and I provided them with more information about myself and my role as a doctoral researcher at the University of Birmingham, the study aims, the interview process and also gave them an opportunity for them to ask me any questions regarding the study and their potential participation. If participants were happy and interested to take part, a *Participant Information Sheet* (see Appendix 21) was sent via their preferred method (e.g. post/email/in-person). This provided more written information

about the study, including any potential harms and benefits. Upon receiving the *Participant Information Sheet*, I gave participants at least 24 hours to absorb the information before contacting them again. The second phone call involved participant's verbal consent to take part in the research study sharing their lived experience. Following the receipt of their verbal consent and again an opportunity to ask questions, we arranged for the interview at a convenient place and time. Women were given an option for the interview to take place at the Trust, their home, the University of Birmingham or a preferred quiet location. As participants were new mothers with a child up to a year old, we appreciated that childcare may be involved, and so, childcare costs were covered. However, none of the women in the research study required childcare. Four women chose to have the interview at their home and one woman chose to have the interview at the Trust.

Study participants and demographic information

Table 12 summarises participant demographic information, which collected at the beginning of the interview. The study used a purposive homogenous sample of five South Asian women who were diagnosed with a severe postnatal psychiatric illness with their first child. A homogenous sample is a selection of participants who share similar characteristics so that they are able to share their experiences on a specific phenomenon e.g. lived experiences of severe postnatal psychiatric illnesses. All women were South Asian females and all but one were in a marital relationship. Women's ages ranged within the 30s from 31 to 34. One woman was educated up until College, two women held a Bachelor's degree and the other two women held a Master's degree. Three women were born in the UK and two women were born outside of the UK in countries such as Pakistan. All women were first-time mothers.

Table 12.
Participant demographics

Code	Age	Date of birth	Marital status	Level of Education	Occupation	Country of Origin	Ethnicity	Religion	Children (No.)	Where Living	Household Members	Language Spoken at Home
001	34	18.08.1983	Married	Masters	Pharmacist	England, UK	Indian	Hindu	1	London	3	English / Gujarati
002	31	09.06.1987	Married	Bachelors	Unemployed	Pakistan	South Asian/Muslim	Islam	1	London	3	Urdu
003	32		Married	Bachelors	Art patient co-ordinator at a NHS hospital	England, UK	Bangladeshi	Islam	1	London	5	English / Bengali
004	31	04.17.1986	Married	College	Private Teacher	Pakistan	British South Asian	Islam	1	Birmingham	3	English / Urdu
005	33	22.01.1985	Unmarried, Long-term partner	Masters	Trainee	England, UK	British Asian	Islam	1	Birmingham	4	English / Urdu / Punjabi

Methods of data collection

IPA is best suited to a method of data collection that will facilitate a rich, in-depth and first-person account of the research question. In-depth face-to-face interviews are consonant with an intimate focus on one person's lived experience and offer the opportunity for people to tell their stories and to speak openly and reflectively as well as engaging with their thoughts and feelings (334). I believe that as part of sharing sensitive and private information, face-to-face interviews were appropriate as it maintained the human to human interaction and respect for receiving their personal story. A telephone or skype interview as a potential option would have possibly weakened the rapport and participants' willingness to openly share their experiences.

For this qualitative research study, I employed semi-structured in-depth face-to-face interviews as the method of data collection, which has been suggested by Reid et al. as the preferred means for data collection (334). This method enabled the development of rapport between myself and the participant and aimed to approach the interview as *"a conversation with a purpose"* (299). Approaching the interview in this way permits the participant to set the parameter, whilst I remained an active listener and guided the conversation with a predetermined set of open-ended questions, to ask and probe in order to learn more about their lifeworld, when needed (312). Although the *Interview Schedule* (see Appendix 22) was developed in an order that I wanted to ask the questions, if during the interview the direction changed, it was possible to change the structure of the questions, to remain in line with the story and the participant. Therefore, depending on what the participant was saying, I decided what would be appropriate to ask next. Developing the interview schedule allowed me to understand and reflect what I expected the interview to cover in order to achieve a "good" interview and rich data for the analysis. Furthermore, it also allowed me to challenge any

difficulties, for example phrasing of questions. This also allowed me to be more attentive in the interview as I already had a virtual map in my mind and I was familiar with the questions. By keeping the research question at the forefront of my mind, the questions were developed so that the participant could talk at length and in detail about their experiences relating to the research question. Questions were developed in aim of the interview to last up to 60 minutes. Pilot interviews were conducted with friends and colleagues and the questions were re-drafted where necessary. All interviews lasted approximately 1 hour and were audio-recorded with participant's permission. A letter was sent to participants' GPs to inform them of their participation in the study (see Appendix 23).

Ethical practice

Consent

It was essential that participants for study participation had full capacity to provide informed consent for themselves. Verbal and written informed consent was obtained from all those who were directly involved in the research after they were informed about the following issues:

- *The purpose of the study*
- *The types of data and methods of data collection*
- *Confidentiality and anonymity conditions*
- *The time commitment expected from participants*
- *The right to decline information*
- *The opportunity to withdraw at any time during the interview*
- *Details of any risks and benefits*
- *Any plans for debriefing*
- *How the data will be used and*
- *How the results can be made available to participants*

Verbal consent was received over the initial telephone call and ALL participants strictly signed and dated the Informed Consent Sheet (see Appendix 24) prior to starting the interview. A duplicate of the Informed Consent Sheet was sent to participants via their preferred method after their interview.

Participant withdrawal

If the participants, for any reason, wished to withdraw their participation prior to or during the interview, they had the right to do so. However, a cut-off point of two weeks after the interview was added to the withdrawal of data.

Benefits to participants

Living with a severe psychiatric illness is still viewed as a taboo subject in the South Asian community and is often said to decrease self-esteem and confidence. As women were given the opportunity to reflect on their experience, they were able to fully explore their illness, which may have given them a new perspective. This sense of self-awareness and self-exploration may be empowering for women in the study. Moreover, their data will be used to understand their experiences, which may also help other women to accept and understand their illness.

Deception

The participants in the study were not deceived in any way. All information regarding the study was provided verbally and in writing prior to the interview.

Confidentiality

Subject to the 1998 Data Protection Act, information obtained about the participant during the study will be kept confidential. Personal information collected will be kept secure and maintained. Data will be stored in password protected folders, in which the researcher will only have access. When analysing the data collected from the interviews, participant names will be replaced with data codes. This will be maintained throughout the data analysis process. This will allow other members of the research team to discuss themes, whilst maintaining confidentiality and anonymity of personal information. All data will be kept anonymised at dissemination. For the duration of the study, the researcher will have the responsibility to store and keep safe the data. For the purpose of the thesis, I created a name for the participants, which I felt reflected their personalities.

Psychological discomfort and distress

We envisaged that the women in the study may experience some emotional distress when recalling events and memories about their psychiatric illness. However, the study was designed in a way that would minimise potential distress. Sufficient time was provided for the participant to complete the interview and the participant could pause or stop the interview if they wished too and continue at a time when they felt more comfortable. If they no longer wished to continue, they had the opportunity to withdraw. As I am not a licensed health professional, I had a list of contact details in connection with their current mental health team, if participants that were provided to the women if they required support. Moreover, I used my own judgement to terminate the interview if the participant seemed too ill to partake on initial meeting. If during the interview the participant mentioned current thoughts of harm or suicide,

relapse, malpractice or abuse, this information was disclosed immediately to the clinical team at the trust, for the safety of the participant.

Safe-working practices

As there may be potential high risk for the researcher, they will adhere to the University of Birmingham *'Out of Hours Activities and Lone Working Policy'*. As the researcher conducting the interviews, I had regular access to a strong support-network including supervisors, mentors, colleagues, trusted friends and family. Debriefing measures were available throughout the study, so there is not a risk of carrying the stories around with me, which may have possibly be detrimental for my emotional well-being. A safety protocol (see Appendix 25) was put in place to minimise any potential physical risks. I let a colleague know that I arrived safely at the location of the interview and also report back to a colleague of my safety at the end of the interview.

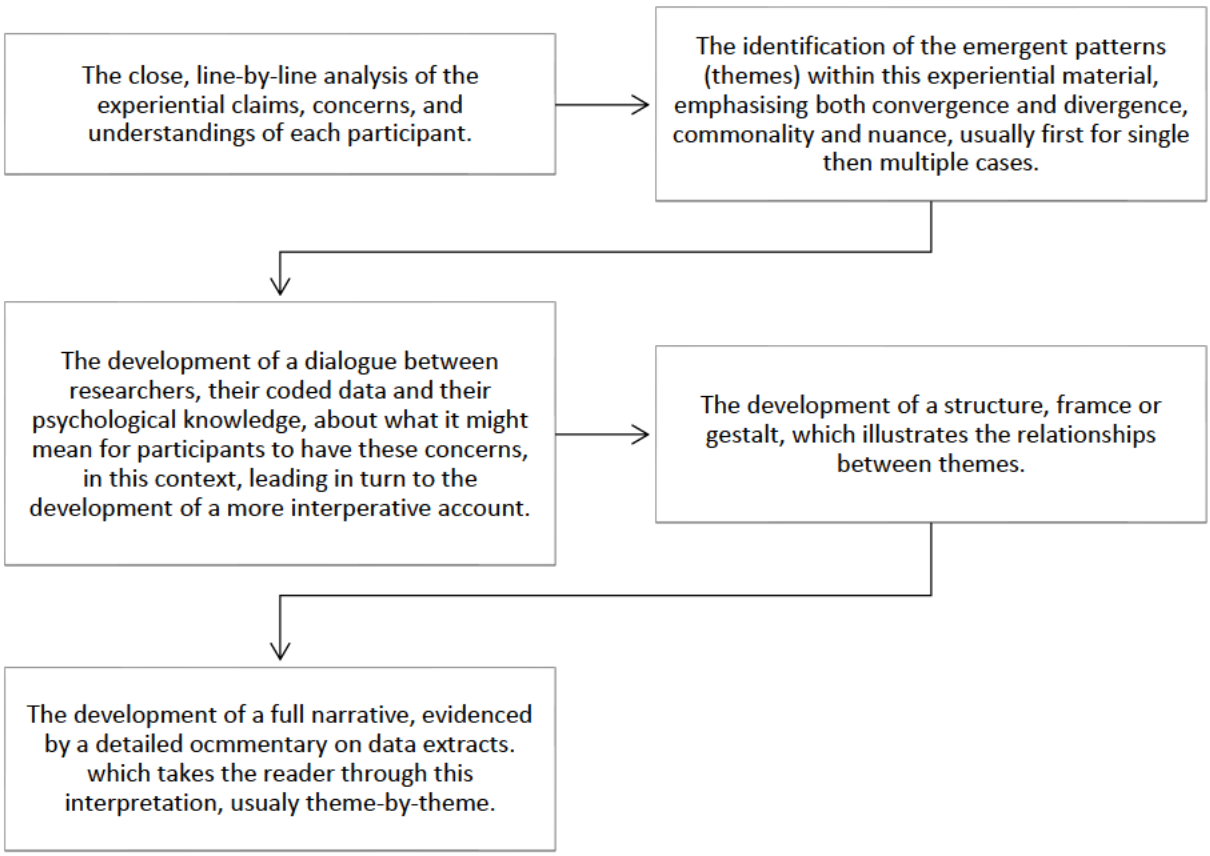
Data storage

The data from this study will be stored and archived on the University of Birmingham's Research Data Archive for 10 years.

Methods of data analysis

Prior to the analysis, I transcribed all interview recordings verbatim. A total of 7 hours worth of recordings were transcribed and the word count for interviews in total were 58951. Transcribing and listening to the interviews really allowed me to become familiar with the data. The analytic process followed IPA and involved a set of processes such as moving from the descriptive to the interpretative. Typically, the analysis is an inductive an iterative process. I transcribed each interview verbatim with meticulous accuracy prior to the analysis, which served as the raw data to be analysed following the principles of IPA (312). As set out by Smith et al. the following steps describe the framework of IPA analysis. Figure 6 summarises the steps of conducting an IPA analysis.

Figure 6.
Summary of IPA analysis



Step 1: Reading and re-reading

The first step of analysis involved multiple readings of the transcripts, which allowed me to actively engage in the data and view myself in the participant's shoes. As well as multiple readings, I listened to the interviews to remind myself of the participant's voice during the analysis. Whilst re-reading the transcripts and listening to the interviews, I returned to my diary and added any recollections of the interview experience, any prominent observations and my emotional responses to the participant and their story. To being with, the data seemed overwhelming, however recording notes/thoughts in my diary allowed me to put aside any *"noise"* or distractions, so I could proceed with the analysis. Furthermore, this *"free-coding"* enabled me to put down any initial ideas prior to adopting a more systematic approach to the analysis.

Step 2: Initial noting

This exploratory step required the most consuming time as part of the initial stages of analysis. See Appendix 26 for an example of initial noting from each transcript. The aim was to develop a detailed and comprehensive set of notes that will be used for the analysis. In line with Smith et al. the three main components of initial noting included (see Table 11.):

- *Descriptive comments*
- *Linguistic comments*
- *Conceptual comments*

Table 13.
IPA Initial noting

Descriptive comments	I focused on describing the content of what the participant said at face value, including keywords, phrases or explanations. This large had a phenomenological focus.
Linguistic comments	I also focused on exploring the specific use of language the participants used, therefore how the content of meaning was presented by participants' use of language, tone, fluency, pronouns, laughter, repetition etc. The identification of metaphors was also pertinent of exploring linguistic comments.
Conceptual comments	I also engaged in an interpretative exploration and engaged an interrogative and conceptual level and shifted towards my own thoughts and focus. I completed this by reflecting on my personal experiences, asking questions of the data, thinking about the context of the participant and referring to my existing knowledge.

A colour system was employed as part of this process, in order to distinguish the types of comments. This process was very in-depth and I began to identify ways in which the participant talks about, understands and thinks about an issue. A phenomenological focus was maintained by keeping close to the participant's explicit meaning, which developed the descriptive comments. These comments described things that mattered to them and the meaning that those things had for them. During this stage, I also attempted to also put aside and presumptions, which involved the process of *"bracketing"* (312). Through engaging in a more interpretative stance and understanding *how* and *why* the participants had certain concerns, I studied the language, the context of their concerns and any abstract concepts.

Metaphors in talk of illness

Previous research examines the way individuals talk about their illness experiences through the use of metaphor (335). A metaphor is *"essentially a word picture that says, 'try seeing it like this'. It is intended to help the hearer or reader understand something by describing it as something else"* (336). A metaphor has been highlighted as a way of expressing experience in the context of health psychology and medicine (337, 338). Although patients are influenced by medical terminology that is given to them about their illness, it is also apparent that patients also make sense of what is happening to them using metaphorical language (335). However, one may query, *how might metaphor contribute towards an understanding of the participant experience?* Metaphors appear to have a representational function for the individual by reflecting on past experiences (339). This allows the patient to personally define their illness that is unique and central to their subjective experiences, producing richer depictions of illness experiences (340, 341). Metaphor is ubiquitous in all aspects of language and thought and may allow the participant to access and reveal emotions that have previously been unrecognised or unexplored (335, 342).

Lakoff and Johnson stated that *"metaphor is one of our most important tools for trying to comprehend partially what cannot be comprehended totally: our feelings, aesthetic experiences, moral practices and spiritual awareness"* (343). Thus, metaphor is important in communicating richly textured information about life and experience, through people's basic understanding of places, movement, objects and forces (343). Using metaphoric expressions evokes a more vivid level of understanding and may capture experiences and concepts more precisely (341). Additionally, illness experiences are more likely to be presented metaphorically

than literally, as the intricacies of trying to make sense cannot be communicated through descriptive adjectives alone (341).

Proposed by Todd and Harris, if the goal of the research is not entirely linguistic, then metaphor analysis using thematic analysis may be beneficial (344). Therefore considering the hermeneutic/interpretative philosophies of the overall study, we used IPA analysis with consideration of metaphors.

Step 3: Development of emergent themes

Through the initial development of exploratory commenting, the data had substantially grown and it was this large data set that guided the next stages of analysis; the development of emergent themes.

In looking for emergent themes, my aim was to reduce the volume of detail, however also maintain the intricacy of the interrelationships, connections and patterns between explanatory notes and also remain close to the original transcript. The analysis thus far was participant-led, however at this point by engaging in the hermeneutic circle, I led more of a central role in interpreting and organising and re-organising the analysis and write-up. I was always always mindful of the *"I"* and *"P"* part of *"IPA" (299)*. Although at this point *"I"* was an important part in facilitating the analysis, this remained embedded to the experiences of the participants. Thus, the success of the product was a shared effort between the *"P"*articipants and *"I"*.

The emergent themes were a concise piece of information which summarised the various comments from Stage 2 and reflected the synergy of my own interpretation and also the participant's original words.

Step 4: Searching for connections across emergent themes

Up until this stage, I developed a set of themes within the transcript, which then led to the development of how the themes fit/linked together. Keeping the research question in the forefront of my mind, some themes were made redundant as they did not seem relevant. All of the themes were written onto a whiteboard and links were made between words/phrases that linked together. There were ways of IPA that looked for patterns and connections between emergent themes. *Abstraction* involved identifying patterns between emergent themes in order to develop 'superordinate' themes. This included a cluster of themes that surrounded a similar topic. Moreover, as well as looking for similarities, I examined the transcript for differences between emergent themes. This is known as the *Polarization* process part of IPA.

Step 5: Moving to the next case

The next step of analysis required moving onto the next case. Steps 1 to 4 were repeated for subsequent transcripts. To keeping with IPA's idiographic focus, it was important for me to bracket aside what I had learnt and developed from the analysis of previous transcripts, to allow for new emergent themes to develop. As an IPA research, it was important that I suspend any predisposition during the analysis stages. By keeping mindful of my thinking activity, this allowed me to identify and realise any potential influence throughout the analysis. To maintain this trustworthiness, I kept referring to the original transcripts, and ensure that the participant's experience is corrected interpreted.

Step 6: Looking for patterns across cases

The final part involved observing patterns across cases to develop the overall picture, which often required re-labelling and re-organisation of themes. All emergent themes were laid out onto a table and I identified connections for the group as a whole. This also required going back to the original transcript, to clarify that the development of the superordinate themes remained within the remit of the participant's experiences. The main theme which included a list of sub-themes were titled at the Superordinate theme and the sub-themes were titled as the subordinate themes. The subordinate themes reflected the participants' own words from the interviews. I revised the list of superordinate and subordinate themes until I felt it truthfully reflected women's experiences.

Credibility and validity of the analysis

Norman K. Denzin outlined four basic types of triangulation: (345)

- *Data triangulation*
- *Investigator triangulation*
- *Theory triangulation*
- *Methodological triangulation.*

To develop a deeper and comprehensive understanding of the phenomena and to uphold credibility, validity and trustworthiness of the data, my supervisors and I engaged in the practice of regular *investigator triangulation*. This offered several perspectives to the interpretation of data, which strengthened the trustworthiness of the analysis by reaching consensus. The overall themes were chosen collaboratively between myself and my supervisors. Moreover, all interpretations in the findings section have been illustrated with numerous examples from the data.

Reflections and challenges faced

One of the biggest challenges was that this was my first experience doing an IPA study. A large part of IPA was knowing *how* to be interpretive and *how* to do IPA correctly and as mentioned by Larkin earlier and IPA study is *"easy to do badly and difficult to do well" (311).* However, prior to starting the analysis, I read multiple sources on how to do a good analysis and existing publications and PhD thesis that used IPA. Moreover, I attended Phenomenology of Health And Relationships (PHAR) research groups every fortnight at Aston University, hosted by Dr Michael Larkin and Dr Rachel Shaw and colleagues, which provided me with great insights and knowledge of IPA. Moreover, a recent publication by Smith presented core features of high-quality IPA work (321). This provided top tips as to what makes a good IPA paper.

Secondly, recruiting South Asian women into the study proved challenging. As a *'hard to reach'* group and small patient cohort, we envisioned potential challenges. Through consultations with local collaborators and the MDT team, one of the biggest issues was language difficulties. Many women did not speak sufficient English and so, I became aware that this was a big challenge to recruitment. Therefore, if we chose to include non-English speaking women in the study, this may have facilitated recruitment better. Nonetheless, we still managed to recruit enough women who met eligibility for the study.

On reflection, silences were a temporary challenge for me that I learnt to appreciate as a process of the interview. In 'normal' conversation silences can be a natural cue for the other person to start talking. However, in the interview setting, silences have to be waited out slightly longer. Either, it can signal that I was waiting for more detail, or for the participant to require additional time to think or an opportunity to ask a new question. As I was interviewing the

participants, I kept a notepad to write down anything that I felt would be invaluable to explore further. Moreover, I kept a diary, which I wrote in after each interview to reflect my own reflections, thoughts and any initial ideas. I identify myself as a visual learner, which was reflected during the creativity of developing emergent themes.

Chapter 5

Research Findings

In chapter 5, I will reveal the findings of the IPA study that explores South Asian women's lived experiences of severe postnatal psychiatric illnesses and experiences of Perinatal Mental Health Services. I present the findings according to the three principles of IPA as explicated by Smith et al (299). They are phenomenology, idiography and include my subjective hermeneutic exegesis. It is hoped that these findings will illuminate and add to the existing literature in the field of research.

Reflexivity

As a fundamental feature of IPA, Smith and colleagues defined reflexivity as *"deliberate controlled reflection".* In a research methodology such as IPA, reflexivity is also a way of enhancing the rigour and validity of the research. To eliminate researcher biases, reflexivity should be a longitudinal process from setting out the rationale, developing the research question(s) and study design, through data collection and analysis and within the discussion of findings. Moreover, an IPA study should remain true to its theoretical underpinnings, thus reflexivity becomes a way of not only eliminating researcher biases but also a way of authenticating the rigour and validity of this relativist approach.

I am a 26-year-old second-generation South Asian British Sikh woman and I have lived in England all of my life. I am the daughter of first-generation immigrant parents, who immigrated to the UK from East Africa. Since birth, I have been living in the West Midlands. I am heterosexual and I am currently planning a wedding with my fiancé, Harinder. I graduated with a Bachelors (with Honors) in English Literature followed by a Master in Psychology. It was during my Masters that I undertook a clinical placement at a MBU, which developed my passion for wanting to research in this topic. Therefore, with an interest in the topic and being a South Asian woman, I was interested to 'help' women similar to myself, which influenced my decision to develop the current study.

During my PhD, I have become interested in the personal life experiences of individuals living with a psychiatric illness. I believe each individual has their personal life stories that influence their psyche. I have never personally experienced a psychiatric illness, however for most of my

life I have certainly been aware of the prevailing societal issues, such as mental health, especially among ethnic groups.

Individual idiographic statements

All identifiable details of women in the study, such as their names, have been modified without losing the core essence of the lived experiences. I selected names that had an underlying meaning to them, which I felt best described their persona after meeting them in person. I have provided a meaning of the names below. All participants thanked me for the opportunity to take part in the interview.

Namita (meaning humble and kindness)

At the time of the interview, Namita was a 34-year-old pharmacist, who was diagnosed with postnatal psychosis and subsequently admitted to a Mother and Baby unit as an inpatient. During her third trimester, her and her husband moved from her in-laws home to an apartment in West London and at the time of the interview she was living with her husband (a General Practitioner) and her son. This was a big and lonely transition for her as she was used to having everyone around her and identified this as a possible explanation for her illness after childbirth. Other explanations for her illness included hormones, stress factors, breastfeeding difficulties and a lack of support from her husband. When reflecting her antenatal and early postnatal birth experiences, she spoke about her unsupportive husband that also continued during the early days after childbirth, which made her angry. However, she later mentioned that he became supportive as she was unwell in hospital.

Her pregnancy was planned so it was no surprise to her and her husband. After childbirth, her husband first noticed signs of her behaviour that did not appear to be *"normal"*. Whilst living through her illness, she felt that she was unable to cope and she felt as though she did not *"want to be here"*, which she viewed as very similar to feeling suicidal. She believed her

previous life was much simpler without a baby. However, at the time of the interview, she adored her son and referred to her son as *"beta"*, which translates to *"love"* in Punjabi/Hindi. She described herself as generally quite anxious, which heightened as she became severely unwell after childbirth.

As a consequence of her lived experiences, she felt she had more empathy and understanding with those who experience mental health problems. However, she believed that the label of her diagnosis would remain with her *"forever"* because of the stigmatising nature of mental illness in the South Asian community. Overall, she felt that her experiences of living through postnatal psychosis knocked her confidence.

As a pharmacist, she emphasised the importance of taking her medicine, however, she did also complete some CBT sessions as well. In addition to conventional medicine, she also wrote down her thoughts and did some art therapy, which she found helpful.

Aaryaa (meaning noble)

Aaryaa was a 31-year-old married woman at the time of the interview. Aaryaa came across slightly different from the other participants. At the start of the interview it was quite marked that Aaryaa was quiet and resigned, however as the interview progressed she became noticeably more talkative and angry.

She was born in Pakistan and migrated to the UK a few years ago to marry her husband, who was a British citizen. She was introduced to her husband through her family and she did not know him prior to getting married. She expressed how she prefers it back *"home"* in Pakistan

and misses her family. At this point in the interview she cried as she remembered her life back in Pakistan.

Similar to Namita, soon after childbirth, her husband recognised that she was *"not so well"*. She was later diagnosed with postnatal psychosis and she was admitted to a general psychiatric unit as her baby was admitted in a different hospital. After 10 days, she was admitted to a Mother and Baby unit as an inpatient and reunited with her daughter. Although her husband was *"heartbroken"* he was very supportive. Her father also visited her for additional support. Her daughter was born with severe disability due to a chromosomal disorder and she felt the baby was *"demanding"* and that she could not cope with the *"circumstances"*. She recognised this as a causal explanation but also recognised that it was a medical illness and she needed medicine and therapy to get better. She felt consumed by her illness and also felt consumed as an inpatient at the Mother and Baby Unit. She described the services as *"pathetic"* as they did not facilitate for her child. Moreover, she felt the services and therapy were not *"culturally sound"* and did not respect her culture, which she believed have *"cultural issues"* that are different from Western culture. For example, she believed as women in her culture, they *"hold a place of honour".* As a result of her illness, she felt that society viewed her as an individual with no authenticity. Additionally, she felt a loss of self-respect, a loss of self and a loss of confidence.

Haniya (meaning polite and bubbly)

Haniya was a 32-year-old woman, who was married to and living with her husband, her first child, her 3 sisters and parents in East London at the time of the interview. Because she had

no brothers and she was the eldest daughter, she felt it was her responsibility to stay at home and look after her parents.

Her pregnancy was planned and she was very happy when finding out she was expecting. She described a painful delivery, for which she was given an epidural. She then had to have a forceps delivery as shoulder dystocia unexpectedly occurred during childbirth. Her baby had breathing difficulties and he had to be incubated. She initially blamed this event for her illness. She was diagnosed with severe postnatal depression and received care as an outpatient from Perinatal Mental Health services in London. She explained that her symptoms start with *"religious guilt"* and feels as though she is being punished by God or a *"super powerful being"*, for not following the *"strict"* religious teachings of Islam. However, she later described the influence of brain structures and despite her religious belief, she felt that she needed medication to make her better. She felt that therapy was too broad and there was no sub-division treatment plan for South Asian women.

Living through her illness, impacted and affected all aspects of her life. She felt isolated and felt as though she was the only one living with this illness. She felt that the South Asian community do not accept mental illness. Therefore, whilst living through her illness, she felt ashamed and embarrassed about being perceived as a *"weak"* individual in society. However, her husband was very supportive during this period, even though their sexual life was impacted. As a result of her illness, she described the loss of self and her *"sparkle"* and *"glow"* no longer existed. However, similar to Namita, she also felt more sympathy to others with mental health problems.

Serina (meaning a calm and tranquil nature)

Serina was a 31-year-old married woman, who was living in Birmingham with her husband and her son at the time of the interview. Prior to this, she lived with her in-laws. She was born in Pakistan and migrated to the UK when she was a child. At the time of the interview, she was working as a part-time private teacher in Islamic religious studies. Serina had previous bipolar disorder and relapsed after childbirth.

Due to a health condition, Serina was told by the consultant that she may never conceive and she and her husband were amazed, grateful and blessed when she fell pregnant. She was given a preventative measure because of her history of bipolar disorder, however she decided not to take it.

Her pregnancy experience was described as *"really bad"*. After childbirth, she viewed her symptoms as a *"normal"* reaction that women experience after childbirth, however, it became apparent that she was severely unwell when things became more *"dangerous"*. She was admitted to a Mother and Baby Unit in the West Midlands and diagnosed with postnatal bipolar disorder. She viewed this as an opportunity to bond with her baby.

Whilst living with her illness, she became superstitious and believed in nazar (black magic), however, she also believed in stress factors, sleeplessness and hormonal imbalances. Although she adhered to the medication prescribed for her illness, she also maintained a healthy organic diet and kept dedicated to her faith. Prayer was a big part of her recovery.

Jiya (meaning lucky)

At the time of the interview, Jiya was a 33-year-old woman. She was unmarried but in a relationship with her long-term partner. She was born in the UK and identified herself as British Asian and she was living with her mum, her sister and her newborn daughter. She also had previous history of bipolar disorder and was diagnosed with this shortly after her father passed away. Prior to finding out she was pregnant, she had 6 -7 miscarriages and was diagnosed with a heart condition (syncope) and polycystic ovaries and was informed that she may never get pregnant. The news of becoming pregnant was incredibly shocking for her and her husband. She experienced many incidents during her pregnancy, including several bleeds and a fall down the stairs at 5months. At this point in her pregnancy, she felt scared. She then gave birth to her daughter via a c-section.

Shortly after childbirth, her bipolar symptoms reappeared and she was diagnosed with postnatal bipolar disorder. She felt so consumed, that she felt as though she had lost herself. The majority of her illness experiences was consumed by *"high days and low days"*, which lasted for about 4 - 5 months. This made her feel like a *"bad mum"*, however as she began to recover, she kept positive and believed as a mum, she had to stay *"strong"* and *"healthy"* for her daughter. She described herself as a private person and has not shared her experiences with many people. However she mentioned how she would have preferred *"to see somewhere South Asian women's experiences"*, so she could relate to their illness.

She struggled to understand what may have caused her illness, however, she briefly mentioned that it was medical and because it was medical there must be a cure. She also believed it may have been due to breastfeeding difficulties and a lack of support from some family members.

It was only until she was an outpatient at Perinatal Mental Health services that she began to feel more understood and supported. She felt the care was tailored to her needs and they treated her like a person. She felt that the person she used to be 10 years ago has completely gone.

Superordinate and Subordinate themes

The idiographic statements highlighted above demonstrate that although women were similarly diagnosed with a severe psychiatric illness after childbirth that included postnatal psychosis, severe postnatal depression and postnatal bipolar disorder and were patients who received care from UK Perinatal Mental Health Services, there appeared to be many individual differences. Therefore, although the methodology of IPA allows for a wider examination of those individual accounts and examines the similarities and differences across perspectives, IPA also allows the idiographic statements to retain throughout the findings. The following findings section will examine the themes across the participants. The IPA analysis developed 7 super-ordinate themes from the five in-depth and detailed interviews about women's lived experiences of a) living with a severe postnatal psychiatric illness b) Perinatal Mental Health Services. Table 12 presents a summary of these themes.

Table 14.
Table of superordinate and subordinate

Superordinate themes	Subordinate themes
Superordinate Theme 1 ***"Never heard of it"***	*"the first time actually I heard about this kind of illness"* *"I've never heard about the services"*
Superordinate Theme 2 ***"I wasn't acting normal"***	*"I wasn't acting normal"* *"how many 70-year-old Asians who come from India Pakistan, you know they've never heard of anything like this"* *"I didn't really tell anyone"*
Superordinate Theme 3 ***"That triggered it off"***	*"cultural expectations"* *"The baby he couldn't breathe properly"* *"We tried breastfeeding it wasn't working"* *"a lot of stress"* *"the child was quite demanding"* *"I still couldn't sleep"* *"something is lacking in my brain"* *"my illness always triggers from religion"* *"she's done black magic on me"* *"we were in hospital because of him"*
Superordinate Theme 4 ***"I was like there but not there"***	*"I don't want to exist"* *"everyday it was a struggle…I felt like I had died"* *"state of mind"* *"mentally so so powerful"* *"I just went crazy"*

	"the world's against you" *"I had so much paranoia kicking in me"* *"Do not start an argument with me"*
Superordinate Theme 5 ***"I've completely lost me"***	*"I've completely lost me"* *"my head was like you're a bad mum"* *"it affected our relationship a lot"* *"I have more sympathy"* *"that stigma…would stay with you forever"*
Superordinate Theme 6 Experiences of Perinatal Mental Health Services	*"I need medicine, I need therapy"* *"I was able to care for baby"* *"They were so focused on me"* *"they were not culturally sound"* *"I suffered through the red tape as well"*
Superordinate Theme 7 ***"it used to take it all out"***	*"it used to take it all out"* *"my parents and my family were there to help"*

Superordinate Theme 1
"Never heard of it"

This superordinate theme captured women's lack of understanding and knowledge about severe postnatal psychiatric illnesses and Perinatal Mental Health Services when the conversation led to questions such as, *"Did you know what sort of illness it was?*, *"Had you heard of postnatal mental illness before having a baby?"* and *"Had you heard of Perinatal Mental Health services?"*. Most of the women did not have existing knowledge about severe postnatal psychiatric illnesses and this was something new they learned as part of their journeys. Moreover, women did not know about Perinatal Mental Health Services and this was something new they learned about as a patient receiving care from these services.

"the first time actually I heard about this kind of illness"

Namita was an allied health professional in pharmacology, however, despite her profession in the medical field, she did not have any previous knowledge about *"this kind of illness"*:

> *"It's the first time actually I heard about this kind of illness" (Namita).*

Nonetheless, Namita continued to give a brief account of her understanding of postnatal psychosis:

> *"So, it's just after you have a child sometimes erm *pause* you get like psy basically psychosis erm *pause* where *pause* it doesn't last for many days it can, sometimes it can last for weeks" (Namita).*

The few pauses and hesitancy in her description may have suggested insufficient understanding. However, it was clear that she was trying to make sense of *"this kind of illness"*. She recognised that it was an illness that can occur after *"childbirth"*. As part of her understanding, Namita made it clear that the illness does not happen to every mother after childbirth and it only happens *"sometimes"*. She also mentioned her understanding of the

duration of the illness, which may echo her personal experience. Similarly, Jiya articulated how she had no previous knowledge of her diagnosis of postnatal Bipolar Disorder and her understanding increased through her experiences:

> *"I'd never heard of bipolar, I don't know if South Asian women have it differently from other people, I don't know anything I'm just going on from what I'm suffering" (Jiya).*

Firstly, she identified herself as belonging to *"South Asian women"* and that they are separate group with unique experiences from *"other people"*. Her lack of understanding was shown through *"I don't know…I don't know"* and her subjective understanding of *"bipolar"* increased through her own lived experience. It was clear that she viewed her experience as a period of distress as she used the word *"suffering"* to describe what she was going through. In comparison to Namrita and Jiya, Aaryaa revealed some understanding of PND, a moderate psychiatric illness after childbirth:

> *"I've read some of it *pauses* about postnatal depression actually."*

However, if Aaryaa had been given the opportunity to read about severe forms of postnatal psychiatric illness she would have preferred not to know:

> *"There's no point, because like you don't take it seriously."*

Thus, it is possible that she did not anticipate herself developing a severe postnatal psychiatric illness as she did not *"take it seriously"*.

"I've never heard about the services"

As part of living through a severe postnatal psychiatric illness, women were involved with Perinatal Mental Health Services. Being an inpatient or an outpatient was a component of their lived experiences. When I asked the participants to share with me what they knew about Perinatal Mental Health Services, most women reported no previous knowledge:

"No" (Aaryaa).

*"No I didn't, I didn't even know about it *laughs* (Haniya)*

*"It was something new yhh it was yh it was yh *laughs*" (Serina).*

"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, my partner was very surprised" (Jiya).

Given Jiya's previous history of bipolar disorder, which is the biggest known risk factors for postnatal bipolar disorder, not even her *"GP mentioned anything"*. At the time of the interview, she was shocked about this and would have preferred the GP to have told her about these services.

Superordinate Theme 2
"I wasn't acting normal"

"When terms like abnormality or mentally ill are spoke, what kinds of images comes to mind?"
Paula Caplan (1995)

This superordinate theme demonstrated women's recollection of their families' reaction when they were presenting symptoms after childbirth and women's' own reactions. The adjective *"normal"* was frequently referred to in the interview by most women when women and their family members realised something was *"not normal"*. Some women also chose not to disclose their mental illness as they did not want to be perceived as *"weak"* and instead wanted to be perceived as a *"normal functioning person".*

"I wasn't acting normal"

Prior to their postnatal diagnoses, Haniya and Namita described themselves and their circumstances as *"normal"*:

> *"It does make me sad, because sometimes I wanna be like, sometimes you feel why, is it a big mistake that I've done this because *pause* everything was normal before" (Namita).*
> *"…before I was normal err but all of a sudden, just this depression just strikes me" (Haniya).*

Therefore, they were both aware that *"before"* their illness after childbirth they were living a *"normal"* life. Namita was working as a pharmacist and Haniya was working as an art patient co-ordinator at an NHS hospital and so they were both leading normal lives. Haniya used the metaphor *"strikes"*, which implied that the unwelcoming phenomena of *"this depression"* vehemently struck her with a *"sudden"* onset. Contrastingly, Serina recognised her symptoms

and described her illness as a gradual *"build up"* as opposed to an abrupt onset described by Haniya:

> *"in my mind I was thinking this feels like a build up to an episode" (Serina).*

Serina's symptoms appeared slowly and were progressively building up, which she then recognised as a *"build up to an episode"*. It was clear that she was aware and conscious of her symptoms as she was *"thinking"* that her experience felt like an *"episode"*. With a previous lived experience of bipolar disorder, she still failed to immediately identify the seriousness of her symptoms after childbirth when she eventually realised, *"this isn't normal"*:

> *"I read in books you know in magazines etc. and I've heard from other people that normal women go through the experiences as well so I kind of normalised them rather than looking at it from a bipolar of mental health perspective from what I've been through in the past so that's how I made sense of it before but after I knew needed help I I knew this isn't right this isn't normal I need help" (Serina).*

In Serina's account, the word *"normal"* appeared to be carrying different meanings. Firstly, before she knew she needed help she *"made sense"* of her experience as a *"normal"* process of childbirth *"that normal women go through"*. Therefore, it seemed that initially, she chose to normalise her experiences by finding some familiarity with *"normal women"* after childbirth. This may have lessened her isolation from *"normal women"* and perhaps even a way of repressing her fear of what was to come. Nonetheless, it was only until *"things started feeling a bit a bit bit more erm dangerous"* that she eventually understood and accepted that she was not part of the *"normal women"* sphere and she required help. Secondly, she realised her experiences were not *"normal"*. The *"dangerous"* feeling could be the danger of slipping out of what she perceived to be *"normal"* for herself. Similarly, a sense of not acting *"normal"* was used by Namita when she recalled her husband who *"noticed it"*:

*"Soo, erm *pause* it was like *pause* my husband noticed it *pause* he was very concerned because he was just saying that I wasn't acting normal" (Namita).*

Her husband's definition of not being *"normal"* was presented by her unusual behaviour, which he questioned with other family members such as, Namita's father. However, according to Namita, her father believed:

""oh no, she's fine, she just had a child you know, it happens, hormones"" (Namita).

Similar to Serina and in line with her own initial recognition as the *"normal"* experiences of childbirth, her father also viewed her illness as part of the common childbirth process suggesting that *"it happens"*. Moreover, she recalled her father making sense of her illness by attributing it to faulty biology and blamed it on *"hormones"*. Later, she recalled her father speaking about the taboo and shame in the South Asian culture. Moreover, Namita remembered her father's reaction after her husband approached her GP:

"My husband was really concerned then he went to my GP which is just round the corner. Then my dad, obviously because it's quite a taboo in, in Asian families you know, so he was like "no no no there's nothing wrong with her, she's fine, she'll be alright, we don't want anything to happen, we don't want anyone to come"" (Serina).

From this account, it appeared that her father tried to believe *"she's fine, she'll be alright"* to avoid the conversation of mental health *"because it's quite a taboo in, in Asian families".* The repetition of *"no no no"* demonstrated his resilience and could suggest that he tried to convince himself that "*there's nothing wrong with her".* The shift in pronouns transitioned from *"he"* to *"we"* inferring that her father inflicted his opinions on the whole family and spoke on behalf of everyone. The use of *"we"* demonstrated that Namita appeared to be the potential problem for the whole family as her father said, *"we don't want anything to happen, we don't want anyone to come"*. Furthermore, as Namita recognised my ethnicity as a South Asian

woman, the phrase *"you know"* could be perceived as a subconscious request to confirm that I share her opinion and may in return expect a nod or *"hmm"* as a mark of shared cultural knowledge. Following her father's imitation, she also recalled and described her husband's reaction:

> *"My husband was like "no", he put his foot down basically and the GP was like "no, he's doing the right thing"" (Serina).*

Her husband and the GP both agreed that she needed help and according to the GP, her husband was "*doing the right thing"*. She used the metaphor *"put his foot down"* to indicate her husband's affirmation with his decision on behalf of Namita. It appeared that Namita's world was orbited by competing patriarchal figures, which plausibly left her feeling powerless and unrepresented as a female in a South Asian family setting. In an environment where men in her family try to reflect their social position in the home through decision-making, it could also be understood that she may have felt trapped between the conflicting opinions between these two generations. Namita continued to explain to me that her husband's profession as *"a doctor"* may explain his medical *"understanding"* of her illness and help-seeking behaviour:

> *"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 and he was saying that it was like kind of mania kind of symptoms" (Namita).*

Nonetheless, again, similar to her own understanding of postnatal psychosis, there is a lack of fluency as she misidentified her illness, however, she did correct her error from *"postnatal depre"* to *"psychosis"*. She similarly demonstrated that her understanding of her illness had been guided by her occupation as a pharmacist:

*"At the time I didn't think anything was wrong with me. Erm, then after *pause* I guess you kind of know it's mental illness erm obviously I'm I know a bit about mental illness and things like that because I'm a pharmacist" (Namita).*

On reflection, she made sense that something was *"wrong"* with her whilst she was unwell, however *"at the time"* she believed she was well. She established her identity and her sense of belonging to occupation by referring to herself and affirming *"I'm a pharmacist*". She used the word *"obviously"* to demonstrate that expectedly, she had some understanding of *"mental illness and things like that"*, which contradicted her earlier statement, *"It's the first time actually I heard about this kind of illness".*

Similar to Namita's husband, medical attention was sought by Aaryaa's husband, suggested his medical understanding of her illness:

"My husband took me to the hospital…He noticed that I'm not so well" (Aaryaa).

Her husband is a British citizen, which may explain his Western biomedical understanding of her illness, hence why he sought medical attention when he recognised she was *"not so well".*

"how many 70-year-old Asians who come from India Pakistan, you know they've never heard of anything like this"

This subordinate theme highlights women's recollections of their family member's negative responses towards their psychiatric illness after childbirth. For example, Serina's mother-in-law discouraged her from taking medication:

"my mother-in-law in the beginning she was kind of like "oh you need to get off the medication you know get off the medication" and that would really annoy me" (Serina).

Similarly, Namita's grandmother did not believe she needed *"medication"*:

> *"My gran was like "well why are you taking your medication for, you know, you don't need it"…I think mental illness is not really, it's kind of frowned upon I guess in South Asian families, and more like "oh my god she's she's mad" you know?" (Namita).*

Therefore, not only was a stigmatising attitude about mental health medication presented but also the condemnation of mental illness was vocalised by Namita. In an attempt to vindicate her grandmother's remarks, P001 provided an explanation demonstrating that her grandmother's reaction was constructed on the concept of shame and disapproval of mental illness in the South Asian culture as *"it's kind of frowned upon"*. Instead, individuals are labelled as *"mad"* and so, do not require Western medication. Haniya also recognised that in *"the South Asian community they don't want to accept the mental illness"*:

> *"…my mum and dad always used to tell me "why are you depressed, you've got no reason to be depressed, you're happily married, you have a loving and supportive husband, you've got your parents…you are quite stable life and family"…but you know in the South Asian community they don't want to accept the mental illness, they think, especially depression" (Haniya).*

Therefore, her family did not understand their daughter's excuse, given her family support system and *"stable life"*. She acknowledged that across the *"South Asian community"* mental illness is generally ill seen, *"especially depression"*. She may have felt even more stigmatised as she put emphasis on *"especially depression",* the type of illness she experienced after childbirth, but severely. Furthermore, she used the pronoun *"they"* to address the community, possibly suggesting the disconnection she felt from the community and the lack of acceptance, because of her diagnosis. Her family continued to trivialise her illness and she was eventually told to *"snap out of it"*:

> *"So I was going through a depressive phase and I was after said, "oh you know you need to snap out of it or get out of it stop thinking like that" and that was really hard because*

for someone going through depression or through a mental illness to be told snap out of it…it was really difficult for me" (Haniya).

Her family members were demeaning towards her illness and believed that someone with depression can just *"snap out of it"*, which she felt *"really difficult"*. Jiya was also told to *"snap out of it"*, however as opposed to finding that response difficult to deal with, she understood that *"old Asians who come from India Pakistan"* were not well educated and *"medically they're not inclined like that":*

> *"My mum…bless her soul, she knows I've got bipolar, she knows I have temper issues, she's trying to understand…seeing me for 25 26 years of my life normal, then seeing me like this was a big shock for her and because of that shock she's trying to understand but there are days where she doesn't and she thinks I can "snap out of it, sort yourself out". I understand because how many 70-year-old Asians who come from India, Pakistan, you know they've never heard of anything like this, they used to fob things off medically they're not inclined like that. Unless they could see it, you're not ill" (Jiya).*

Despite her mother's lack of understanding, the opening sentence conveys her compassion and sympathy towards her mother as she says *"bless her soul"*. Jiya concluded this narrative by suggesting that illness is only defined and recognised when an individual appears physically unwell. Moreover, Jiya described her family's lack of understanding and dismissal of her illness:

> *"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"" (Jiya).*

Therefore, her *"other family"* including her brother believed she should be insusceptible to bipolar disorder because of her qualifications and education status, suggesting that those individuals who are illiterate and uneducated should be vulnerable to mental illness.

"I didn't really tell anyone"

Namita chose not to talk openly or disclose her illness, as she felt she would be perceived as a weak and fundamentally flawed individual:

> *"I didn't really tell anyone about it because, you know, you think "oh if you're in depression, you're weak" erm people don't understand, they think differently of you I guess. So I didn't really tell anyone" (Namita).*

This suggests that there is a universal perception that mental illness represents weakness, so she "*didn't really tell anyone"*. Nonetheless, during the interview, she was happy to discuss her illness experiences openly in a confidential environment. Mental illness as a sign of weakness was also expressed by Haniya:

> *"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" (Haniya).*

Therefore, she felt *"embarrassed"* about not being what she perceived as being *"normal"* and instead believed she is inoperative. Moreover, she described how her mental illness led to her feeling *"inferior"* suggesting how she felt unworthy and unimportant in society. Thus, by choosing not to disclose her illness, she felt this would protect her overall image in society. This shame she felt prevented her from honesty about her health and well-being and in parallel to Namita she chose not to disclose her illness.

Moreover, Jiya was "very private" and she has not discussed her illness with her partner's family.

> *"none of them know that I'm bipolar…I dunno, if it's an egotistic thing erm it's like his family don't know I'm bipolar…they know I've got health issues, but that's about it, I haven't discussed it with them and in my family, only my immediate family knows I'm bipolar. I'm very private but I have been like that always" (Jiya).*

She mentioned that her family knows she *"is bipolar"*, therefore this seemed this is what she was labelled and identified by her *"immediate family"*.

Superordinate Theme 3
"That triggered it off"

This superordinate theme revealed women's belief systems as to what *"triggered"* their severe postnatal psychiatric illnesses. When participants were asked *"What do you think caused your illness?"* the majority of women referred to *"triggers"* therefore this was used to reflect the women's own language. Many *"triggers"* were reported by all the women in the study. My initial thought of the word *"trigger"* may also resonate to the *"trigger"* of a shotgun, causing explosions and destructive consequences, mirroring women's lived experiences of their severe postnatal psychiatric illnesses.

"cultural expectations"

Cultural expectations are sources of ideas about what should be expected from an individual within a particular culture, and in this instance, the South Asian culture appeared pressurising and challenging for some of the women. Serina found it *"challenging…living up to the cultural expectations"*, which began prior to conception and continued until after childbirth:

> *"So the year prior to falling pregnant it was quite uh roller-coaster of a journey…I was told there was a chance I may never conceive etc. and obviously being in our you know culture so to speak it's kind of expected you know you get married you have children etc. there's kind of like an expectation…so that was quite challenging…I think that that's the probably the hard part was, living up to the cultural expectations" (Serina).*

She uses the metaphor *"roller-coaster of a journey"* to make sense of her experiences before she became pregnant, implying sudden and extreme changes in her emotional state and moods. *"Falling pregnant"* could suggest a decline and descent as part of her *"roller-coaster"* journey. As she could not meet the traditional events of marriage and kids, she felt this

underlying pressure from a South Asian culture that was *"challenging"*. She described how a failure to meet cultural expectations was *"mentally…at times straining"* and described it as *"the hard part"*. Moreover, her family members expected her to return back to what was expected from a daughter-in-law, because after all, *"she's just gonna pop the baby out"*:

> *"…I don't know they're a bit bitchy I don't know they could have been expecting oh she's just gonna pop the baby out oh now she's here she's gonna serve us tea, I was like you've come to see the baby, see the baby and go, give me some space, they were like are you gonna start looking for work, there was too much intrusion too soon, I'm like I've got a baby, everything is fine, she's fine, I'm fine, thank you, I was really losing my temper a lot, I know that triggered it off…cuz I was very sensitive emotionally, little little things were triggering it off and I was starting to lose my temper even more. And my temper started becoming emotional and it got from worse to worse" (Serina).*

The metaphorical use of *"pop the baby out"* obliterated the actuality of childbirth and instead of the word *"pop"* implied the image of birth with an image of an explosive sound. In her narrative, there appeared to be a strong emotion and resentment towards some family members who were *"expecting"* her to carry on as normal after childbirth. She was aware that she was *"very sensitive emotional"* and she was certain it *"triggered"* off her illness and she started to lose her temper even more, which went "*from worse to worse"*. Furthermore, Serina was 1 of 3 participants who described how she felt overwhelmed by visitors instantaneously after childbirth and requested *"some space"*:

> *"I didn't get that time to kind of rest my thoughts either…obviously she was the first grandchild…everyone wanted to come and see her as soon as we came home from the hospital an hour later we were flooded by guests" (Serina).*

She used the image of water and described how she felt *"flooded by guests",* which prevented her from resting her thoughts. Water can be both wild and calm, dangerous and beautiful,

however, in this instance, it seemed that she felt inundated by the rising number of guests during the early hours of the postnatal period. Similarly, Naimta described that when she returned home after childbirth she felt engulfed by *"a big welcoming party…a chati"*:

> *"We had a big welcoming party when I came home from the hospital *laughs* there were like 30 40 people in the house…it's quite overwhelming *laughs*…maybe it wasn't for the best, I think it was a bit too much…We had a chati, so you know when people come over, family and I was just a bit erratic…so there was a lot lots of stuff going on" (Namita).*

Her laughter at the start may suggest that, on reflection, the expectation to continue as normal after childbirth and entertain a gathering of *"30 40 people in the house"* seemed nonsensical. The modification of pronoun *"lot"* to *"lots"* may suggest her recognition of the multiple events ongoing through the early postnatal period, including the overwhelming experience of this family gathering, which added to her erraticism. Therefore the *"chati"* had an undesirable emotional impact on her and she ultimately realised that perhaps for her health and well-being *"it wasn't for the best…it was a bit too much".* A similar experience was shared by Jiya as *"the house was packed with people"*:

> *"the first weekend we came home the house was full…the house was packed with people that day…and they were like oh you gotta breastfeed her you know you gotta do this and my head was like erm ok I was really out of it…I was really really tired and I was like you know what I'm either gonna cry or I'm gonna scream…I went upstairs shut my door and I just screamed my head off…I wanted everyone to go…I've just come home and I wanna hold my daughter and I wanna rest" (Jiya).*

The reiteration of *"the house was full…the house was packed"* emphasised the crowded environment she was exposed to after childbirth and restraint in her home, most likely causing her to feel trapped suffocated and confined. In addition to her post-childbirth enervation, she

was demanded by her family members *"you gotta breastfeed her"*, suggesting a cultural expectation for new mothers to breastfeed straight away. The accumulation of events eventually led her to want to either *"cry"* or *"scream".* Although not literally, she used the metaphorical expression *"screamed my head off"* to highlight the essence of her experience through the extremely loud and powerful emotion. This release of emotion may have been cathartic for her after the string of events. Jiya continued to describe another South Asian cultural *"pressure":*

> ***"****basically 40 days you don't leave the house, I wasn't planning to leave the house anyway ermm then there was the pressure oh you need to attend the next function because they need to see the baby, and I wasn't feeling up to it, they were like you need to go, I was like it's a baby not a bloody trophy" (Jiya).*

Even though Jiya was not *"planning to leave the house anyway"*, after childbirth it is a South Asian cultural expectation for mothers and their baby to stay indoors for 40 days. Eating certain foods after childbirth was another South Asian cultural expectation described by Serina. Nutritional South Asian supplements such as *"panjeeri…a sweet dish made with semolina"* has health constituents such as whole-wheat flour, dried fruits, nuts, seeds and herbal juices, which supposedly improves a new mother's metabolism after childbirth. P004 was expected to eat *"panjeeri"* as part of her post-childbirth diet:

> *"er like a a sweet dish made with semolina, nuts…it is panjeeri…but because all the nuts they said it's quite hot to temperament in terms of food temperament and I was already had too much heat in me because of all the medication etc I couldn't have them it it really triggered me worse…so I didn't really take a lot of the things that culturally they expect you to for example eating the panjeeri or you know avoiding certain food…I did it for probably about a day or so but then I was getting nose bleeds I was getting you know er not palpitations but feeling agitated…they call it uh gurum gurum…some people naturally have a gurum temperament obviously you have to counterbalance that*

so with the nuts and everything cuz they're quite gurum that's the reason I was not couldn't tolerate them mmm" (Serina).

She felt as though she already *"had too much heat"* in her *"because of all the medication"*. The additional heat from the panjeeri *"triggered"* her worse and exaggerated her temperament. In the context of being irritated from other cultural expectations mentioned earlier, the heat from the food intensified her temperament.

"The baby he couldn't breathe properly"

Pregnancy trauma and childbirth difficulties were also experienced by some women and they perceived this to trigger their postnatal psychiatric illness. Jiya shared with me her *"incidents"* that were *"brewing"* in her from her pregnancy that left her feeling *"scared"*:

> *"my pregnancy it wasn't easy, I had several bleeds in between and with my syncope I fell down the stairs at 5 months, so I had a lot of incidents in my pregnancy so from my pregnancy I was mostly scared… I was scared during my pregnancy, I was in hospital for 9 10 days beforehand, wasn't dilating correctly, my BP wasn't right, my heart beat was off the scale so it was just 1 problem after another, so it as just brewing in me erm you know so it just kind of exploded" (Jiya).*

Therefore, all of the *"incidents"* and *"problems"* during her pregnancy were *"brewing"* in her and contributed and triggered the explosion during the early postnatal period. As she described her fall *"down the stairs"* this can be symbolic of her journey towards her physical and mental descent.

Haniya experiences childbirth difficulties. It appeared that she gradually built to the climax of her childbirth experiences by saying, *"And then yh then the uh the time of the uh birth came"*,

implying to me in the interview that something was about to occur. She continued to describe what happened during her childbirth:

> *"It was forceps delivery er and err the baby was quite big cuz I had diabetes as well gestational diabetes…because I had epidural I couldn't push properly I had I had because like I had no feeling it was numb so the baby's shoulder kind of got stuck" (Haniya).*

As expected when anesthetised, she described that she *"had no feeling"* and felt immobilised during childbirth and so, *"she couldn't push properly"*. Therefore, she may be blaming herself that *"the baby's shoulder kind of got stuck."* Shoulder dystocia is the medical term used for when the baby's shoulder gets stuck during vaginal birth. This may interrupt a baby's supply of oxygen, leading to neonatal complications, which is what happened to her baby as she went on to further describe:

> *"so when they took the baby out er when the doctor examined the baby he couldn't breathe properly, he was having some breathing problems and they quickly straight away they had to take the baby to the neonatal unit…he had some uh sep sepsis septic shock so he had to be incubated and on antidepress anti uh antibiotics and uh breathing support and everything uhh so I didn't see the baby until the next day…I started crying in the neonatal unit when I saw the baby with so many pipes and uh all that crap" (Haniya).*

Therefore, as the baby was taken *"straight away"* as common practice in a hospital setting for babies who are under medical distress, it was clear this was distressing for herself as she *"started crying in the neonatal unit."* Although it seemed she was reflecting transparently about her childbirth experiences, she unintentionally and mistakenly said: "*antidepress anti uh antibiotics"* demonstrating that she may have been constantly preoccupied with her current medication for her illness. A sense of feeling physically *"numb"* was also experienced by Serina because she *"had the epidural"* during childbirth:

> *"Awful it was awful because I had the epidural I couldn't physically you know I felt like my legs were numb…I was trying to go to the toilet but before I'd been I'd you know erm I'd already been to the toilet while I was in the bay basically and the nurse came and she was shouting at me…I was not in any kind of state to do any of them things so mentally all of this was building up just after literally hours of giving labour….I think that's when that was rock bottom for me…to the point where I was hallucinating".*

She reported this as an *"awful"* experience highlighted through the repetition. Similar to Haniya, she had no feeling because of the numbness of her legs during childbirth. She realised that she *"was not in any kind of state"*, mentally or physically. Similar to Jiya, everything *"was building up"* and in contrast to her earlier description of a *"smooth sailing"* pregnancy, she described her early postnatal experiences *"rock bottom"* implying her lowest possible of being unhappy and no hope of feeling better. The metaphorical language may suggest she had drowned and is now at the sea bed. As well as her *"post-delivery complications"* Serina described a *"torturous labour"*:

> *"I had quite a a a quite a torturous labour as well *laughs* ermm because my waters had broken but not fully…luckily I went into hospital they tried breaking my waters…I was being induced within 2 days no food no water…I had to have a few internal examinations and I've never been compliant towards internal examinations and then in 1 day to have 3 or 4 you just really uhh really pushed my pain threshold out the window *laughs*" (Serina).*

She frequently used laughter perhaps as a way of relieving her stress and anger as she recollected her *"torturous labour."* Her beliefs were disregarded by the healthcare system and her *"pain threshold"* had also been defenestrated. She could not deal with any more pain from the *"internal examinations"* as it reached her limit. She demonstrated this using the metaphor, *"really pushed my pain threshold out the window."* Her annoyance was further heightened

because of the lack of support from healthcare staff, which *"was a really horrible experience"* for her:

> *"the nurse…she had to do an internal examination and she was really really err erm very cold attitude towards me and then she came and shouted at me for crying…it was a really horrible experience!" (Serina).*

"We tried breastfeeding it wasn't working"

Breastfeeding difficulties were experienced by 3 women and they believed this contributed to their illness. Serina was certain that her inability to breastfeed *"triggered it off"*:

> *"and me not being able to breastfeed my daughter that triggered it off" (Serina).*

Serina viewed breastfeeding as her responsibility as she referred to herself, *"me not being able to breastfeed"*. On the other hand, Namita considered breastfeeding a joint effort between her and her husband as she said *"we tried breastfeeding"*:

> *"We tried breastfeeding it wasn't working…So, every time I'd feed him my husband would be there, "you're not feeding him properly, look at him, he's dropping, you're doing this" very critical and he'd always get angry and I think I wasn't there, my frame of mind was a bit not there as well!" (Namita).*

Similar to her husband's actions and behaviour during her childbirth, she described how her husband was constantly criticising her ability to breastfeed. When breastfeeding the baby, the responsibility transitioned from her perspective, *"we tried breastfeeding"* to her husband's perspective, *"you're not feeding him properly"*. Therefore, the culpability and responsibility of failing to feed the baby shifted towards the new mother through, demonstrated through her use of pronouns. As she recalled this time, she metaphorically explained, *"I wasn't there, my frame of mind was a bit not there"*. Therefore, it seemed that in addition to her husband's

criticism and anger towards her, she felt absentminded and mentally, she felt as though she was *"not there"*. Eventually, Namita explained how she could not breastfeed her baby son:

> *"He was breastfeeding initially when I was breastfeeding him, tried it, you know it wasn't working and had a lot of issues trying to start breastfeeding as well. Erm there was so much going on at that point of time erm *pauses* it felt really stressful…erm and then I said look I can't breastfeed him" (Namita).*

Again, her perspective changed from *"We tried breastfeeding"* to *"I was breastfeeding him"*. Although physiologically the mother is solely responsible, she did not receive any support, encouragement or any valuable perspectives from her husband, which helped with *"issues trying to start breastfeeding."* It seemed that she realised breastfeeding was not easy for her, as well as everything else that was *"going on at that point of time".* Soon after when Namita was admitted as an inpatient, eventually her baby *"was well established on breastfeeding"*, however, she was not told that she could continue breastfeeding *"and have medication at the same time".* She was later informed later that *"of course, you can it's fine…most women do"*:

> *"I stopped breastfeeding when I went into hospital because and then I wasn't told that I could breastfeed and have medication at the same time…because obviously being a pharmacist I checked it up and it said you know avoid in breastfeeding…when he was six weeks and then I said to the doctor look that really upset me…I took took so long and so much effort to start that and he was well established on breastfeeding and then for it to be taken away from you, that was a bit of a shock…made me a bit upset…she's like "of course, you can it's fine…most women do…I was like I wasn't told *angry tone*…no-one had that conversation with me" (Namita).*

As Namita talked about this experience in the interview, her tone of voice progressively increased as she became infuriated by the lack of communication from the doctor. Again, it seemed clear that her occupation as a pharmacist was important and played an important role

in determining her behaviour and actions. Therefore, something positive that *"took so long and so much effort to start"* had been *"taken away"* unnecessarily, which turned her experience negative and *"really upset"* her. Therefore, the loss of breastfeeding was described as upsetting for her and the lack of information provided was frustrating for her. Similarly, Jiya experienced difficulties whilst trying to breastfeed her baby and she felt this did not allow her to bond with her baby:

> *"I just couldn't stop crying and I didn't feel like I was bonding with the baby…I really wanted to breastfeed and it didn't happen…she wasn't attaching…and she was crying and I was scared and I felt as soon as that happened I'm a bad mother, I'm a bad mother" (Jiya).*

Therefore, it was clear that breastfeeding was important to her as this would allow her to bond with her baby. Cecause of her inability to breastfeed, she did not feel the maternal sensory experiences that occur when breastfeeding, such as the attachment bond, which was distressing for her. However, she did not mention what or whom the baby *"wasn't attaching"* to, therefore the word *"attaching"* could be understood in two ways. First, the physical inability to attach to the mother's breast and second, the inability to emotionally attach to the mother. She was saddened by this as she "*couldn't stop crying".* Her baby reciprocated her weeping and when her baby started to cry, she *"was scared"* and on reflection she perceived herself as *"a bad mother".* The repetition of *"I'm a bad mother"* may suggest that she evaluated her parenting skills and instead of feeling a sense of bonding with her baby, she engaged in self-criticism and emphasised a sense of failure as a mother. Jiya's inability to breastfeed was also noticed by her family members when she recalled them asking her *"are you breastfeeding, are you breastfeeding?"*:

> *"My mum goes "try", I tried for 6 weeks and she was hungry and I couldn't just like you know, so I thought forget it and I just gave her the bottle and then everyone was like "are you breastfeeding are you breastfeeding", I was like no! I was just like shut up about it *cries*…think I got very annoyed with his family when they go you should be breastfeeding her, and then when they found out I had a c-section, why didn't you naturally give birth and I go, the baby is out isn't it!" (Jiya).*

During the interview, Jiya began to cry as she already felt she failed to provide for her baby and then she was being asked questions regarding breastfeeding from her mum and family members. Moreover, when they found out that she had a C-section, this method of delivery was also questioned as to why she did not *"naturally give birth"*.

"a lot of stress"

Namita and Serina described the accumulation of stress factors that triggered their illness. Namita identified *"2 major things"*:

> *"Maybe if we didn't have a baby it wouldn't have happened, maybe if erm you know we didn't move because I kind of put it down to we had a lot of stress before the before the birth…Moving, I think, being on my own, that kind of scared me a little bit…I didn't really think much of it when we we're moving, I thought you know I'll be fine, but then when I actually thought I'm gonna be on my own, I've never been on my own before, I've never even gone to university and lived on my own. So it's a BIG big thing, especially with that plus a child. That's 2 major things" (Namita).*

Firstly, she thought having her baby triggered her illness, suggesting if she did not have a baby "*it wouldn't have happened*". During the third trimester of her pregnancy, she and her husband moved into a new home, from her in-law's home. Thus, as part of her second explanation, she understood that if she did not move home, perhaps she would not have become ill. *"Being on my own"* carried the connotation that she felt alone from her family and isolated from any

other *"being"*, which was a result of *"moving"*. When reality hit home and her thoughts became transparent, this was a frightening and lonely experience for her. The repetition and exaggeration of *"big"* amplified the significance and impact of *"moving"*. This new experience was *"kind of"* scary for her and this was identified as a major thing that triggered her illness. However, the use of the modal verbs *"maybe"* and doubt in *"kind of"* implied the possibility there is a likelihood that these understandings are not definite triggers. This may also infer that she was still scrambling for a trigger to understand and explain her illness. Ultimately, she accentuated the great volume of the stress she underwent. Elements of stress were echoed by Serina that *"added up to it"*, therefore as well as *"back magic"* mentioned earlier, she also identified stress as definite *"triggers"*:

> *"all the stresses that added up to it, for example, sleeping less loss of appetite…all these little little things were triggers" (Serina).*

Although in isolation these *"stresses"* were *"little little things"* and perhaps may have not had a similar impact when experienced together these were stressful and caused her bipolar disorder after childbirth.

"the child was quite demanding"

In contrast to Jiya whose baby *"had a bit of colic and stuff"* and experienced *"no problems"*, other women expressed their negative experiences and described their baby as *"demanding"*. For example, Namita described how she became unwell because of her *"demanding"* baby, in addition to the stresses she mentioned earlier:

> *"He got very colicky, he was un, he was very demanding baby as well…my whole kind of life revolves around the baby. And then I just thought, I kind of went into depression" (Namita).*

Her *"demanding"* baby appeared consuming for her as she described that the baby was the core of her *"whole kind of life"*, which she circumnavigated. Because of her *"very demanding baby",* she described how she *"went into depression"*. Using the preposition *"into"* her understanding of becoming ill suggests that she entered "*into depression"* and became enclosed and perhaps even trapped by her illness. Aaryaa identified her child as *"too demanding"*:

> *"er the child was quite demanding…as in, she's special child…child is too demanding, so probably that's why I wasn't able to cope with it…this was too much for me to digest" (Aaryaa).*

Again, it was clear that the baby was too much to handle with and too much for her to *"digest"*. She used the basic act of eating in ordinary human experience to make sense of her own experience. The intake and swallowing of food corresponded to an abstract kind of taking in of life's experiences, whereby events in the outside world become part of their inside self. The experience here, being her demanding baby, which was described as *"too much for her to digest"*.

It was interesting how both women did not refer to their baby with their forename and instead addressed their baby as *"the baby"* (Namita), *"the child…it"* (Aaryaa). Therefore, it seemed they felt a sense of detachment understood through the way they addressed their baby, referring to their baby in the third person perspective. It may also be that these mothers are objectifying their children, transforming their children into objects and almost dehumanising them.

"I still couldn't sleep"

Rest and sleep were paramount for new mothers after childbirth, however, the inability to sleep was experienced by 2 new mothers during the early postnatal period. Namita emphasised that *"the most the most important thing was to get sleep"*, however she described that she could not sleep:

> *"Friday night, I I couldn't sleep. After I had him I was only having like 2 to 3 hours sleep the whole day for about a week…I still couldn't sleep…then on Friday I was trying to sleep, I was erm and then I think I went into some sort of, like a dream but it almost felt really real!" (Namita).*

Namita described her inability to sleep as an ongoing problem as she said: *"I still couldn't sleep"*. The word *"still"* demonstrated the longevity of her sleeplessness. Moreover, the irony of the use of the adjective *"still"* which defines as deep silence and calmness is contrasted with her inner restlessness and incapability to remain *"still"*. Furthermore, she described her sleep using the simile *"like a dream"*, portraying her state of ontological dichotomy, meaning she felt unsure about what was real and what was not real. Nonetheless, she noted her ontological position and had knowledge that the phenomenon was believable and believed it was her reality. Her dream gained reality no matter how extraordinary.

Aaryaa also believed sleeplessness may have contributed to her illness:

> *"I thought it was lack of sleep" (Aayaa).*

Here, she shared her belief that sleep triggered her illness and reduced her trigger in a short and simple sentence.

"something is lacking in my brain"

Haniya and Jiya drew on medical discourse and believed their brains were malleable or susceptible to damage when they attempted to make sense of their illness. Although earlier in the interview, Haniya mentioned that she was punished by God, she also shared an understanding of her illness from a Western biological perspective:

> *"my depression is, it has to be something biological, or something in my brain, I dunno *laughs*…I just said to myself it must be something wrong with my brain, inside my brain" (Haniya).*

The first person presentation of *"my depression"* gave strong personal ownership of her experiences. She tried to understand that it was the organ inside her head, the *"brain",* that are malfunctioned. It appeared that she attempted to convince herself *"it has to be something biological"* and in contrary to her earlier spiritual understanding, this demonstrated that no other option was acceptable. Therefore, it was also interesting to look at Haniya's account in light of the earlier sense-making of her aetiology. Again, and interestingly, she challenged her statement and the contraction *"I dunno"* suggested her biological understanding may not be definite. Her laughter may be evoked from her realisation of her confusion between two different belief systems. Later in the interview, she clarified her understanding of *"something biological"* when she compared herself to *"other people's brain"*:

> *"I still feel like something is lacking in my brain, that er some other people's brain must be the people who are well they must have something different or something better in their brain structure, but something that is lacking in my brain all those structure, or neurochemicals".*

This sense-making for Haniya was clearly happening at the time of the interview as she said she was *"still"* engaged in the problem of *"something lacking in my brain"*. This curious

"something" was revealed through *"those structure, or neurochemicals"*. In contrast to Haniya's uncertainty about what triggered her illness, Jiya was certain and *"always believed it was medical":*

> *"I always believed it was medical, I always believed…I've always believed that I don't believe any other malarkey business out there, "you been cursed" no nothing like that, I know it's medical, that's why I was hoping there was a cure, it's not permanent, there's a cure, something can resolve it" (Jiya).*

Jiya recognised her illness was *"medical".* This may have been a pre-existing notion as she *"always"* believed in the medical model. Yes, there is something objective about her belief that it is *"medical"*, but her subjective understanding about what this meant was apparent as she believed "*it's not permanent, there's a cure, something can resolve it".* She revealed that she did not believe in *"any other malarkey business",* which perhaps demonstrated the lack of acceptability of non-medical explanations in a Western setting.

"my illness always triggers from religion"

Haniya was the only participant who believed that *"religion"* was a fundamental trigger of her psychiatric illness after childbirth and the metaphors and imagery she used were very striking to me and powerful. She believed her illness was a punishment from God as a result of not adhering to the *"very strict"* religious teachings of Islam. She stated that *"my illness always triggers from religion*" and further went on to describe*:*

> *"Erm I always have religion guilt…no-one forces me about religion… just whatever I learnt or read about religion in my life, it just, all the negative things come into my head *laughs* like about death and afterlife and punishment and hell and heaven erm because our religion is very strict…" (Hainya).*

She explained that religion fostered her *"guilt"* as she did not follow the *"very strict"* teachings of her religion. The *"guilt"* she felt may suggest an act of committing an offence or crime, which implied she may have felt policed by her religion. Although she made clear that *"no-one forces me about religion"*, she then mentioned *"our religion is very strict",* insinuating that her religion somehow forces individuals to follow the Islamic path. Therefore, her laughter midway through her sentence may be a recognition that these two statements do not sit together. She shared further information about some of the religious teachings, which she did not adhere to:

> *"uhh all the all the teaching and everything that I have learnt from my religion, I was always, I was not that religious as in I have to wear a hijab and I have to pray 5 times like Muslims…we have to pray 5 times a day everyday and this is a serious matter, we have to, according to our religion we have to pray 5 times and if er and if someone doesn't pray they will be punished severely in their afterlife and er if people don't fast during Ramadan, all 30 fasts there will, there is punishment waiting in the in the afterlife, after death" (Hainya).*

The strong obligation to follow her religion was expressed through the repetition of *"we have to…we have to…we have to"* and was aware that *"this is a serious matter"*. Thus, even though mandatory within the whole community, she did not adhere to the critical tenets of being Islam and she made it clear that she was mindful that *"if someone doesn't pray they will be punished severely"*. She continued to illustrate the visions of fire and hell that symbolised the phenomenon of her punishment:

> *"I have this visions erm of this God and punishment and er I have visions of fire and hell fire…I still ponder upon the negative things, not me but my negative part in my mind" (Haniya).*

Therefore, the symbolic use of *"fire"* and *"hell fire"* in the context of her religion epitomised the damnation she suffered and encountered in these *"visions"*. Her loss of control over her

"visions" was demonstrated as she blamed her *"negative part"* of her *"mind"* that was responsible for the *"negative things"*. She explained that her *"mind"* is made of fragments, suggesting each entity of her mind is accountable for numerous emotional responses. Nonetheless, she still declared ownership as she referred to *"my mind"*. Additionally, Haniya referred to her *"mind"* and not her brain or head, therefore suggesting that these visions appear from the element that enables a person to be aware of the world and their experiences and feel emotions.

"she's done black magic on me"

Serina believed that the supernatural phenomena of *"black magic…jadoo or er nazaar"* was the dominant source of her illness:

> *"my mother-in-law is some reason I was thinking that she's done black magic on me…you know jadoo or err nazaar…at the time when I'm going through it it's what I believe and what I think in my head and I will never override that thought" (Serina).*

Therefore, as part of her explanatory model of illness at the time of her illness, she believed her mother-in-law imposed evil spirits such as *"jadoo or err nazaar"* for evil purposes, which triggered her ultimate suffering. She may have recognised my ethnicity as South Asian, and so chose to use the words to reflect black magic in her mother tongue. However, later in the interview her tone altered and this belief lessened and although she believed there was a supernatural influence, *"they're not the be all and end all"*. She continued to understand that *"there are physical reasons"* and *"it's not always the case that someone's done black magic on you or you're possessed".* These thoughts were powerful for her, which she could *"never override".* Serina also descried stress factors, which will be discussed in the next section *"a lot of stress".*

"we were in hospital because of him"

Only one participant, Namita, spoke of her unsupportive husband during her labour and early postnatal period, which was a pertinent story she shared as part of her lived experiences. At the time of the interview, feelings of anger and hatred were at the forefront of Namita's consciousness as she frequently blamed her husband for her postnatal psychiatric illness:

> *"I was like [husband's name] I'm bleeding! And I don't know what's wrong! And then he's like "it's fine it's normal"…and I I had diarrhoea, I felt sick, my husband was like "what are you doing!? What's wrong with you!? I can't handle you!"...he was being really dramatic…my sister came and we went straight to the hospital…the nurses looked at me…checked and I was like 7cm dilated already and they were like "you're ready to deliver, what are you doing" *laughs*…Erm, and, like, you know instead of holding my hand or like giving me gas and air or whatever, my sister was doing that, and he was standing when he was coming out and just looking at me and "push push" with his hands on his hips! And I'm like, I'm like really angry and focusing my anger on him when I'm pushing my baby out *laughs*…So it's probably like I guess it was a bit traumatic in that *laughs*" (Namita).*

Her husband's lack of practical and emotional support was described through his hostile and negative attitude towards her. It also seemed that she was wronged about her actions from not only her husband but also the nurses. Although her husband inaccurately perceived *"bleeding"* as a *"normal"* part of pregnancy and telling her *"it's fine"*, this was contradicted by the nurses and in fact, she was *"ready to deliver".* During her childbirth experiences, again it was clear that her husband did not support her the way she desired. She wanted him to hold her hand or give her *"gas and air"*, nonetheless instead her husband stood with *"his hands on his hips!".* As she recalled this, her mind seemed to be preoccupied with anger towards her husband. She described this experience as *"traumatic".* It appeared that on her reflection the situation seemed laughable depicted via her laughter towards the end. She suddenly stopped

laughing and she described her traumatic experiences that continued and as a result of her childbirth she was taken to the theatre:

> *"I had a lot of bleeding I had a lot of tears, they couldn't fix me, so they they they said I have to take you to the theatre" (Namita).*

Because of the *"bleeding"* and *"tears"* she considered herself broken as she was taken to theatre to be fixed. This was an interesting analogy as it appeared she felt damaged by her childbirth experiences. During her early postnatal experiences, she described the continuity of her husband's lack of emotional and practical support, and blamed this for making her feel *"really angry"*:

> *"I've done nothing wrong, it's you because I was blaming a lot of it on my husband saying he was, he was making me really angry…because he kept saying "there's something wrong with you or are you ok, you're acting weird", so I thought he was the one, that's why we were in hospital because of him!...He was being very analysist, critical of me, when I was feeding him and I was um you know at home, my behaviour, he was very critical of me then, I thought he kind of pushed me over the edge *laughs*" (Namita).*

The word *"wrong"* was used and conveyed different meanings. Firstly, it was used by P001 as she did not believe she did anything in an undesirable manner. Secondly, as she imitated her husband, he *"kept saying there's something wrong"* to indicate her peculiar behaviour. Therefore, there appeared to be conflict in relation to *"blaming"* each other. Because of his constant criticism of her, she believed *"we were in hospital because of him"*. Moreover, she used metaphorical language to show that *"he kind of pushed me over the edge"*. Thus he *"pushed"* her into a psychological state that made her completely lose control. He was perhaps the one that *"pushed"* her towards her mental decline and breakdown. Despite her husband's profession as a GP, compassion and care were not reflected in his behaviour towards her. In

the end, she may have used laughter to buffer the stress. Laughter may have also been used to mitigate the overall impact of her husband's behaviour and instead downplay the seriousness and frustration.

Superordinate Theme 4
"I was like there but not there"

In the section, I drew on the rich descriptions of women's experiences of what it was like living with a severe psychiatric illness after childbirth. Everyone's experiences were unique and were particular to their biographical experiences. I chose to name this theme *"I was like there but not there"*, as it captured the essence of *What is reality?* which was an important aspect of participants' lived experiences. It became apparent that experiences were shared and also contrasting.

"I don't want to exist"

Although some women did not explicitly say they felt suicidal or they wanted to commit suicide, their suicidal thoughts were conveyed through other expressions. Namita acknowledged that her feelings were comparable to thoughts of suicide:

> *"I was feeling a lot I don't want to do this anymore, I don't wanna have baby erm I didn't feel suicidal as such, sometimes I felt like I don't want to be here, which is quite similar I guess like I don't want this life, it was much simpler without having a baby sort of thing" (Namita).*

Her understanding progressed from not wanting to have her baby to not want to exist. She promptly became aware that *"I don't want to be here"* is *"quite similar"* to feeling *"suicidal"*. The more informed she became, the clearer her understanding became of her lived experience. Haniya interestingly mentioned how she was *"part of suicidal"* as she talked about her *"catastrophic"* experience:

> *"Uh I've had this sort of depression before, about 3 4 times but it was not that severe…but this time it was like catastrophic…I got stuck in depression…erm I was part of suicidal…I was feeling overwhelming sadness, anxiety" (Haniya).*

When she compared her current experience of severe depression with prior experiences, she recognised and understood this postnatal experience was *"catastrophic"* and caused great suffering for her. She felt *"stuck in depression"*, implying how she felt immovable and restricted living through her postnatal illness. It was interesting how she said *"I was a part of suicidal"*, inferring her active thoughts in suicide. Jiya demonstrated how she was dissatisfied with her existence and wanted to stop experiencing her sentience:

> *"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, I don't want to exist" (Jiya).*

She described how she felt that her body had *"been through war"*, implying a series of terrible physical and emotional experiences among a deadly and terrifying setting. Moreover, the key simile is given by Jiya in this account *"I wanted to be like a turtle in a shell"* expressed how she *"wanted"* to be trapped and isolated in a dark and enclosed area, which is quite comparable to a war zone. She incorrectly used her faith and prayed for her non-existence:

> *"I prayed, and I'm a Muslim and this is really bad, I prayed that I didn't wake up. I prayed that something would happen to me in my sleep…I just prayed something naturally happened to me" (Jiya).*

She first clarified and was mindful that she used her faith erroneously and recognised *"this is really bad"*. Her *"sleep"* was an opportunity for *"something"* to *"happen"*. She also hinted a sense of suicidal thoughts later in the interview as she shared a moment of her *"lowest ever"* point:

> *"You know when you wanna cry but the tears are dried up, you wanna scream but there is no sound, you're like in a vacuum, it's it's so consuming. It's horrible, nasty, disgusting, it's like stuff that nightmares are made of, it's a horrible thing but it's all inside you, no*

one can see it…my insides are like screaming. Screaming screaming like I don't wanna be here. That's my lowest ever" (Jiya).

In contrast to her euphoric state mentioned earlier, she made sense of her *"lowest point"* as part of her *"rapid cycling"*. This was a terrifically unpleasant time for her and she described it as a *"nightmare",* which she seemed to be living through. My reading of this was: 1) she felt impotent as she attempted to silently scream for help and 2) the nightmare she had echoed an inner implosive experience and she felt trapped within her own body. She did not identify what this *"thing"* or *"it"* is what happened to be but she was aware that *"it's all inside"* of her. As a result of this experience, I could only presume that she did not want to exist by saying *"I don't wanna be here"* as an ultimate relief from her agonising suffering.

Therefore, from the discussion of these personal accounts, it seems apparent that these women did not want to kill themselves and did not have plans for intentional self-harm or suicide, however, they did not want to exist.

"everyday it was a struggle…I felt like I had died"

Most women described the struggles they experienced when living through their postnatal illnesses after childbirth. For example, Aaryaa described her thoughts that she was struggling with:

"I was struggling with my thoughts" (Aaryaa).

When I asked Aaryaa to expand on this in her own words, she simply answered *"no"*. She may have been keeping some of her experiences in privacy and certainly did not want to share her thoughts she struggled with, with me. Later in the interview, Aaryaa said, "*I'm quite an introvert*

person", which may have explained her reluctance to share her thoughts and experiences openly. Contrastingly, Haniya shared her *"intrusive"* thoughts:

> *"all the things I read in Quran, they keep coming in my head and they really scare me! They give me anxiety, erm uh it keeps repeating in my head, I can't I can't get out of the thoughts out of my head, they're like intrusive…the thoughts I I I used to get thoughts like someone is always watching over me, some something is not wanting to let me not wanting to let me get better, I felt like there was like some erm some uh sort of super superpow superpowerful being, I don't know whether it's God or some sort of force uh like I was a victim of of those things and I was not going to get better and I would have to live like this for the rest of my life…I was the chosen one, I felt I was a chosen one of special victim to be to be the prey of this devastating illness…all those thoughts just erm I just couldn't get rid of them" (Haniya).*

It was evident that a lot of time was spent in dialogue with the thoughts in her head and she struggled to beat its domination. Again, it was clear that religion foregrounded the content of her thoughts, which aroused feelings of anxiety. Her constant thoughts were described as a physical presence *"watching over"* her. It was not apparent if they were eyes that she could or could not see, or whether this was merely just a powerful feeling of scrutiny or surveillance. Haniya believed God or a *"superpowerful being"* had absolute control and authority *"over"* her. Furthermore, she felt like a *"special victim to be to be the prey of this devastating illness"*. She used this metaphor to imply how she felt subordinate to any other existence by viewing herself as *"prey"* waiting to be engulfed by *"this devastating illness"*. She identified herself as the *"chosen one"* suggesting how she felt victimised by the whole experience. She felt daunted by the immensity of her thoughts and later went on to say:

> *"my life is just a curse like a living hell I see my life as a living hell basically, everyday it was a struggle, er nothing is fun".*

To demonstrate how it was living through her illness, she used a powerful simile *"like a living hell"* possibly referring to her earlier discussion of religion and hell. It may also be possible that she was confirming her punishment from God, which is what she identified as a *"trigger"*. This comparison further emphasised the sinister, evil and disturbing nature of her illness, which caused a continuous state of extreme pain, melancholy and torment with seeing no chance of reprieve. Serina referred to the imagery of *"hell"* as part of her *"ideology"* and core sets of beliefs and values:

> *"I felt like I had died and this is the other side now as in like this is it heaven or hell and my ideology was that I've died and I've reborn now and it's according to me how I make this life" (Serina).*

It was fascinating how she made sense of her experience from a metaphysical perspective and expressed *"I feel like I had died…I've died and I've reborn"*. The language used here was striking and fielded many questions. What was her experience of feeling like she had died and what did she mean by this? There was a clear link to her religion about the cycles of life and the afterlife here that were important elements as part of her *"ideology"*. Unlike Haniya, she was unsure if *"it is heaven or hell"*, nonetheless, she had an awareness that it may be hell. Her *"ideology"* can be compared to a phoenix as she *"had died"* and obtained a new life and felt liberated to control *"this life."*

"state of mind"

Serina described how she had temporarily *"forgotten"* about the birth of her daughter:

> *"I'd forgotten I'd given birth, I'd forgotten all about her until I saw her and then I remembered oh yh" (Serina).*

It was only until she saw her daughter that she *"then remembered"* her experience of giving birth. Therefore, the event that she had given birth slipped out of her conscious mind as she *"forgotten all about her".* Her expression *"oh yh"* revealed her recollection about her baby and giving birth. Similarly Namita was unaware of her reality as she also did not acknowledge her son after childbirth:

> *""You didn't even acknowledge that he was your son" and that kind of made me feel a bit sad…I did feel a bit upset and like you know a bit shocked that I was at that kind of state of mind" (Namita).*

Therefore, it was her *"state of mind"* that she was *"at"* during the time of her illness, which made her unaware of her baby son. Initially she felt *"kind of…sad"*, suggesting her slight feeling of sadness, however she realised and rectified the certainty of how she *"did"* feel *"upset"*. The lack of awareness may also demonstrate that these women may have lost their identity as new mothers. Namita's lack of awareness of reality continued as an inpatient:

> *"they [staff] were like "oh you talked to me yesterday" and I'm like I'm really sorry but I don't know what we talked about…I must have talked a lot…So it was just really bad *laughs* you know when you, when that happens *pause* you just feel like *pause* I dunno, I guess, I've never been drunk as well so I dunno what that feeling's like you know" (Namita).*

Interestingly, despite that she had *"never been drunk"*, Namita used the analogy and state of feeling *"drunk"* to portray how she could not recall a conversation she had with one of the nurses. During her pause, she may have realised that it cannot be accurate to say *"you just feel like drunk"* as she had never experienced the feeling of being drunk. However, the characteristics of being *"drunk"* were the only thing that came to her mind as she attempted to make sense and depict how she was feeling to me during the interview. This feeling

continued as Namita described and make sense of the *"whole time"* later in the interview and explained how she was physically present, but mentally *"somewhere else":*

> *"During this whole time I was like, I was there but not there, like mentally I was just somewhere else, in a different world, it was just like a dream sort of thing erm I didn't know what was going on or like talking a lot of rubbish *laughs*" (Namita).*

This is a very interesting and personal account from Namita and when understanding this with a phenomenological perspective, she described her *"mental"* self-being in a *"different world"*. She did not clarify where *"there"* was, thus I could only assume that *"there"* was *"in a different world"*. As I engaged in a hermeneutic perspective, I reached several readings. First, there appeared to be a state of absence and existence and misconstruction of her ontological position as she felt both *"there but not there"*. Second, she seemed to experience some sort of out of body experience as she described *"mentally I was just somewhere else"*, demonstrating the dualism of her mind and body as separate entities. Therefore, her experience did not feel part of her reality and she was unaware of her conscious mind and *"didn't know what was going on."*

"mentally so so powerful"

Women usually described their unique experiences that were so different to medical discourse and clinical symptomology. Namita and Serina described their experiences that seemed to be at odds with the societal stigma of labelling an individual as *"weak"*. Namita spoke about her anomalous experiences, which at the time of her psychosis she perceived *"normal"*:

> *"You know you you think everything's normal and you think you've got sup, not superpowers…but you've got this, *pause* abili, you know this, *pause* you kind of feel strange" (Namita).*

It was very clear to me that Namita struggled to put her thoughts into words, presented through the interrupted construction of her sentence. Though it is natural to pause and think, she may have found it difficult to articulate because of the strangeness of her experience. She did not abandon her utterance *"sup"* as she continued to say the full word *"superpowers"*. She then contradicted this and instead she felt *"strange"*. She had no clear way of making sense of her anomalous experience, which I questioned whether or not she really understood what she was living through. Serina also experienced psychological anomalies and explained how she felt extraordinarily *"powerful"*:

> *"doing things my way thinking what I'm doing is right and others are wrong…I'm mentally so erm I feel so strong or mentally so so powerful my physical nature I don't think about and I don't realise I'm physically for example my legs are aching because I'm mentally so strong and so strong minded about things it's only until afterwards I feel the pain…I became so self-centred" (Serina).*

What a powerful narrative from Serina. It is pretty evident she declared herself as a self-righteous infallible champion by demonstrating her omnipotence as she *"is right and others are wrong."* She illustrated how she felt *"mentally…so strong"* and so the upper body weight of carrying this may have led to her aching legs. However, as she became mentally *"so powerful"*, she developed insensitivity to physical pain. She not only experienced psychological sensations but also physical as part of her whole experience. She said how she *"became so self-centred"* suggesting her awareness that she was not "*self-centred"* prior to her illness. Later in the interview Serina revealed the *"pinnacle point"* of her psychiatric illness and described how she was *"spiritually so strong"*:

> *"The heightened part will be erm hallucinations in terms of thoughts, beliefs about people, beliefs about myself…I was spiritually so strong that I you know erm I'm divinely protected erm nothing can harm me erm err you know someone's done black although*

I the funny thing is I was contradicting myself, I was telling myself someone's don't black magic on me but I was telling myself that black magic can't hurt me because I'm divinely protected… I feel like I'm being divinely inspired or you know err err you know through you know I won't say I hear physically hear voices but the voices in my head that they're angelical voices".

As well as her mental strength, she described her spiritual strength and her belief that she was *"divinely protected"* and appeared to be in the thrall of a supernatural force. This might have derived from her belief in her faith and in God that protected her from the suffering. Nonetheless, she apprehended her contradiction that *"someone's done black magic"*, which involved evil spirits for evil purposes. Thus, it appeared that her thought process was in conflict as firstly she told herself she is being harmed and secondly, she told herself this cannot be possible because she was *"divinely protected"*. She realised her illogicality was a *"funny thing"*. She continued to describe her *"superstitious"* behaviour and the *"weird things"* she did to counteract *"black magic"*:

"I cut the back of my hair off just snipped…it was the bit just underneath the pony tail…cut a bit of my hair off cuz to combat that was a way of combatting something they done towards me and then things like erm I just became superstitious" (Serina).
"I'd take ages in the bathroom and I thought there were signs of black magic done in the bathroom for example if there was a pin or needles or not realising these are pins that we wear in out scarf but we tuck them in but at the same time I was thinking no this is these have been had a spell casted on them" (Serina).

Therefore, it seemed that her spiritual strength became overridden by the strength of her superstitious thoughts and behaviours. When thinking about the adjectives *"superpowers", "powerful"* and *"so strong"*, I was curious about their choice of words. This sense of power might suggest their strength required as a new mother (primary caregiver) to combat their

psychiatric illness and to care for their baby. Serina may have believed that her maternal instinct was always *"right"*.

"I just went crazy"

A feeling of manic was described by Jiya as she recalled her experiences during the early hours after childbirth:

> *"it's only been like you know 48 hours…annnnd it just went worse from there that day and I think my emotions went into manic, it went into manic where I spend one grand on one outfit for my daughter…then I realised I was going manic and going crazy…I was buying and I was buying and I was buying and I was buying maxing out cards maxing out cards and it just went stronger and stronger...and yh I just went crazy…It went into a crescendo where I literally didn't sleep for a week or two…that includes naps everything I literally went whoosh I collapsed" (Jiya).*

She began unfolding her mania with a protracted *"annnnd"* followed by a sequence of her manic events. Her pressure of speech was rapid during the interview and this almost provided a sense of mania that she experienced. Her mania was manifested by her ill-advised purchases and these events accumulated to a point, which eventually made her realise that she was *"manic and going crazy"*. It was interesting how she chose to use the non-medical word *"crazy"* to describe her mania. The way she recalled this episode seemed quite animated. She used metaphorical language to describe her manic progressively reaching a high level of intensity as she *"went into a crescendo."* Contrastingly, she used onomatopoeia and sound to tell what happened. Although *"whoosh"* represents an air sound, in this instance it seemed to be the decline towards her fall as she collapsed and perhaps the dramatic ending to her *"crescendo"*. Jiya continued to share her experiences of *"rapid cycling"*, a term that is used to describe the "highs" that come with mania and "lows" that come with depression:

> *"I was like up and down and another thing they told me that I'm going through is rapid cycling. So either I was really low or really high, there was no middle ground…it was continuous, I'd have like 2 3 days low 2 3 days high 2 3 days low 2 3 days high, there was no middle ground" (Jiya).*

It is apparent that her mood was not in equilibrium suggested by her emotional oscillation between *"really low or really high"* days. The label also helped with her experience and she demonstrated her subjective understanding of the medical term *"rapid cycling"*. She used visually descriptive language to illustrate the *"continuous…2 3 days low 2 3 days high":*

> *"And oh my God when I was manic, I felt wonderful, I'm so energetic and I'm talking and I'm singing and I'm laughing…I was sooo energetic and I don't sleep, when I'm high I don't sleep. It's like my batteries are fully charged all the time. Fully fully fully fully charged. I need too much to do…I literally bounce up and down" (Jiya).*

During her manic phase she emphasised a euphoric state and *"felt wonderful"*. She implied how she felt *"sooo energetic"* as her *"batteries"* were *"fully fully fully fully charged"*, demonstrating her mental and physical capacity to do so much. Her energy and spring in her step were depicted through the metaphor *"I literally bounce up and down"*. As part of Jiya's recollection, it was apparent that she frequently used similes and metaphors to best describe, understand and make sense about living through her illness. As a literary function, I was able to capture the essence of her subjective lived experiences.

"the world's against you"

Haniya felt alone whilst living with her illness as she felt like the *"unlucky one"*:

> *"no one in my family in my whole in my both sides of my family…no one had this in their it's only me so that made me feel even more convinced that I must be err unlucky one…why me not anyone else *laughs*…I look at my sisters and they're so happy and*

enjoying life doing everything and look at look at me I'm so miserable being, I'm just miserable all the time".

She compared her *"miserable"* self to her *"happy"* sisters and questioned why she and *"not anyone else".* She may have used laughter as a way of alleviating the stress in trying to understand why she experienced suffering alone. She struggled to articulate an understanding about why she was *"just miserable all the time".* She was convinced that she was the *"unlucky one"* and could not see or hear about any other women with shared lived experience. Jiya also articulated how she felt alone and isolated and yearned for some familiarity with *"South Asian women's experiences"*:

> *"I really really want to be able to see somewhere South Asian women's experiences in this so I feel I can relate to someone throughout, since I have been diagnosed to now with my illness I cannot related to anyone…I've got bipolar, I've got no-one to talk to. I have professionals, yh but it would be nice to know there is someone else because with bipolar I feel like it makes me feel very alienated, like you're the only one and that's exactly how I felt. I'm the only one" (Jiya).*

Ultimately, this account showed how she felt as though she was the *"only one"* suffering from bipolar disorder after childbirth. Although she had *"professionals"* to talk to, she did not have anyone who shared her lived experiences to talk to or *"relate to someone throughout."* This may have lessened her feeling *"very alienated"* and relate to someone's story in order to make sense and understand her own personal journey. Namita similarly expressed that she had no-one to talk to who *"knows what you're talking about":*

> *"You feel like sometimes the worlds against you and everyone's against you and no-one knows what you're talking about" (Namita).*

"The worlds against you" was a metaphor used by Namita as a way of expressing how she felt lonely whilst living with her illness. She felt as though everyone she was surrounded by in the *"world"* did not understand what she was going through.

"I had so much paranoia kicking in me"

Jiya also described how the world was against her as she became paranoid that everyone was critical of her:

> *"it's not easy anymore I could go out you know I've had days where I could go out and I'm looking down because I had so much paranoia kicking in me. I've never been paranoid, I could be so nasty I used to laugh at people being paranoid…but when I went through it and I was like that person is looking at me oh my god I look really fat look at them they are talking about me…I would come home…I'm sweating I'm so nerv wrecked up I was literally sweating the back of my dress would be clung onto my back…I was literally shaking the words wouldn't come out" (Jiya).*

It was clear that this was a distressing and psychologically harmful experience for Jiya that led to her social withdrawal. She used personification *"kicking in me"* to suggest that her internal paranoia was an abrupt forceful jolt physically attacking her. Her *"shaking"* and excess *"sweating"* were bodily responses to the paranoia and social anxiety she experienced. As a result, she described how this ensued her social isolation:

> *"The reason I stopped talking to my friends was that there were dark phases it was like "come on let's go here let's go there" and I literally was like I can't…they back off themselves so yh I kind of did push majority friends away for that reason…none of them know that I'm bipolar" (Jiya).*

Because of the *"dark phases"* and inner struggle of her paranoia, she experienced a loss as her friends backed *"off themselves."*

Feelings of paranoia were also experienced by Namita and Serina as inpatients on the Mothers and Baby Unit. Namita verbalised the paranoia she felt about *"other patients"*:

> *"The other patients kind of were not talking about me but being a bit *pause* saying things and I I thought they were talking about me and my situation like…if I hear them, I just go away because I don't wanna get involved with any issues like that, I've noticed" (Namita).*

She contradicted herself by initially saying *"were not talking about me"* then stating *"they were talking about me".* It appeared that she was observant as she *"noticed"* how she dealt with her paranoia when she felt they were talking about her. It was clear she did not feel united with *"other patients"* and did not see herself as part of a group on the psychiatric unit, demonstrating a sense of separation on the ward. Serina also remembered her experiences on the Mother and Baby Unit and described her paranoia:

> *"I remember the first day I was there that that particular patients trying to come into my room and then I was conscious that oh my god what if she comes in my sleep you know does something to the baby" (Serina).*

Thus, as *"particular patients"* tried to access her room and invade her privacy, she viewed this as a potential threat and so, she became conscious about the safety of her baby, which led to her paranoia.

"Do not start an argument with me"

Serina and Jiya portrayed how they became verbally aggressive whilst living with a severe postnatal psychiatric illness. They were aware of the fluctuations in their temperaments that were not present prior to their illness. Serina illustrated how she became *"a really volatile person"*:

"I was never physically aggressive but verbally just like quite insulting towards people like I'd never normally swear but then I was swearing I was accusing people, calling them names…I was shouting at you know people senior to me like my mum my aunty" (Serina).

She was aware of her sense of self and personal values, conveying that this was not a part of her normal self and began by clarifying that she was *"never physically aggressive".* This suggested that her psychosis emerged as a malevolent, controlling entity, beyond the control of the individual. Jiya similarly felt more verbally aggressive:

"if you started a confrontation with me I'd drag it so the whole neighbourhood can hear. Do not start an argument with me" (Jiya).

She emphasised the loudness and intensity of her arguments going beyond the home to her *"whole neighbourhood".*

Superordinate Theme 5
"I've completely lost me"

Negative and positive consequences from developing and then living through a severe postnatal psychiatric illness were shared by the women.

"I've completely lost me"

When reflecting their losses, most women redefined themselves as a result of living through a severe postnatal psychiatric illness. Whilst unwell, Aaryaa described how she felt about herself:

> *"It was a loss of self-respect and a loss of self, I mean, I felt that I am not right" (Aaryaa).*

In contrast with how she previous respected herself, she highlighted how her self-respect slowly began to erode as a result of her illness as she was aware *"it was a loss of self-respect"*. She demonstrated how she felt there was something wrong as she did not feel *"right"*. A sense of loss of self was also felt and shared by Haniya:

> *"I feel like I have lost myself, I've lost the person that I used to be…when I look in the mirror I feel like I I I search for the person that I used to be before erm but now when I look in the mirror I feel like I see a person with miserable face er kind of gloomy, I always look sad…there's no sparkle or that glow in my face anymore…Erm yh and I sometimes I wish I had any other illness, I wish I had epilepsy or high blood pressure, or kidney problems, but why depression because this is the most complex and hard to treat for some people like for me, erm I had in the last 1 and a half years I have had I have been on 5 anti-depressants and I'm still kind of struggling I'm still not the person I used to be before, like er normally when I'm not depressed I'm very fun loving, very talkative and outgoing I love socialising, going watching movies, and I'm very adventurous, going for holidays err love shopping and all that, but when I'm depressed it's just a completely different different person" (Haniya)*

Therefore, at the time of the interview she compared her previous self to herself after her illness, she felt as though she had *"lost the person"* that she *"used to be"*. She did not address herself in the first person and instead addressed herself as *"the person…a completely different different person*". The repetition of *"different"* emphasised the change in herself that was incomparable to her pre-illness self. *"Normally"* she described herself as *"fun and loving"*, however as she looked at her reflection in the mirror, she described herself as *"gloomy"*, which represents someone as depressed or a person who is sad. Jiya also talked about her pre-illness self as she alluded to herself in third person:

> *"I can really never be that person I was 10 years ago, I was really proud, she's gone, she's completely gone, it's hard, this tunnel is very long *sigh* I'm happy as well as I can manage my illness, I'm content with that" (Jiya).*

Similar to Haniya, Jiya recognised that her previous self had *"completely gone"* and she could not view the sight of *"that person"* returning back. She addressed herself in the third person to demonstrate the distance between her current self and *"that person…10 years ago".* When she accepted this, her sense of disappointment and sadness was shown through her sigh. The image of the *"tunnel"* illustrated a dark and restricted place as she travelled through this experience. Nonetheless, she finished with a positive attitude to almost portrayed the light at the end of the *"very long" "tunnel"*. Moreover, Jiya described how her confidence wavered when living with her illness:

> *"I was so bloody confident no one could knock me over…no matter how I look I've always been confident because I don't believe in looks I believe in what you've been taught…what you've learnt and how you present yourself…my personality the way I was, the way I used to do things, I lost a lot of confidence a lot of confidence" (Jiya).*

She portrayed her physical presence and strength and implied that *"no one could knock me over"*. However, it appeared that her illness *"knocked"* her *"over"* and as a result she *"lost a lot of confidence a lot of confidence."* Implied from the repetition *"a lot of confidence"*, this emphasised the huge degree of confidence lost. It is clear that she defined herself by her personality, however her illness changed her definition as she lost confidence and she was aware of her personality change. Similarly, Aaryaa clarified how she *"certainly"* lost confidence:

> *"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 *cries*" (Aaryaa).*

She was saddened by this as she cried, perhaps because coming across and being confident was significant to her. It seemed she felt she had no authority, which was contrasted to her belief that women *"hold a place of honour"* in society. She felt this superiority had diminished as she lost confidence and *"because nobody's really believing in you".*

"my head was like you're a bad mum"

The majority of women experienced and described their difficulties when living through their severe postnatal psychiatric illness and perceived themselves as a *"bad mother".* They used negative vocabulary such as *"I can't"* to demonstrate their inability to cope as a new mother. This concept of internal critic perpetuates a negative thought process and often produces feelings of guilt, shame, low self esteem and depression. In this study, a negative internal commentary was experienced by mothers. Mothers often reflected on themselves and on their role as a mother. For example, the phenomena of feeling *"bad"* was experienced by Serina. She expressed her unhappiness as she began with a sign:

> *"*sigh* uh I felt really disabled by it erm and and bad I felt really uh uh a sense of erm not annoyance but I felt not usele, not useless but like I felt like I wanted to help but I*

couldn't do anything because I was just sedated by the medication I felt really bad" (Serina).

She searched for adjectives to accurately recall how she felt, such as *"disabled…annoyance…useless"*. It was interesting how she said *"not useless"*, however, she somewhat described her feelings of uselessness straight after. She avoided blaming herself for this and instead pointed the blame towards the medication, which made her feel *"sedated"*. Namita also regarded herself as a *"bad mum"* and felt apprehensive about how she would be evaluated by people around her and possibly other mothers too, as she *"took him to playgroup":*

> *"I took him to playgroup…Initially I was scared, I didn't know what to do because I'd be like ohh what if he cries, you know, people are going to think that "she's such a bad mum, she doesn't know how to look after a baby"…what if he start's crying, um you know then I'll get stressed out and might start crying as well and if I'm by myself with him, it's, you can't do that *laughs*" (Namita).*

Therefore, I got the sense that she was more *"scared"* about people's reactions to her parenting skills. There appeared to be societal constructs that defined how a mother should respond appropriately to her baby, and a failure to do so portrays the mother as a *"bad mum"*. Unlike Serina, she pointed the blame towards herself and felt responsible when her baby cried. She was aware that she had to remain responsible as a new mother and mirroring her baby's crying would be irresponsible and she knew that by telling herself, *"you can't do that"*. She may have used laughter to demonstrate the inappropriateness if she were to *"start crying as well"* like her baby. Haniya echoed Namita in that she also considered herself as a bad mother:

> *"I didn't get to enjoy baby as much…I wasn't really enjoying, like when I looked at the baby, I felt happy but the happiness was overwhelmed by the by the overwhelming*

feeling of depression and feeling low and anxiety yh and er I always had negative thoughts about the future I felt like I can't be a good mum" (Haniya).

When she returned to her early postnatal experiences with her baby, *"the happiness was overwhelmed by the by the overwhelming feeling of depression…".* Thus, although initially, she felt happy this was *"overwhelmed"* by her negative feelings, which prevented her to *"enjoy baby as much".* This was reflected in her *"negative thoughts"* and ultimately she believed she *"can't be a good mum"*. Furthermore, Haniya experienced changes in her fundamental motivation to complete everyday taken for granted activities, including caring for her baby:

"Err I felt like erm I have this baby now I wanted er I I wanted a baby boy and I had a baby boy and then er everything was fine and while I was depressed I was feeling like why can't I get over it why can't I just get better…I was finding it difficult to do everything ermm feeding the baby, bathing the baby, err waking up in the night…cleaning, washing, cooking" (Haniya).

Firstly, it is apparent that gender was explored as she stated the significance of wanting a *"baby boy".* The use and repetition of *"wanted"* verified her definite desire for a son. She described how her psychiatric illness was as a barrier to optimum parenting. Her gender role as a female in the home was also established as she further described how her illness hindered her from everyday domestic duties, therefore she experienced multiple caregiving and household duties.

Jiya became exhausted as she struggled with her thoughts that kept telling her she's *"a bad mum"*:

"And I was holding my baby and in my head I thought I done something to her and I didn't, I was holding her and she was crying and I said check her did I do anything, did I

hurt her? And for a good 2 3 hours I kept checking her, I thought I hurt her, in my head I thought I hurt her, my head was like you're a bad mum".

She became *"exhausted"* and *"fearful"* as a result of these *"episodes"*. On the other hand, at the time of the interview, Jiya expressed her sense of determination to be a *"strong"* mother:

> *"I believe that I'm a mum now, and I need to be strong for my daughter so anything I do, I've got to think about her. She needs her mum, she needs a healthy mum, a mother that can actually do things with her, look after her and everything so right now, I'm just taking a step at a time to do things for her… so yh everything that I'm doing right now, is to make sure I'm here for her. I'm clearly mentally and physically here for her" (Jiya).*

It was refreshing to listen and engage with the positive attitude, nonetheless, she did not refer to herself and instead refers to *"a healthy mum"*, possibly indicating that she does not believe she is *"a healthy mum"* to her baby, yet. She realised as a mother she needs to remain *"strong"* and be responsible.

"it affected our relationship a lot"

Difficulties in marital relationships were described by women, as a result of their postnatal psychiatric illness. Serina recognised the challenges between her and her husband:

> *"it affected our relationship a lot as well to the point where ermm I was saying to him that's it go, because I wasn't in the right frame of mind I was not in control of what I was saying what I was doing and it was really it was really really challenging…I was giving him ultimatums for no reason and really just really rocked the boat definitely" (Serina).*

She used the adverb *"a lot"* to demonstrate that her illness had not only impacted her but also her husband and ultimately their *"relationship"*. Again, in contrast to the earlier reference of her *"smooth sailing"* pregnancy, she used the metaphor *"rocked the boat"* to convey how her

"frame of mind" caused disharmony and instability in their relationship. Aaryaa also recounted how her illness impacted her relationship with her husband:

> *"My husband felt that, you know you lose sense of respect and not respect, a sense of uh, someone is out there for you, so he felt no one is out there anymore for me…so he felt, er, at risk" (Aaryaa).*

She rectified and realised it was *"not respect"* that was lost, however a lack of support that her husband felt from her, which made him feel *"at risk"*. Although it seemed unclear from the text what her husband was *"at risk"* from, I assumed he was *"at risk"* from losing something, or even quite possibly, Aaryaa.

Namrita reported that her illness affected her sexual relationship with their husband:

> *"Um I did have that conversation with him like you know *pause* how, why did you take so long to kind of…like you know, have that closeness" (Namrita).*

She used pauses and fillers in her dialogue such as *"you know"* to avoid the discomfort or awkwardness in approaching the conversation regarding sexual intimacy. In contrary, Haniya's sexual intimacy with her husband was not affected by her depression:

> *"uhh sexual life I would say errm *pause* intimacy wise err we were still intimate like erm that wasn't really affected that part wasn't affected by my depression" (Haniya).*

"I have more sympathy"

It was refreshing to hear positive consequences from living through a severe postnatal psychiatric illness from Namita and Haniya. Namita reported that having lived experience provided her with *"a bit more understanding"* of people who share similar lived experiences:

> *"I guess I do have a bit more not sympathy, but a bit more understanding…like before when people used to come to the pharmacy with a prescription for say you know say an antidepressant or something, you don't look much in it, but now you'd be like you have*

a bit more of a sy like an understanding a bit of empathy because you've kind of been there and you can relate to that person a bit more. I guess that's what's kind of changed in my thinking" (Namita).

Initially, she was aware that she had shared lived experience, therefore she realised that it was *"empathy"* and not *"sympathy"* she had for other people. Thus, her experiences had been a positive turning point for her *"thinking"* as it enabled her to relate better to people with mental health issues. Through reflecting on her personal experiences, she felt more connected to people, as opposed to a person just coming *"to the pharmacy with a prescription"*. She added more emotion to this and appreciated their probable suffering. Although sharing a lived experience, Haniya expressed her *"sympathy":*

"I have more sympathy for for people and erm for ill people or if I see any disabled less able people I feel sympathy towards them and I feel compassionate, I feel like they're human they're just ill erm it's something they can't help" (Haniya).

Not only did she become more sympathetic towards people who are mentally ill, but all people who experience some sort of suffering. She elaborated on how she had changed as a person:

*"it's changed me as a person…and it made me a more patient person…and uhh yh it taught me not to give up *laughs* and keep fighting and keep going and not to give up" (Haniya).*

Through her sense-making and learning, she gained a positive attitude and became determined to overcome her illness through her strength and her willingness to accept her illness. Therefore, it appeared she gave herself the responsibility to overcome her illness *"and keep fighting and keep going and not to give up".*

"that stigma…would stay with you forever"

It was interesting to hear from Namita about the long-term impact of living with the label of severe psychiatric illness:

> *"I guess people would think that, that stigma and that that label would stay with you forever, even if you're fine, you know that's how people would remember you, you know you know her she was the mad one *laughs*" (Namita).*

It appears that she identified her illness as a *"label"* that has permanently marked her in society as *"the mad one"*. This demonstrates that as a result of her illness, the stigma has a long-term consequence for the way she is perceived by others around her. It appeared she used laughter here as a coping mechanism to deal with this permanent *"label"*.

Superordinate Theme 6
Experiences of Perinatal Mental Health Services

"I need medicine, I need therapy"

This subordinate theme captured women's experiences of treatment preferences and adherence. Women either preferred medicine, talking therapies a combination of both or alternative medicine and this was discussed as part of their overall experiences. Although Jiya reported very good experiences as an outpatient, she was administered with *"different tablets"* and felt saddened to have to *"rely on medication":*

> *"Like if there was a booklet about South Asian women who talk about their experiences and you know I don't rely on medication, but if there was something along with that, I could go and talk to something or I could hear someone say I went through a similar experience. I'm on 11 different tablets, 12 sorry, I'm 33 I don't wanna carry on like this, I want to see a community out there that we can talk to, go to, share with, you know cla work, therapeutic classes, you know something else out there that helps us, because just taking medication…Because all the professionals, no one said this is bipolar, this is what it does to you, this is what symptoms you'll have, I was just given a name and a list of tablets and that is it, it's always medication and I found that really sad…I wasn't given any other option, I was not given any option" (Jiya).*

It appeared that Jiya's treatment plan revolved around *"a name and list of tablets"*, which did not allow her to learn about her illness including *"what it does to you"*. She would have preferred *"something along with that"*, however she *"was not given any option"*. Although Jiya was advised to take medication as a preventative strategy after childbirth, she did not adhere to the advice given by the professionals:

> *"they said as soon as you give birth take this medication and I didn't take it, I didn't, my fault, I didn't do it, I just thought I'm going to be fine, I can control it I didn't need drugs,*

*it didn't work *sense of disappointment and sadness* very unexpectedly and very quick" (Jiya).*

A sense of disappointment was felt as she realised it was a mistake and it was her *"fault"* and could have potentially prevented her illness. Her denial cost her the suffering of her illness. Aaryaa and Serina also believed that a combination of therapy and medicine received was the best form of treatment for their illness. Aaryaa believed:

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

Thus, she was firm in her belief that she needed both *"medicine"* and *"therapy"* to *"heal"* her. She also believed that prayer would not *"easily heal"* her, which may because she is *"not that religious"*. In isolation to medication alone, Serina felt *"talking counselling therapy"* also helped:

"I did receive other kinds of help which was talking counselling therapy…for me that's always helped in terms of therapy rather just than medication ermmm you know being able to talk things through and made sense of what I'm going through, that really helps me" (Serina).

It seemed that the process of *"being able to talk"* helped Serina understand and conceptualise what she was going through, which ultimately allowed her to make sense of her experiences. Her understanding of what she was *"going through"* was gained via verbal communication. However, Serina also shared the belief that she needed medication:

"I think I was to the point where I did need medication" (Serina).

Therefore, this *"point"* may refer to the most severe *"point"* of her experience whereby she realised that she *"did need medication"*. Nonetheless, initially, Serina was reluctant to adhere to the suggested treatment plan. She explained that her disinclination was a consequence of

her husband's family and their lack of acceptance of *"conventional medicine"* and added that she *"fell into that trap of thinking…which obviously didn't help things"*. By calling it a *"trap"* she suggested her freedom of choice and autonomy had been restricted by the prevailing belief of the family. Furthermore, her treatment preferences were also influenced by her unpleasant experiences *"in the past"*:

> *"because of my you know the way I took on board medication in the past and er you know I never had a pleasant you know er time with medication to be honest…cuz number 1 the drowsiness factor I have heavy sedated affect from them ermm which affects everything like I couldn't do a normal 9-5 job I couldn't finish my education it really really took its toll on me…yh so I didn't have a pleasant time with medication which kind of pushed me away from it even more" (Serina).*

Because of her negative experiences with *"conventional medicine"* she was more inclined with herbal remedies:

> *"I was trying to do like other herbal for example trying to eat more healthy trying to eat more organic erm more vegan kind of diet"*

In contrast to Aaryaa and Serina, Namita was more inclined to medication. The following excerpt shows that Namita was advised by her doctor to *"try a bit of CBT"*, however eventually she returned to her GP for anti-depressants:

> *"She did suggest to either go to your GP or we can try on anti-depressants…I saw a psychologist and then we did try a bit of CBT…then in December I went to the GP, I got some anti-depressants and I said I'll take it if *pause* if I need to" (Namita)*

When she discussed CBT in comparison to anti-depressants, she used the personal pronoun *"we did try"*, demonstrating her understanding that CBT was a two-way interactional practise between herself and the *"psychologist"*. She then gained a sense of power and control from

her decision making about taking her medicine and the use of the first personal pronoun as she added *"if I need to"* suggesting it was a self-directed process. She evaluated her own health prior to taking her medicine. Her ultimate preferred choice of anti-depressants may be linked to her occupation as a pharmacist. Moreover, she used her wittiness to show how she was proponent with medication and *"obviously being a pharmacist"* she followed her treatment plan:

> *"So I'd take my medication, obviously being a pharmacists *laughs* you know you've got to take your medication…I'm the first person…you know to get my medicine *laughs* it's my medication time, can I have my medicine please, you know!! *laughs* (Namita).*

Thus, she implied there was an obvious predetermined rule that she had to take medication due to her occupation of being a pharmacist, and so automatically know you have to take medicine. There appeared to be a role reversal as she now was on the other side of the counter asking for her medication. Stating that she was the *"first person"* to get her medication may suggest that she was keen to follow her treatment or keen to follow her profession? Similarly, Haniya described part of her identity and how that influenced how she *"stuck to the treatment plan"*:

> *"I feel like erm I'm I'm very like medication orientated…I I I stuck to the treatment plan I I listened to everything the doctor said apart from not wanting to have the cognitive behavioural therapy *laughs*" (Haniya).*

Not only did she listen *"to everything the doctor said"* she also had her own autonomy about her treatment plan, demonstrating her power and control. Her laughter may be indicative of the fact that initially, she said she *"stuck to the treatment plan"*, however contradicted this statement by not adhering to the *"cognitive behavioural therapy",* which was part of the

"treatment plan". Additionally, Haniya felt that there needed to be a more robust *"treatment plan"* in an era where *"there's so much technology"*:

> *"I feel this is the time of the world like where everything there's so much technology everything is so advance…this illness, there should be more to it like there should be more easier treatment methods or definitive more robust but it's still like those antidepressants try it for 6-8 weeks and then see if it doesn't work move to the next one, that should be more definitive or quicker" (Haniya).*

Therefore, although she gladly accepted the *"treatment plan"* she felt as though the treatment was disorientated through trial and error with no clear pathway. This may have caused a sense of bewilderment for Haniya, as she suggested that there should be a *"quicker"* and *"easier treatment"*. This may imply that she found her treatment plan problematic and a long journey to overcome her illness. Nonetheless, she was glad she attended her appointments and adhered to the medication:

> *"I still didn't want to uhh discontinue my treatments or uh erm stop coming to the appointments or getting access because I didn't have any other option to to try to get better yh those were my only option" (Haniya).*

I questioned whether it was her own choice continuing the treatment for the management of her symptoms or by default due to no alternative treatment.

"I was able to care for baby"

The continuation of being a mother on the Mother and Baby Unit was very important for Serina when she was an inpatient. Despite her illness, she was aware that she had to fulfil her role as a new mother for her daughter:

> *"I thought it was the best thing at the right time cuz for me I wasn't looking at my mental health I was looking at my relationship with my daughter I thought good thank God I'm*

away from everyone…this is me and her time now so I was quite quite happy with going into perinatal care…I'm away from everyone now and it's just me and [baby's name] I can bond with her the way I wanted to do" (Serina).

Her relief was conveyed through her expression *"thank God"*, which could also be a reference to her religion and thanking God. She prioritised the quality of the relationship between herself and her baby rather than her mental health. She perceived *"perinatal care"* as a space to care for her baby without the interference of *"everyone".* Therefore, as opposed to clinical intervention for her mental health, *"perinatal care"* was viewed as an intervention that facilitated her attachment bond with her baby. During the analysis, the continuation of being a mother and caring for her baby was similarly echoed by Namita:

*"baby was there as well erm and it just meant that I was able to care for baby…I'd check on him…when's his next feed due…nurses would help if we needed the help, but usually we were left to our own devices…plus my husband with me, so they were quite happy for us to kind of continue with what we were doing and they were a bit short staffed, so I think they were a bit relieved! *laughs*…They were always running around, always short staffed." (Namita)*

The lack of support from the nurses did not impact her because of the support she received from her husband. She reiterated that they were *"always short staffed"*. Therefore, there was a benefit of her husband visiting her, which reduced the burden for the staff to care for the patient and her baby. The constant chaotic environment was reported as staff were *"always running around"*.

Although some mothers reported they were able to care for their baby, disappointment was encapsulated by Serina when she could not care for her baby because she was *"so sedated"* and the night time staff did not help her the way she desired:

"The night time staff, the only issue is that I had issues with night time staff to be honest because there were times when [baby] was crying and crying and even though physically I wasn't awake, subconsciously I could hear I knew she was crying but I couldn't get up cuz I was so sedated and I felt like she was crying for ages and then the nurse came at one point and said she's been crying for quite some time…and I didn't like that because you know she's only a few weeks old…Erm and then she was being overfed…I don't think they were looking into things properly and they were doing things er willy-nilly…Er so I wasn't happy with that…her milk was being given the wrong dose or the wrong amount or it was misplaced by someone else's milk…she was given the wrong milk a couple of times…" (Serina).

Therefore, she implied how her maternal instinct was part of her conscious and her subconscious mind, and she operated as a mother beyond her level of consciousness as *"subconsciously I could hear I knew she was crying"*. To describe the care, she used the phrase *"willy-nilly"* to suggest the disorganisation and lack of individualised care for each baby. This echoed Namita's account of the disorganisation of MBU. It was obvious that she was aware of the responsibilities of caring for her new baby, however the impact of her medication disenabled her from being a mother to her baby.

"They were so focused on me"

The following are accounts of Jiya's positive experiences as an outpatient, reflected through the patient-centred care she received:

"like exactly how I am, they spoke to my partner, to my mum, wanted to see the house, how the house was for me, whether I was comfortable, it was really intense but it was like we are here".

"Everything was taken into consideration, it was catered for me, everything worked for how I wanted to, it was an ideal plan, it really helped".

"They were so focused on me, focused on an individual and how I am and how I feel, she spent like a whole hour really getting to know me".

*"They literally got to know me, I'm [name] for them, not another patient, a bipolar patient, it's so personable *cries* that's the kind of care we need and it's really hard to get, it's impossible".*

"I won't get that anywhere, they're underselling themselves, their services and impeccable".

"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, the normalness that left, they actually put it back in, so they made me feel normal, I'm not weird, I'm not a freak. It happens".

"They care as a whole and they treated me as a human. They've set the bar really high, I won't be able to accept anything less".

"because they have been amazing, getting an appointment easy, getting seen, easy, wonderful doctors, understanding, they give you sufficient amount of time, they've worked around me, if I can't make it, they come home…the care has been first class, anytime I've needed to see them I've seen them, there hasn't been no long wait".

It is evident that she was really pleased with the *"impeccable"* services and her experiences as an outpatient. She described how the care was individualised and *"catered"* to her experiences and how she was treated and recognised as *"individual"* with a name as opposed to *"another patient, a bipolar patient"*. She became emotional as she recalled this and it seemed that she felt overwhelmed by the quality of care she received and perhaps for the first time she felt accepted and understood. This was confirmed as they made her *"feel very normal"* as opposed to *"a freak."* A holistic care approach was demonstrated as *"everything was taken into consideration"* and family members were also involved in the process. Moreover, in contrast to other women, Jiya felt understood by the clinicians:

> *"I wanted to speak to someone who relates to it and then when I got to the XXX, I felt kind of understood because they heard of it more often…The people who have really understood are the XXX, because they've seen it all postnatal ermm they're the only ones who have really understood, but before that no-one, nothing" (Jiya).*

Therefore prior to her admission, she did not feel understood, however by attending specialist services, she felt understood, which contributed to her overall positive experience. In contrast to Jiya's positive experience, Haniya felt angry as she did not feel the clinicians understood her *"fully":*

> *"because I was able to come to all the treatments er all the appointments…I never attempted suicide and things like that the doctors didn't believe I was actually that depressed and maybe sometimes I didn't look depressed…so those things kind of erm disappointed me sometimes…even the doctors and psychiatrists sometimes are you sure that you are depressed…that just puts me off, that makes me angry, because you can't see it obviously it's not written like I don't have a broken arm or a high fever…it's just my internal feelings…they didn't understand me fully"(Haniya).*

Because of her ability to regularly attend appointments and her physical appearance, there was a lack of belief from clinicians, despite her severe diagnosis. This lack of belief often seemed to upset and disappoint Haniya, however, it did not doubt herself or her experiences. She compared mental illness to physical illness demonstrating that mental illness is an *"internal"* feeling and something that cannot be physically viewed with the naked eye. However, to clinicians it appeared that is something that can be assessed and questioned through the physical appearance of the patient.

"they were not culturally sound"

This theme encapsulates the issues raised with a lack of cultural competency in Perinatal Mental Health services expressed by some women.

Namita discussed the lack of diversity among staff:

> *"They had erm, the didn't, like the diversity in their staff was more erm like Afro-Caribbean or White erm nurses but they didn't have many Asian nurses…but I guess that's just the way it is *laughs* they can't obviously er the doctors were mainly Indian *laughs* the pharmacists" (Namita)*

She tentatively approached this topic demonstrated by the interrupted construction of her sentence structure. She may have mentioned the lack of *"Asian nurses"* as she may have preferred Asian nurses who understand the worldwide view and religious or cultural backgrounds of Asians. Nonetheless, she used humour to indicate that occasionally *"that's just the way it is"*, implying her disappointment but acceptance of the situation. She also used humour to demonstrate how the majority of other medical professionals are Indian. She is also Indian and a pharmacist, supporting her statement about ethnicity-based occupational stereotypes.

Out of the five women, Aaryaa was the most critical in her description of how the services lacked respect to her religion and culture:

> *"The place is very poorly ethnically designed, I mean, in terms of uh the place itself, there is no prayer area, if you're Muslim you can't be there…It's just horrible, you wake up in the morning, you go downstairs and then you cannot go back upstairs, there is no prayer area downstairs" (Aaryaa).*

Vocalised with a tone of annoyance, she felt isolated and segregated from other women through the mere design of the psychiatric unit. She demonstrated how the unit was not inclusive of all women with religious needs and are selective of who can and cannot be there by stating *"if you're Muslim you can't be there"*. Overall, she described her experiences as being *"just horrible".* Moreover, Aaryaa identified cultural differences among South Asian women that were not acknowledged or understood by the therapy team:

> *"…and then the therapy team, they were not culturally sound. There was another South Asian with me and we have few issues, South Asian issues, cultural issues. They didn't know about it…firstly, they need to know the culture, they need to study, they need to have a, a ,a this us anthropology subject…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" (Aaryaa).*

She conveyed *"issues"* that were *"very unique"* to the South Asian culture that was not understood by the therapy team. She made sense of her issues and clarified that the *"issues"* were *"cultural issues"* that were a part of her identity and culture. The only familiarity she may have had as a patient was with *"another South Asian"*, whom she shared *"few issues"* with. She continued to suggest that *"they"* need to be aware of cultural issues and the differences among ethnic groups. She enumerated her concerns to inform that they *"need"* to know this essential knowledge and become self-aware of culture when communicating to someone from a different cultural background. Again, she reiterated *"things in this culture"* that is *"very very unique".* Thus, a level of understanding about each other will facilitate collaboration and cooperation in a hospital setting. She did not feel understood by the care team.

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

She continued by stating that clinician's need to *"know how this culture is different"*. Thus, the common experiences shared by her community may influence and shape their experiences and understanding of the world. She expanded and explained how women are *"treated differently"* in South Asian culture:

> *"They hold a place of honour" (Aaryaa).*

This was a very interesting and powerful comment made by Aaryaa. Her evaluation of South Asian women (which also refers to herself) included their value, worthiness and respectability that they embrace in society. As well as a woman, motherhood may also be near to divinity and the highest and holiest service to be assumed by mankind, suggesting that there is no greater good in this world other than motherhood. The following quote illustrates another cultural difference highlighted in relation to childbearing practices:

> *"They thought that I am having some confused thoughts, because I did not let them change her clothes. I wanted to change her clothes. So we have this uh shame and uh you know in Muslim we have purdah as well and then we have shame. They they thought I was confused…I was cleaning her with water, when she poo I used to clean her with water…they thought this was very very improper…the men don't change the nappy of the children…my husband was forced to do that…of the girls, they don't do, this is culturally, just a way we have, the the idea of shame" (Aaryaa).*

Therefore, it appeared that the shared cultural understanding was not present between herself and the clinicians who she referred to as *"they"*. She alluded to herself in the third person using *"we"* to imply a sense of belonging to her community. The Islamic position on *"purdah"* and *"shame"* is very important and refers to the rights of a female and dress code. And so, to maintain her daughter's modesty, *"she did not let them change her clothes"* and neither did she allow her husband to change her daughter's nappy. It can be comprehended

that what was normal within the Muslim context with regards to caring for her baby was seen as "*improper*" to the clinical team and was misrepresented as *"confused thoughts"*. After articulating all of the above she said:

> *"I will be off from here in some time, I don't really care and it's not even so far my country" (Aaryaa).*

Therefore, not only did she feel an exile as a patient but also residing in the UK. She ultimately did not care, which did not align with her attitude when voicing her opinions. Moreover, not only did she feel *"they"* were not culturally competent for South Asian women, she also believed:

> *"They would not know about different cultures, they only know about American culture, this British culture and I'm not just talking about the South Asians, I'm talking about the Blacks and the different other ethnicities that there are, the Europeans…they would not facilitate for them" (Aaryaa).*

Therefore, she believed that they are biased towards Western cultures and *"they would not facilitate"* for *"different other ethnicities"*. In a similar way, Haniya conveyed a lack of cultural competency in the *"treatment plan"* for South Asian women:

> *"in this uh mental facilities the treatment options or the treatment plan just its they're very broad, they're obviously designed for all the ladies, there's no sub-division like specific er wise specific treatment plan for South Asian women err it's it's all very generic" (Haniya).*

It is noteworthy how she rectified *"treatment options"* to *"treatment plan"* as she realised there were no options and there was one "broad" treatment *"designed for all the ladies"*. A treatment plan is usually tailored to the individual and their experiences, however, based on the account of Haniya, this was not reflected and seemed *"all very generic"*. A sense of

disappointment was felt as she implied the need for a *"specific treatment plan for South Asian women"*. This may have been due to her understanding that her culture is different and so, the treatment needs to reflect these cultural and individual differences among South Asian women.

A sense of disbelief was experienced by Serina as she was *"kind of ignored"* by the clinical team when she described how she was feeling and her thoughts about superstitious beliefs:

> *"they kind of wouldn't respond to it in terms of react and say oh you know this this and this so it was kind of ignored…maybe they didn't know how to react to it maybe they didn't believe in it err they probably just thought she's hallucinating again…maybe it's more of a taboo for them than it is for us" (Serina).*

Therefore, her subjective experiences that were not in line with medical discourse were not treated seriously by the clinicians who viewed her experiences as *"hallucinations"*. She also recognised that alternative explanations that do not fall in line with the Western biomedical concept may be *"more of a taboo for them than it is for us"*, implying that these explanations are socially disapproved for all cultures and ethnicities. Conversely, when asked about their experiences of the treatment, Serina expressed positive comments. On reflection, Serina mentioned that clinicians were *"quite understanding"* and respected her culture. For example, she was *"offered only female staff members"*:

> *"I was offered only female nurses staff members to come to see me er but at that time because I wasn't myself I made the decision that no one whoever needs to see me has to come and see me you know whether it's a male staff of whatever but in my right of mind you know thinking I would have probably said yh I should thank you for that option I'll take that on board" (Serina).*

She demonstrated how the NHS protected her cultural values and her rights as a patient by offering *"female nurses staff members."* However, she was aware that she was not herself and her decisions at the time of her illness did not reflect her personal cultural values. Therefore her beliefs of what is culturally appropriate was overridden by her *"right of mind"*, and her ability to make decisions that fell in line with her belief system. Namita also demonstrated how her cultural values were respected.

> *"I didn't have any issues, they were, they were really nice as I said erm they knew I was vegetarian so, meal times they always had like a vegetarian options" (Namita)*

"I suffered through the red tape as well"

As well as suffering through a severe psychiatric illness after childbirth, Aaryaa also described suffering through *"red tape"* as an inpatient on the Mother and Baby Unit:

> *"I was kept there for about three months…there was a lot of, what do you say *pause* red tape…I suffered through the red tape as well" (Aaryaa).*

She used derogatory language to criticise the healthcare system showing strong disapproval. Therefore, her experiences reflected how she felt trapped, stuck and powerless through a system of excessive bureaucracy in a health care setting. Because of this, she felt disempowered and felt a general lack of autonomy and her identity as a powerful woman was suppressed by the healthcare system. As a patient she felt did not get the treatment she wanted/needed because the hospital was bound up in rules, regulations and procedures. Serina also felt that she *"didn't have much to say"* in relation to her medication:

> *"And then my medication dose was being increase and that again errm I wasn't happy with that but I felt that I didn't have much of a say because they wanted to still increase it anyway" (Serina).*

She demonstrated that the clinicians had ultimate authority and controlled her medication dose, which she *"wasn't happy with"*.

Superordinate Theme 7
"it used to take it all out"

"it used to take it all out"

As well as care and support received from Perinatal Mental Health Services, women also helped themselves through writing, art, faith, cultural norms and their family. Namita expressed and acknowledged her feelings through writing and art:

> *"I felt like writing things…then I would just sit there and write, write lots and lots of things just random thoughts of whatever was going on in my head erm and it used to take it all out! And that really helped me… it was just like, you know kind of letting go *laughs* of all your thoughts and that erm really helped" (Namita).*

She viewed her illness as an internal process *"of whatever was going on in my head"*. Art appeared to be a form of liberation and relief for her thoughts, which enabled her to *"take it all out"*. She almost let go from her path of suffering by taking a conscious choice in letting go. Through this liberation journey, she may have felt a sense of control of her thoughts, which *"really helped"*.

Faith played an important part in recovery for Serina. As part of her everyday role as a teacher in religious studies, she demonstrated how her faith and religious teachings were central to her ontological existence and kept her *"strong"*:

> *"I think my faith has kept me strong…It really has it really has…you know in the Quran there's a verse which says after hardship will come ease and then that verse is repeated so I remind myself through these things and that would really help me at that time and in the long run I'm thinking alright I'm going through it now it will get better it will get better it will get better so just being positive on things" (Serina).*

She took quotes from the *"Quran"* and applied it to her situation and perceived her experiences as *"hardship"*. She embraced a positive attitude by referring to her faith and believed *"after hardship will come ease"*. By putting the teachings of her religion at the forefront of her mind, her clouds of worry and fear had been driven away by her optimism. Her faith and religious beliefs weaved a potent thread throughout her story. Serina again demonstrated how religion was central to her life and her baby as it was an important feature of her early postnatal experiences:

> *"I had given birth and after you have the local bleeding so I couldn't pray do the physical prayers but we would listen to erm the Quran…so I'd play that to her…so not only would that help me but I thought it was good for her as well…and I would recite other prayers which I could but not the physical prayer" (Serina).*

Although there were religious restrictions on prayers, she viewed regularly listening to prayers as a traditional way of relieving her illness as well as staying well. She illustrated the dual purpose of prayer not only for herself but also for her baby. Nonetheless, she expressed that she did not believe traditional religious prayers would have overridden the care from Perinatal services that she needed. On the other hand, although Jiya felt she should pray to help her, she described how she lost her faith during her experiences:

> *"I haven't don't nothing, I feel like I should pray, I used to pray a lot, I'm not a 5 time reading type of person but I pray in my own way, I've got a lot of respect for my religion and then this happened to me and I think this is the first time I've said this out loud but I feel disheartened, I've been through so much and this adds to it , I've got a very unique heart condition called syncope, where I can just collapse without any warning…I was 5 months pregnant, I was on top of the stairs, I woke up in the hospital, they said you just fell down the stairs, my faith dwindled a lot, I now it's a horrible thing to say, but it did" (Jiya).*

Therefore, she did not view her experience as hardship and instead felt disappointed by her religion and lost faith. She acknowledged the inappropriateness of that, however, asserted her honesty.

"my parents and my family were there to help"

This sub-theme was strongly supported by the analysis of the participant data. Women frequently spoke about the usefulness of the support they received from family members during their illness experiences. Namita mentioned a postnatal tradition for additional support from her maternal home:

> *"Kind of tradition where the girl goes home to her mother's house and then they look after her".*

She recognised how she needed care and support after childbirth as it is a tradition where *"they look after her", "her"* referring to new mothers i.e. referring to herself. She felt lucky because of all the support she had received from her family, demonstrating a sense of belonging and protection from those around her:

> *"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" (Namita).*

It can be assumed that *"it"* was her illness and her baby would have been kept safe if her illness exacerbated. Therefore, through this tradition, not only was she supported but also her baby. She paused before she realised her illness may get *"worse"*, possibly implying her anxiety and potential harm to her baby.

Haniya, Serina and Jiya talked about their supportive and understanding husbands: Jiya demonstrated her husband's reaction *"to make it easier for her"*:

> *"His reaction was, "ok so what do I have to do to make it easier for her", he never questioned it, he's never, he has never ever thrown it at my face, he's never been unsupportive, he is the most supportive human being on this planet" (Jiya).*

Thus, her husband acknowledged living through her illness will be difficult, however made every attempt to help her. Haniya also sang her husband's praises:

> *"He was still very supportive and he understood that it's an illness…he was always err accepting of what I was going through…he was just ok, he wasn't retaliating…he was always patient…that gave me kind of strength and hope" (Haniya).*

Therefore, the overall impact of his patience kept her hopeful of the future. As he husband *"understood that it's an illness"*, his understanding may be in line with a medical theory of illness. It is clear that through her husband's support she was given *"strength and hope"*, suggesting that without his support she may not have felt as optimistic. Strength has several shades of connotations, though in this sense, it may appear that he gave her psychological strength. Serina also described how her husband kept her *"strong"*:

> *"That's what kept me strong cuz he understood and that he knew that this isn't me I'm going through an episode…so yhh I'm so honestly I'm really really fortunate that you know he was the way he was…he stood there he stood by me through it all" (Serina).*

Thus, in a similar way, Serina's husband was supportive and understanding, despite her behaviour and accusations. In comparison, he also recognised what she was going through as *"an episode"*. In contrast to her husband who recognised her illness as an *"episode"*, the phenomenon of *"nazar"* influenced her parent-in-laws recognition of Serina's ilness:

> *"my in-laws believe in the whole nazar and the ways of contracting It by doing getting some chillies and waving it over the baby etc bla bla bla…initially I was quite annoyed and I was like oh my God I don't want them to do that, it's superstitious it's not true bla bla bla..but just to keep the peace between us so I let them do it" (Serina).*

Thus, as a method of casting off their *"nazar"* (evil eye), her parent-in-laws believed this would help her. She described the process using *"bla bla bla"* to criticise their beliefs and imply that it made no sense to her and were not in line with her belief system, however she wanted to *"keep the peace"*. Eventually, her father-in-law was also understanding about her illness:

> *"I remember my father-in-law hugging me when I came to the home visit…saying you be there as long as you need to, so long as you're better and you're well that's what we need, so hearing that form him really gave me that confidence that that that understanding that ok and they are understanding" (Serina).*

She imitates her father-in-law saying *"that's what we need"*, which can be interpreted that the family needed a *"well"* daughter-in-law.

Chapter 6

Discussion, Conclusion &

Implications for Clinical Practice & Future Research

A summary of the IPA findings

The aims of the empirical study were:

- *To explore South Asian women's lived experiences of a severe postnatal psychiatric illness*
- *To explore South Asian women's experiences of Perinatal Mental Health Services, care and support*

Chapter 5 demonstrated that IPA techniques can be used to develop rich contextual understandings of the experiential dimension of living with a severe postnatal psychiatric illness through the use of an idiographic interpretative approach. Each woman's life and diagnosis varies and too does the individual's experience. This IPA study has documented the rich and detailed accounts of five South Asian women who were diagnosed with a severe psychiatric illness after childbirth.

The research highlighted eight superordinate themes. These constituted a picture of what it was like living with a severe psychiatric illness after childbirth and experiencing Perinatal Mental Health Services. When an overview of the subjective realities is taken, an overall picture of this experience emerges. Most participants did not feel *"normal"* and experienced external stigma from family members. Women described "triggers" of their illnesses such as expectations from their culture, their religious beliefs, belief in black magic, stress, a demanding child, an unsupportive husband, childbirth, breastfeeding and sleeping difficulties and biological factors. Days were often troubled by intrusive thoughts and women described a range of feelings such as *"crazy"*, *"so powerful"*, *"paranoid"* and argumentative. As a result of their illnesses, women felt a great loss in relation to their identity and sense of self; most

women labelled themselves as a *"bad mum"*. However, some women felt they also had positive effects such as an increase in sympathy with other individuals with similar lived experiences. The women in the study reported mixed views about their experiences of Perinatal Mental Health Services. Firstly, being a patient at the Mother and Baby unit allowed some mothers to continue caring for their baby however other mothers expressed the lack of support they received from the nurses. Secondly, some mothers felt the care they received was good and they felt they were treated as an individual person, on the other hand, some women felt the care was *"too broad"* and lacked cultural competency for South Asian women, perhaps because of the bureaucratic nature of the services. In addition to Perinatal Mental Health Services, women received additional support through their family members, their husbands and found additional strategies that they used to help them during their recovery. Overall, some women chose not to *"tell anyone"* about their severe postnatal psychiatric illnesses. This period of reflection in the interview enabled women to gain an overall picture of their experience.

As an IPA doctoral researcher, I witnessed the individual accounts of the women and took one step further to carefully examine the patterns in their accounts and present them in a conceptual framework, which was grounded in and connected to their personal experience and reaches out to theoretical and existent literature.

The main discussion points that emerged from the data that are:

1. What are the lived experiences of South Asian women with severe postnatal psychiatric illnesses?
    - *A lack of knowledge and understanding*
    - *Women's Identity*
        - *Normality*
        - *Women's identity as a South Asian woman*
        - *Women's identity as a new mother*
        - *Women's redefined identity*
    - *Living with a severe postnatal psychiatric illness*
    - *South Asian women's multiple models of illness*

2. What are South Asian women's experiences of Perinatal Mental Health services, care and support?
    - *Healthcare experiences*
    - *Culturally competent services*
    - *Coping strategies*

1. What are the lived experiences of South Asian women with severe postnatal psychiatric illnesses?

A lack of knowledge and understanding

The majority of South Asian women in this IPA study reported no previous knowledge of severe postnatal psychiatric illnesses or about Perinatal Mental Health Services. A lack of awareness and knowledge among women about Perinatal Mental Health Services and perinatal psychiatric illnesses previously been reported by women in the childbearing period (346). Watson et al. conducted a systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe (346). Similarly in the systematic review, some women with psychiatric illnesses (including South Asian women) were not aware of the support in the perinatal period and this was often reported as a barrier to accessing appropriate care (346). Moreover, women were not familiar with perinatal mental health problems and did not consider them an illness (346). Smith et al. echoed these findings and demonstrated that South Asian women were not familiar with psychiatric symptoms in the perinatal period because of poor general knowledge and education about Mental Health Services (97). When I looked at the literature that focused on all types of psychiatric illness, a poor understanding of mental illness was revealed in a study that explored illness perceptions in patients with schizophrenia in Pakistan (347).

Women's identity

When revisiting the findings from the IPA study, I noticed that women's identity appeared to be prominent across many superordinate themes. Women's identity included:

- *the way they were viewed in society and the way they viewed themselves*
- *their identity as a South Asian woman*
- *their identity as a new mother and*
- *their re-defined identity after living through a severe postnatal psychiatric illness.*

Normality

Motherhood is a very normative life experience, one that most women go through without experiencing psychological, emotional or physical problems (348). However, not feeling *"normal"* or not being perceived by others (including their family members) as *"normal"* was experienced by some women in the IPA study. This made living with a severe psychiatric illness after childbirth difficult and instead, women were perceived as marginalised from *"normal"* members of society.

In 1954, Psychologist Leon Festinger proposed Social Comparion Theory suggesting that individuals have an innate drive to evaluate themselves, often in comparison to others (349). Individuals tend to make judgments about themselves and one of the key ways this self appraisal is achieved is in relation to others around them. In most cases, people attempt to compare themselves to others in a similar group or those who share similar characteristics. The IPA study findings can related to Festinger's theory as most women recognised and understood that their experiences were unlike that of most other mothers and the IPA analysis clearly depicted how South Asian mothers perceived themselves as not being "*normal"*. Their

families also recognised their unusual behaviour that fell outside of *normality* and was not in line with their *"normal"* behaviour. Definitions of *normality* and being "*normal"* vary and it is often simpler to identify between what is not *normal* than what is *normal*. In the psychological sense, being *normal* encompasses the need for one to *fit* into and *align* to the rest of their society. Normality is generally perplexing because of the presumptions related to it. Contemporary society often tags *normal* individuals as *"good and healthy"* and *abnormal* individuals as *"bad and unhealthy"*, which can have profound ramifications on the individual, such as public stigma. For psychologist and philosopher Derek Bolton, the term *normal* carries the connotation *"like us"* and *abnormal "not like us"* (350). Thus, psychiatric symptoms can be described as *deviations* from appropriate normative behaviour among contemporary society. Labelled individuals are arranged into categories different from the majority often resulting in separation of *"us"* from the majority *"them"* (351). Clinical psychologist Paula Caplan wrote in her book: *They say you're crazy: How the world's most powerful psychiatrists decide who's normal (1995):*

> *"When terms like abnormality or mentally ill are spoke, what kinds of images comes to mind? Usually, images of difference and alienation, suggesting that 'they' are not competence, human, or safe to be around the rest of 'us.' And often, 'abnormal' and 'mentally ill' are equated with 'crazy', a label that calls forth images of someone who is out of control, out of touch with 'reality,' incapable of forming a good relationship, untrustworthy, quite possibly dangerous, and probably not worth one's attention, time or energy" (352).*

The theoretical framework of Thomas Scheff's sociological theory of mental health is suitable to discuss here (353). Labelling theory was first applied to psychiatry by Scheff in 1966 when he published: *Being Mentally Ill: A Sociological Study* (353). According to Scheff, society has negative perceptions about people with psychiatric illness, which are influenced by non-

verbalised media representations and common stereotypes associated with mental disturbances. Scheff's theory explained deviance as breaching standard cultural norms or rule-breaking (354). Certain behaviours such as not acting *"normal"* in psychiatrically ill individuals can be identified by the public as *deviant*. In order to come to term and understand these actions, the label psychiatric illness is often placed on those who exhibit them; the deviant is the one to whom the label has been successfully applied. Although my study was not specifically designed to confirm or test labelling theory, it is plausible to provide a support for labelling theory. The superordinate and subordinate themes *"I wasn't acting normal", "how many 70-year-old Asians who come from India Pakistan, you know they've never heard of anything like this" and "I didn't really tell anyone"* complements Scheff and Caplan's work. When some South Asian women recollected their family's reactions, findings mirror this sentiment as women were viewed as slipping out of *normality*, markedly a deviant person. Furthermore, it is evident from the subordinate theme *"how many 70-year-old Asians who come from India Pakistan, you know they've never heard of anything like this"* that the concept and knowledge surrounding mental health in a South Asian community may appear to be to an intergenerational difference. In the older generation, it is the lack of knowledge and understanding that has led to negative attitudes and can have more of an impact on the younger generation.

Terms such as *"weird"*, *"mad"* and *"crazy"* were reported in the IPA study by women talking about themselves and discussing the reactions of family members. Generally, lay perceptions of mentally ill people are not the same as psychiatrists identifying clinical *"cases"* who present clinical symptoms (355). Moreover, to represent societal control of mental illness, Horwitz pinpointed the use of labels such as *madness*, *craziness* or *insanity* (356). Community members

(including family members) are usually the primary people that take note that someone is unwell, prior to psychiatric professionals. In line with Scheff, Horwitz also defined *deviance* as behaviour that violates social norms, that is sometimes equated with psychiatric illness.

Moreover, women in my study were apprehensive of how they may be perceived in society. Goffman's modified labelling theory predicts that individuals have societal conceptions of what it means to be a *"mental patient"*, which include perceptions of devaluation, discrimination and stigmatisation (357). Official labelling was apparent in this IPA study when South Asian mothers did not uncover their illness because of the ideas of being *"mentally ill"* and *"weak"*, which became so personally relevant and fostered negative feelings. In line with Goffman's modified labelling theory, this strategy was driven because of the potential impact this would have on them as an individual in a South Asian culture. Stigma is common to all types of psychiatric illnesses and it is greater for people with a severe psychiatric illness (358). Although we are in an era where nationwide we are talking more about mental health in society and in the media, normalising conversations about mental health to help end the stigma and discrimination faced by people, we recognise from the IPA study and the mental health literature that not everyone has benefitted equally from the progress that has been made so far. It is evident from the findings that women from ethnic minority communities still experience stigma and conversations around mental health are sparse and viewed as taboo subjects amongst families and society. Even though the public has become more aware of the nature of different mental health conditions, public stigma appears to be widespread.

Although not unique to women, there is evidence to demonstrate that stigma is greater in women, having a greater impact on their willingness to disclose problems (241). A critical

review of the qualitative literature by Wittkowski et al. aimed to explore psychosis and bipolar disorder in women and found that women tended to try and appear normal to reduce the public stigma. An IPA study by Howe et al. explored service users' experience of receiving a diagnosis of schizophrenia (359). All participants in the study were aware of the potential stigma if their diagnosis became public hence, participants tried to maintain 'normality' and protect themselves from stigma. A sense of wanting to feel *"normal"* was also described by participants in an IPA study of first-episode psychosis (360). *"Appearing normal"* was also a central theme for women with bipolar disorder and psychosis. Similar to Howe et al, this was mainly driven by the fear of stigma (361). Moreover, a qualitative analysis of individuals responding to early psychosis and making sense of psychosis (362). Some women in Howe et al's. study viewed their change of behaviour as *"it was normal"*, thereby indicating that they did not need an intervention. They simply viewed their behaviour as part of who they were rather than immediately recognising it as an illness.

Women's identity as a South Asian woman

Women in the IPA study reported that the notion of normality was held by family members as central to their lives. When they began to slip out of normality, this had the potential to eradicate the family reputation as well as bringing shame upon the family. Some family members, especially the elderly, tried to preserve their perception of the women as normal by dismissing their symptoms; they did not recognise their behaviour as an illness. For example, Namita recalled that her father initially believed that she would be fine and she voiced this was because of the taboo of psychiatric illnesses in the South Asian culture. The work of Ahmed et al. complements my findings (363). Authors outlined cultural issues in the primary care of South Asians and revealed the importance of family values and structures (363). The

embeddedness of *"we"* in South Asian families is typically very firm and represents a common collectivist orientation. There is the consistent reminder of the importance of children bringing credit to the family and problems such as mental health are sources of great shame for the whole family (363). This has been echoed in previous research outlining that a mother with PND can be seen as a risk to the whole family unit (364). Moreover, *"Being subordinate"* was a common theme in a study by Gilbert et al. that aimed to explore the impact of *izzat* (shame), subordination and entrapment on mental health and service use in South Asian women living in Derby (365). As part of South Asian women's experience, the notion of family *izzat* (shame) played a powerful role (365). Women were afraid of bringing shame to others, which was referred to as *reflected shame* (366). In a qualitative study in India that explored perceptions about psychosis and psychiatric services, participants with psychosis were also viewed by their family members as *"normal before this"* or *"abnormal"* and were disinclined to accept *"this"* as a disease (367). When I looked at research conducted on other population groups, Knight et al. conducted a study of people with psychosis experience; their IPA methodology was consonant with this project (368). Authors concluded that participants experienced stigma from a plethora of sources including family members, leading to feeling isolated and *"subsumed"* within society (368).

For some women in my study, an important theme running through their interviews was the sense of obligation they felt to their families and their commitments to fulfilling cultural expectations as a South Asian woman. The findings revealed that women often experienced dual role pressures more than unmarried women. It appeared that marital status was the dominant factor that affected dual role pressures in South Asian women. For example, in addition to being a wife, responsible mother and daughter-in-law, some women were also

expected both to hold employment and take on domestic responsibilities in the household straight after giving birth. Some women were directly asked by family members to fulfil particular duties (such as hosting family gatherings), which made them feel constrained by cultural expectations. Moreover, some women were expected to follow cultural practices in the postnatal period, such as staying indoors after childbirth and following dietary recommendations. These expectations were viewed as challenging for new mothers, whilst living with a severe psychiatric illness after giving birth; some mothers even identified this cultural pressure as a *"trigger"* for their illness. In the early 1990s, Raleigh and Balarajan found that the rigidly defined gender roles in the Indian society led to higher suicide rates among South Asian women in the UK (369). Some of my findings are comparable to the findings of a study conducted by Grewal et al. who used ethnographic methods to examine the influence of family members on immigrant South Asians women's health (370). Findings acknowledged that expected cultural roles and responsibilities often had inimical effects on South Asian women's health. Cultural expectations included producing children soon after marriage, adhering to traditional practices for the well-being and long life of their husbands, being obedient wives, being a full-time working woman, to take responsibility for domestic chores and to maintain the family harmony, ensure smooth functioning and happiness in the family unit and uphold the family *izzat* (honour and respect) in the community (370). Furthermore, findings from a qualitative study by Fenton & Karslen that explored the narratives of causes of mental distress revealed cultural expectations from South Asian women (371). For example, an Indian woman described how her family and the wider Indian community made her feel inadequate that she was not fulfilling familial obligations (371). However, findings from my study demonstrated that although obligations were there, some women did not follow them. For example, whilst living with her illness, Serina became verbally aggressive to senior people, therefore perhaps

their illness was a 'licence' to be aggressive, which may have reinforced her family's sense that she was not 'normal'.

Women's identity as a new mother

Many women view the role of mother as a source of identity, pride and achievement (372). However psychiatric illnesses can impact the mother's parenting skills and abilities (373). Mothers with severe psychiatric illness can face the difficulty both of negotiating their own psychiatric illness and adjusting to their new identity and role as a mother (268). *The Darkest Days of My Life: Stories of Postpartum Depression* (2002) by Natasha S. Maunther is a collection of individual accounts of PND. The findings of my study that were related to motherhood as a social role closely links with Maunther's interpretation:

> *"Whatever their expectations, the women felt deeply disappointed with their experiences of motherhood. They did not turn out to be the perfect mothers they wanted to be, and many were disappointed that their babies were not the peaceful, content little creatures they had anticipated. This discrepancy between their expectation and their experiences was devastating because they interpreted it as a personal failure. Rather than questioning the cultural images that gave rise to their expectations, or challenge the relationships that upheld them, they blamed themselves for being bad mothers" (374).*

As part of living with a severe postnatal psychiatric illness, attempting to fulfil the social role of a mother was naturally enmeshed within women's experience in my study. Some felt their psychiatric illness threatened their identity of being a *"good"* mum to their son or daughter. The difficulties of coping with being a new mother whilst and after living with a severe postnatal psychiatric illness developed from the data and were discussed in the sections titled *"my head was like you're a bad mum"* and *"I was able to care for my baby"*. Most mothers did

not seem to talk about their ideas or expectations of being a mother and instead they concentrated their experiences on a failure to reach their maternal responsibilities. Mothers identified that what they were doing and how they were behaving as wrong and often identified themselves as *"bad"* mothers. Mothers wanted to attend to the needs and care of their baby, however felt their illness prevented them from being a *"good"* mother; hey felt that they had failed to live up to the expectations of being a mother to their baby. The majority of mothers used negative vocabulary to demonstrate their faliure when they tried to engage in their identity as a new mother. Mothers realised that their maternal competencies were overshadowed by the debilitating nature of their illness. Some mothers such as Namita and Serina temporarily lost their identity as a mother when they did not recall their childbirth as their symptoms began to appear. Mothers felt debilitated and labelled themselves as a *"bad mum"*, thus demonstrating an understanding that to be a *"good"* mum, stable mental health is desired. My study findings complement my findings from the literature discussed in chapter 2, in that mothers with PND also labelled themselves as *"bad mothers"* when they were unable to breastfeed. Mothers felt guilt for being unable to fulfil their responsibility for providing for their baby. Moreover, my findings resonate with the majority of the literature in the field that mothers with a psychiatric illness tend to identify themselves as a *"bad mother".* Beck's meta-synthesis revealed that when mothers with PND experienced incongruity between the expectations and reality of motherhood, they viewed themselves as *"bad or abnormal mothers"* (375). My findings from chapter 3 also revealed findings of mothers' sense of failure of being unable to fulfil their role as a mother. This resulted in some mothers feeling *"bitter"* and disappointed and some mothers lacked confidence and this sense of failure also lowered their self-esteem.

Maternal competencies have also been explored in the literature. In a qualitative study by Chiu et al. South Asian mothers with a serious mental illness felt that their mothering responsibilities had been taken away because of their compounding illness experiences (204). When reviewing the small qualitative literature, in a study that examined interactions between depressed mothers and their infants aged three months, these were found to be less responsive to context, less positive, more negative and less frequent (376). Thiels and Kumar found that eight of 26 infants in a London MBU to be definitely or possibly at risk of harm from their mothers (377). There is quantitative literature that addresses the psychiatric status of the mother postpartum and their maternal competencies. Thiels and Kumar found that the severity of psychiatric illness strongly correlates with disturbances of maternal activities (377). Furthermore, a narrative synthesis of qualitative research that reports women's experiences of mothering disrupted by both physical and mental illness found that women's illness disrupted their mothering (372).

A study by Carolan found that women treated being a mother as a major project in their lives and wanted to get it *'right'* (378). Only one out of four of the women I interviewed mentioned a *"good"* way of being a mother. Jiya recognised her new identity as a mother and how she needed to be *"strong"* for her daughter. Regardless of her illness and suffering, she realised she had to remain responsible for her child and create a meaningful relationship. This aligns with previous scholars who found that some mentally ill women cared for and interacted with their infants despite their severe disorganisation their admission to hospital (377, 379). Mothers in this study attempted to *"appear normal"* to keep close to the values of the romantic image of motherhood in Western culture. Mothers wanted to be the 'perfect' mother and did

so by prioritising the needs of their babies, by putting theirs aside. By camouflaging their illness, mothers felt this would secure their identity as a mother.

A previous meta-ethnography included nine studies that explored the transition to motherhood using Noblit and Hare's method of meta-synthesis development (6, 233). Authors developed several thematic categories that represented areas of disruption. The first thematic category included making the decision to mother, feeling the maternal and child bond and accepting responsibility. Secondly, women reported learning motherhood and using role models in their daily life. Thirdly adapting changed relationships with partner, family and friends was described by women. The category self was developed including facing the past, facing oneself and coming to feel like a mum and finally work was reported as a disruption including returning to work and dealing with conflict and search for balance (6). The study found that maternal transition is influenced by many subjective and contextual factors causing women to feel overwhelmed and unprepared to deal with the maternal transition, despite preparatory effort (6). Although this synthesis demonstrated that many mothers share similar components, the transition to motherhood is not experienced the same for all mothers. Therefore the subjective experiences of these women need to be assessed to customise postnatal support for individual's needs. My findings highlight how myths surrounding motherhood prevail in contemporary society. Society can be critical about how well a woman performs her duty as a mother to her children and also expectations as to how a mother should uphold her responsibilities. It seems that the ideology that motherhood is a happy and fulfilling experience permeates in contemporary society, setting women up to developing a sense of failure when they do not meet these expectations.

Women's redefined identity

It is long established in the literature that a loss of identity seems to be a major component in the everyday experiences of severe psychiatric illnesses (380). Psychiatric illnesses are often perceived as an alien influence, which separates the individual from their pre-illness self and may bring about temporary or even permanent destruction of that self and identity (381). Therefore, being diagnosed with a stigmatising illness can have important negative effects on identity and self-definition (382). The superordinate theme *"I've completely lost me"* in my study captured South Asian mothers' identity loss as a result of their diagnoses. Mothers felt that they had lost the person that they used to be before their postnatal psychiatric illness experiences. Findings from my systematic review about women's experiences of severe psychiatric illnesses also revealed identity loss as a theme; mothers felt their severe psychiatric illness after childbirth challenged their personal identity. In a phenomenological hermeneutical study on women's lived experience of PND, Lawler and Sinclair found that women experienced a cycle of grief before they were able to accept their new self (383). The loss of self was also reiterated in a meta-synthesis of qualitative studies exploring the experiences of psychosis by McCarthy-Jones et al. Being labelled with a diagnosis was associated with a change in identity; for example, living with schizophrenia was experienced as dehumanising and devaluing. Moreover, participants felt that clinicians contributed to their loss of self-identity as they did not feel treated like a person with clinicians focusing on symptoms and medication (281). Charis et al. conducted a meta-synthesis of lived experiences of severe mental illness (384). The meaning of mental illness as it was revealed through the experiences of people with severe mental illness encompassed a *"sense of a titanic disruption in one's life…an interruption of life"* (384). Moreover, through the continuum of severe mental disorders, themes such as having one's life stolen loss of identity were identified (384). Similar to some women in my study, loss

of identity seemed to be the main source of suffering as participants felt their previous life had been taken away once and for all (384).

Living with a severe postnatal psychiatric illness

Every woman in this study voiced their experiences of living through their severe postnatal psychiatric illness. Although all women in the study were given with a diagnostic label, this did not appear to be central to understanding their lived experiences. Similar to the women in this study, Luhrmann et al. also found that women in India with schizophrenia tended to use their diagnostic labels less to describe their experiences (385). Despite the diversity of women's lived experiences of their illness, it was revealed that most women described enormous suffering and experienced a harsh encounter. Figure 7 gives an illustration of women's experiences living through their psychiatric illnesses after childbirth:

Figure 7.
Women's experiences living through their psychiatric illnesses

While postnatal psychiatric illness may be a Western concept deriving from a medical disease model, women's illnesses were subjectively experienced. This was also the case in my systematic review that explored women's experiences of severe postnatal psychiatric illnesses (chapter 3). The systematic review findings demonstrated that women felt isolated, abandoned, exhausted, confused and disorientated. Moreover, women experienced thoughts about the baby, which were often distressing and women felt a detachment from reality. Some of my findings from the IPA study can compare to the wider published literature in the field. For example, some women reported experiences of feeling *"low"* and *"down"*, which formed part of the subordinate themes *"I just went crazy"*, *"I don't want to exist"* and *"my head was like you're a bad mum".* This echoes South Asian women's experiences of depression (161). The first stages of a UK study by Burr and Chapman involved discursive descriptions and identified women's subjective feelings of depression in women from South Asian communities (161). Women similarly used the terms *"low"* and *"down"* to describe their experiences of depression (161). Feelings of hopelessness, bleakness and a sense of dissociation from the world were experienced (161). Namita discussed that she mentally felt as though she was "in a different world" which links to a meta-synthesis of qualitative studies by McCarthy-Jones et al., where a theme entitled *"The loss of consensual reality"* captured how the experience of psychosis often leads to a feeling of being in a different reality (281). However, McCarthy-Jones et al. concluded that one of their limitations was the lack of cross-cultural generalisability because their results did not foreground the experiences of culture and religion. Some of the findings from the IPA study demonstrated the importance of the role of culture and religion in women's lived experiences. For example, Serina described that the voices she heard were *"angelical voices"* and she felt *"divinely protected"* despite her thoughts that someone had done *"black magic"* on her. In a study that looked at voice-hearing experiences of people with

psychosis, participants from Chennai talked about the voices they heard as part of their experiences and described the voices as predominantly benign pirits or magical beings, that was predominantly good (385). However, Haniya's thoughts in relation to her religion were experienced in a negative way that impacted her psychological state as she believed her illness experiences was a punishment from God. Previous research has supported this notion that mental illness may also be perceived as a test or punishment from God (386-388).

When South Asian mothers in the IPA study were describing their experiences of living through a severe postnatal psychiatric illness, they described feeling alone, isolated and alienated, again similar to findings reported in chapter 3 that reviewed women's experiences of a severe postnatal psychiatric illness. There is consistent evidence that associates isolation and mental health problems i (389, 390). Fazil and Cochrane found that feelings of social isolation were part of Pakistani women's experiences of depression (391). Gask et al. supported these findings and demonstrated that isolation (which may be determined socially or culturally) was experienced by British Pakistani women with depression (392). However, feeling isolated is an experience that is solely not unique to the South Asian population with psychiatric illnesses. In fact, social isolation and loneliness have also been associated with all types of ill health (389). Feelings of loneliness are greater and social networks are smaller among psychiatric patients than in the general population (393-395). An overview of systematic reviews on the public health consequences of social isolation and loneliness revealed associations with poorer mental health outcomes (389). Previous research has found an association between loneliness, perceived alienation and depression, suicidal behaviour, personality disorders and psychoses such as schizophrenia (396-399). A US-based study found that individuals with higher support

systems (family, friends and professional support) were likely to recovery quicker from a severe mental illness (400).

The notion of somatization whereby psychological distress is represented by the presentation of physical symptoms, is prominent in the literature on South Asian women. Studies have demonstrated that in contrast to their Western counterparts who use 'appropriate' psychological terms, South Asians tend somatise their psychological experiences (401, 402). For example, in a Punjabi community living in Bedford, UK, participants referred to *dil ghirda hai "sinking heart"* (physical sensations in the chest) to explain their mental illness (403). Therefore this Punjabi model of a *"sinking heart"* offers a cultural explanation in transcultural psychiatry (403). A review of depression in South Asian women living in the UK by Hussain and Cochrane also discuss literature on somatization among this population group (401). They reviewed research that supports this notion that South Asian women were more likely to express their problems in physical terminology (401). Beliappa suggested that a holistic model of health and illness should incorporate somatization and not assume a distinction between mind and bodily experiences (404). However, this was not the case for the South Asian women from this IPa study.

South Asian women's multiple models of illness

Some South Asian women in my study constructed explanatory models that did not incorporate information from the dominant Western biomedical paradigm. Findings of the IPA study demonstrated that some women believed in non-medical *"triggers"* for their illness, revealing the complex nature of internal belief systems, which made sense to their local world of meaning. An important part of appraising illness is to make sense of it and patients often search for causes, to which they attribute the onset of an illness (405). These can involve processes that are best understood from biological, psychological and sociocultural perspectives (406). This goes against the incorrect notion that psychiatry can only be understood from one universal perspective (406). Eliciting the patient model gives the physician knowledge of the beliefs that the patient holds about their illness. Kleinman's theory of Explanatory Models (discussed in chapter 1) proposed that although physician's explanatory models of illness are still largely biomedical, patients or individuals who are experiencing illness may have very different explanatory models (407).

I discussed earlier in chapter 1 the multidimensional factors that can contribute to a patient's understanding of their illness. Chapter 2 discussed women's belief system about PND which fell into 2 categories: Western and non-Western. The IPA findings revealed that some women embraced a Westernised biomedical understanding of their illness (Haniya and Jiya) and emphasised hormones and brain structures and other women described non-biomedical understandings. These included cultural expectations, religion and supernaturalism, increased stress, child health and temperament, low levels of husband support, breastfeeding difficulties and sleeplessness. Studies have investigated that explanatory models are influenced by people's social and cultural contexts and prior experiences (164, 165). Among health studies

in South Asian, findings have found that cultural and social factors affect explanatory models of specific diseases such as depression (165).

This IPA research highlights that some second-generation South Asian women who have lived in the UK still hold traditional explanatory models about the causation of their illness. For example, religion was central to the lived experience of Haniya. As part of her belief system, she was the only participant who viewed her illness as a punishment from God, however she also viewed her illness from a medical perspective. There is previous research that has reported that South Asian participants hold contradictory and multiple models of their illness (408). In a study that explores explanatory models in British South Asians, participants also help multi-explanatory models about their psychotic illnesses (209). Participants understood their illness in term of their cultural and religious beliefs, but also about what they knew about psychotic illnesses from medical contexts (209). The belief in the supernatural, black magic, *"nazar or jadoo"* was another non-biomedical conceptualisation that helped some women understand their psychiatric illnesses after childbirth in this study. This is supported in the literature on South Asian women with a severe psychiatric illness outside of the postnatal period, in India and Pakistan, whereby women attributed their illness to a supernatural cause (409-413).

Moreover, a qualitative study from India that explored perceptions about psychosis implied that participants were also more likely to *"see psychosis as the result of karmic deeds, magico-religious influences and family influences"* (367). Religious and supernatural conceptualisations were also mentioned by South Asian women with schizophrenia living in Toronto (414). Typically, those with a religious/supernatural/spiritual attribution seek traditional healers to

recover from their illness (415). Singh et al. conducted an observational study that statistically examined the influence of culturally mediated illness attributions in patients with psychosis. Findings revealed that Asian patients were: a) more likely to report supernatural attributions that White British patients and b) more likely to consult faith-based institutions than White British patients (416). Furthermore, another recent quantitative study by Mirza et al. (2019) aimed to examine cultural differences in psychosis between White British and South Asians in the UK (417). Supporting their hypothesis, findings of this study revealed that South Asians reported higher beliefs in supernatural causes than White British participants. Authors concluded that there needs to be greater culture-sensitive understanding of mental health among ethnic minorities with psychosis, including the South Asian population group (417). These findings also revealed that South Asians were less likely to contact mental health services, which mirror the official statistics in the UK in 2016/2017. Asian and Asian British were 30% less likely than average to have accessed an NHS mental health service, compared to White British (418). A reason for this may be because ethnic minorities such as South Asians may turn to traditional modes such as faith services, before turning to Western services providing medication and therapy (419).

2. What are South Asian women's experiences of Perinatal Mental Health Services, care and support?

Healthcare experiences

Similar to the multiple explanatory models discussed above, a crucial finding from the IPA study findings that some participants concurrently used their existing culturally specific and religious coping strategies and the evidence-based treatment offered by the health services. All of the women were under the care of Perinatal Mental Health Services in London or Birmingham areas either as an inpatient or an outpatient. As mentioned in chapter 1 this is the recommended treatment pathway according to the UK NICE guidelines for new mothers with severe and enduring postnatal psychiatric illnesses. Although there are recommended guidelines for treatment, evidence does suggest that women from an ethnic minority background tend to underutilise services, despite their disproportionaite risk factors. Values and beliefs held by individuals from ethnic minority communities may impact their willingness to access help from mainstream services. For example, Wynaden and colleagues found that shame and stigma, causes of mental health, family reputation, hiding up, seeking help and a lack of collaboration influenced access to care, also echoed by the IPA findings (207). Similarly, a study examined factors that affected intention to access psychological services in a sample of British South Asians indicated that shame/izzat predicted lesser intent to access services. On the other hand, however, it was also higher levels of education and acculturation predicted greater intention to psychological services (420).

In a study that compared cultural differences in psychosis in a sample of White British and South Asians, White British reported more previous contact with mental health services than

South Asians. Additionally, they also reported lower stigma. Authors argued a greater cultural sensitive understanding of mental health to reach ethnic minorities with psyshosis (417). There is also research that investigates the subjective views of South Asian patients about mental health service experiences and how they may be improved. Findings from a qualitative study revealed that South Asian service users felt continuous insensitivity towards their particular needs and moreover felt unsafe to share their particular concerns (421). To improve services, service users suggested financing of culturally appropriate services, further development of cultural competence staff and education about mental health directed at minority communities.

Women in the IPA study spoke both positively and negatively about their Perinatal Mental healthcare experiences. Firstly, some mothers felt that as an inpatient they were able to maintain their identity as a mother and were able to care for their baby, which allowed them to bond with their baby. However, at times, inpatient mothers felt debilitated by their medication, unable to care for their baby; they also often reported the lack of practical help and support from nurses. Similar findings were evident in a survey by Nair et al. (422). 37 women who had previously been admitted to an MBU, women reported areas that can be improved, which included increased practical support availability (422). Secondly, Some South Asian mothers in the IPA study had differing opinions in relation to how they felt understood by healthcare professionals as she was in a setiing where people understood postnatal psychiatric illnesses. Haniya and Serina felt that healthcare professionals were dismissive, similar to other, South Asian mothers with PND in a UK study (245).

It was very clear from the IPA analysis that Jiya spoke very highly of Perinatal Mental Health Services and described the services as *"impeccable"*. In contrast to other women in the study, she felt the healthcare professionals got to know her as an individual as well as her family members; her access to outpatient appointments were easy. Her overall experience was extremely positive. Although the qualitative literature is sparse on women's experiences of Perinatal Mental Health services, a study in New Zealand explored patient experience of a psychiatric MBU (423). A thematic analysis revealed that patients were satisfied with co-admission with their infant, staff warmth and availability, transparent practice, the inclusion of family members and having a comfortable environment (423). Moreover, women felt they received practical support with caregiving and a range of therapeutic approaches in their treatment plan (423). There is some quantitative literature that has examined patient satisfaction of Perinatal Mental Health Services, including MBUs. Generally, patient satisfaction with MBUs has been documented to be positive and preferable to general psychiatric wards (424). A previous survey revealed that women were most satisfied with baby equipment, arrangements for visitors, partner involvement with baby, appearance of the ward, privacy and waiting times (424). Similarly, Antonysamy et al. (2009) surveyed 57 women and found that mothers were satisfied with baby care, baby equipment and advice on child development (425).

Culturally competent services

It has been reported in the UK NICE guidelines that as part of ethnic minority women's postnatal treatment, they should be provided with culturally sensitive information and treatment (16). Moreover, the Equality Act 2010 states that NHS treatment and care, including the care for perinatal mental health problems, should be equitable and no person should be discriminated against on the basis of their ethnicity. Although some South Asian mothers in the IPA study such as Jiya, were happy with the care and support received, others clearly identified negative issues, such as a lack of cultural competency in Perinatal Mental Health Services. A key subordinate theme *"they were not culturally sound"* reflected some South Asian mother's experiences in relation to culturally appropriate ways of caring for baby, generic treatment plans and a lack of cultural awareness from members of the clinical team. For example, Aaryaa described in her interview that it is not permissible for her husband to change the baby's diaper, due to her daughter's dignity. This was not understood by the care team and instead they encouraged her father to become more involved in childcare duties. There is some existing research on the failure of Perinatal Mental Health services to adequately meet the culturally specific needs of South Asians women. Watson et al. (2019) conducted a systematic review of ethnic minority women's experiences of perinatal mental health conditions, which also included their experiences of Perinatal Mental Health Services (346). Similar to the IPA study findings, a theme that emerged from the literature was entitled *"Lack of culturally appropriate services" (346)*. Issues that were identified by South Asian women included culturally insensitive services, the services that were facilitated by male providers and lack of healthcare professionals from ethnic minority backgrounds. However, when support groups were facilitated by someone from the same ethnic background, women felt the sessions were culturally competent and sensitive (346). Overall, women in this study suggested

that healthcare professionals would benefit from training in cultural competency (346). Moreover, in a study that was included in chapter 2, South Asian mothers living in Great Britain felt that they were not understood by healthcare professionals and reported a lack of cultural and religious insensitivity (245). Wittkowski et al. concluded that a greater awareness is needed of the various cultural and religious needs and sensitivities of South Asian mothers in the postnatal period (245). Takegata et al. identified factors of perinatal depression that were unique to the Indian population such as living only with the husband, pregnancy not welcomed by the husband, a female baby, and poor relationship with in-laws (426). These findings highlighted the importance of incorporating these factors in culture-specific interventions (426).

Not only has a lack of cultural competency been identified in South Asian women receiving treatment during the childbearing period, but this is also the case when South Asian patients received care and treatment for their psychiatric illness at other times. For example, Ric Bowl conducted a qualitative study with Pakistani and Indian service users diagnosed with schizophrenia, psychosis and depression on their experiences of mental health services (421). Patients reported insensitivity towards their needs and wanted more resources for competent services (421). Bowl concluded that UK mental health services yet remain unresponsive to the views of South Asian services users and that a major cultural change is needed (421). Bhikha et al. explored models of psychosis amongst British South Asians (209). Participants were of South Asian origin, which included Bangladeshi, Indian or Pakistani and were diagnosed with schizophrenia or schizoaffective disorder (209). Few patients cited biological factors and the majority of patients attributed their illness to a supernatural cause (209). Authors concluded the importance of culturally adapted psychological interventions and possibly working

collaboratively with traditional healers in the UK (209). Furthermore, Agius et al. (2010) identified issues regarding the delivery of early intervention psychiatric services to the South Asian population in England (427). In comparison to their Caucasian or Afro-Caribbean counterparts, South Asian patients were more likely to miss their outpatient appointments. The Bangladeshi subgroup missed more appointments and had a higher rated of medication refusal than other South Asian subgroups (427). Therefore this study revealed findings that demonstrated that South Asians used psychiatric services different to other ethnic groups and so, authors suggested that interventions should be adapted and tailored to the cultural and language barriers of this group (427).

Given the lack of cultural sensitivity reported by South Asian patients receiving treatment for their psychiatric illness, studies have documented the effectiveness of culturally adapted treatment options for South Asian women experiencing psychiatric illnesses within and outside of the postnatal period. A recent study demonstrated the effectiveness of culturally competent care for South Asian mothers with PND, such as culturally adapted CBT (329). Authors assessed the overall acceptability and overall experience of the Positive Health Programme in a group of British South Asian mothers with PND (329). Overall, mothers reported a positive experience and found the intervention acceptable, thus supporting the argument that culturally sensitive care can lead to better overall outcomes. For example, women were able to speak in their mother tongue, information was provided in patients' language, women's specific cultural issues were understood by the facilitator (329). A qualitative study aimed to explore Pakistani patients' carer' and healthcare professionals views to culturally adapt CBT for psychosis (428). The results revealed that patients and their carers used a bio-psycho-spiritual-social model of illness, so therapists should make minor adjustments in the therapy (428). The establishment

of the first dedicated MBU was started in Bengaluru, India. The MBU was an adaptation of a Western model to meet local cultural and resource needs (107). In keeping in line with the local cultural traditions, mothers and their babies were admitted with an additional family member (usually a woman) for additional support (107).

Coping strategies

Together with using statutory Perinatal Mental Health Services, some South Asian women in my IPA study also maintained cultural and religious coping strategies such as dietary regimens, home remedies, prayers and rituals. Therefore, there was the idea that South Asian women were combining two types of *"treatments"* to achieve a holistic approach in life. My findings revealed that religiosity can have a positive impact on facilitating coping with psychological disorders. There is empirical evidence that has demonstrated religion and faith as traditional healing in conjunction with Western medicine, which was employed by women in my IPA study, to help with experiences (415). Although there is a wealth of literature to demonstrate the efficacy of religion coping for the general population, such as prayer and meditation, the literature is not uniformly positive, as individuals can also report negative experiences with religiosity, including disillusionment with one's faith (429).

The integration of Western medicine with traditional health practices was also reported in research that explored health practices in South Asian Canadian women (430). Although these women were not diagnosed with a severe psychiatric illness, there is some overlap with our findings that relate to traditional health practices in the South Asian culture to maintain health. Choosing to use traditional health practices were influenced by family members, the nature of the severity, beliefs and prior experiences and the feasibility of using these practices (430).

Findings in Dein and Sembhi's study demonstrated the importance of hot and cold foods as a common treatment to address humoral imbalances. Findings from this study can also be discussed in relation to the humoral theory of disease in that foods can be manipulated to restore the balance of hot and cold states. Serina avoided *"hot"* foods that were to be eaten after childbirth, as she believed her temperament was already too *"hot"* because of the medication thus, the regulation of her food intake protected her against her illness.

Alternative coping strategies such as seeking traditional healing in collaboration with Western medicine were previously investigated by Dein and Sembhi in a group of South Asian psychiatric patients in the London Borough of Waltham Forest (415). Their findings demonstrated that South Asian psychiatric patients did resort to various forms of traditional healing in conjunction with professional psychiatry (415). Authors discussed their findings in relation to globalisation and modernisation, implying that despite the global hegemony of Western medicine, local healing practices still survive in many parts of the world (415). They suggested that this may be because local healing addresses the links between illness and social, moral and religious events (431). However, the South Asian women in this study living in the UK who believed in religion and supernaturalism did not consult a traditional healer for treatment and instead adhered to Western treatment and developed their own coping straregies. From a psychological stance, an explanation for this may be *Acculturation* developed by John Beryy's (1997) acculturation framework (432). Acculturation refers to the changes that occur when individuals from one culture come into contact with individuals from another culture (433). According to Berry's framework, there are two dimensions:

1. The degree of participation within the mainstream culture
2. The degree of maintenance of heritage culture

The discrepancy of some women's belief systems and their adherence to treatment maybe because they are in the process of acculturation by managing two conflicting cultures. The model views acculturation as a continuum, whereby an individual's cultural identity changes over time and results in values and beliefs from the heritage culture being replaced by the mainstream culture. Gordon proposed that one's heritage culture eventually becomes diluted as that individual assimilates into the host culture.

Conclusion

This IPA empirical study intended to phenomenologically capture how South Asian women who lived through a severe psychiatric illness after childbirth made sense of their experiences. Findings from the in-depth, rich interviews included interesting insights into the value of this type of research inquiry and it appears that the inductive methodology of IPA enabled me to develop these insights.

By studying the totality of South Asian women's lived experiences, qualitative studies consider and offer possible explanations of the complex interplay of contextual, interpersonal and cultural factors and how this influence, impacts and maintains women's illnesses. Rather than simply being an individual problem, living with a severe postnatal psychiatric illness is part of the larger societal issues, for example the socially constructed nature of ideal motherhood. All women constructed their own models of their illness, which were based on their personal understandings and beliefs. The findings of my study suggest that some factors that play a unique role in the experiences of South Asian women with a severe postnatal psychiatric illness. These included cultural expectations of having children by a certain age after marriage, postnatal healing traditions such as eating certain warming foods, being unable to leave the house until 40 days after childbirth for healing purposes, feeling guilty of not following religious teachings and thus experiencing postnatal mental illnesses as a punishment from God and the supernatural phenomena of black magic. Additional factors that were unique to the South Asian culture were also reflected in Chapter 2, such as dietary restrictions, cultural preference for males to be born and the existence of evil spirits. It is important to note that no women in chapter 3 reported cultural or religious factors when speaking about their experience.

Therefore, my IPA study has contributed to the evidence base and demonstrated the various factors that can contribute to South Asian women's experiences of a similar health-related illness. Clinicians should be aware of these various concepts in order to meet women's needs, beliefs and treatment preferences and achieve culturally competent care.

Strengths and limitations

Limitations

Whilst my IPA study provided fascinating insights into South Asian women's lived experiences, like any qualitative study, it does not come without limitations and these will be addressed and discussed. Firstly, although the South Asian population share common practices, beliefs and rituals, they are in reality a culturally diverse and heterogeneous group. There are many sub-groups and religious groups that have their own language, practices and histories. These differences should not be ignored and should be investigated further.

Secondly, IPA is committed to idiography, which allows for a more in-depth and detailed exploration of a small selection of participants with similar characteristics. While this does focus on the quality of the individual's personal life-world, it is limiting in that it does not allow for generalisability. IPA is cautious of claiming the transferability of results to the wider population. However rather than an empirical generalisability, findings can be linked on a theoretical level and connect with the extant literature. Whilst we could have recruited more participants into the study, the problem with larger samples for an IPA study is that it can hinder the comprehensive idiographic focus. IPA advocates that *"less is more"*. This research

supports the need for continued small-scale projects that explore human experiences and help to understand of human life by analysing rich and in-depth accounts of real-life people.

Thirdly, this research study only included English speaking women because of limited funding sources. There are numerous South Asian non-English speaking women in the UK who may also share similar experiences. Their expression in their mother tongue may also be valuable to explore as this may reveal additional factors that have not been discussed in this study, such as language barriers and the need for interpreters etc. Moreover, women's expression of illness may be different from the way English speaking South Asian women express their illness.

Strengths

Despite the limitations discussed above, my IPA study also has many strengths. Firstly, a major strength is that this is the first study to explore South Asian women's experiences of severe postnatal psychiatric illnesses and South Asian women's experiences of Perinatal Mental Health services, care and support. Employing the methodology of IPA is a great starting point to gain an in-depth understanding of women's' experiences.

Secondly, the involvement of a study team including academic supervisors, clinicians and services users' strengthened the development of the study design and study materials. Moreover, this also strengthened the analysis process and the development of the superordinate and subordinate themes, which enhances the trustworthiness and reliability of the study findings. This allowed for discussion around the development of the themes, to ensure they reflect women's lived experiences as truthfully as possible.

Implications for clinical practice and future research

Implications for clinical practice

Firstly, a note of caution: this is a study of five women and as stressed in the outset, they may not be representative of the whole South Asian population, or other population groups. However, the strength of the research and prominence of the findings in the literature, both generally and in regards to postnatal psychiatric illnesses, suggest one can perhaps look at possible clinical implications of the study, which are suggested below.

Cultural competency in healthcare

The study findings revealed that there are many elements to culture and religion, which can influence the development, expression and overall illness experiences of South Asian women during the childbearing period. Moreover, ethnicity and culture can affect women's help seeking behaviours for mental health problems and many women do not access services because they feel services are not sensitive to their beliefs. Thus, it is important that services meet the needs and preferences expressed by women. Western-trained healthcare professionals should continually be provided with culturally competent training so they are fully aware and educated and well equipped in providing culturally competent and individualised care. This includes understanding patient explanatory models and understanding the traditional remedies among the South Asian population. This can increase overall patient satisfaction, cultural sensitivity and the reduction of health disparities in a superdiverse setting. Services can involve women from ethnic minorities in the design of future research and the co-production of policies, interventions and services to ensure that services

are shaped to meet women's needs and preferences. This includes both English and non-English speaking women from ethnic minority groups.

Individualised care

It is vital that women with moderate to severe perinatal mental illness are involved in decisions about their treatment and that there are a wide range of options available. This will ensure that treatment and care is individualsed and tailored to the patient and where appropriate to their family and friends. This patient centered care should be respectful of, responsive to individual patient preferences, needs and values. This approach must also ensure that patient values are at the forefront of all clinical decisions and have clear knowledge of their treatment pathway. By giving patients the autonomy in their treatment plan, this may increase engagement with services and acceptability of services.

Information needs for new mothers

To psychologically prepare women for the transition to motherhood, closer involvement with existing family members may facilitate women's preparation for taking on the role of a new mother (434). Additionally, women from a South Asian background could be provided with information across the continuum of the antenatal and postnatal period and about psychiatric illnesses for themselves, their friends and relatives. This should include information about the recognition of signs and symptoms of psychiatric illnesses and available health and support types and treatment options. This may increase earlier recognition of symptoms and quicker access to care. Moreover, if women's families know the symptoms to look out for, they may be more likely to seek help if required. Information about Perinatal Mental Health Services should also be provided during the antenatal period to make women aware of the support

available. This could be provided in a leaflet as participants in the IPA study suggested, in an information booklet that can be given to women during antenatal appointments. These leaflets can also be available at GP practices, health or baby clinics and/or pre-conception counselling sessions. Furthermore, information materials should be available in different languages as language may continue to be a barrier preventing some women from ethnic minority backgrounds accessing care. For women who do not speak sufficient English, qualified interpreters should be available during consultations to ensure understanding.

Normalising mental health

Furthermore, it is important to communicate to women that they are not alone if they experience a psychiatric illness after childbirth. This can be effectively achieved through portraying experiences of others via communications and group sessions, or case example which women can identify and relate to. Efforts to publish personal accounts that focus on patient stories and experiences could be helpful. In particular, stories that provide examples of individuals recovering from psychiatric illnesses may be important guidance and hope for patients with severe mental illness. If such information around motherhood was available to women before and after childbirth, there would be greater awareness of the possible challenges and possibly normalise women's experiences. This opportunity to connect with other similar mothers might allow new mothers to talk openly about their difficulties and access help and support, as opposed to feeling of being a *"bad mother"*. Moreover, there seems to be stigma associated with perinatal mental health problems. There is a need for more openness and transparency on the subject so that partners and family members can support women who require perinatal mental health services.

Implications for future research

The findings of my study can inform areas of future research:

- Firstly, as addressed in the limitations sections, the Indian, Pakistani and Bangladeshi sub-groups that make up the South Asian culture each have their own unique religious and cultural conceptualisation that can be important to some women's expression and experiences of psychiatric illnesses, for example through somatisation and physical expression. Therefore, future research studies can explore postnatal psychiatric illnesses in sub-groups within the South Asian culture and employ research methodologies that achieve generalisability. This will provide a clearer understanding of the heterogeneity between the different cultural groups and help tailor services to meet the needs of women, which could encourage women from ethnic minority groups to seek help.

- Secondly, also addressed in the limitations section, this study did not include non-English speaking women. Future studies should focus on the exploration of non-English speaking South Asian women affected by postnatal psychiatric illnesses, which may reveal additional understandings that were not reported by English speaking women in this research study. These findings should be published in different languages, so that women who do not speak English are able to access journal articles that are published in their native languages.

- Thirdly, future research should consider clinicians' understanding of cultural competency and what they believe to be 'culturally competent services'. From this

data, training materials and training programmes can be developed that enhance clinicians understanding of cultural competency. It is helpful for clinicians to have some anthropological knowledge about cultural systems when the patient and clinician are from different ethnic backgrounds. Not only will this increase respect and mutual undersrandings, but also decrease any unwanted surprise that may hinder treatment and management progress.

- Fourthly, research studies using qualitative methods should explore the impact and experiences of family members/partners who care for women with a severe perinatal mental illness. Including their own understanding of mental health in general, any support they received as a carer and their own knowledge of Perinatal Mental Health Services. This may identify how mental health is conceptualised and viewed in society and also any additional barriers that prevent women in accessing services.

Thesis conclusion

Overall, my PhD thesis has explored the following:

- *Women's beliefs about the causes of PND*
- *Women's experiences of a severe postnatal psychiatric illness and,*
- *South Asian women's experiences of a severe postnatal psychiatric illness and experiences of Perinatal Mental Health Services, in the UK.*

Women's beliefs about what caused their depression after childbirth varied from biological influences to the social, cultural and spiritual. Therefore, this supports scholars who argue for studying women's subjective explanatory models of their illness, in order to gain a transparent understanding. Women's experiences of a severe postnatal psychiatric illness also varied, although many women had shared experiences such as loneliness, exhaustion and disturbing thoughts about harming their baby. However, a major limitation of the literature review s presented in chapters 2 and 3 was that the studies only included White British or White European mothers hence, the role of culture/religion was not reported. Given that South Asian women are the largest ethnic minority group within UK Perinatal Mental Health Services, my IPA study was designed to explore South Asian women's lived experiences. The findings both complemented women's experiences outlined in chapter 3 and added new findings in the literature that culture and religion can influence women's experiences living with a severe postnatal psychiatric illness and also experiences of Perinatal Mental Health Services, care and support. New mothers' experiences are important to understanding so that they receive individualised culturally competent care, for optimal outcomes for the mother and her infant. When we return back to the introduction of this thesis, the importance of asking individual questions to understand experience within a healthcare setting in a superdiverse era has been

highlighted. My IPA study has demonstrated that despite being from a similar ethnic background, all patient experiences are unique. Thus, the importance of asking subjective and open ended questions elicits a better understanding and allows the patient to be treated as an individual, which is an important component of their care.

References

1. Geldof D. Superdiversity as a lens to understand complexities. The Routledge Handbook of Language and Superdiversity. 2018:43.
2. Edge D. Perinatal mental health care for black and minority ethnic (BME) women: a scoping review of provision in England. Ethnicity and Inequalities in Health and Social Care. 2010;3(3):24-32.
3. Smith JA. Identity development during the transition to motherhood: An interpretative phenomenological analysis. Journal of reproductive and infant psychology. 1999;17(3):281-99.
4. Makkar D. Postpartum Depression—An Overview. Pan. 2018;1(2):11-7.
5. Nicolson P. Postnatal depression: Facing the paradox of loss, happiness and motherhood: John Wiley & Sons; 2011.
6. Nelson AM. Transition to motherhood. Journal of Obstetric, Gynecologic, & Neonatal Nursing. 2003;32(4):465-77.
7. Rallis S, Skouteris H, McCabe M, Milgrom J. The transition to motherhood: towards a broader understanding of perinatal distress. Women and Birth. 2014;27(1):68-71.
8. Jones I, Chandra PS, Dazzan P, Howard LM. Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. The Lancet. 2014;384(9956):1789-99.
9. Grover S, Sahoo S, Chakrabarti S, Basu D, Singh SM, Avasthi A. ECT in the postpartum period: A retrospective case series from a tertiary health care center in India. Indian journal of psychological medicine. 2018;40(6):562.
10. O'Hara MW, Wisner KL. Perinatal mental illness: definition, description and aetiology. Best Practice & Research Clinical Obstetrics & Gynaecology. 2014;28(1):3-12.
11. Ford E, Lee S, Shakespeare J, Ayers S. Diagnosis and management of perinatal depression and anxiety in general practice: a meta-synthesis of qualitative studies. Br J Gen Pract. 2017;67(661):e538-e46.
12. Stocky A, Lynch J. Acute psychiatric disturbance in pregnancy and the puerperium. Best Practice & Research Clinical Obstetrics & Gynaecology. 2000;14(1):73-87.
13. Adams SM. Psychiatric Complications in the Postpartum Period. Obstetric Triage and Emergency Care Protocols. 2017:365.
14. Susman JL. Postpartum depressive disorders. Journal of Family Practice. 1996;43(6):S17-S.
15. Brockington I. Postpartum psychiatric disorders. The Lancet. 2004;363(9405):303-10.
16. Health NCCfM, editor Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance: Updated edition2014: British Psychological Society.
17. England N. NHS Standard Contract for Specialised Perinatal Mental Health Services. Leeds: NHS England. 2013.
18. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstetrics & Gynecology. 2005;106(5):1071-83.
19. O'hara MW, Swain AM. Rates and risk of postpartum depression—a meta-analysis. International review of psychiatry. 1996;8(1):37-54.
20. Zambaldi CF, Cantilino A, Montenegro AC, Paes JA, de Albuquerque TLC, Sougey EB. Postpartum obsessive-compulsive disorder: prevalence and clinical characteristics. Comprehensive psychiatry. 2009;50(6):503-9.
21. Ross LE, McLean LM. Anxiety disorders during pregnancy and the postpartum period: A systematic review. The Journal of clinical psychiatry. 2006.
22. Grekin R, O'Hara MW. Prevalence and risk factors of postpartum posttraumatic stress disorder: a meta-analysis. Clinical psychology review. 2014;34(5):389-401.
23. Farr SL, Dietz PM, O'Hara MW, Burley K, Ko JY. Postpartum anxiety and comorbid depression in a population-based sample of women. Journal of Women's Health. 2014;23(2):120-8.

24. Howard LM, Molyneaux E, Dennis C-L, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. The Lancet. 2014;384(9956):1775-88.
25. Seyfried LS, Marcus S. Postpartum mood disorders. International Review of Psychiatry. 2003;15(3):231-42.
26. Dalton K. Depression after childbirth: how to recognize and treat postnatal illness: Oxford University Press, USA; 1989.
27. Association AP. Diagnostic and statistical manual of mental disorders (DSM-5®): American Psychiatric Pub; 2013.
28. Lee DT, Chung TK. Postnatal depression: an update. Best Practice & Research Clinical Obstetrics & Gynaecology. 2007;21(2):183-91.
29. Chivers ML, Pittini R, Grigoriadis S, Villegas L, Ross LE. The relationship between sexual functioning and depressive symptomatology in postpartum women: a pilot study. The journal of sexual medicine. 2011;8(3):792-9.
30. Beck CT. The lived experience of postpartum depression: a phenomenological study. Nursing research. 1992.
31. Beck CT. Predictors of postpartum depression: an update. Nursing research. 2001;50(5):275-85.
32. Onozawa K, Kumar R, Adams D, Dore C, Glover V. High EPDS scores in women from ethnic minorities living in London. Archives of Women's Mental Health. 2003;6(2):s51-s5.
33. Klainin P, Arthur DG. Postpartum depression in Asian cultures: a literature review. International journal of nursing studies. 2009;46(10):1355-73.
34. Falah-Hassani K, Shiri R, Dennis C-L. Prevalence and risk factors for comorbid postpartum depressive symptomatology and anxiety. Journal of affective disorders. 2016;198:142-7.
35. Paschetta E, Berrisford G, Coccia F, Whitmore J, Wood AG, Pretlove S, et al. Perinatal psychiatric disorders: an overview. American Journal of Obstetrics and Gynecology. 2014;210(6):501-9. e6.
36. Simpson W, Glazer M, Michalski N, Steiner M, Frey BN. Comparative efficacy of the generalized anxiety disorder 7-item scale and the Edinburgh Postnatal Depression Scale as screening tools for generalized anxiety disorder in pregnancy and the postpartum period. The Canadian Journal of Psychiatry. 2014;59(8):434-40.
37. Misri S, Abizadeh J, Sanders S, Swift E. Perinatal generalized anxiety disorder: assessment and treatment. Journal of Women's Health. 2015;24(9):762-70.
38. Wenzel A, Haugen E, Jackson L, Robinson K. Prevalence of generalized anxiety at eight weeks postpartum. Archives of women's mental health. 2003;6(1):43-9.
39. Reck C, Noe D, Gerstenlauer J, Stehle E. Effects of postpartum anxiety disorders and depression on maternal self-confidence. Infant Behavior and Development. 2012;35(2):264-72.
40. Stein A, Lehtonen A, Harvey AG, Nicol-Harper R, Craske M. The influence of postnatal psychiatric disorder on child development. Psychopathology. 2009;42(1):11-21.
41. Tietz A, Zietlow A-L, Reck C. Maternal bonding in mothers with postpartum anxiety disorder: the crucial role of subclinical depressive symptoms and maternal avoidance behaviour. Archives of women's mental health. 2014;17(5):433-42.
42. Goodman JH, Watson GR, Stubbs B. Anxiety disorders in postpartum women: a systematic review and meta-analysis. Journal of Affective Disorders. 2016;203:292-331.
43. McGuinness M, Blissett J, Jones C. OCD in the perinatal period: Is postpartum OCD (ppOCD) a distinct subtype? A review of the literature. Behavioural and cognitive psychotherapy. 2011;39(3):285-310.
44. Abramowitz JS, Meltzer-Brody S, Leserman J, Killenberg S, Rinaldi K, Mahaffey BL, et al. Obsessional thoughts and compulsive behaviors in a sample of women with postpartum mood symptoms. Archives of women's mental health. 2010;13(6):523-30.
45. Uguz F, Ayhan MG. Epidemiology and clinical features of obsessive-compulsive disorder during pregnancy and postpartum period: a review. Journal of Mood Disorders. 2011;1(4):178.

46. Wisner KL, Peindl KS, Gigliotti T, Hanusa BH. Obsessions and compulsions in women with postpartum depression. The Journal of clinical psychiatry. 1999;60(3):176-80.
47. House SJ, Tripathi SP, Knight BT, Morris N, Newport DJ, Stowe ZN. Obsessive-compulsive disorder in pregnancy and the postpartum period: course of illness and obstetrical outcome. Archives of women's mental health. 2016;19(1):3-10.
48. Brandes M, Soares C, Cohen L. Postpartum onset obsessive-compulsive disorder: diagnosis and management. Archives of Women's Mental Health. 2004;7(2):99-110.
49. Ballard C, Stanley A, Brockington I. Post-traumatic stress disorder (PTSD) after childbirth. The British Journal of Psychiatry. 1995;166(4):525-8.
50. Olde E, van der Hart O, Kleber R, Van Son M. Posttraumatic stress following childbirth: a review. Clinical psychology review. 2006;26(1):1-16.
51. Simpson M, Schmied V, Dickson C, Dahlen HG. Postnatal post-traumatic stress: An integrative review. Women and Birth. 2018;31(5):367-79.
52. Anniverno R, Bramante A, Mencacci C, Durbano F. Anxiety disorders in pregnancy and the postpartum period. New insights into anxiety disorders: IntechOpen; 2013.
53. Beck CT. Post-traumatic stress disorder due to childbirth: the aftermath. Nursing research. 2004;53(4):216-24.
54. Andersen LB, Melvaer LB, Videbech P, Lamont RF, Joergensen JS. Risk factors for developing post-traumatic stress disorder following childbirth: a systematic review. Acta obstetricia et gynecologica Scandinavica. 2012;91(11):1261-72.
55. Furuta M, Sandall J, Bick D. A systematic review of the relationship between severe maternal morbidity and post-traumatic stress disorder. BMC pregnancy and childbirth. 2012;12(1):125.
56. Plowright L. Tyano, S., Keren, M., Herrman, H., Cox, J.(eds). Parenthood and mental health (a bridge between infant and adult psychiatry). Springer; 2011.
57. Austin M, Highet N, Committee GEA. The beyondblue clinical practice guidelines for depression and related disorders—anxiety, bipolar disorder and puerperal psychosis—in the perinatal period. A guideline for primary care health professionals providing care in the perinatal period Melbourne: beyondblue: the national depression initiative. 2011.
58. Fenech G, Thomson G. Tormented by ghosts from their past': a meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. Midwifery. 2014;30(2):185-93.
59. McKenzie-McHarg K, Ayers S, Ford E, Horsch A, Jomeen J, Sawyer A, et al. Post-traumatic stress disorder following childbirth: an update of current issues and recommendations for future research. Journal of Reproductive and Infant Psychology. 2015;33(3):219-37.
60. Parfitt YM, Ayers S. The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent–baby bond. Journal of Reproductive and Infant Psychology. 2009;27(2):127-42.
61. Pawlby S, Sharp D, Hay D, O'Keane V. Postnatal depression and child outcome at 11 years: the importance of accurate diagnosis. Journal of affective disorders. 2008;107(1-3):241-5.
62. Ayers S. Thoughts and emotions during traumatic birth: a qualitative study. Birth. 2007;34(3):253-63.
63. Beck CT. Postpartum onset of panic disorder. Image: the Journal of Nursing Scholarship. 1998;30(2):131-5.
64. Beck CT, Driscoll J. Postpartum mood and anxiety disorders: A clinician's guide: Jones & Bartlett Learning; 2006.
65. Beck CT. A checklist to identify women at risk for developing postpartum depression. Journal of Obstetric, Gynecologic, & Neonatal Nursing. 1998;27(1):39-46.
66. Wisner KL, Peindl KS, Hanusa BH. Effects of childbearing on the natural history of panic disorder with comorbid mood disorder. Journal of Affective Disorders. 1996;41(3):173-80.
67. Byrnes L. Perinatal mood and anxiety disorders. The Journal for Nurse Practitioners. 2018;14(7):507-13.

68. Howard LM, Megnin-Viggars O, Symington I, Pilling S. Antenatal and postnatal mental health: summary of updated NICE guidance. Bmj. 2014;349:g7394.
69. Musters C, McDonald E, Jones I. Management of postnatal depression. Bmj. 2008;337:a736.
70. Tomruk NB, Saatcioglu O. Treatment Challenges in Schizophrenia in The Perinatal Period and Infanticide. Klinik Psikofarmakoloji Bülteni-Bulletin of Clinical Psychopharmacology. 2010;20(3):266-8.
71. Wesseloo R, Kamperman AM, Munk-Olsen T, Pop VJ, Kushner SA, Bergink V. Risk of postpartum relapse in bipolar disorder and postpartum psychosis: a systematic review and meta-analysis. American Journal of Psychiatry. 2015;173(2):117-27.
72. Doyle M, Carballedo A, O'Keane V. Perinatal depression and psychosis: an update. BJPsych Advances. 2015;21(1):5-14.
73. Zdanowicz A, Wierzbinski P. Psychotic depression. PSYCHIATRIA I PSYCHOLOGIA KLINICZNA-JOURNAL OF PSYCHIATRY AND CLINICAL PSYCHOLOGY. 2017;17(2):115-9.
74. Almond P. Postnatal depression: a global public health perspective. Perspectives in public health. 2009;129(5):221-7.
75. Jennings KD, Ross S, Popper S, Elmore M. Thoughts of harming infants in depressed and nondepressed mothers. Journal of affective disorders. 1999;54(1-2):21-8.
76. Miller LJ. Postpartum mood disorders: American Psychiatric Association; 1999.
77. Netsi E, Pearson RM, Murray L, Cooper P, Craske MG, Stein A. Association of persistent and severe postnatal depression with child outcomes. JAMA psychiatry. 2018;75(3):247-53.
78. Kendell R, Chalmers J, Platz C. Epidemiology of puerperal psychoses. The British Journal of Psychiatry. 1987;150(5):662-73.
79. Heron J, McGuinness M, Blackmore ER, Craddock N, Jones I. Early postpartum symptoms in puerperal psychosis. BJOG: An International Journal of Obstetrics & Gynaecology. 2008;115(3):348-53.
80. Essali A, Alabed S, Guul A, Essali N. Preventive interventions for postnatal psychosis. Cochrane Database of Systematic Reviews. 2013(6).
81. Sit D, Rothschild AJ, Wisner KL. A review of postpartum psychosis. Journal of women's health. 2006;15(4):352-68.
82. VanderKruik R, Barreix M, Chou D, Allen T, Say L, Cohen LS. The global prevalence of postpartum psychosis: a systematic review. BMC psychiatry. 2017;17(1):272.
83. Brockington I. Motherhood and mental health Oxford University Press Oxford Google Scholar. 1996.
84. Chaudron LH, Pies RW. The relationship between postpartum psychosis and bipolar disorder: a review. The Journal of clinical psychiatry. 2003;64(11):1284-92.
85. Freeman M, Gelenberg A. Bipolar disorder in women: reproductive events and treatment considerations. Acta Psychiatrica Scandinavica. 2005;112(2):88-96.
86. Rusner M, Berg M, Begley C. Bipolar disorder in pregnancy and childbirth: a systematic review of outcomes. BMC pregnancy and childbirth. 2016;16(1):331.
87. Yonkers KA, Wisner KL, Stowe Z, Leibenluft E, Cohen L, Miller L, et al. Management of bipolar disorder during pregnancy and the postpartum period. American Journal of Psychiatry. 2004;161(4):608-20.
88. Seeman MV. Schizophrenia during pregnancy and the postpartum period. Current Clinical Practice: Psychiatric Disorders in Pregnancy and the Postpartum: Principles and Treatment. 2006:139-52.
89. Robinson GE. Treatment of schizophrenia in pregnancy and postpartum. Journal of Population Therapeutics and Clinical Pharmacology. 2012;19(3).
90. Vigod SN, Ross LE. Epidemiology of psychotic symptoms during pregnancy and postpartum in women with schizophrenia. Current Women's Health Reviews. 2010;6(1):17-21.
91. Snellen M, Mack K, Trauer T. Schizophrenia, mental state, and mother—infant interaction: examining the relationship. Australian and New Zealand Journal of Psychiatry. 1999;33(6):902-11.

92. Wan MW, Warren K, Salmon MP, Abel KM. Patterns of maternal responding in postpartum mothers with schizophrenia. Infant Behavior and Development. 2008;31(3):532-8.
93. Solari H, Dickson KE, Miller L. Understanding and treating women with schizophrenia during pregnancy and postpartum. Journal of Population Therapeutics and Clinical Pharmacology. 2009;16(1).
94. Rai S, Pathak A, Sharma I. Postpartum psychiatric disorders: Early diagnosis and management. Indian journal of psychiatry. 2015;57(Suppl 2):S216.
95. Closa-Monasterolo R, Gispert-Llaurado M, Canals J, Luque V, Zaragoza-Jordana M, Koletzko B, et al. The effect of postpartum depression and current mental health problems of the mother on child behaviour at eight years. Maternal and child health journal. 2017;21(7):1563-72.
96. Parameshwaran S, Chandra PS. Will the DSM-5 and ICD-11 “Make-over” really make a difference to women's mental health? Indian Journal of Social Psychiatry. 2018;34(5):79.
97. Smith MS, Lawrence V, Sadler E, Easter A. 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. 2019;9(1):e024803.
98. Robertson E, Lyons A. Living with puerperal psychosis: A qualitative analysis. Psychology and psychotherapy: Theory, research and practice. 2003;76(4):411-31.
99. Gillham R, Wittkowski A. Outcomes for women admitted to a mother and baby unit: a systematic review. International journal of women's health. 2015;7:459.
100. Cazas O, Glangeaud-Freudenthal N-C. The history of mother-baby units (MBUs) in France and Belgium and of the French version of the Marcé checklist. Archives of women’s mental health. 2004;7(1):53-8.
101. Elkin A, Gilburt H, Slade M, Lloyd-Evans B, Gregoire A, Johnson S, et al. A national survey of psychiatric mother and baby units in England. Psychiatric Services. 2009;60(5):629-33.
102. Kumar R. Evolution of psychiatric services for mentally ill childbearing women. Journées biannuelles des unités mère-bébé, La Sorbonne, Paris. 1997.
103. Baker A, Morison M, Game J, Thorpe J. Admitting schizophrenic mothers with their babies. The Lancet. 1961;278(7196):237-9.
104. Meltzer-Brody S, Brandon AR, Pearson B, Burns L, Raines C, Bullard E, et al. Evaluating the clinical effectiveness of a specialized perinatal psychiatry inpatient unit. Archives of women's mental health. 2014;17(2):107-13.
105. Howard L, Shah N, Salmon M, Appleby L. Predictors of social services supervision of babies of mothers with mental illness after admission to a psychiatric mother and baby unit. Social Psychiatry and Psychiatric Epidemiology. 2003;38(8):450-5.
106. Glangeaud-Freudenthal N-C, Group M-SW. Mother-baby psychiatric units (MBUs): national data collection in France and in Belgium (1999–2000). Archives of women’s mental health. 2004;7(1):59-64.
107. Chandra PS, Desai G, Reddy D, Thippeswamy H, Saraf G. The establishment of a mother-baby inpatient psychiatry unit in India: Adaptation of a Western model to meet local cultural and resource needs. Indian journal of psychiatry. 2015;57(3):290.
108. Stephenson LA, Macdonald AJ, Seneviratne G, Waites F, Pawlby S. Mother and Baby Units matter: improved outcomes for both. BJPsych Open. 2018;4(3):119-25.
109. Stickley T, Wright N. Theories for mental health nursing: a guide for practice: Sage; 2013.
110. Adams F, Society S. The Genuine Works of Hippocrates: Sydenham Society; 1849.
111. Miller LJ. Postpartum depression. Jama. 2002;287(6):762-5.
112. Brockington I. A historical perspective on the psychiatry of motherhood. Perinatal stress, mood and anxiety disorders: From bench to bedside (Bibliotheca Psychiatrica). 2005:1-5.
113. Demand N. Birth, death, and motherhood in classical Greece: JHU Press; 1994.
114. Hallett C. The attempt to understand puerperal fever in the eighteenth and early nineteenth centuries: the influence of inflammation theory. Medical history. 2005;49(1):1-28.

115. Fleming J. Semmelweis Commemoration: Puerperal Fever: The Historical Development of its Treatment. SAGE Publications; 1966.
116. Tasca C, Rapetti M, Carta MG, Fadda B. Women and hysteria in the history of mental health. Clinical practice and epidemiology in mental health: CP & EMH. 2012;8:110.
117. Mason-Hohl E. The Diseases of Women, by Trotula of Salerno: A Translation of Passionibus Mulierum Curandorum by Elizabeth Mason-Hohl, MD. Los Angeles, Ward Ritchie Press; 1940.
118. Littlewood J, McHugh N. Maternal distress and postnatal depression: the myth of Madonna: Macmillan International Higher Education; 1997.
119. Freeman PR, Bogarad CR, Sholomskas DE. Margery Kempe, a new theory: the inadequacy of hysteria and postpartum psychosis as diagnostic categories. History of Psychiatry. 1990;1(2):169-90.
120. Oates M. Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. British medical bulletin. 2003;67(1):219-29.
121. Esquirol E. Mental maladies; A treatise on insanity: Lea and Blanchard; 1845.
122. Hamilton JA. Postpartum psychiatric problems. Academic Medicine. 1962;37(5):528.
123. Strecker EA, Ebaugh FG. Psychoses occurring during the puerperium. Archives of Neurology & Psychiatry. 1926;15(2):239-52.
124. McWilliam W. Psychoses occurring during the Puerperium.(Arch. of Neur. and Psychiat., February, 1926.) Strecker, EA, and Ebaugh, FG. Journal of Mental Science. 1926;72(298):424-5.
125. Freud S. The psychogenesis of a case of female homosexuality. International Journal of Psycho-Analysis. 1920;1(2):129-30.
126. Zilboorg G. Post-partum schizophrenias. The Journal of Nervous and Mental Disease. 1928;68(4):370-83.
127. Zilboorg G. Malignant psychoses related to childbirth. American Journal of Obstetrics & Gynecology. 1928;15(2):145-58.
128. Cohen LS, O'Hara MW. Postpartum Depression: Causes and Consequences: Springer New York; 1994.
129. Cohen CI. The biomedicalization of psychiatry: A critical overview. Community Mental Health Journal. 1993;29(6):509-21.
130. Mauthner NS. It's a woman's cry for help': A relational perspective on postnatal depression. Feminism & Psychology. 1998;8(3):325-55.
131. Hamed S, Attiah F. Peripartum Psychological Distress Conditions and Disorders: Biopsychosocial View. Journal of Neurology and Psychiatric Disorders. 2019;1(1).
132. Elwood J, Murray E, Bell A, Sinclair M, Kernohan WG, Stockdale J. A systematic review investigating if genetic or epigenetic markers are associated with postnatal depression. Journal of affective disorders. 2019;253:51-62.
133. Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M. Postpartum depression risk factors: A narrative review. Journal of education and health promotion. 2017;6.
134. McInerney S. Introducing the biopsychosocial model for good medicine and good doctors. BMJ. 2015;324:1533.
135. Organization WH. Social determinants of mental health: World Health Organization. 2014.
136. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977;196(4286):129-36.
137. Engel GL, editor The clinical application of the biopsychosocial model. The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine; 1981: Oxford University Press.
138. Borrell-Carrió F, Suchman AL, Epstein RM. The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. The Annals of Family Medicine. 2004;2(6):576-82.
139. Organization WH. Towards a common language for functioning, disability, and health: ICF. The international classification of functioning, disability and health. 2002.
140. Toombs SK. The meaning of illness: A phenomenological approach to the patient-physician relationship. The Journal of medicine and philosophy. 1987;12(3):219-40.

141. Buultjens M, Murphy G, Robinson P, Milgrom J. The perinatal period: A literature review from the biopsychosocial perspective. Clinical Nursing Studies. 2013;1(3):19-31.
142. Saxbe DE. Birth of a new perspective? A call for biopsychosocial research on childbirth. Current Directions in Psychological Science. 2017;26(1):81-6.
143. Mastrogianni A, Bhugra D. Globalization, cultural psychiatry and mental distress. Sage Publications; 2003.
144. Benning TB. Limitations of the biopsychosocial model in psychiatry. Advances in Medical Education and practice. 2015;6:347.
145. IPA O. Exploring lived experience. Psychologist. 2005;18(1):20.
146. David DH, Styron T, Davidson L. Supported parenting to meet the needs and concerns of mothers with severe mental illness. American Journal of Psychiatric Rehabilitation. 2011;14(2):137-53.
147. Holopainen A, Hakulinen T. Easing the transition to parenthood: the importance of perinatal and postnatal mental health for mothers and fathers. JBI Evidence Synthesis. 2019;17(9):1727-8.
148. Greenhalgh T. Patient and public involvement in chronic illness: beyond the expert patient. Bmj. 2009;338.
149. Shaw J, Baker M. “Expert patient”—dream or nightmare? : British Medical Journal Publishing Group; 2004.
150. Koivisto K, Janhonen S, Vaisanen L. Patients’ experiences of psychosis in an inpatient setting. Journal of Psychiatric and Mental Health Nursing. 2003;10(2):221-9.
151. Conrad P. Qualitative research on chronic illness: a commentary on method and conceptual development. Social Science & Medicine. 1990;30(11):1257-63.
152. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS medicine. 2006;3(10):e294.
153. Hall P. Mothers' experiences of postnatal depression: an interpretative phenomenological analysis. Community Practitioner. 2006;79(8):256.
154. Grigoriadis S, Robinson GE, Fung K, Ross LE, Chee C, Dennis C-L, et al. Traditional postpartum practices and rituals: Clinical implications. The Canadian Journal of Psychiatry. 2009;54(12):834-40.
155. Kleinman A. “Everything that really matters”: social suffering, subjectivity, and the remaking of human experience in a disordering world. Harvard Theological Review. 1997;90(3):315-36.
156. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. Journal of the National Medical Association. 2008;100(11):1275-85.
157. Jacob KS. Perspectives about mental health, illness, and recovery. Current opinion in psychiatry. 2017;30(5):334-8.
158. Kirkpatrick H. A narrative framework for understanding experiences of people with severe mental illnesses. Archives of Psychiatric Nursing. 2008;22(2):61-8.
159. Connelly FM, Clandinin DJ. Stories of experience and narrative inquiry. Educational researcher. 1990;19(5):2-14.
160. Ussher JM. Are we medicalizing women’s misery? A critical review of women’s higher rates of reported depression. Feminism & Psychology. 2010;20(1):9-35.
161. Burr J, Chapman T. Contextualising experiences of depression in women from South Asian communities: a discursive approach. Sociology of Health & Illness. 2004;26(4):433-52.
162. Kleinman A. Rethinking psychiatry: Simon and Schuster; 2008.
163. Bhui K, Bhugra D. Explanatory models for mental distress: implications for clinical practice and research. RCP; 2002.
164. Blaxter M. The causes of disease: women talking. Social science & medicine. 1983;17(2):59-69.
165. Karasz A. Cultural differences in conceptual models of depression. Social science & medicine. 2005;60(7):1625-35.
166. Pill R, CH SN. Choice or change: Further evidence on ideas of illness and responsibility for health. Social Science & Medicine. 1985;20(10):981-91.

167. Higgins A, Downes C, Monahan M, Gill A, Lamb SA, Carroll M. Barriers to midwives and nurses addressing mental health issues with women during the perinatal period: The Mind Mothers study. Journal of clinical nursing. 2018;27(9-10):1872-83.
168. Wittkowski A, Patel S, Fox JR. The experience of postnatal depression in immigrant mothers living in Western countries: A meta-synthesis. Clinical psychology & psychotherapy. 2017;24(2):411-27.
169. Tirodkar MA, Baker DW, Makoul GT, Khurana N, Paracha MW, Kandula NR. Explanatory models of health and disease among South Asian immigrants in Chicago. Journal of immigrant and minority health. 2011;13(2):385-94.
170. Ugarriza DN. Postpartum depressed women's explanation of depression. Journal of Nursing Scholarship. 2002;34(3):227-33.
171. Lindenmeyer A. 11 Using superdiversity as a lens to view migrant health. Ethical, Legal and Social Aspects of Healthcare for Migrants: Perspectives from the UK and Germany. 2018:114.
172. Howard R. Transcultural issues in puerperal mental illness. International Review of Psychiatry. 1993;5(2-3):253-60.
173. Gopalkrishnan N. Cultural diversity and mental health: Considerations for policy and practice. Frontiers in public health. 2018;6.
174. Fernando S. Race and culture in psychiatry (Psychology Revivals): Routledge; 2014.
175. Biswas J, Gangadhar B, Keshavan M. Cross cultural variations in psychiatrists' perception of mental illness: A tool for teaching culture in psychiatry. Asian journal of psychiatry. 2016;23:1-7.
176. Templeton L, Velleman R, Persaud A, Milner P. The experiences of postnatal depression in women from black and minority ethnic communities in Wiltshire, UK. Ethnicity & health. 2003;8(3):207-21.
177. Thakker J, Ward T, Strongman K. Mental disorder and cross-cultural psychology: A constructivist perspective. Clinical Psychology Review. 1999;19(7):843-74.
178. Gopalkrishnan N. Cultural diversity and mental health: Considerations for policy and practice. Frontiers in public health. 2018;6:179.
179. Tylor EB. Primitive culture: researches into the development of mythology, philosophy, religion, art, and custom: J. Murray; 1871.
180. Johnson TM, Hardt EJ, Kleinman A. Cultural factors in the medical interview. The medical interview: Springer; 1995. p. 153-62.
181. Hernandez M, Nesman T, Mowery D, Acevedo-Polakovich ID, Callejas LM. Cultural competence: A literature review and conceptual model for mental health services. Psychiatric Services. 2009;60(8):1046-50.
182. Ware NC, Kleinman A. Culture and somatic experience: the social course of illness in neurasthenia and chronic fatigue syndrome. Psychosomatic medicine. 1992;54(5):546-60.
183. Bains J. Race, culture and psychiatry: A history of transcultural psychiatry. History of Psychiatry. 2005;16(2):139-54.
184. Kleinman AM. Depression, somatization and the "new cross-cultural psychiatry". Social Science & Medicine (1967). 1977;11(1):3-9.
185. Gaw A. Culture, ethnicity, and mental illness: American Psychiatric Pub; 1993.
186. Littlewood R. From categories to contexts: a decade of the 'new cross-cultural psychiatry'. The British Journal of Psychiatry. 1990;156(3):308-27.
187. Hechanova R, Waelde L. The influence of culture on disaster mental health and psychosocial support interventions in Southeast Asia. Mental Health, Religion & Culture. 2017;20(1):31-44.
188. Nguyen D, Bornheimer LA. Mental health service use types among Asian Americans with a psychiatric disorder: Considerations of culture and need. The journal of behavioral health services & research. 2014;41(4):520-8.
189. Nilaweera I, Doran F, Fisher J. Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: a systematic review of the evidence. Journal of Affective Disorders. 2014;166:213-26.

190. Patel V, Rodrigues M, DeSouza N. Gender, poverty, and postnatal depression: a study of mothers in Goa, India. American journal of Psychiatry. 2002;159(1):43-7.
191. Kumar R. Postnatal mental illness: a transcultural perspective. Social psychiatry and psychiatric epidemiology. 1994;29(6):250-64.
192. Arifin SRM, Cheyne H, Maxwell M. Review of the prevalence of postnatal depression across cultures. AIMS public health. 2018;5(3):260.
193. Bina R. The impact of cultural factors upon postpartum depression: a literature review. Health Care for Women International. 2008;29(6):568-92.
194. Cox JL. Perinatal mental disorder—a cultural approach. International Review of Psychiatry. 1996;8(1):9-16.
195. Oates MR, Cox JL, Neema S, Asten P, Glangeaud-Freudenthal N, Figueiredo B, et al. Postnatal depression across countries and cultures: a qualitative study. The British journal of psychiatry. 2004;184(S46):s10-s6.
196. James S, Prilleltensky I. Cultural diversity and mental health: Towards integrative practice. Clinical Psychology Review. 2002;22(8):1133-54.
197. Bhugra D, Bhui K. Cross-cultural psychiatric assessment. Advances in Psychiatric Treatment. 1997;3(2):103-10.
198. Bhugra D. Severe mental illness across cultures. Acta Psychiatrica Scandinavica. 2006;113(s429):17-23.
199. Campinha-Bacote J. Cultural competence in psychiatric mental health nursing. A conceptual model. The Nursing Clinics of North America. 1994;29(1):1-8.
200. Ramadas S, Kumar R. Postnatal depression: a narrative review. International Journal of Culture and Mental Health. 2016;9(2):97-107.
201. Pargament KI. APA Handbook of Psychology, Religion, and Spirituality: American Psychological Assoc.; 2013.
202. Morley J. Taking religious experience seriously. Philosophy, Psychiatry, & Psychology. 2006;13(3):201-3.
203. Jung CG, Jung C, Dell WS, Baynes CF, Dell WW, William Stanley Dell CGJCFB, et al. Modern Man in Search of a Soul: Harcourt, Brace & World; 1933.
204. Chiu L, Morrow M, Ganesan S, Clark N. Spirituality and treatment choices by South and East Asian women with serious mental illness. Transcultural Psychiatry. 2005;42(4):630-56.
205. Lamba R. A Qualitative Study Exploring Migrant Pakistani-Muslim Women's Lived Experiences and Understanding of Postnatal Depression: University of East London; 2015.
206. Malik R. Counselling and ancient belief systems. Race and cultural education in counselling. 1998.
207. Wynaden D, Chapman R, Orb A, McGowan S, Zeeman Z, Yeak S. Factors that influence Asian communities' access to mental health care. International Journal of Mental Health Nursing. 2005;14(2):88-95.
208. Razali S, Khan U, Hasanah C. Belief in supernatural causes of mental illness among Malay patients: impact on treatment. Acta psychiatrica scandinavica. 1996;94(4):229-33.
209. Bhikha A, Farooq S, Chaudhry N, Naeem F, Husain N. Explanatory models of psychosis amongst British South Asians. Asian journal of psychiatry. 2015;16:48-54.
210. McCabe R, Priebe S. Explanatory models of illness in schizophrenia: comparison of four ethnic groups. The British Journal of Psychiatry. 2004;185(1):25-30.
211. Thippeswamy H, Dahale A, Desai G, Chandra PS. What is in a name? Causative explanatory models of postpartum psychosis among patients and caregivers in India. International Journal of Social Psychiatry. 2015;61(8):818-23.
212. Hanely J, Brown A. Cultural variations in interpretation of postnatal illness: Jinn possession amongst Muslim communities. Community mental health journal. 2014;50(3):348-53.
213. Vertovec S. Super-diversity and its implications. Ethnic and racial studies. 2007;30(6):1024-54.

214. Fernando S, Keating F. Mental health in a multi-ethnic society: A multidisciplinary handbook: Routledge; 2008.
215. Knight M, Tuffnell D, Kenyon S, Shakespeare J, Gray R, Kurinczuk JJ. Saving lives, improving mothers' care: Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland. Confidential enquiries into maternal deaths and morbidity 2009-13. 2015.
216. England N. Five year forward view. 2014. 2016.
217. NHS England NI, National Collaborating Centre for Mental Health, National Collaborating Centre for Mental. The Perinatal Mental Health Care Pathways. NHS England; 2018.
218. Halvorsrud K, Nazroo J, Otis M, Hajdukova EB, Bhui K. Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. BMC medicine. 2018;16(1):1-17.
219. Barnett P, Mackay E, Matthews H, Gate R, Greenwood H, Ariyo K, et al. Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. The Lancet Psychiatry. 2019;6(4):305-17.
220. Cheng A, Fujitake E, Koo JM, Rahman A, Cai W, Li YM, et al. Ethnic differences in compulsory admissions for psychiatric disorders in the UK: a systematic review and meta-analysis. The British Student Doctor Journal. 2018;2(2):3-16.
221. Jarvis GE, Iyer SN, Andermann L, Fung KP. Culture and psychosis in clinical practice. A Clinical Introduction to Psychosis: Elsevier; 2020. p. 85-112.
222. Norhayati M, Hazlina NN, Asrenee A, Emilin WW. Magnitude and risk factors for postpartum symptoms: a literature review. Journal of affective Disorders. 2015;175:34-52.
223. Husain N, Bevc I, Husain M, Chaudhry I, Atif N, Rahman A. Prevalence and social correlates of postnatal depression in a low income country. Archives of women's mental health. 2006;9(4):197-202.
224. Murray L, Cooper PJ. Effects of postnatal depression on infant development. Archives of disease in childhood. 1997;77(2):99-101.
225. Boath E, Pryce A, Cox J. Postnatal depression: the impact on the family. Journal of Reproductive and Infant Psychology. 1998;16(2-3):199-203.
226. Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. General hospital psychiatry. 2004;26(4):289-95.
227. Ross LE, Sellers E, Gilbert Evans S, Romach M. Mood changes during pregnancy and the postpartum period: development of a biopsychosocial model. Acta Psychiatrica Scandinavica. 2004;109(6):457-66.
228. Bloch M, Daly RC, Rubinow DR. Endocrine factors in the etiology of postpartum depression. Comprehensive psychiatry. 2003;44(3):234-46.
229. Dennis CL, Hodnett ED. Psychosocial and psychological interventions for treating postpartum depression. Cochrane database of systematic reviews. 2007(4).
230. Brown GW, Bifulco A, Harris TO. Life events, vulnerability and onset of depression: some refinements. The British Journal of Psychiatry. 1987;150(1):30-42.
231. Kendler KS, Karkowski LM, Prescott CA. Causal relationship between stressful life events and the onset of major depression. American Journal of Psychiatry. 1999;156(6):837-41.
232. Kleinman A. Suffering, healing and the human condition. Encyclopedia of Human Biology. 1988.
233. Noblit GW, Hare RD. Meta-ethnography: Synthesizing qualitative studies: sage; 1988.
234. Cooke A, Smith D, Booth A. Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qualitative health research. 2012;22(10):1435-43.
235. CASP U. Critical appraisal skills programme: Making Sense of Evidence. See: www casp-ulr net (Accessed: 21/12/2014]. 2013.
236. Long AF, Godfrey M. An evaluation tool to assess the quality of qualitative research studies. International Journal of Social Research Methodology. 2004;7(2):181-96.

237. Chan SWC, Levy V, Chung TK, Lee D. A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. Journal of Advanced Nursing. 2002;39(6):571-9.
238. Edhborg M, Friberg M, Lundh W, Widström A-M. ``Struggling with life'': Narratives from women with signs of postpartum depression. Scandinavian journal of public health. 2005;33(4):261-7.
239. Rodrigues M, Patel V, Jaswal S, De Souza N. Listening to mothers: qualitative studies on motherhood and depression from Goa, India. Social science & medicine. 2003;57(10):1797-806.
240. Kathree T, Selohilwe OM, Bhana A, Petersen I. Perceptions of postnatal depression and health care needs in a South African sample: the “mental” in maternal health care. BMC women's health. 2014;14(1):140.
241. Patel S, Wittkowski A, Fox JR, Wieck A. An exploration of illness beliefs in mothers with postnatal depression. Midwifery. 2013;29(6):682-9.
242. Savarimuthu R, Ezhilarasu P, Charles H, Antonisamy B, Kurian S, Jacob K. Post-partum depression in the community: a qualitative study from rural South India. International Journal of Social Psychiatry. 2010;56(1):94-102.
243. Edhborg M, Nasreen HE, Kabir ZN. “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. 2015;10(1):26226.
244. Habel C, Feeley N, Hayton B, Bell L, Zelkowitz P. Causes of women’ s postpartum depression symptoms: Men’ s and women’ s perceptions. Midwifery. 2015;31(7):728-34.
245. Wittkowski A, Zumla A, Glendenning S, Fox J. The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. Journal of Reproductive and Infant Psychology. 2011;29(5):480-92.
246. Callister LC, Beckstrand RL, Corbett C. Postpartum depression and help-seeking behaviors in immigrant Hispanic women. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2011;40(4):440-9.
247. Mamisachvili L, Ardiles P, Mancewicz G, Thompson S, Rabin K, Ross LE. Culture and postpartum mood problems: Similarities and differences in the experiences of first-and second-generation Canadian women. Journal of transcultural nursing. 2013;24(2):162-70.
248. Lam E, Wittkowski A, Fox JR. A qualitative study of the postpartum experience of Chinese women living in England. Journal of Reproductive and Infant Psychology. 2012;30(1):105-19.
249. Chan S, Levy V. Postnatal depression: A qualitative study of the experiences of a group of Hong Kong Chinese women. Journal of Clinical Nursing. 2004;13(1):120-3.
250. Chen CH, Wang SY, Chung UL, Tseng YF, Chou FH. Being reborn: The recovery process of postpartum depression in Taiwanese women. Journal of Advanced Nursing. 2006;54(4):450-6.
251. Leung S, Arthur DG, Martinson I. Stress in women with postpartum depression: a phenomenological study. Journal of Advanced Nursing. 2005;51(4):353-60.
252. Thurtle V. First time mothers' perceptions of motherhood and PND. Community Practitioner. 2003;76(7):261.
253. Ball JA. Postnatal care and adjustment to motherhood. Midwives, research and childbirth: Springer; 1989. p. 154-75.
254. Organization WH. Gender and mental health. 2002.
255. Skalkidou A, Hellgren C, Comasco E, Sylvén S, Poromaa IS. Biological aspects of postpartum depression. Women’s health. 2012;8(6):659-72.
256. Corwin EJ, Johnston N, Pugh L. Symptoms of postpartum depression associated with elevated levels of interleukin-1 beta during the first month postpartum. Biological research for nursing. 2008;10(2):128-33.
257. Khalsa SR, McCarthy KS, Sharpless BA, Barrett MS, Barber JP. Beliefs about the causes of depression and treatment preferences. Journal of Clinical Psychology. 2011;67(6):539-49.

258. Spiro ME. Cultural determinism, cultural relativism, and the comparative study of psychopathology. Ethos. 2001;29(2):218-34.
259. Tucker CM, Arthur TM, Roncoroni J, Wall W, Sanchez J. Patient-centered, culturally sensitive health care. American Journal of Lifestyle Medicine. 2015;9(1):63-77.
260. LeMasters K, Dussault J, Barrington C, Bengtson A, Gaynes B, Go V, et al. " Pain in my heart": Understanding perinatal depression among women living with HIV in Malawi. PloS one. 2020;15(6):e0227935.
261. Johansson M, Benderix Y, Svensson I. Mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth: a qualitative study. International journal of qualitative studies on health and well-being. 2020;15(1):1722564.
262. Ng'oma M, Meltzer-Brody S, Chirwa E, Stewart RC. "Passing through difficult times": Perceptions of perinatal depression and treatment needs in Malawi-A qualitative study to inform the development of a culturally sensitive intervention. PloS one. 2019;14(6):e0217102.
263. Park VMT, Goyal D, Suen J, Win N, Tsoh JY. Chinese American women's experiences with postpartum depressive symptoms and mental health help-seeking behaviors. MCN: The American Journal of Maternal/Child Nursing. 2019;44(3):144-9.
264. Chandra PS, Bhargavaraman R, Raghunandan V, Shaligram D. Delusions related to infant and their association with mother–infant interactions in postpartum psychotic disorders. Archives of women's mental health. 2006;9(5):285-8.
265. Riordan D, Appleby L, Faragher B. Mother–infant interaction in post-partum women with schizophrenia and affective disorders. Psychological medicine. 1999;29(4):991-5.
266. Hipwell A, Goossens F, Melhuish E, Kumar R. Severe maternal psychopathology and infant–mother attachment. Development and psychopathology. 2000;12(2):157-75.
267. Doucet S, Jones I, Letourneau N, Dennis C-L, Blackmore ER. Interventions for the prevention and treatment of postpartum psychosis: a systematic review. Archives of women's mental health. 2011;14(2):89-98.
268. Dolman C, Jones I, Howard LM. Pre-conception to parenting: a systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. Archives of women's mental health. 2013;16(3):173-96.
269. Latif Z. The maternal mental health of migrant women. Race Equality Foundation; 2014. Report No.: 31.
270. Engqvist I, Ferszt G, Åhlin A, Nilsson K. Women's experience of postpartum psychotic episodes—analyses of narratives from the Internet. Archives of Psychiatric Nursing. 2011;25(5):376-87.
271. Heron J, Gilbert N, Dolman C, Shah S, Beare I, Dearden S, et al. Information and support needs during recovery from postpartum psychosis. Archives of women's mental health. 2012;15(3):155-65.
272. Wyatt C, Murray C, Davies J, Jomeen J. Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others. Journal of Reproductive and Infant Psychology. 2015;33(4):426-42.
273. Barr JA, Beck CT. Infanticide secrets: qualitative study on postpartum depression. Canadian Family Physician. 2008;54(12):1716-7. e5.
274. Glover L, Jomeen J, Urquhart T, Martin CR. Puerperal psychosis–a qualitative study of women's experiences. Journal of Reproductive and Infant Psychology. 2014;32(3):254-69.
275. Doucet S, Letourneau N, Blackmore ER. Support needs of mothers who experience postpartum psychosis and their partners. Journal of Obstetric, Gynecologic & neonatal nursing. 2012;41(2):236-45.
276. Edwards E, Timmons S. A qualitative study of stigma among women suffering postnatal illness. Journal of Mental Health. 2005;14(5):471-81.
277. McGrath L, Peters S, Wieck A, Wittkowski A. The process of recovery in women who experienced psychosis following childbirth. BMC psychiatry. 2013;13(1):341.

278. Chandra PS, Venkatasubramanian G, Thomas T. Infanticidal ideas and infanticidal behavior in Indian women with severe postpartum psychiatric disorders. The Journal of nervous and mental disease. 2002;190(7):457-61.
279. Ali E. Women's experiences with postpartum anxiety disorders: a narrative literature review. International journal of women's health. 2018;10:237.
280. Murray L, Finn M. Good mothers, bad thoughts: New mothers' thoughts of intentionally harming their newborns. Feminism & Psychology. 2012;22(1):41-59.
281. McCarthy-Jones S, Marriott M, Knowles R, Rowse G, Thompson AR. What is psychosis? A meta-synthesis of inductive qualitative studies exploring the experience of psychosis. Psychosis. 2013;5(1):1-16.
282. Bell AF, Andersson E. The birth experience and women's postnatal depression: A systematic review. Midwifery. 2016;39:112-23.
283. Schmied V, Black E, Naidoo N, Dahlen HG, Liamputtong P. Migrant women's experiences, meanings and ways of dealing with postnatal depression: a meta-ethnographic study. PloS one. 2017;12(3):e0172385.
284. Coleman P, Nelson E, Sundre D. The relationship between prenatal expectations and postnatal attitudes among first-time mothers. Journal of Reproductive and Infant Psychology. 1999;17(1):27-39.
285. Anderson FM, Hatch SL, Comacchio C, Howard LM. 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. 2017;20(3):449-62.
286. Geekie J, Read J. Making Sense of Madness: Contesting the Meaning of Schizophrenia: Taylor & Francis; 2009.
287. Leedy PD, Ormrod JE. Practical Research: Planning and Design: Pearson Education; 2013.
288. Creswell JW. Five qualitative approaches to inquiry. Qualitative inquiry and research design: Choosing among five approaches. 2007;2:53-80.
289. Fraser H. Doing narrative research: Analysing personal stories line by line. Qualitative social work. 2004;3(2):179-201.
290. Squire C, Andrews M, Davis M, Esin C, Harrison B, Hyden L-C, et al. What is narrative research?: Bloomsbury Publishing; 2014.
291. Glasser B. Advances in the methodology of grounded theory. Theoretical sensitivity San Francisco: University of California. 1978.
292. Urquhart C. Grounded theory for qualitative research: A practical guide: Sage; 2012.
293. Petty NJ, Thomson OP, Stew G. Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. Manual therapy. 2012;17(5):378-84.
294. Reeves S, Kuper A, Hodges BD. Qualitative research methodologies: ethnography. Bmj. 2008;337:a1020.
295. Freud S. Analysis of a phobia in a five year old boy, Standard Edition, Vol. 10. Hogarth Press, London; 1909.
296. Cresswell JW. Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage; 1998.
297. Van Manen M. Researching lived experience: Human science for an action sensitive pedagogy: Routledge; 2016.
298. Rodriguez A, Smith J. Phenomenology as a healthcare research method. Royal College of Nursing; 2018.
299. Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory, method and research: Sage; 2009.
300. Tomkins L, Eatough V. Reflecting on the use of IPA with focus groups: Pitfalls and potentials. Qualitative Research in Psychology. 2010;7(3):244-62.
301. Willig C, Rogers WS. The SAGE Handbook of Qualitative Research in Psychology: SAGE Publications; 2017.

302. Smith JA. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. Qualitative research in psychology. 2004;1(1):39-54.
303. Brocki JM, Wearden AJ. A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. Psychology and health. 2006;21(1):87-108.
304. Shahmoon S, Smith JA, Jahanshahi M. The lived experiences of deep brain stimulation in Parkinson's disease: an interpretative phenomenological analysis. Parkinson's Disease. 2019;2019.
305. Rhodes JE, Hackney SJ, Smith JA. Emptiness, engulfment, and life struggle: an Interpretative Phenomenological Analysis of chronic depression. Journal of Constructivist Psychology. 2019:1-18.
306. Smith JA, Spiers J, Simpson P, Nicholls AR. The psychological challenges of living with an ileostomy: An interpretative phenomenological analysis. Health Psychology. 2017;36(2):143.
307. Smith JA, Osborn M. Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. British journal of pain. 2015;9(1):41-2.
308. Smith JA. Interpretative phenomenological analysis: Getting at lived experience. The Journal of Positive Psychology. 2017.
309. Brentano F. Psychologie vom empirischen Standpunkt [1874]. Partial translation in [10]. 1973:39-61.
310. Wagstaff C, Jeong H, Nolan M, Wilson T, Tweedlie J, Phillips E, et al. The accordion and the deep bowl of spaghetti: Eight researchers' experiences of using IPA as a methodology. The qualitative report. 2014;19(24):1-15.
311. Larkin M, Watts S, Clifton E. Giving voice and making sense in interpretative phenomenological analysis. Qualitative research in psychology. 2006;3(2):102-20.
312. Biggerstaff D, Thompson AR. Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. Qualitative research in psychology. 2008;5(3):214-24.
313. Heidegger M. Being and time. 1927. Trans John Macquarrie and Edward Robinson New York: Harper. 1962.
314. Smith J, Osborn M. Interpretative phenomenological analysis. Qualitative psychology: a practical guide to methods. London: Sage; 2003.
315. Weick KE. Sensemaking in Organizations: SAGE Publications; 1995.
316. Lyons E, Coyle A. Analysing qualitative data in psychology: Sage; 2016.
317. Smith JA, Eatough V. Interpretative phenomenological analysis. IN: Lyons, E. and Cole, A. Analysing qualitative data in psychology. 2007:35-50.
318. Larkin M, Thompson AR. Interpretative phenomenological analysis in mental health and psychotherapy research. Qualitative research methods in mental health and psychotherapy. 2012:101-16.
319. Yilmaz K. Comparison of quantitative and qualitative research traditions: Epistemological, theoretical, and methodological differences. European Journal of Education. 2013;48(2):311-25.
320. Salvatore S, Valsiner J. Between the general and the unique: Overcoming the nomothetic versus idiographic opposition. Theory & Psychology. 2010;20(6):817-33.
321. Smith JA. Evaluating the contribution of interpretative phenomenological analysis. Health psychology review. 2011;5(1):9-27.
322. Martyn H. The Dilemma of qualitative Method. London: Routledge; 1989.
323. Seale C. Researching Society and Culture: SAGE Publications; 2011.
324. Cassidy E, Reynolds F, Naylor S, De Souza L. Using interpretative phenomenological analysis to inform physiotherapy practice: An introduction with reference to the lived experience of cerebellar ataxia. Physiotherapy theory and practice. 2011;27(4):263-77.
325. Braun V, Clarke V. Successful Qualitative Research: A Practical Guide for Beginners: SAGE Publications; 2013.
326. Strauss A, Corbin J. Basics of qualitative research: techniques and procedures for developing grounded theory. Sage Publications. Thousand Oaks, CA. 1998.

327. Braun V, Clarke V. Novel insights into patients' life-worlds: the value of qualitative research. The Lancet Psychiatry. 2019.
328. George LS, Shyamala G, Noronha JA, Mayya S. Associated risk factors of postnatal depression in South Asian region-a narrative review. Manipal Journal of Nursing and Health Sciences (MJNHS). 2018;4(1):45-8.
329. Masood Y, Lovell K, Lunat F, Atif N, Waheed W, Rahman A, et al. Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. BMC women's health. 2015;15(1):109.
330. Brett J, Staniszewska S, Mockford C, Herron-Marx S, Hughes J, Tysall C, et al. Mapping the impact of patient and public involvement on health and social care research: a systematic review. Health Expectations. 2014;17(5):637-50.
331. Evans TW. Best research for best health: a new national health research strategy. Clinical Medicine. 2006;6(5):435-7.
332. Staley K. Changing what researchers' think and do': is this how involvement impacts on research? Research for all. 2017;1(1):158-67.
333. Stacey G, Felton A, Houghton P, Hui A, Morgan A, Shutt J, et al. Informed, Involved and Influential: The 3 I's model of Shared Decision Making in Mental Health Care. Mental Health Practice. 2015;19(4):31-5.
334. Reid K, Flowers P, Larkin M. Interpretative phenomenological analysis: An overview and methodological review. The Psychologist. 2005;18(1):20-3.
335. Gibbs Jr RW, Franks H. Embodied metaphor in women's narratives about their experiences with cancer. Health Communication. 2002;14(2):139-65.
336. Charteris-Black J. Shattering the bell jar: Metaphor, gender, and depression. Metaphor and Symbol. 2012;27(3):199-216.
337. Kirmayer LJ. The body's insistence on meaning: Metaphor as presentation and representation in illness experience. Medical anthropology quarterly. 1992;6(4):323-46.
338. Schoeneman TJ, Schoeneman KA, Stallings S. “The black struggle”: Metaphors of depression in Styron's Darkness Visible. Journal of Social and Clinical Psychology. 2004;23(3):325-46.
339. Siegelman EY. Metaphor and meaning in psychotherapy: Guilford Press; 1993.
340. Low SM. Embodied metaphors: nerves as lived experience. Embodiment and experience: The existential ground of culture and self. 1994;2:139.
341. Shinebourne P, Smith JA. The communicative power of metaphors: An analysis and interpretation of metaphors in accounts of the experience of addiction. Psychology and Psychotherapy: Theory, Research and Practice. 2010;83(1):59-73.
342. Lyddon WJ, Clay AL, Sparks CL. Metaphor and change in counseling. Journal of Counseling & Development. 2001;79(3):269-74.
343. Lakoff G, Johnson M. Metaphors we live by. Chicago, IL: University of. 1980.
344. Hesse-Biber SN, Leavy P. Handbook of emergent methods: Guilford Press; 2010.
345. Denzin NK. Sociological Methods: A Sourcebook: Taylor & Francis; 2017.
346. Watson H, Harrop D, Walton E, Young A, Soltani H. A systematic review of ethnic minority women’s experiences of perinatal mental health conditions and services in Europe. PloS one. 2019;14(1):e0210587.
347. Hussain S, Imran N, Hotiana UA, Mazhar N, Asif A. Illness perceptions in patients of schizophrenia: A preliminary investigation from Lahore, Pakistan. Pakistan journal of medical sciences. 2017;33(4):829.
348. Nicholson J, Sweeney EM, Geller JL. Focus on women: Mothers with mental illness: I. The competing demands of parenting and living with mental illness. Psychiatric Services. 1998;49(5):635-42.
349. Greenwood D. Social comparison theory. The International Encyclopedia of Media Effects. 2017:1-9.

350. Bolton D. What is mental disorder?: an essay in philosophy, science, and values: Oxford University Press; 2008.
351. Link BG, Phelan JC. Conceptualizing stigma. Annual review of Sociology. 2001;27(1):363-85.
352. Caplan PJ. They say you're crazy: How the world's most powerful psychiatrists decide who's normal: Addison-Wesley/Addison Wesley Longman; 1995.
353. Scheff TJ. Being Mentally Ill: A Sociological Study: Routledge; 2017.
354. Thoits PA. Sociological approaches to mental illness. A handbook for the study of mental health. 1999:121-38.
355. Bhugra D. Attitudes towards mental illness: A review of the literature. Acta Psychiatrica Scandinavica. 1989;80(1):1-12.
356. Horwitz AV. The social control of mental illness. 1982.
357. Goffman E. 1963Stigma: Notes on the management of spoiled identity. New York: Simon & Shuster. 1963.
358. Crisp AH, Gelder MG, Rix S, Meltzer HI, Rowlands OJ. Stigmatisation of people with mental illnesses. The British journal of psychiatry. 2000;177(1):4-7.
359. Howe L, Tickle A, Brown I. 'Schizophrenia is a dirty word': service users' experiences of receiving a diagnosis of schizophrenia. The Psychiatric Bulletin. 2014;38(4):154-8.
360. Perry BM, Taylor D, Shaw SK. "You've got to have a positive state of mind": an interpretative phenomenological analysis of hope and first episode psychosis. Journal of Mental Health. 2007;16(6):781-93.
361. Wittkowski A, McGrath LK, Peters S. Exploring psychosis and bipolar disorder in women: a critical review of the qualitative literature. BMC psychiatry. 2014;14(1):281.
362. Judge AM, Estroff SE, Perkins DO, Penn DL. Recognizing and responding to early psychosis: A qualitative analysis of individual narratives. Psychiatric services. 2008;59(1):96-9.
363. Ahmed SM, Lemkau JP. Cultural issues in the primary care of South Asians. Journal of Immigrant Health. 2000;2(2):89-96.
364. Lindridge AM, Hogg MK, Shah M. Imagined multiple worlds: How South Asian women in Britain use family and friends to navigate the "border crossings" between household and societal contexts. Consumption Markets & Culture. 2004;7(3):211-38.
365. Gilbert P, Gilbert J, Sanghera J. A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. Mental Health, Religion & Culture. 2004;7(2):109-30.
366. Gilbert P. Body shame: A biopsychosocial conceptualisation and overview with treatment implications. Body Shame: Routledge; 2014. p. 17-68.
367. Saravanan B, Jacob K, Deepak M, Prince M, David AS, Bhugra D. Perceptions about psychosis and psychiatric services: a qualitative study from Vellore, India. Social Psychiatry and Psychiatric Epidemiology. 2008;43(3):231-8.
368. Knight MT, Wykes T, Hayward P. 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). Journal of Mental Health. 2003;12(3):209-22.
369. Raleigh VS, Balarajan R. Suicide and self-burning among Indians and West Indians in England and Wales. The British Journal of Psychiatry. 1992;161(3):365-8.
370. Grewal S, Bottorff JL, Hilton BA. The influence of family on immigrant South Asian women's health. Journal of Family Nursing. 2005;11(3):242-63.
371. Fenton S, Karlsen S. Explaining mental distress: narratives of cause. Ethnic differences in the context and experience of psychiatric illness: a qualitative study. 2002:17.
372. Vallido T, Wilkes L, Carter B, Jackson D. Mothering disrupted by illness: a narrative synthesis of qualitative research. Journal of Advanced Nursing. 2010;66(7):1435-45.
373. Maybery D, Reupert A. Parental mental illness: a review of barriers and issues for working with families and children. Journal of psychiatric and mental health nursing. 2009;16(9):784-91.

374. Mauthner NS. The darkest days of my life: Stories of postpartum depression: Harvard University Press; 2002.
375. Beck CT. Postpartum depression: A metasynthesis. Qualitative health research. 2002;12(4):453-72.
376. Field TM. Early interactions between infants and their postpartum depressed mothers. Infant behavior & development. 1984.
377. Thiels C, Kumar R. Severe puerperal mental illness and disturbances of maternal behaviour. Journal of Psychosomatic Obstetrics & Gynecology. 1987;7(1):27-38.
378. Carolan M. The project: having a baby over 35 years. Women and Birth. 2007;20(3):121-6.
379. Stewart DE. Psychiatric admission of mentally ill mothers with their infants. The Canadian Journal of Psychiatry. 1989;34(1):34-8.
380. Davidson L, Strauss JS. Sense of self in recovery from severe mental illness. British Journal of medical psychology. 1992;65(2):131-45.
381. Gergel T, Iacoponi E. Psychosis and identity: Alteration or loss? Journal of evaluation in clinical practice. 2017;23(5):1029-37.
382. Estroff SE, Lachicotte WS, Illingworth LC, Johnston A. Everybody's got a little mental illness: Accounts of illness and self among people with severe, persistent mental illnesses. Medical Anthropology Quarterly. 1991;5(4):331-69.
383. Lawler D, Sinclair M. Grieving for my former self: a phenomenological hermeneutical study of women's lived experience of postnatal depression. Evidence-Based Midwifery. 2003;1(2):36-42.
384. Kaite CP, Karanikola M, Merkouris A, Papathanassoglou ED. “An ongoing struggle with the self and illness”: α meta-synthesis of the studies of the lived experience of severe mental illness. Archives of psychiatric nursing. 2015;29(6):458-73.
385. Luhrmann TM, Padmavati R, Tharoor H, Osei A. Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: interview-based study. The British Journal of Psychiatry. 2015;206(1):41-4.
386. Rassool GH. The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. Journal of advanced nursing. 2000;32(6):1476-84.
387. Abu-Ras W, Gheith A, Cournos F. The imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim community. Journal of Muslim Mental Health. 2008;3(2):155-76.
388. Borras L, Mohr S, Brandt P-Y, Gillieron C, Eytan A, Huguelet P. Influence of spirituality and religiousness on smoking among patients with schizophrenia or schizo-affective disorder in Switzerland. International Journal of Social Psychiatry. 2008;54(6):539-49.
389. Leigh-Hunt N, Bagguley D, Bash K, Turner V, Turnbull S, Valtorta N, et al. An overview of systematic reviews on the public health consequences of social isolation and loneliness. Public Health. 2017;152:157-71.
390. Smith KJ, Victor C. Typologies of loneliness, living alone and social isolation, and their associations with physical and mental health. Ageing & Society. 2019;39(8):1709-30.
391. Fazil Q, Cochrane R, editors. The cultural dimension in a causal model of depression. Fourteenth International Congress of Cross Cultural Psychology, Bellingham, WA; 1998.
392. Gask L, Aseem S, Waquas A, Waheed W. Isolation, feeling ‘stuck’and loss of control: Understanding persistence of depression in British Pakistani women. Journal of affective disorders. 2011;128(1-2):49-55.
393. Clinton M, Lunney P, Edwards H, Weir D, Barr J. Perceived social support and community adaptation in schizophrenia. Journal of Advanced Nursing. 1998;27(5):955-65.
394. Borge L, Martinsen EW, Ruud T, Watne Ø, Friis S. Quality of life, loneliness, and social contact among long-term psychiatric patients. Psychiatric Services. 1999;50(1):81-4.
395. Palumbo C, Volpe U, Matanov A, Priebe S, Giacco D. Social networks of patients with psychosis: a systematic review. BMC research notes. 2015;8(1):560.

396. Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA. Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. Psychology and aging. 2006;21(1):140.
397. Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE. Reducing suicide: A national imperative: National Academies Press; 2002.
398. Richman NE, Sokolove RL. The experience of aloneness, object representation, and evocative memory in borderline and neurotic patients. Psychoanalytic psychology. 1992;9(1):77.
399. Deniro DA. Perceived alienation in individs with residual-type schizophrenia. Issues in Mental Health Nursing. 1995;16(3):185-200.
400. Calsyn RJ, Winter JP. Social support, psychiatric symptoms, and housing: A causal analysis. Journal of Community Psychology. 2002;30(3):247-59.
401. Hussain F, Cochrane R. Depression in South Asian women living in the UK: a review of the literature with implications for service provision. Transcultural Psychiatry. 2004;41(2):253-70.
402. Hoge EA, Tamrakar SM, Christian KM, Mahara N, Nepal MK, Pollack MH, et al. Cross-cultural differences in somatic presentation in patients with generalized anxiety disorder. The Journal of nervous and mental disease. 2006;194(12):962-6.
403. Krause I-B. Sinking heart: a Punjabi communication of distress. Social Science & Medicine. 1989;29(4):563-75.
404. Beliappa J. Illness or Distress?: Alternative Models of Mental Health: Confederation of Indian Organisations (UK); 1991.
405. Gidron Y. Explanatory Models of Illness. Encyclopedia of Behavioral Medicine. 2013:733-4.
406. Kendler KS. Explanatory models for psychiatric illness. American Journal of Psychiatry. 2008;165(6):695-702.
407. Kleinman A. Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry: Univ of California Press; 1980.
408. Srinivasan T, Thara R. Beliefs about causation of schizophrenia: Do Indian families believe in supernatural causes? Social Psychiatry and Psychiatric Epidemiology. 2001;36(3):134-40.
409. Joel D, Sathyaseelan M, Jayakaran R, Vijayakumar C, Muthurathnam S, Jacob K. Explanatory models of psychosis among community health workers in South India. Acta Psychiatrica Scandinavica. 2003;108(1):66-9.
410. Charles H, Manoranjitham S, Jacob K. Stigma and explanatory models among people with schizophrenia and their relatives in Vellore, South India. International Journal of Social Psychiatry. 2007;53(4):325-32.
411. Saravanan B, Jacob K, Johnson S, Prince M, Bhugra D, David AS. Belief models in first episode schizophrenia in South India. Social psychiatry and psychiatric epidemiology. 2007;42(6):446-51.
412. Weiss MG, Sharma SD, Gaur R, Sharma J, Desai A, Doongaji D. Traditional concepts of mental disorder among Indian psychiatric patients: preliminary report of work in progress. Social Science & Medicine. 1986;23(4):379-86.
413. Zafar SN, Syed R, Tehseen S, Gowani SA, Waqar S, Zubair A, et al. Perceptions about the cause of schizophrenia and the subsequent help seeking behavior in a Pakistani population–results of a cross-sectional survey. BMC psychiatry. 2008;8(1):56.
414. Virdee G, Frederick T, Tarasoff LA, McKenzie K, Davidson L, Kidd SA. Community participation within the context of recovery: Multiple perspectives on South Asians with schizophrenia. International Journal of Culture and Mental Health. 2017;10(2):150-63.
415. Dein S, Sembhi S. The use of traditional healing in South Asian psychiatric patients in the UK: Interactions between professional and folk psychiatries. Transcultural Psychiatry. 2001;38(2):243-57.
416. Singh SP, Brown L, Winsper C, Gajwani R, Islam Z, Jasani R, et al. Ethnicity and pathways to care during first episode psychosis: the role of cultural illness attributions. BMC psychiatry. 2015;15(1):287.

417. Mirza A, Birtel MD, Pyle M, Morrison AP. Cultural differences in psychosis: The role of causal beliefs and stigma in White British and South Asians. Journal of Cross-Cultural Psychology. 2019;50(3):441-59.
418. Baker C. Mental health statistics for England: prevalence, services and funding. Second Reading London: House of Commons Library Briefing. 2018.
419. Islam Z, Rabiee F, Singh SP. Black and minority ethnic groups' perception and experience of early intervention in psychosis services in the United Kingdom. Journal of Cross-Cultural Psychology. 2015;46(5):737-53.
420. Pilkington A. Psychological well-being and barriers to accessing psychological services within South Asian and Muslim populations: Lancaster University; 2010.
421. Bowl R. The need for change in UK mental health services: South Asian service users' views. Ethnicity and Health. 2007;12(1):1-19.
422. Nair R, Bilszta J, Shafira N, Salam N, Buist A. Review of patients admitted to a specialist inpatient parent-infant psychiatric service. Australasian Psychiatry. 2010;18(6):567-72.
423. Wright T, Jowsey T, Stanton J, Elder H, Stevens S, Wouldes TA. Patient experience of a psychiatric Mother Baby Unit. PloS one. 2018;13(5):e0198241.
424. Neil S, Sanderson H, Wieck A. A satisfaction survey of women admitted to a Psychiatric Mother and Baby Unit in the northwest of England. Archives of women's mental health. 2006;9(2):109-12.
425. Antonysamy A, Wieck A, Wittkowski A. Service satisfaction on discharge from a psychiatric mother and baby unit: a representative patient survey. Archives of women's mental health. 2009;12(5):359.
426. Takegata M, Ohashi Y, Lazarus A, Kitamura T, editors. Cross-national differences in psychosocial factors of perinatal depression: A systematic review of India and Japan. Healthcare; 2017: Multidisciplinary Digital Publishing Institute.
427. Agius M, Talwar A, Murphy S, Zaman R. Issues regarding the delivery of early intervention psychiatric services to the South Asian population in England. Psychiatria Danubina. 2010;22(2):266-9.
428. Naeem F, Habib N, Gul M, Khalid M, Saeed S, Farooq S, et al. A qualitative study to explore patients', carers' and health professionals' views to culturally adapt CBT for psychosis (CBTp) in Pakistan. Behavioural and cognitive psychotherapy. 2016;44(1):43-55.
429. Webb M, Charbonneau AM, McCann RA, Gayle KR. Struggling and enduring with God, religious support, and recovery from severe mental illness. Journal of Clinical Psychology. 2011;67(12):1161-76.
430. Ann Hilton JLB, Joy L. Johnson, Lisa J. Venables, Sonia Bilkhu, Sukhdev Grewal, Neleena Popatia, Heather Clarke, Pauline Sumel, B. The desi ways: traditional health practices of South Asian women in Canada. Health care for women international. 2001;22(6):553-67.
431. Ayora-Diaz SI. Globalization, rationality and medicine: Local medicine's struggle for recognition in Highland Chiapas, Mexico. Urban Anthropology and Studies of Cultural Systems and World Economic Development. 1998;27(2):165-95.
432. Berry JW. Immigration, acculturation, and adaptation. Applied psychology. 1997;46(1):5-34.
433. Berry JW. Globalisation and acculturation. International Journal of Intercultural Relations. 2008;32(4):328-36.
434. Smith JA. Towards a relational self: Social engagement during pregnancy and psychological preparation for motherhood. British journal of social psychology. 1999;38(4):409-26.

Appendices

Appendix 1.

Step 4: Summary of findings about women's beliefs about the causes of PND

Study	First-order constructs	First-order constructs	First-order constructs
A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with Postnatal depression Chan, 2002 Hong Kong	Trapped in the situation • Angry with the way they were being treated by their husbands and in-laws. Ambivalent towards the baby • Blaming the baby of the burden that caused their unhappiness. Blame the baby for causing their distance from their husbands. Uncaring husbands • Relationships with the husbands were cited as an important source of unhappiness. • After the birth of the baby, some reported marital tension and a deterioration of the relationship during pregnancy. • The husbands were becoming over-controlling once the woman left her job to take care of the baby. • Husbands offered little help to women. This was in relation to taking care of the baby and housework. • Husbands could not understand their feelings. Controlling and powerful in-laws • Unhappiness to the relationship with their parents-in-law. • Complained of the mother-in-law's behaviour. • Living with the parent- in-laws was problematic. • Participants felt that the husbands were on the side of the inlaws. • No support from the husbands. • In-laws were authoritative and dominant. • Gender of the baby was another issue affecting the mother and parent-in-laws. The woman was under pressure to give birth to a boy, as senior members of the family preferred boys.	Lack of support from husband/partner Conflict with parent-in-laws Gender preference of the baby Unhappy relationship	Social-support Cultural Social difficulties

A qualitative study of the postpartum experiences of Chinese women living in England Lam, Wittkowski, Fox, 2012 UK	Language and cultural norms • Bilingual mothers were more likely to experience conflict and brief isolation whereas Chinese speaking mothers experienced isolation and not being understood by others. This resulted in conflict. • Cultural norms appeared to play a crucial role in causing conflicts, determining a mother's support network, coping strategies and how she perceived her situations. Isolation • Traditionally, new mothers in the Chinese culture received much attention and support during the traditional practices of Zuo Yue. • Mothers felt isolation from their social network and outsider support. This was often profound for bilingual mothers because this traditional practice required them to stay indoors for one month, restricting their contact to immediate family and friends only. • Chinese speaking mothers experience a different form of isolation resulting in a lack of support, caused by family absence and communication/language problems. Adjustment • All mothers mentioned feeling some degree of low mood, confusion or loss. • Overwhelmed with new responsibilities, sacrifices and unsure of their new role. • They experienced it as an additional strain to the traditional practice of Zuo Yue. • Mothers felt trapped and restricted by these traditional practices. Two mothers were relatively new immigrants to the UK. They were forced to leave their country of origin. They had to cope with potentially traumatic travelling experiences, adjusting to new life, language and culture in the UK. And the addition to adjusting to the new role of motherhood. Lack of support • A lack of support identified were language barriers and communication difficulties, great geographical distances to family and to the mother's residential status. • Chinese-speaking mothers suffered from isolation. • It was the lack of involvement from the services, resulting mainly from communication difficulties. This affected the quality of support they received. This has stopped many women from accessing services. Great geographical distance to family • Chinese-speaking mothers relied on phone conversations and felt more isolated.	Conflict with parent-in-laws Cultural clash Cultural postnatal traditions/practices/ri tuals Social and residential status Childcare	Cultural Social difficulties Obstetric/Paediatric Social- support

	• Bilingual mothers seemed to have the support from the family, they were prone to exhibit sudden anxiety when this support terminated and they needed to re-adjust their role again. Status • The mother's residential status was another crucial factor contributing to the lack of perceived support. • Bilingual mothers gained permanent living status and family could regularly visit. • Immigration laws restricted Chinese-speaking mothers and visa for family visits was often improbable and often lacked support from mother and mothers-in-law. Development of conflict • Conflict only developed when mediating factors were present e.g. value systems, integration attempts or if the mother has no strong model of parenting. Role of mother-in-law • Mothers regarded the help from their own mothers as positive guidance and emotional support, whereas mothers-in-law were regarded as providing merely practical help. • Conflict arose due to various hidden confrontations between the mother and mother-in-law in relation to food customs and the practice of traditions. • Parents-in-law usually ensure that traditional cultural practices are followed. • Chinese practices enforced by the mother-in-law may cause a lot of conflict in the new mother's life, especially when the mother felt she had to obey. • Some of the conflicts in relation to the mother-in-law were due to cultural attitudes: having respect for the elderly and dutifully maintaining family harmony. Different value systems • Mothers who had a clear idea of their own cultural values and followed a particular set of chid raring practices were more likely to seek advice only from sources that shared their cultural ideas. • Chinese mothers were unenthusiastic about mixing with others and showed no interest integrating into the UK culture. • The language barrier stopped them from accessing English based services.		

An exploration of illness beliefs in mothers with postnatal depression Patel et al, 2013 UK	Unmet expectations • Incongruence mothers experience post-birth between their idealised expectations and their early motherhood experiences. • Mother's experiences of motherhood were dominated by difficult emotions of low mood, anxiety and anger and poor physical health from obstetric complications. • This did not match their expectations of motherhood. This created awareness that something was not right. • Women with no previous experience of depression did not understand what was happening when their mood was deteriorating. • All mothers appraised these first experiences as threatening to their self-concepts as good mothers. • They initially denied their depressive symptoms e.g. baby blues, a passing phase, hormones, exhaustion etc. Identifying stressors in their life context • The causes mothers held responsible for their depression. Participants began to develop personal narratives of their difficulties. • A psychological aetiology – dominant framework help as mothers searched from tangible and understandable stressors in their lives. This allowed mothers to adopt a coping strategy where they externalised their PND. • Varied psychological factors were cited as causal: traumas, difficulties in adjusting to parenting role, personal factors and other psychological factors and stressors. • Childhood abuse, traumatic pregnancies and births. • Difficulties adjusting to motherhood. • Other psychosocial factors included lack of social support, weight gain, changes to lifestyle, relationship problems, financial concerns and work-related worries. • Several participants related their own PND to characteristics of their personalities and blame themselves. This reinforces them into thinking they were not good mothers. • Biomedical factors included; some participants indicated genetic hormones and brain factors. • Only one participant endorsed a purely medical model - chronic mental health difficulty	Lack of support from family/friends Poverty and/or financial worries Unhappy relationship Genetics, hormones or biological influences Physical changes Childbirth complications Expectations vs the reality of motherhood Previous history of PND	Obstetric/Paediatric Psychological Social difficulties Biological/Physical
Being reborn: the recovery process of postpartum depression in Taiwanese women Chen et al, 2006 Taiwan	Shattered role identify • Participants described how after childbirth they were faced with many changes that had an impact on their lives. • Physical exhaustion, loss of former identity, problems with the neonate and difficulty adjusting to new relationships. • They found themselves deeply isolated, fatigued physically and psychologically with no one to turn for support	Conflict with parent and parent-in-laws Physical change after childbirth Expectations versus the realities of motherhood	Cultural Psychological Biological/Physical

	Feeling trapped and breaking down • Mothers voluntarily expressed that excessive distress over the traditional gender roles expectations they faced. • Mothers were expected to transform and adjust to new systems. • For example to concede to the traditional social norms of obeying parents-in-law, helping the husbands and nurturing the children. • Threatened self-identity. Regaining vitality • Postnatal changes became so seemingly unbearable that the experiences turned into a kind of survival training.		
Causes of women's postpartum depression symptoms: Men's and women's perceptions Habel et al, 2015 Canada	Societal expectations and pressure • When women's sense of themselves and of their abilities as women and as mothers fell short of societal expectations, this has a negative impact on their psychological well being. • Specific pressures such as breastfeeding. Physical health problems • Childbirth complications. • Hormonal fluctuations. • These physical health challenges were seen as having a negative effect on women's ability to cope with caring for the newborns and on their psychological well-being. • Lack of sleep, due to the infant care and demands and/or physical health problems and the ensuring fatigue were other types of health challenges as contributing to symptoms. Transition to parenthood • Difficulty coping with the transition to parenthood. • A loss of their previous identity as a person was experiencing. • The women had difficulty in coping with this and adjusting to this change. • Others felt that their current experience of motherhood did not coincide with their expectations of motherhood and this led to unhappiness. Social connectedness and support • Symptoms were related to a lack of support and/or social interactions with others. • Help from the partner, family or friends did not coincide with or meet the women's needs. • Remaining at home for long periods to take care of the infant or the household resulted in a lack of social support with others. Personality traits and past psychological history	Lack of support from family relations Poverty and/or financial worries Social and residential status Breastfeeding Genetic, hormones or biological influences Physical changes after childbirth Unwanted pregnancy, fear of childbirth and childbirth complications Child's health and temperament Expectations versus the reality of motherhood Previous history of PND	Social-Support Social difficulties Biological/Physical Obstetric/Paediatric Psychological

	• Personality characteristics, temperament and a history of mental health problems as possible causes of symptoms. • All the women who had a previous history of mental health problems thoughts this contributed to their symptoms. Child health or temperament • The health or temperament of their newborn or of their other children played a role in the onset of their PND symptoms. • The additional challenges of caring for a child who was unwell caused great stress. Unmet healthcare needs • PND symptoms were also related to the care they received during pregnancy and/or after childbirth. • The care was reported as inappropriate, or inadequate in meeting their needs. • The pressure to breastfeed caused additional distress. • Inadequate communication from the healthcare team and difficulty navigating the healthcare system were also identified as contributing to the symptoms. Unmet birth expectations • The actual experience of how the childbirth would transpire did not meet expectations. Other life stressors • Events unrelated to pregnancy or parenting were also perceived as having contributed to the aetiology of women's PND symptoms. For example, immigration difficulties, financial uncertainty and the accumulation of multiple stressors		
Culture and postpartum mood problems: Similarities and differences in the experiences of first and second generation Canadian women Mamisachvili et al, 2016 Canada	Conflict with parent/parent/in-laws • Most participants reported experiencing conflict with the parents and/or parents-in-law. This was over parenting practices as well as parents' lack of understanding of postnatal mood problems. • Participants described experiencing stress as a result of discordance between their chosen parenting styles and those recommended by their parents-in-law. This was attributed to cultural practices. • Parents and parents-in-law did not understand the concept of postnatal mood problems, and so were unsupportive when participants tried to articulate their feelings. Expectations about managing motherhood • Participants had expectations of motherhood as a blissful experience. • They had no expectation that they would need emotional and practical support during the transition to parenthood. When this expectation was not met, participants experienced significant distress.	Lack of support from family relations Conflict with parents and parent-in-laws Social and residential status Expectations versus the reality of motherhood	Social-Support Cultural Social difficulties

	• The expectation that they should be able to manage motherhood without support was described as a primary factor in contributing to mood problems for all participants. • Women also expressed a lack of societal support for new mothers and babies in Canada. • Both mothers shared fear for failing to be a good mother and the guilt for not living up to their own ideals of motherhood. Identity as a Mother • Some participants reported experiencing a loss of self and felt trapped in their new roles. • This loss of self was the key reason for their mood problems. • These participants struggled to redefine their identities after childbirth.		
First time mothers' perceptions of motherhood and PND Val, 2003 UK	Support • This introduced the issue of practical and emotional support. • All of the women mentioned their husbands or partner in terms of practical and emotional help. • The value placed on the partners was underlined by the spontaneous comments from the mothers who did not know how single mothers coped. Change in life/expectation • Many talked of the dramatic changes in the lifestyles and this was linked with their expectations of what life with a new baby might be life. • One of the biggest changes was that the baby's needs and demands came first. • The extent of the change is closely linked to what they had expected and what they read/saw did not reflect the reality. Postnatal Depression • Few say it was having one sole cause, but suggested a variety of origins with the most frequent being a lack of support. • Hormones and physical causes were also mentioned.	Genetics, hormones, or biological influences Childcare Expectations vs reality of motherhood	Biological/Physical Obstetric Paediatric Psychological Social-support
"I can't stop worrying about everything" – Experiences of rural Bangladeshi women during the first postpartum months Edhborg et al, 2015 Bangladesh	Family dynamics • The parents of the family arrange most marriages. • Most mothers lived with their in-laws in the same bari, but most had separate households. • Some lived in a polygamous marriage. • Although most women reported supportive relationships, they had fights and quarrels in the family. • Some mothers reported their babies having sleeping problems or eating problems. Violence	Gender preference of the baby Cultural postnatal traditions/practices/ri tuals Violence and/or abuse Poverty and/or financial worries Infidelity or polygamous relationships	Cultural Social difficulties Biological/Physical Obstetric/Paediatric

	• Some women reported on intimate partner violence and were sometimes beaten by their husbands. • Even with no partner violence, women reported problematic relationship or sometimes violence in the family. • The mothers also reported conflicts about inheritance in the families. Limits of survival Poverty • Most women reported that their families were poor and had a difficult economic situation. Most of the women's partners did farming on the land and did not have a steady income. • The mothers complained of not having enough to eat and had difficulties in properly feeding at all. Insecurity • Pregnancy and childbirth were very insecure period associated with risk for the woman's life. Several mothers fearer of dying during delivery of fear that the child would die. • Fear of complications throughout childbirth and this may force them to go to the hospital for the delivery and this would put some strain on the economic situations that they have encountered. • Women were always afraid and worried about unpredictable life events. And the lack of money for these unpredictable events. • Husbands did not want birth control and mothers were afraid that she would fall pregnant again. • 1/3 mothers had lost at least one child, many dies during childbirth. Some husbands had accidents (traffic and work-related) Decreasing the husband's ability to work full-time and needed more expensive medicines to treat their husbands. Health • Mothers with depressive symptoms reported poor physical health problems after giving birth. • Mothers felt poor and weak, which they explained through the loss of blood during delivery or as lacking vitamins and calcium. • Multiple health problems were explained, including stomach pains, chest pains, headaches, dizziness, low or high blood pressure, jaundice, urinary problems, gastric problems, a tumour in the throat and having trouble walking after childbirth. • Mothers were worried and anxious about their infants' health. Infants had been ill several times with fever. Several mothers reported their children to have pneumonia.	Unhappy relationship Physical changes after childbirth Unwanted pregnancy, fear of childbirth and childbirth complications Child's health and temperament	

	Role of cultural context Traditional rules • Women were well aware of the traditional customs around childbirth, but only a few mothers followed the custom of "giving birth in the fathers home" to get support from her mother and female relatives. • Some women preferred to give birth to their marital homes. • The majority of women followed traditional food restrictions. • Mothers believed in the "evil eye" and that both they themselves and the baby could be jinxed. They said they were scared to go out in the evenings and feared something may happen. • Restriction of staying indoors. • Some women complained of the male not doing housework or "women duties". • Mothers did not have preferences for the gender of the child. But many said they wanted sons.		
Listening to mothers: qualitative studies on motherhood and depression from Goa, India Rodrigues et al, 2003 India	Causes of illnesses associated with childbirth • Overwork and lack of practical support were the most common causal models for health problems in PND mothers. Support and maternal wellbeing Practical support • Mothers expressed the desire for more support • Feeling overworked and unsupported was linked to tiredness and other symptoms. This led to a strained relationship. • Husbands were less aware of the need to offer practical help to their wives. They only felt the need to support them financially. Husbands received support from their brothers, in-laws and their own mothers. Emotional support • Mothers reported a similar degree of emotional support from their husbands and mothers • Mothers also spoke of strained relationships with their husbands and in-laws because of the gender of the baby. • Some mothers spoke of physical abuse from their husbands. Rituals of childbearing • Several rituals are performed to celebrate the birth of the baby. • Specific practices are carried out to maintain good health for the mother and the baby. • There were slight variations in the rituals according to the baby's gender. • Oil massage for the mothers was a popular custom, to improve strength and maintain general health in mothers and their babies.	Lack of support from the husband/partner Lack of support from family relations Gender preference of the baby Poverty and/or financial worries Unhappy relationship Physical changes after childbirth	Social – support Cultural Social difficulties Biological/Physical

	• Some mothers were also on a specific diet in the postnatal period following childbirth. Causal models • Economic difficulties were the commonest causal model. • Poor relationship with significant others in the family, in particular, the husbands or the mother-in-law • The birth of a girl child contributed to their strained relationship with their husbands and in-laws.		
Perceptions of postnatal depression and health care needs in a South African sample: the "mental" in maternal health care Kathree et al, 2014 Africa	Causes of postnatal depression • The result of adverse circumstances. • Life events that cause feelings of pain and sadness. Poverty and dependence • Food, housing and financial insecurities. • Poverty renders mothers dependent on state support and/or families. These are sometimes inadequate or withheld, resulting in despair or hopelessness. • A lack of education. • Abusive partner and unable to extract herself from the abusive relationship due to financial dependency. Partner conflicts • Serious partner conflicts. • Rejection by the partner. • Lack of emotional support. • Disinterest in the child. • Denial of paternity. • Physical abuse. Infidelity • Unfaithful partners were a major source of stress. • Spectre of HIV and another sexually transmitted disease. Unwanted pregnancy • Unwanted pregnancy trigger of depression. • Unwanted pregnancy was a complication that bounded men and women unwillingly to the relationship. • Reasons for unwanted pregnancy included the inability to support the child and lack of support from the partner. Lack of supportive family relationships • Lack of support from parents and/or family. • Mothers felt no-one cared for them. Some in-laws did not accept the baby.	Lack of support from family relations Violence and/or abuse Poverty and/or financial worries Infidelity or polygamous relationships Unhappy relationship Unwanted pregnancy, fear of childbirth and childbirth complications	Social – support Social difficulties Obstetric/Paediatric

Postnatal depression: a qualitative study of the experiences of a group of Hong Kong Chinese women Chan, Levy, 2003 Hong Kong	Experiences of PND • Women were overwhelmed by the endless things they had to do. • The baby cried a lot of the time. • Poor self-esteem was expressed. • They could not accomplish tasks that they used to be competent in. Factors perceived as contributing to their depression • Uncaring husbands. • Controlling and powerful in-laws. • Unkind comments and behaviour from their mother-in-law. • Angry the way they were being treated by their husbands and in-laws.	Lack of support from the husband/partner Conflict with parents and parent-in-laws	Social – support Cultural
Postpartum depression and helpseeking behaviours in immigrant Hispanic women Callister, Beckstrand, Corbett., 2011 US	Personal barriers • Beliefs about emotional health, the perceived stigma of mental health and hesitancy to seek treatment for symptoms of PPD. • Women couldn't handle the responsibilities of motherhood. Cultural beliefs about motherhood and the role of women • Motherhood viewed as a valued and respected role in Hispanic cultures. • It was difficult to admit they were unwell. Respecto • Respect and value of motherhood. • This put extraordinary pressure on women. • Living apart from their child in another country. Social barriers Lack of support • Women felt isolated and lacked social support. • Longing for family support. Familism • A powerful cultural value and family social networks ameliorate stress.	Lack of support from family relations Social and residential status	Social – support Social difficulties Cultural
Postpartum depression in the community: A qualitative study from rural South India Savarimuthu et al, 2010 India	Sociodemographic factors and clinical characteristics • Low education. • Family history of depression. • Unhappy marriage. • Physical abuse during pregnancy and the postpartum period. • Husbands misuse of alcohol. • Gender preference of baby – a boy was preferred. Explanatory models associated with PND • Black magic. • Karma.	Gender preference of the baby Cultural/Religious beliefs for PND Unhappy relationship Physical changes after childbirth Child's health and temperament	Cultural Social difficulties Psychological Obstetric/Paediatric Spirituality

	• Punishment by god. • Evil spirit	Previous history of PND	
Stress in women with postpartum depression: a phenomenological study Leung, Arthur, Martinson., 2004 Hong Kong	Parenting competencies • Difficulties performing basic tasks when taking care of the baby, including changing the diapers, preparing the right amount of milk and sterilising bottles. • Breastfeeding was another area of the incompetence of new mothers. • Not knowing how much milk the baby had taken in. • Problems, when mother planned to breastfeed but had to bottle, feed her baby. The expectation-experience gap • The reality and expectation of motherhood were frustrating for the mothers. Baby-minder arrangements • This was challenging for most mothers. • Working mothers felt they could not fulfil their 'responsibility' of taking care of the baby. • Important to identify a suitable and reliable baby-minder. • Putting the baby in the hands of a stranger was very difficult for some mothers. • Baby-minder arrangements caused conflicts between the new mothers and spouse when they could not reach a mutual agreement. • Difficult to find a trusted baby-minder. • Financial pressure was a factor for lower-income groups who had to spend a large amount of money on the baby. Childcare demands • Health and safety of the baby was a primary concern for new mothers. • Family hygiene and keeping the house tidy. • When the baby was sick, crying more or eating and sleeping less, this increased levels of stress for new mothers. Conflict with culture and tradition • Having doubts about mother-in-law's customs caused a dilemma for the participants. • The Chinese culture prefers boys to girls because the girls will not continue the family name. • 'Doing the month' is a Chinese traditional ritual – the mother-in-law cares for the new mother in the first postpartum months. • Mothers had to follow a strict diet and activity. • Mothers felt trapped and bored inside the house for the whole month.	Conflict with parents and parent-in-laws Gender preference of the baby Cultural postnatal traditions/practices/ri tuals Poverty and/or financial worries Breastfeeding Child's health and temperament Expectations versus the reality of motherhood	Cultural Biological/Physical Obstetric/Paediatric Psychological Social-support

"Struggling with life": Narratives from women with signs of postpartum depression Edhborg et al, 2005 Sweden	"Struggling with life • Mothers felt overwhelmed with strong feelings of failure, disappointments, guilt worries, loneliness, uncertainty, bereavement and unfulfilled expectations. Struggling with life-related to the self • Women struggled to redefine a sense of identity. • Women felt a loss of their previous professional identity. Change in physical appearance. • Living up to the image of a "good mother". • She would be a 'good mother' if the child was healthy. • She would not be a 'good mother' if unable to breastfeed. Struggling with life-related to the child Feelings of uncertainty and ignorance and felt unprepared to have a child given all the implications of parenthood and its associated worries. • Lack of confidence when alone with the child. • Not being able to fully provide for the child. • Lack of confidence with breastfeeding. • Struggling with life-related to the child. • Negative influences on their marital relationship. • Misunderstandings with a partner. • The arrival of the baby led to discord and the pair relationship were threatened. Father-child relationship • Mothers thought their partners worked too much and did not spend time with the baby. • Partners did not fulfil the responsibilities of caring for the baby.	Lack of support from the husband/partner Lack of support from family relations Unhappy relationship Breastfeeding Physical changes after childbirth Childcare Expectations versus the reality of motherhood	Social – support Social difficulties Biological/Physical Obstetric/Paediatric Psychological
The experiences of postnatal depression in South Asian mothers living in Great Britain: a qualitative study Wittkowski et al, 2012 UK	Internalising misery • Cultural shock. • Cultural clash. • Cultural/religion suppression. • Adjustment to married life was difficult for mothers. • Mothers missed their previous life and their family. • The change was dictated by culture and it was not what they expected. • Religious and cultural practices did not encourage mothers to engage with their thoughts and feelings – a source of evil. • Mothers did not speak English. Others will judge me and I feel like I am on my own • Lack of support for the mother. • Feelings of being isolated and desperate for support.	Lack of support from the husband/partner Conflict with parents and parent-in-laws Cultural postnatal traditions/practices/ri tuals Social and residential status	Social – support Cultural

	Social status • Being part of an ethnic minority group is also related to their PND.		

Appendix 2.

Summary of findings about women's experiences of severe postnatal psychiatric illness

Study title Author(s) Year Country Country income group Study Aim	First-order constructs	Second-order constructs	Third-order constructs
1.Infanticide secrets: qualitative study on postpartum depression Jennieffer A. Barr Cheryl T. Beck Dec 2008 Australia High-income group Study Aim: To explore thoughts of infanticide that did not lead to the act among mothers with postpartum depression Examining the characteristics of infanticidal thoughts experiences by women with postpartum depression	Imagined acts of infanticide • The first theme related to women imagining acts of infanticide • Throwing the baby off the balcony or dropping the baby onto the cement • Sit for hours trying to determine if just dropping the baby from a standing position would be sufficient enough to kill the baby – speculate about what the baby would look like and how much blood would be present and how she would know that the baby had died • *"silly thoughts kept happening"* The experience of horror • Women's responses to having thoughts about harming their babies – women were shocked at having such thoughts and horrified by the nature of thoughts • *"I do a lot of things in the microwave, reheating things up, and I would suddenly stop seeing the food and see the baby going into the microwave, or I would be bathing him and realise how easy it would be to push him under the water…Shocking isn't it?"* Distorted sense of responsibility • Women felt despondent and believed that the situation was hopeless • They felt they couldn't ensure their suffering anymore • Women described having suicidal thoughts – occurred at the same time as the thoughts of infanticide • Feelings of distorted responsibility toward their babies • *"I use to plan the suicide and intended to take him with me. I believed that he was my responsibility and he would be disadvantaged by not having a mother, so it was better to take him with me"* • *"I felt that it wasn't fair on [the baby] to have a terrible mother, but it also wasn't fair on him not to have a mother. And so, to take him with me was the only option* Consuming negativity • Consuming negativity reflected the anger and hate – associated with thoughts of infanticide • *"You are so angry it's like a rage, it's all consuming, like a furry, like a volcano, you know, when it erupts. You feel like the lava as it starts at your feet and flows through your veins, rushing, and you can't stop it. It's so frightening and you can't stop it."* • Grave consequences of such anger could have resulted for some of the participants – especially when directed at the babies • *"The way I felt about [the baby], the frustration, I could have strangled him at times*	Momentary but recurring obsessions thoughts of harm to an infant are commonly experienced by depressed mothers Feelings of disgust and guilt about having such thoughts are common in women who have depression Validates that women experiencing thoughts of infanticide might come to realise that they need help Findings provide an insight into how women who have infanticidal thoughts might seek help Women did not mention thoughts of infanticide to a health professional. When suicidal thoughts are mentioned, health professionals should probe into infanticidal thoughts The morbidity and quality of life issues surrounding these distressing thoughts are key issues	Experiences of illness Consequences of illness Stigma Feeling judged Loss - Custody Loss

	[pause]. I put a teddy bear over him and could have easily suffocated him" Keeping secrets • All admitted to feeling ashamed and unable to share these thoughts with family/health professionals • Mothers were afraid they would be judged to be inappropriate mothers and their babies would be taken away • *"I had suicidal thoughts and plans for 3 weeks…but you know, you don't come straight out with it to your GP or your psychiatrist"* • *"I mean to say, why would you leave a baby with a mother who is thinking about putting him in a microwave. I used to see, in my mind, a pillow going over his head. So easy … the doctor says it's only thoughts. I get that, but what sort of a person am I even to imagine such things? … I have cried and cried over this [pause]. It was easier when I was numb and didn't feel at all. At least I didn't have these awful thoughts."* • *"My GP and psychologist always know when things are bad…but don't tell them the whole truth"* Managing the crisis • Fearful they were of opportunistic harm when they could not stop their babies from crying • Mothers organised paid help in the evenings at mealtimes – reduced the tension when the baby was restless • Delay bath time until their partners came home from work • Some women found it helpful to avoid of use distraction when thoughts of harming the baby occurred • *"I just try to think of something else…get up and watch the television"*		
2.Support needs of mothers who experience postpartum psychosis and their partners Shelley Doucet Nicole Letourneau Emma Robertson Blackmore March-April 2012 Canada High-income group Study Aim: To explore the perceived support needs and preferences of women with postpartum psychosis	Support Needs • The need for instrumental, informational, emotional and affirmational support – generic parenting needs and serious mental illness needs • Generic parenting needs – instrumental and informational support (help with house cleaning and looking after the infant) • Informational support (caring for their newborns) • Support needs related to mental illness focused on emotional, affirmational, informational and instrumental support • Mothers wanted reassurance that the aetiology of their illness was biological • Mothers wanted to know more about their treatment options, medication safety when breastfeeding, long term prognosis, risk of relapse with future pregnancies, birth control methods, and community support • Mothers also reported they needed information repeated often and in a variety of contexts – they wanted someone continually providing them with information – written down • Some mothers described needed a lot of instrumental support with caring for their infants – night feeding due to exhaustion from	All mothers expressed the need for more information on PP Women felt anger and frustration toward the health care system and reported inadequate access to information about their illness The stress endured by their families could have been alleviated and their recovery could have been improved Family members lack understanding proved a barrier to providing assistance and support Women preferred one-to-one support, as they lacked insight or were too paranoid to share experiences prior to this time Women experienced difficulties in having their illness recognised	Social Support Illness Explanatory Models Understanding of illness Experiences of illness

	sleep loss during a manic state or from side effects of medications • *"It was helpful having people come over and play with him and take care of him"* • Some women also described needing instrumental support to look after their own physical needs – bathing and eating • They needed a lot of guidance due to their confusion, disorientation, memory loss and poor judgement resulting from their illness • *"I need somebody with me at all times to be told what I had to do…I needed someone with me 24 hours, 7 days a week"* Support preferences • Informational support from professionals • Emotional, affirmational, and instrumental support from their informal networks • All women preferred one-on-one support immediately after their symptoms started and group support once their symptoms started improving Availability and Accessibility to Support • All mothers were able to obtain access to a general psychiatric unit for immediate support • Most would have preferred access to a unit specialised in postpartum mood disorders • They all discussed the importance of seeing their infants while in hospital – did not have access to their infants in the general psychiatric unit and found this hindered their recoveries • *"You can't logically figure out where your babies are or what happened to them. You get screwed up because you can't check, you think did my baby die – did I kill my baby?"* • Several mothers reported that the availability of support in the community was limited to monthly appointments with their psychiatrist – many had difficulties accessing community support due to long waiting lists • All mothers reported a divide between the hospital and the community – wished they would have provided more collaborative care • *The majority of available support was provided by mothers' partners and immediate families* Barriers to Support: health service barriers and lack of knowledge about PP • Mothers identified that the main barrier to support was their perception that health care providers were too clinical, uncaring and disinterested • Health care providers restricted access to their families in their treatment plan • Mothers reported they were left alone in the isolation rooms in hospitals • Most mothers felt that had their family members fully understood about their illness, they could have provided more support • *"If my husband had a support group for new fathers to deal with a psychotic wide, it would have changed everything. He would have been far more compassionate"*	None of the mothers reported stigma as being a barrier to accessing support Mothers require more support than is currently available	

3.A qualitative study of stigma among women suffering postnatal illness Elizabeth Edwards Stephen Timmons October 2005 United Kingdom High-income group Study Aim: To explore and gain an understanding of a mother's experiences, feelings and emotions in relation to stigma and the woman's perception of herself as a mother	Stigma • Stigma was perceived to exist from others, therefore women concealed their mental illness • *"When I was on the (mother and baby) unit I was really paranoid about what people would think, really paranoid…I didn't want [husband] to tell anybody where I was…but I just didn't want people to know I had a mental illness, I would have preferred them to think I was in hospital for a physical illness, definitely"* • Women felt able to disclose their illness as they recovered • Some women felt that other people had guessed, as a new mother do not tend to just disappear for a few weeks or months with a new baby • All the women spoke of having received negative experience on disclosing their illness, however people were understanding and supportive • Whilst women are in hospital they are thrown in to contact with others from the same group who share the same stigma enabling the women to discover that others like themselves exist – the woman to become a "we" • Women spoke of how their attitudes towards others with mental illness changed as a result of their own experiences – they spoke of being more compassionate towards others and feeling a need to help others from their own group by being open about mental illness and dispelling the myths • *"now we all know somebody affected by cancer, mental health should be like that"* Access to mental health services • Women experienced difficulty in having their illness recognised and therefore there was a delay before they received appropriate services and treatment Feel a "bad mother" • All of the women felt that the symptoms of their illness were a sign that they were unable to cope as a mother • Women spoke of how they were that distraught at feeling this way that they feared that their baby would (should) be removed into the care of others • These feelings were very difficult for women to comprehend • They described a lack of love or maternal instinct • They could not always complete the basic baby care tasks e.g. feeding, bathing and changing their baby • *"I had this vision of, picture of how I would be as a mother and I didn't live up to that expectation, so it made me feel quite bad"* Labels/diagnosis • All of the women found the symptoms of the illness, their thoughts, actions and behaviours frightening, horrifying and debilitating • However, when they were given their label/diagnosis they found it reassuring and a great relief	Stigma as a possible explanation for the reluctance to access to motherhood and mental health services Women feel a stigma towards themselves and they feared being viewed as being unable to cope with their new baby Mothers concern about being seen as a "bad mother" – a broader social construct When their illness progressed towards recovery, they felt they were about to disclose their illness to others All participants accepted the mental illness "label". They found it a source of relief As a medically recognised condition, they found it comforting that it was treatable	Stigma Unable to Cope as a Mother Custody Loss Experiences of illness

4.Experiences of the First Days of Postpartum Psychosis: An interview Study with Women Next of Kin in Sweden Inger Engqvist Kerstin Nilsson January 2013 Sweden High-income group Study Aim: To explore descriptions of the first days of postpartum psychosis from different perspectives, namely of the women and the of kin	• Most women stated that their pregnancy was normal and free from complications • One woman felt her pregnancy was difficult, as the pregnancy was unwanted and another had difficult experiences, which was related to illness and death among close family members • Most women said their childbirth as normal and some felt that giving birth was difficult • One ended in a caesarean section and for another the delivery was prolonged Loss of Sleep • After birth, they began to have problems sleeping – they had not expected and could not control. • They were exhausted and just wanted to sleep or rest after giving birth • They physically could not fall asleep, even though they were exhausted • *"I was so wound up. I couldn't relax…Then it was full speed ahead at night"* • One woman was scared and nervous to sleep • Another woman was scared her baby would die – her child had been found quite blue and lifeless in bed one day earlier • *"Then I decided to check the baby every 15 minutes to see if she was breathing"* Being in an unreal world • Instead of describing a sense of joy at the birth, the women said that even on the postnatal ward it all felt unreal – as if they were in a vacuum • Fear and anxiety arose about daring or wanting to go home from the hospital • One woman felt that something had happened in her brain – something had left it – as if she had lost something – to restore the loss, the woman bought a drink thinking this would restore her mental capacity • The whole world was unreal and the woman did not understand what was happening around her • She felt her thoughts were completely wrong – it was like falling into a tumble dryer – everything just rolled around without making any sense – a never-ending circle – in complete turmoil, totally confused and with enormous feelings of insecurity, fear and horror • *"I knew that something had happened in my brain and I needed something to restore it…the whole world was unreal…everything was horribly unusual and unreal"* • When one woman disappeared into a state of psychosis, she felt it was all messy inside her and so unreal that she must be dead • *"It was just messy…Then it all became just a mess…I thought I was dead"* • Being paranoid was both very uncomfortable and a common experience among the women • One woman felt constantly persecuted – a victim of conspiracy perpetrated by strangers and by people she knew • The clock was part of their delusions and an early sign of psychosis – seen as enlarged and dangerous • Time passed too quickly and the clock towered over the women – what they saw was a false and distorted reality	The overall perspective was that it was a difficult and dark experience Loss of sleep, being in an unreal world, infanticidal ideation and suicidal ideation Lack of sleep during the early stages of illness. Therefore a good sleep during the first few days could prevent an episode All women reported how a feeling of unreality came on and how this feeling emerged in conjunction with their sleeping difficulties A definite feeling of unreality, a "bubble", "being in my own world", "disappeared in unreality" Several women did not want the baby, "disgust for the baby", "fear of the baby", "hated being his mother" Women described strong infanticidal thoughts, often associated with psychotic delusions and loss of reality Several women stated they did not want to live, "all the doors were closed", "only total darkness", "I was useless and worthless" The feeling of not being able, and having no strength or desire to take care of the child was so severe that death was better The first symptoms the women in this study experienced were insomnia, feelings of unreality, not wanting the baby and infanticidal and suicidal thoughts	Antenatal experiences Childbirth experiences Experiences of illness Expectation versus the reality of Motherhood Unwanted pregnancy

From wanting the baby to not wanting the baby

- The women had not been looking forward to the birth with joy
- One of the women mentioned that her pregnancy was unwanted – after giving birth, they did not want the baby to produce feelings of anxiety and fear in the women and gave rise to guilt and shame
- The women were uncertain whether the baby was really theirs
- They had no desire to touch, kiss or embrace the child
- Only one woman stated that she loved her baby deeply and she never had any intention or urge to harm it
- One woman described a great fear of her child – her child was about to eat her and she was only calm when the baby was asleep – there was a "wall" between her and the baby and she could not reach her
- A woman was ashamed that she had betrayed her child by not being healthy during the first important period of her life
- *"I was afraid that she would eat me. It was like a dream…I was so afraid of her"*
- One woman gave a vivid account of not really wanting her baby and that he was unwanted – she wanted her old life back – before giving birth – she wished fervently that she could put him back into her womb and continue living as before – she had deep feelings of guilt about the way she thought
- *"I regretted it all the time, all the time, all the time – THAT I HAD THIS BABY! I would have done anything to undo it…I would have avoided everything that was so difficult and painful; all the sleeplessness and all this horror"*
- The woman could not see herself as his mother and she hated the word "mother" in connection with her son
- *"He was not my child…the word mother was a dirty word to me"*

Infanticidal ideation

- Recurring thoughts of harming or killing the baby – also wanting to kill all their children
- One woman did not trust herself and she felt that she wanted to save children so they could get away from this evil world
- *"I would give them something to eat so they would die, or I might strangle them. Killing them in a way that would not scare them"*
- One woman described the thoughts of her dead baby appearing as pictures from the outside, sailing like clouds from a black cover she felt was surrounding her
- *"They came like clouds out of this blackness…pictures of when he was dead…they just came to me in a way, as well as the desire for him not to be there"*

Suicidal ideation – A complete darkness

- The women stated they felt as if all the doors were closed and they had entered total darkness – without any hope
- They tried to cut themselves and kill themselves with an overdose of tablets

	• They said they were totally confused and felt fearful about their personality change – they did not recognise themselves • None of them said they refrained from suicide because of the newborn baby • *"IT was total darkness and there was no hope anywhere…complete hopelessness, totally black, totally…worse than hell!!"* • The felt abandoned and excluded from any form of fellowship – like living in a different place from where there were no human beings, just darkness and loneliness – life was just black, silent and empty – the baby was no longer in their thoughts • *"I was living in my own. A black world and very negative"* • If she did not have the strength to cope with feeling as bad as she did and being as worthless as she felt herself to be, then death was a better choice • *"You have no confidence. I was worthless"* The overall theme: shades of black with a ray of light • The experience of darkness, despair and suffering		
5.Puerperal psychosis – a qualitative study of women's experiences Lesley Glover Julie Jomeen Tracy Urquhart Colin R. Martin February 2014 United Kingdom High-income group Study Aim: This study aimed to gain further insight into women's individual experiences of puerperal psychosis and the context in which they make sense of it	The path to puerperal psychosis • Most women reported another stressful event in their lives before and during their pregnancy • Most started their narrative pre-pregnancy, describing anxieties, distress and difficult events linked to pregnancy and birth • Often the baby was unexpected, albeit due to different reasons but still surprising • *"It was a big shock because I'd had such a lot of gynaecological problems and didn't think I could have any more"* • This led to worries about behaviours in pregnancy that might impact on the well-being of the pregnancy-baby • Anxiety about the well-being of the pregnancy • *"it was ectopic…if I had not had any previous problems I would have not have known it was ectopic and that could have been life threatening. Eventually when I got pregnancy again, I was petrified"* • Pregnancy was disruptive to work, relationships and life in general • *"Well the baby wasn't really planned…my career was going really well…then we had to buy a house with a mortgage and everything"* • Beyond high levels of worry, other women reported psychological problems that began in pregnancy that were not addressed • *"I was depressed in the pregnancy…it was not easy pregnancy"* • Some of these same women then went on to describe their births as difficult, words like 'traumatic' and 'distressing' exemplify their negative perceptions of their birth experience • *"I was 36 weeks. I went into labour and that was quite traumatic because the labour lasted about 72 hours and I was so exhausted afterwards all I wanted to do was go to sleep but I couldn't."* • Several women then described a lack of control, a sense of detachment or unreality • One women thought it was normal after her first baby	Women identified factors including unplanned pregnancy, lack of social support, a conflict between work and motherhood, anxiety, depression, traumatic birth experiences, sleep deprivation and feelings they had fallen short in their mothering Women's experiences and implications for the stress vulnerability model Rather than reporting life events, women express a presence of negative emotions antenatal The content of delusions for women with PP relating to the baby may have a relationship to perinatal anxiety and emotional concerns about motherhood and mothering The processes which parallel those of delusion formation in psychosis are at play in PP The inconsistent message which a woman with PP may receive over causation and the exclusively medical management of the condition presents a context of incoherence This potentially places the woman in a situation of diminished personal control and a further heightened emotional context	Understanding of illness Antenatal Experiences Unplanned Pregnancy Childbirth Experiences Experiences of illness Expectation to uphold social role Stigma / Feeling judged Social support

	Unspeakable thoughts and unacceptable self • The content of their thoughts at the time of their illness was unbearable • Women were distressed with some of the thoughts they had • The sense of fear that began in pregnancy continues in relation the postnatal thoughts they were having and some still relate to the well-being/loss of their baby • The extreme and frightening nature of those thoughts is clear in women's accounts – most terrifying is that they were in a room with the very thing that scared them most • "*In the hospital and telling me to breastfeed…at one point I thought the baby was the devil and by feeding her she was sucking my life blood away* • A woman described how she could not comprehend her own thoughts, the sense of detachment and unreality first experienced during birth remain lucid • *"It was so scary, I just woke up and thought that someone had taken my brain out and I was trying to explain it to [HUSBAND] that someone had sawn off my head to get my brain and put someone else's in and I didn't know me anymore"* • Women felt they were not listened to – attempts to share their thoughts and feelings were largely dismissed • *"I desperately wanted help, it felt as though I was screaming inside my head and no one was listening"* Snap out of it • The notion of dismissal persists within the women's personal network – which would often be a normal source of support • "you've only had a baby, what's wrong with you, why you acting like that?" • The women felt there was an expectation by others – mainly mothers or mother-in-laws about motherhood that did not allow for a mental illness • Feelings of being judged by others – exacerbated feelings of distress • Most women described this general consensus of being able to just snap out of it as being the most unsupportive element of their illness – support as a potentially important aspect of the journey Perceived causes • All the women had been told and hence believed it was unavoidably caused by biological factors related to childbirth • *"They told me that I was unlucky that it was some sort of chemical imbalance in the brain caused by the pregnancy* • Some women persisted in describing other factors as being significant in both their condition's onset and maintenance • The importance of antenatal experiences and feelings were again highlighted • *"the biggest problem with antenatal care is everything is geared to your physical well-being rather than your mental and no one ever asks you how you're feeling emotionally…it is a big change and a lot of it was stress and circumstances"*	Critical comments from family appear to be a feature for women in this study In mainstream mental health, therefore has been a major movement away from medicalised, psychiatric approaches to a more psychological understanding of psychosis. Women themselves seem to point towards a more complex explanation of PP This promotes the value to considering a more holistic perspective of PP treatment and recovery 'Snap out of it' perspective underpinned by historical legacies of women's place in society and attitudes towards mental health. The importance of social aspects within the overall experiences of PP, in particular in terms of guilt and the role that it plays. Also illustrates the value women place on family support In line with the stress-vulnerability continuum model, there may be a need to begin thinking about the recognition of risk for PP antenatally, to facilitate intervention Findings do cautiously suggest a case for a more holistic, multidimensional understanding of PP. Confirmed biomedical factors should not preclude wider investigation of a phenomenon The stress vulnerability model considered within a continuum in the context of pregnancy and childbirth appears to offer a potential plausible theory for PP Recognising and investigating elements of PP may open shared understanding of the contribution of biological, social, environment, contextual risks and early warning signs	

	• Most wished to highlight the childbirth specific nature of their illness • Most women had not heard of PP before they experienced it		
6.Information and support needs during recovery from postpartum psychosis Jessica Heron Naomi Gilbert Clare Dolman Sonal Shah Ines Beare Sarah Dearden Nicola Muckelroy Ian Jones Jonathan Ives October 2011 United Kingdom High-income group Study Aim: The study aims to explore women's experiences of the process of recovery and their beliefs about the services needed to support recovery	Unmet expectations • They felt overwhelmed by the psychological enormity of the event • The unexpected and traumatic has occurred in place of the expected and joyful • Women experienced a sense of loss for the mothering role they had prepared themselves for • They perceived themselves as having failed in the first weeks of their infant's life and having 'let people down' • They felt guilty for the stress and burden caused to family members. • *"I feel like I wasn't there to look after my baby in the first weeks of his life… All these feelings of guilt because you missed out, or not being there, for your new born baby, and guilty"* • Women reported feeling shocked and bewilderment • the event did not make sense and was not consistent with their sense of self • Some women had considered the possibility of low mood or tiredness, but had no idea that it was possible to develop mania or psychosis following childbirth • *"It's such a shock and at the time that you were expecting to be such a wonderful time."* • *"Worst thing was the whole, sort of, psychological impact of it."* • Women described the experience as challenging their sense of personal identity and associated with a loss of dignity and independence • *"Your whole being, how you see yourself, the kind of person you are, and your whole sense of identity is completely devastated really, because you will have behaved in ways that shock you completely"* • The recovery period was dominated by anxieties and uncertainty about the future Medical support • Women admitted to units without their baby reported distress and anger about the separation and low confidence about taking over the mothering role on discharge • Self-esteem and confidence in mothering skills were low. Women often felt isolated and unsupported:	Participants reported a relatively homogenous account of factors that were important for their recovery The experience of PP was generally one of disruption, incoherence, and dissonance The experience is an affront to one's sense of reality and temporal continuity, personal and social identity and expectations about the way the world works and the future Recovery was viewed as a holistic process involving psychiatric symptoms, self-esteem, mothering confidence, social functioning, family functioning and well-being of the baby Emotional reactions include shock, fear, incomprehension, guilt, isolation and failure Women experienced loss, loss of early motherhood with their baby, loss of their normal character, loss of feeling like a value member of society, loss of the right to 'normal' emotions and a loss of equality and reciprocity in their personal relationships	Expectation versus the reality of Motherhood Loss Unable to Cope as a Mother Experiences of illness Feeling alone/isolated
7.The process of recovery in women who experience psychosis following childbirth Laura McGrath Sarah Peters Angelika Wieck Anja Wittkowski November 2013 United Kingdom High income group Study Aim:	Accepting loss • Women found that many losses associated with psychosis • Women expressed feelings of sadness, anger and guilt that they were unable to participate fully in caring for and bonding with their child • Anxiety about the potential adverse consequences of the experience for their child's development and described a painful reliving of their experience at time • Women who felt they could not risk subsequent pregnancies expressed anger, sadness and guilt that this choice had been taken away from them.	Women emphasised the importance of the context in which a diagnosis is given. A lack of information can cause disempowerment and hopelessness Initially, women reported feeling powerless in relation to their symptoms, other people and the mental health system and society	Loss Unable to Cope as a Mother Stigma Relationship Conflict Experiences of illness Expectation versus Reality of Motherhood Understanding of illness

	• Women expressed their desire to reduce stigma associated with mental illness but were resigned to the fact that it would remain to some extent • They discussed how the experience had put a strain on their relationship Using experience positively • Women acknowledged that their experience of psychosis had been extremely traumatic Initial understanding • Women identified a mismatch between their expectations and experience of motherhood. Women discussed feeling devastated that they were unable to meet expectations of them as new mothers imposed by society, leading them to feel guilty and ashamed • *"…it felt like I was- it felt like I'd failed I suppose. I probably felt a bit guilty."* • Women experienced conflict between their sense of self and their perceived movement toward the role of "mentally ill person." • Women's perceptions of this role were influenced by the socially constructed stereotype of someone with a mental illness imposed by society. • If the perception was incongruent with their identities, it caused them shame and fear of stigma Sociocultural context • Contextual factors in women's lives • Although women's beliefs incorporated aspects of the medical model, which dominates the mental health system, they were not restricted by it • Women believed that their experience was the result of multiple causes that combined to create a "perfect storm" or "domino effect," leading to the selection of multiple strategies for recovery • Women stated that biological factors, such as hormones, chemicals and genetics, were important but believed that "it's not the whole story." • They appeared to hold a stress-vulnerability model believing that they were biologically vulnerable to psychosis but that it was triggered by other factors • "My brain doesn't fit well with the birth process but then the sleep deprivation might have been the thing that, the switch that…the fuse that blew." • Triggers discussed by women included sleep deprivation, stress, trauma, bereavement and lack of social support • Many women discussed difficulties associated with breastfeeding, including perceived pressure from professionals, contributing to anxiety and feelings of failure. • Spiritual factors were discussed less often but had important implications for strategy use. • Women discussed that receiving a diagnosis contributed positively to their understanding • It challenged beliefs that they were "going mad" and that there was no hope for recovery • Women discussed how their evolving understanding allowed them to overcome fear of stigma and feelings of shame and	Women found it difficult to trust professionals who had the power to parent their child Women's beliefs about what caused their psychosis. Women's accounts were characterised by a combination of causes both biological and psychosocial Women's uncertainty about what caused their illness support the finding that people have difficulty in conceptualising their mental illness Women were initially driver to conform to society's expectations by concealing their illness experiences Women felt reluctant to share their experiences, presenting a barrier to accessing such support Women felt the desire to be able to share their experiences by helping other women and fighting stigma. Informal social support networks were able to mediate this freedom Culture also plays a role in the nature of support, also, in turn, appears to be related to the course of illness Loss has been recognised as part of the normal adjustment process for new mothers Pertinent to women in the current study were feelings of anger and sadness	

	hopelessness to enable more openness and support seeking		
8. Living with puerperal psychosis: A qualitative analysis Emma Robertson Antonia Lyons December 2003 Not mentioned Study Aim: To explore women's experiences of puerperal psychosis, and to gain some understandings about living with that experience following the illness	A separate form of mental illness • All of the women had very definite views on what caused their illness • They saw childbirth as the precipitant, whether it was due to hormonal changes, trauma during labour or childbirth or feelings of stress leading up to the birth • All women described the cause of their illness as biological • Strong feeling of needing to identify with others and to normalise the experience • Women often used the word 'freak' to describe themselves and needed to be 'normal' • Women described feelings of isolation and being scared • "it is a very scary illness" "you have no idea what's going on, what's real and what's not" Loss • Women felt a loss in motherhood – they missed out on motherhood in the first months of their child's life – guilt and inadequacy • Mothers felt like failures because they could not fulfil the role of a new mother and had become ill • "I get quite bitter about the fact that I couldn't do it" • A loss of control over what was happening to them • Lack of knowledge of the illness – powerless and scared • One woman felt it took away the enjoyable experience of being pregnancy and have more children, because the risk of further illness Relationship and social roles • The illness resulted in the breakdown of relationships – including with spouses • Women described almost a dichotomy between looking after their child and looking after their spouse • *"after I had been discharged my focus was on looking after [daughter], but I wasn't actually taking much notice that my relationship was sort of drifting apart"* • The illness places massive strain on the relationship • The women all spoke of the lack of support for their husbands • *"he was scared, I was being really weird and telling him I wanted to kill myself. He was trying to be supportive but he just look so scared"* • Women's friendships were deeply affected by the illness – a lack of understanding from friends Living with emotions • Women spoke of experiencing various emotions • Particularly guilt – they could not fulfil the role of mother and look after their baby during the first few months	Women viewed their psychosis as a different and separate form of mental illness Women discussed feelings of loss including social roles and changes in relationships as a consequence of their illness Women discussed experiencing guilt and loss. Guilt that they could not fulfil their role as a mother, and guilt because of the trauma that her family had to endure as a result of living with her illness Women were concerned about their child's development Negative emotions arose from the loss of the mother role and subsequent effects on primary relationships Loss on the experience of motherhood because they could not care for their baby or unaware they had a baby because of symptoms This had a detrimental effect on the spousal relationship Traditional views and ideas about motherhood in Western cultures may compound the negative feelings experienced by women with psychosis. Having a baby, being nurturing and taking care of her are 'feminine' roles. Failure to fulfil these social roles leads to feelings of guilt and loss. Women did not feel they were 'being a good mother' and added to their sense of loss and failure Women were inevitably scared by what was happening, leading to changed interactions with significant others – primarily disruption Stigmatisation and isolation experienced by women in the sample Women with psychotic symptoms were likely to experience isolation Women felt unable to experience normal 'ups and downs' in their mood	Understanding of illness Feeling alone/isolation Loss Unable to cope as a Mother Relationship Conflict Guilt

	• Guilty also because they thought that the illness may have a detrimental effect on the child's emotional and intellectual development • *"I was terribly worried when I was in hospital that it would affect her for the rest of her life"* • Other negative emotions – a separate form of mental illness' • Changes in mood and living with emotional ups and downs Regaining and changing self • The illness and its clinical symptoms and presentation meant that the women felt they had 'lost their minds', 'identity' of their personality • *"I didn't have a characteristics left of me at all"* • Life-changing experience • For some women the illness had a positive influence – they became more confident • *"I'm not really scared of anything anymore…apart from something terminal…I've had the most scary thing"*	Women describe losing themselves, their minds and their personalities – their illness changed them in some way Women felt the experience made them stronger, they gained strength, had increased confidence and increased sympathies for others Women's premorbid personality was a marker for normality – regaining self was an indicator for recovery Women's subjective experience of puerperal psychosis was a lonely and isolated one Anger and frustration from difficulties in gaining information about the illness Lack of support from their husbands – strains on spousal relationship Women 'pathologised' by the medical and scientific discourses The illness positions women in very powerless ways – double guilt and failure – double jeopardy	
9. Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others Caroline Wyatt Craig Murray Jenny Davies Julie Jomen April 2015 United Kingdom Study Aim: Explores the meaning ascribed to relationships by mothers who have experienced postpartum psychosis and their significant others	'She wasn't herself': threatened relationships through loss of 'normal' self • Women experiencing PP were perceived to differ from their 'normal' character • *"I was not behaving like myself. I was getting excited over like food and …very direct"* • Several forms of loss were experienced: of expectations of new parenthood; physical loss due to hospital admissions; perceived temporary loss of relationships • *"I'd always had panic attacks"* • Communication challenges were also inherent to PP experiences • Mothers felt unable to communicate their distress and negative responses to attempted communication reinforced this • *"I was quite obviously worried about it and he became quite nasty…I stopped communicating with him"* • Physical intimacy difficulties were challenging to resolve • *"it's probably affected our sex life…not irreversibly but erm, it took a while when I came home from hospital to have a normal relationship again in that way"* • Recovery and return to 'normalcy' was mirrored by a recapturing of fundamental relationship qualities such as communication and physical intimacy • This was facilitated through sharing postnatal experiences and constructing a shared conceptualisations of this individually experiences time	Results reiterate the importance of support networks in recovery from PP Findings suggest that unusual postpartum experiences are often rooted in understandable fears regarding relationships Dyad's experience of the mother become a stranger is experiences within the first few days – partner distress A sense of non-normalcy threatens relationships through disrupting communication, restricting physical affection and altering expected roles Positive changes in relationship in trust and respect – posttraumatic growth – the positive changes that occurs as a result of the struggle with highly challenging life events – facilitates recovery • The connection between relationships and the content of	Experiences of illness Loss Relationship Conflict Feeling alone/isolated Relationship Conflicts Expectation to uphold social role Guilt Social Support

	• Experience was described as cathartic • The PP experience was characterised as a sense of difference, both of the mother and the relationship Invalidation and isolation: relational dynamics in seeking, receiving and providing support • Mothers commonly experienced their distress and unrecognised or minimised • "I got lots of comments like "postnatal depression didn't exist in my day, you just had to get on with it" • Mothers perceived a lack of interest in understanding their experiences • Reparation was difficult • Mothers rarely ascribed retrospective blame to their partner for their role in hospital admissions • The experience of PP engendered feelings of isolation • *"they took a big family picture…that awful picture, everyone's laughing and I'm in tears"* • Mothers felt their experiences were invalidated if their partners did not respond in an empathic or timely way, causing ruptures in relationships, which could not always be repaired 'The worst life can throw at us': shared perceptions of trust and respect following PP • Experiences of PP was linked to positive relationships changes • *"fortunately it only changed it for the better"* • PP was believed to intensify the experience of new parenthood • Providing and receiving support was entwined with perceptions of trust A double-edged sword: understanding the influence of relationships on PP experience • Relationships were viewed as directly influencing PP experiences • Experiences labelled as delusions were grounded with interpersonal reality, for example fears or relatives' ill health due to stress • PP was characterised by relationship-related anxiety • Mothers spoke about the fear of abandonment in a temporary sense, many fearer their partner leaving entirely • Some mothers beliefs centred on the process of dying • Participants felt the pressure to be 'perfect. Mothers felt under a lot of pressure, seen to be doing everything correctly • Mothers tried to maintain this facade of coping, despite experiencing extreme levels of distress • Mothers felt guilty about separating their partner from their baby through hospital admission • Mothers often attempted to mitigate sadness and assuage these feelings • Mothers worried about letting other people down • Mothers also highlighted the importance of relationships within their recovery - the presence of a supportive and containing other provided security	unusual postnatal experiences – fears regarding their relationship with their baby, partner of others Anxiety, elation and guilt may play a central role in the development and content of delusional beliefs. Mothers described strong feelings of anxiety and elation during pregnancy and intense guilt when an immediate connection with their baby was difficult Experiences such as hearing voices are increasingly understood as messages regarding difficult life events and this provide an opportunity to resolve underlying conflicts The interviews highlighted the importance of developing a shared understanding of the postnatal period and the potential for professionals to facilitate this	

	• Mothers could feel contained while also experiencing negative emotions • *"I felt resentment, I felt angry but most of all I think I just felt supported"*		

Appendix 3.
Sponsor Confirmation Letter

FINANCE OFFICE

Dr Qulsom Fazil

Clinical & Experimental Medicine

University of Birmingham

Friday, 25 August 2017

Dear Dr Qulsom Fazil

Project Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study.

Sponsor Reference: RG 17-074
ERN reference: ERN 16-0866

Under the requirements of Department of Health Research Governance Framework for Health and Community Care, the University of Birmingham agrees to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable ethical opinion 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 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/l)ocuments/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

Dr Sean Jennings

Head of Research Governance and Ethics

Research Support Group

Cc Miss Harpreet Sihre

Appendix 4.

Insurance Confirmation Letter

UNIVERSITY OF BIRMINGHAM

FINANCE OFFICE

To Whom It May Concern,

Friday, 25 August 2017

Dear Sir / Madam,

Project Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study.

Sponsor Reference: RG 17-074

The University currently arranges Clinical Research Insurance through membership of UMAL, this cover is renewable annually on 1 st August and the University ensures that there are no gaps in cover.

We confirm that the University will arrange insurance for the above Research Trial for the duration of the Research Project involving human participants including legal liability cover. This will be subject to the terms, conditions and exceptions of the relevant liability insurance policies as detailed in the current trial documentation.

The University will provide notification if there are any changes to the provider in a particular year or if the indemnity limits change. Copies of the trial specific annual confirmatory letters will be available upon request.

Yours faithfully,

Dr Sean Jennings

Research Governance and Ethics Manager

On behalf of the Research Governance & Ethics Team

Research Support Group

Appendix 5.
Fully Authorised CI Agreement

SPONSORSHIP DECLARATIONS

Declaration by Chief Investigator
I, Dr Qulsom Fazil as Chief Investigator for

Project Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in South Asian women, living in the UK: A qualitative study ERN Reference: ERN 16-0866

confirm that:

1. I understand the duties required of the Investigators, the Funders and the Sponsor by the Research Governance Framework and appropriate legislation and I am appropriately trained and qualified to undertake the duties of Chief Investigator.

2. I undertake to comply with the University's policies and procedures and the principles of the Department of Health's Research Governance Framework for Health and Social Care or equivalent in the devolved nations, the principles of Good Clinical Practice, the Protocol, the University of Birmingham's Clinical Trial Management SOP portfolio (http://www.birmingham.ac.uk/research/activity/mds/mds-rkto/governance/index.aspx) and where applicable the relevant legislation to the territory in which the research will be conducted.

3. I confirm that where I wish to delegate duties for carrying out specific functions to another member of the Study team, that individual will be appropriately qualified for the delegated function, will receive sufficient support and training to fulfil that function and all delegated functions will be detailed e.g. in a Delegation Log

4. I take full responsibility for the conduct and delivery of the research as proposed after obtaining favourable REC review and any appropriate Site Research & Development permissions, and, where applicable, authorisation from the relevant competent authority (for the UK this is the Medicines and Healthcare products Regulatory Agency).

5. I shall conform to the requirements for annual reports to the Competent Authority and/or Research Ethics Committee and requirements for reporting of any Urgent Safety Measures, Serious Breaches and Suspected Unexpected Serious Adverse Events as described the UK legislation and in any event shall notify the Sponsor forthwith upon receiving notification of such an event, following the University's Clinical Trial SOP portfolio.

6. I understand and agree that the study files, records data and documents may be subject to review as part of an audit, inspection or for monitoring purposes. I shall assist with audits, monitoring activity and inspections of the conduct of the Study whether undertaken by the Sponsor or a regulatory body.

7. I understand that information relating to this research, and about me as a researcher, will be held by the Research Governance Team and on the Research Governance Database. This information will be managed according to the principles established in the Data Protection Act 1998.

8. I confirm that I have completed the On-line Registration form and lodged details of my research databases/datasets with the information Compliance Manager in accordance with the University's Data protection Policy: https://intranet.birmingham.ac.uk/legalservices/Data-Protection/Data-Protection.aspx

Declaration: I accept : i.those functions delegated to me in the table contained in Schedule A; and

ii. the general responsibilities set out above and the specific responsibilities and duties allocated to me in Schedule A

Signed by the CHIEF INVESTIGATOR

Signature: ……..

Name: ..Dr Qulsom Fazil……

Title: Lecturer in Disability Studies and Behavioural Science……

Date:27/03/2017.

Signed on behalf of THE UNIVERSITY OF BIRMINGHAM

Signature:

Name: Dr Sean Jennings

Title: Head of Research Governance and Ethics

Date: 25….. .enosv. •.ì.. ……

Study responsibilities	Sponsor duty delegated/assigned to Chief Investigator	Clarification of split duties
Authorisation for clinical trials and research ethics committee opinion		
Develop study documentation e.g. Protocol, ICF, PIS, Risk Assessment.	Yes	
Obtain favourable Research Ethics Committee Opinion	Yes	The Research Governance Team will sign as Sponsor Representative.
Obtain other appropriate approvals (e.g. GP practice approval, ARSAC, IRMER)	Yes	The Research Governance Team will sign as Sponsor Representative where required.
Obtain R&D Management Approval at all sites	Yes	Research Governance Team to implement Clinical Trial Site Agreements
Register Study with appropriate database (e.g. ISRCTN or clinicaltrials.gov)	Yes	
Ensure that required contracts and agreements are in place and that the terms and conditions of the contracts and agreements are adhered to.	Yes	Contracts Office to draft agreements, and CI to ensure agreements are adhered to.
Keep records of all amendments to the authorisations and obtain approval where approvals are required	Yes	Research Governance Team to sign as Sponsor Representative and to monitor approvals — CI to ensure approvals are sent to RGT.
Produce undertaking to allow inspection of premises in third countries if required	Yes	Contracts Office to ensure contracts/agreements reflect this.
Ensure study site personnel are aware of dates of approval and implementation of amendments	Yes	
Ensure annual progress reports are submitted to all relevant bodies (e.g. REC).	Yes	CI to copy Research Governance Team in to relevant correspondence.
Notify all relevant bodies of the conclusion or termination of the trial within the specified timeframes	Yes	CI to copy Research Governance Team in to relevant correspondence.
Ensure there are adequate insurance/indemnity arrangements	Yes	As per University of Birmingham Clinical Trial Management Standard

cover provided to compensate any harm as a result of the study		Operating Procedure, Research Governance Team will arrange and confirm insurance cover
GCP and the conduct of clinical trials		
Ensure that requirements for GCP training of study staff are met	Yes	
Ensure that the conditions and principles of Good Clinical Practice and the UoB quality management system are satisfied or adhered to	Yes	Clinical Research Compliance Team to: Develop/maintain the University of Birmingham Clinical Trials Quality Management System to be adhered to by CI/UKCRN registered Clinical Trials Units and other University of Birmingham stakeholders involved in clinical trials Perform and report on sponsor support visits and audits (University of Birmingham sponsored trials, University of Birmingham Clinical Trials Units) and report major issues to Clinical Trials Oversight Committee Clinical Trials Oversight Committee to advise on continuation of sponsorship Research Governance Team to continue/withdraw sponsorship as required.
Oversight of internal functions	Yes	
Oversight of external vendors	Yes	
Oversight of investigator sites	Yes	
Ensure that the trial is conducted in accordance with the protocol and subsequent amendments	Yes	
Ensure that relevant study-specific quality control documents are prepared and available upon request and that these are adhered to.	Yes	

Notify any serious breaches of Good Clinical Practice or the protocol, or any urgent safety measures taken to	Yes	As per University of Birmingham Clinical Trial Management Standard Operating Procedure, Serious Breaches

the appropriate authorities/bodies		must be reported to the Clinical Research Compliance Team for review. The Clinical Research Compliance Team to feedback major issues to CTOC. In addition, Clinical Research Compliance Team to work together with CI/UKCRN registered Clinical Trials Unit to ensure Corrective Action and Preventative Action is appropriate, and Clinical Research Compliance Team to ensure the University of Birmingham Clinical Trials Quality Management System is amended where needed to avoid recurrence.
Ensure study products and relevant devices are available to subjects free of charge	Yes	Contracts Office to ensure contracts/agreements reflect this.
Ensure that the study data is of highquality, accurate and held/processed securely and confidentially.	Yes	
Keep a trial master file to hold all documents relating to that trial	Yes	RGT will hold a Sponsor file to allow for Sponsor oversight.
Ensure site files are maintained at each participating site	Yes	
Obtain written informed consent and ensure consent forms are retained in appropriate site files.	Yes	
Appoint named individuals responsible for archiving the trial essential documents	Yes	
c. Participant Safety		
If applicable ensure an investigator's brochure exists and is validated and updated at least annually	Yes	

Devise and implement urgent safety measures	Yes	
Keep records of all adverse events relating to that trial which are reported by investigators	Yes	
Recording and reporting suspected unexpected serious adverse reactions to appropriate bodies within specified timelines	Yes	

Internal-CI-Agreement-UoB-sponsor-UK-study---non-CTIMPs-V 1

Ensure investigators are informed of suspected unexpected serious adverse reactions	Yes	Research Governance Team will inform CI/UKCRN registered Clinical Trials Units managing University of Birmingham sponsored trials of other University of Birmingham sponsored trials if appropriate.
Provide annual list of suspected serious adverse reactions and a safety report to the appropriate bodies	Yes	

Internal-CI-Agreement-UoB-sponsor-UK-study---non-CTIMPs-V1

Appendix 6.

Public & Products Liability Certificate

Hasilwood House
60 Bishopsgate
London EC2N 4AW
Tel: 020 7847 8670
Fax: 020 7847 8689
Website: www.umal.co.uk

TO WHOM IT MAY CONCERN

15th July 2017

Dear Sir/Madam

THE UNIVERSITY OF BIRMINGHAM
AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following covers are currently in place:-

PUBLIC AND PRODUCTS LIABILITY

Certificate of Entry No.	UM034/95
Period of Cover	1 August 2017 to 31 July 2018
Includes	Indemnity to Principals and includes cover whilst University employees and its students are engaged in Health and Social Care activities world-wide – excluding Medical Malpractice claims except as under
Includes	Medical Malpractice (mis-treatment) claims against the University and its employees and its students providing the latter are working under the supervision of a medically qualified person
Limit Of Indemnity	a) £50,000,000 any one event and in the aggregate in respect of Products Liability and Unlimited in the aggregate in respect of Public Liability b) Medical Malpractice – £10,000,000 any one event and in the aggregate
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE Insurance (Europe) Ltd

Yours faithfully

Susan Wilkinson for U.M. Association Limited

ISO 9001
REGISTERED FIRM

Appendix 7.
Generic Insurance Letter

Hasilwood House
60 Bishopsgate
London EC2N 4AW
Tel: 020 7847 8670
Fax: 020 7847 8689

TO WHOM IT MAY CONCERN

15th July 2017

Dear Sir/Madam

THE UNIVERSITY OF BIRMINGHAM AND ALL ITS SUBSIDIARY COMPANIES

Clinical Trials Coverage

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following cover is currently in place in respect Clinical Trials undertaken within the United Kingdom subject to the cover terms, conditions and exceptions.

Certificate of Entry No.	UM034/95
Period of Cover	1 August 2017 to 31 July 2018
Limit of Indemnity	£30,000,000 any one claim and in the aggregate including claims costs and expenses
Basis of Cover	Legal Liability or No Fault cover
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE Insurance (Europe) Limited
Main Cover Exclusions	i) Trials involving subjects under 5 years of age ii) Trials assisting with or altering in any way the process of conception iii) Trials investigating or participation in methods of contraception iv) Trials involving genetic engineering other than for preventing and diagnosing disease v) Trials involving drugs or surgery or nutrients vi) Trials involving persons known to be pregnant vii) Trials involving products manufactured by the University

Yours faithfully

Susan Wilkinson
For U.M. Association Limited

Appendix 8.
Employers Liability Insurance

Hasilwood House
60 Bishopsgate
London EC2N 4AW
Tel: 020 7847 8670
Fax: 020 7847 8689

TO WHOM IT MAY CONCERN

15th July 2017

Dear Sir/Madam

UNIVERSITY OF BIRMINGHAM
AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following covers are currently in place:-

EMPLOYERS' LIABILITY

Certificate No.	Y016458QBE0117/034
Period of Cover	1 August 2017 to 31 July 2018
Limit of Indemnity	£50,000,000 any one event unlimited in the aggregate.
Includes	Indemnity to Principals
Cover provided by	QBE Insurance (Europe) Limited and Excess Insurers.

PUBLIC AND PRODUCTS LIABILITY

Certificate of Entry No.	UM034/95
Period of Cover	1 August 2017 to 31 July 2018
Includes	Indemnity to Principals
Limit Of Indemnity	£50,000,000 any one event and in the aggregate in respect of Products Liability and unlimited in the aggregate in respect of Public Liability.
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE Insurance (Europe) Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

Susan Wilkinson

Susan Wilkinson
For U.M. Association Limited

Appendix 9.

NHS Health Research Authority approvals

NHS
Health Research Authority

Dr Qulsom Fazil
Institute of Applied Health Research
University of Birmingham
Edgbaston, Birmingham
B15 2TT

Email: hra.approval@nhs.net

29 November 2017 – Re-issued on 18 December 2017

Dear Dr Fazil

Letter of HRA Approval

Study title:	**Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study.**
IRAS project ID:	**220825**
Protocol number:	**RG_17-074**
REC reference:	**17/WM/0350**
Sponsor	**University of Birmingham**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

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

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

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

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is **220825**. Please quote this on all correspondence.

Yours sincerely

Juliana Araujo

Assessor

Email: hra.approval@nhs.net

Copy to: *Sponsor Representative: Dr Sean Jennings, University of Birmingham*
Lead NHS R&D Office Representative: Ms Katie Williams, Birmingham and Solihull Mental Health Foundation Trust

Appendix A - List of Documents

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

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Confirmation Letter]	1	25 August 2017
HRA Schedule of Events [HRA Schedule of Events (Reviewed)]	1.0	29 November 2017
HRA Statement of Activities [HRA Statement of Activities (Reviewed)]	2.0	29 November 2017
Interview schedules or topic guides for participants [Focus Group Schedule_Version 1]	1	04 September 2017
IRAS Application Form [IRAS_Form_14092017]		14 September 2017
Letter from sponsor [Sponsorship Confirmation Letter]	1	25 August 2017
Other [Participant Consent Form Focus Group]	1	23 July 2017
Other [Participant Demographic Information Sheet]	1	22 June 2017
Other [External Review_Professor Bhui]	1	24 November 2017
Other [Participant Information Sheet]	3	24 November 2017
Other [Letter of Invitation to Participant (Sent in Post)]	1	07 November 2017
Other [Interview Schedule]	2	07 November 2017
Other [GP Notification Letter]	2	05 November 2017
Other [Consent to Contact Form]	2	19 November 2017
Other [Advertisement]	2	20 November 2017
Other [Protocol for Managing Disclosure of Risk_BSMHFT patients]	1	23 July 2017
Other [Protocol for Managing Disclosure of Risk_CNWL patients]	1	23 July 2017
Other [Employers Liability Insurance]	1	25 August 2017
Other [Generic Insurance Letter]	1	25 August 2017
Other [Public and Products Liability Certificate]	1	25 August 2017
Other [Professor Gill CV_Version 1]		
Other [CV Antje Lindenmeyer May 17 full]		
Other [Focus Group Schedule]	1	04 September 2017
Other [Dr Lindenmeyer CV]	1	04 September 2017
Other [Professor Gill CV]	1	05 September 2017
Other [REC response letter]	1	20 November 2017

Other [Protocol]	2.0	18 November 2017
Other [Letter of Invitation to Participant]	2	06 November 2017
Participant consent form [Participant Consent Form Interview]	1	23 July 2017
Summary CV for Chief Investigator (CI) [CV Dr Qulsom Fazil]	Version 1	27 March 2017
Summary CV for student [Summary CV]	Version 1	27 March 2017
220825 17WM0350 Provisional Opinion 2017.10.02.pdf		02 October 2017
220825 17WM0350 application valid 2017.09.06.pdf		06 November 2017
220825 17WM0350 Favourable with conditions 23.11.2017.pdf		23 November 2017
220825 17WM0350 Favourable opinion conditions met 18.12.2017.pdf		18 December2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in

England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Dr Sean Jennings
Tel: 01214158011

Email: researchgovernance@contacts.bham.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments

2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will form the agreement between the sponsor and the participating NHS organisations. The Schedule of Events was submitted.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional
Section	**HRA Assessment Criteria**	**Compliant with Standards**	**Comments**
			indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No funding application was made for the study.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	NHS Research Ethics Committee favourable opinion was confirmed by the West Midlands - South Birmingham Research Ethics Committee on 18 December 2017.

6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is a multi-site study undertaking the same research activities; there is therefore one research type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).
As per the Statement of Activities provided a Local Collaborator will be in place at each participating NHS organisation. No assistance to identify potential Principal Investigators is required from participating NHS organisations. GCP training is not a generic training expectation, in line with the HRA/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the preengagement checks that should and should not be undertaken
It is unlikely that letters of access or honorary research contracts will be applicable, except where external staff employed by another Trust (or University) are involved (and then it is likely that arrangements are already in place). Where arrangements are not already in place, external staff would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 10.

NHS Research Ethics Committee approvals

NHS
Health Research Authority

West Midlands - South Birmingham Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

14 February 2018

Miss Harpreet K Sihre

Institute of Applied Health Research

University of Birmingham

Edgbaston, Birmingham

B15 2TT

Dear Miss Sihre

Study title:	**Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study.**
REC reference:	**17/WM/0350**
Protocol number:	**RG_17-074**
Amendment number:	**3**
Amendment date:	**22 January 2018**
IRAS project ID:	**220825**

The above amendment was reviewed on 12 February 2018 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP)	3	22 January 2018
Research protocol or project proposal	3	22 January 2018

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

Yours sincerely

Professor Paula McGee Chair

E-mail: **NRESCommittee.WestMidlands-SouthBirmingham@nhs.net**

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Katie Williams, Birmingham and Solihull Mental Health Foundation Trust*
Miss Harpreet K Sihre

West Midlands - South Birmingham Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 12 February 2018

Committee Members:

Name	*Profession*	*Present*	*Notes*
Ms Philippa Burgon	Retired Local Government Officer	Yes	
Professor Paula McGee	Professor of Nursing	Yes	Chair

Also in attendance:

Name	*Position (or reason for attending)*
Ms Ellen Swainston	REC Manager

Appendix 11.

Confirmation of Capacity and Capability at CNWL

Harpreet Sihre (PhD App Health Resea FT (A900))

From:	NOCLOR, Finance (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) <finance.noclor@nhs.net>
Sent:	31 January 2018 15:56
To:	researchgovernance@contacts.bham.ac.uk; resgoviras@lists.bham.ac.uk
Cc:	Harpreet Sihre; Quisoom Fazil; LEWIN, Jona (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST); NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST); MCNICHOL, Nevan (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST)
Subject:	RE: IRAS: 220825- Local AAC review complete at CNWL
Attachments:	HRA Statement of Activities_CNWL_Fully executed.pdf

Dear All,

RE: IRAS 220825 Confirmation of Capacity and Capability at Central North West London NHS Foundation Trust.

Full Study Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study.

Site PI/LC: Dr Jona Lewin

This email confirms that Central North West London NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached the agreed Statement of Activities as confirmation.

Central North West London NHS Foundation Trust agrees to start this study on a date to be agreed when you as sponsor give the green light to begin. Please ensure the R&D office and local CRN contacts are provided with this date.

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

As specified in the HRA Approval, Letters of Access for the research team are not considered necessary

Please note, in line with national HRA approvals process, you will no longer receive an NHS R&D Approval/Permission letter.

Kind regards,

Rukayat

On behalf of Central North West London NHS Foundation Trust

Rukayat Adewoye
Costing and Contract Assistant

Tel
Email
Website http://www.noclor.nhs.uk
Twitter @NoclorResearch

1

Appendix 12.

Confirmation of Capacity and Capability at BSMHFT

Harpreet Sihre (PhD App Health Resea FT (A900))

From:	ResearchandInnovation (BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST) <bsmhft.researchandinnovation@nhs.net>
Sent:	30 January 2018 14:20
To:	researchgovernance@contacts.bham.ac.uk; Qulsoom Fazil; JANKOVIC, Jelena (BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST); Harpreet Sihre
Cc:	WILLIAMS, Katie (BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST); WARNER, Katie (BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST); 'Everard Linda (Linda.Everard@bsmhft.nhs.uk)'
Subject:	IRAS ID: 220825 – Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK– Confirmation of Local Capacity and Capability at Birmingham and Solihull Mental Heal
Attachments:	HRA Statement of Activities_Version1.pdf; Harpreet Sihre LOA 22 January 2018.pdf
Importance:	High

Dear Dr Jennings, Dr Fazil

IRAS ID: 220825 – Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study –

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 Statement of Activities as confirmation.

We agree to start this study on **30 January 2018**.

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

Please refer to the HRA Approval letter dated **18 December 2017 – Re-issued** for latest versions of approved documentation.

The target date for first patient recruited is **1 March 2018** – 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&I of any amendments to the study, both substantial or non-substantial

- Inform R&I when the study has completed

- Inform R&I of the total recruitment number

- Submit a final report to the R&I department.

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

1

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

Kind regards

Donna

Donna Allin
Business Admin Manager

Birmingham and Solihull Mental Health NHS Foundation Trust
National Centre for Mental Health
The Barberry, Research and Innovation
25 Vincent Drive
Edgbaston
Birmingham
B15 2FG

****
****

This message may contain confidential information. If you are not the intended recipient please inform the
sender that you have received the message in error before deleting it.
Please do not disclose, copy or distribute information in this e-mail or take any action in relation to its contents. To do so is strictly prohibited and may be unlawful. Thank you for your co-operation.

NHSmail is the secure email and directory service available for all NHS staff in England and Scotland. NHSmail is approved for exchanging patient data and other sensitive information with NHSmail and other accredited email services.

For more information and to find out how you can switch,
https://portal.nhs.net/help/joiningnhsmail

Appendix 13.

Research Passport

Research Passport Application Form — Version 3 01/09/2012

Please refer to the guidance notes before completing the form.

Section 1 - Details of Researcher To be completed by Researcher			
1.	Surname: Sihre		Prof☐ Dr☐ Mr☐ Mrs☐
	Forename(s): Harpreet Kaur		Miss Msû Otherû
	Work Tel: Mobile:		
2.	Date of birth:	Gender: Male Female	
	Ethnicity: British Asian	National Insurance number:	
3.	Professional registration details, if applicable (Doctors undertaking any form of medical practice should confirm they have a licence to practise).		
4.	Employer:	or place of study: University of Birmingham	
	Work Address/Place of Study: The Institute of Applied Health Research, College of Medical and Dental Sciences University of Birmingham Edgbaston Birmingham B15 2TT		
	Post or status held: Doctoral Researcher		
Section 2 - Details of Research To be completed by Researcher			

5.	What type of Research Passport do you need? Project-specific E Multi-project			
	If you will be conducting one project only please complete the details below. If you anticipate that you will be undertaking more than one project at any one time, please give details in the Appendix.			
	Project Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK			
	Project Start Date: October 2017 End Date: October 2017 Proposed start and end-date of 3-year Research Passport: Start Date: October 2017 End Date: October 2020			
	NHS organisation(s):	Dept(s):	Proposed research activities:	Manager in NHS organisation:
	Birmingham and Solihull Mental Health Foundation Trust	The Barberry Perinatal Mental Health Service	Interviews/focus groups with out-patients	
	Central and North West NHS Foundation Trust	Coombe Wood Perinatal Mental Health Service	Interviews/focus groups with out-patients	

Section 3 — Declaration by Researcher To be completed by Researcher		
6.	Have you ever been refused an honorary research contract?	Yes No
	Have you ever had an honorary research contract revoked?	Yes No
	If yes to either question, please give details:	
I consent to the information provided as part of this Research Passport and attached documents being used, recorded and stored by authorised staff of the NHS organisations where I will be conducting research.		
Signed:	Date: 21/09/2017	
When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.		

Section 4 - Suitability of Researcher To be com letedb researcher's substantive em 10 er, e. . line mana er, or academic su ervisor		
7.a	Will this person's research activity mean that they may be undertaking regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012 ? lease use the Research Pass ort al orithm to make this •ud ement	Yes ☐ No ☑
7. b	I am satisfied that the above named individual is suitably trained and experienced to undertake the duties associated with the research activities outlined in this Research Pass ort form.	
	Si ned: Qulsom A	Date: 2017
	Name: DR Qulsom	Job Title: Lecturer.
	De artment and Or anisation: Institute	applied Health Research
	Address:	
	Tel No:	Em
	Mana erial res onsibilit for the a licant:	
When Section 4 has been completed, the researcher should forward the form to the appropriate person to com lete Section 5.		
Section 5 - Pre-engagement checks To be completed by the HR department of the researcher's substantive em 10 er orre ist at lace of stud		
8.	Does the above named individual's research involve Regulated Activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended in articular b the Protection of Freedoms Act 2012 ?	Yes Üío
	If yes to the above, has the above named individual been checked against ISA barred lists for adults and/or children, as appropriate and have you received confirmation via the criminal record disclosure that the person is not barred from working with adults and/or children? (NB individuals who are barred from working with adults or children must not undertake a regulated activity in the NHS with the vulnerable group from which they are barred, and ou must not submit a Research Pass ort form in such cases .	Checked against: ISA Adults List? Yes [2 No [2 N/A ISA Children's List? Yes No N/A
	Can you confirm that a clear criminal record disclosure has been obtained for the above-named individual, with no subsequent reports from the individual of changes to this record? NB for Regulated Activity this must be an enhanced level criminal record check. For non-regulated activity, ensure the criminal record check is at the mandated level.	Yes ☑ No ☐ N/A ☐
	If yes, please provide details of the clear disclosure:	
	Date of disclosure: 17 Aug ve--•e	Type of disclosure: Enhanced.
	Disclosure No.. 001584522 60 +	Organisatio that requesßed disclosure: Birmingham.
9.	Have the pre-engagement checks described below been carried out with regard to the abovenamed individual and is confirmation of the necessary checks, including any required satisfactory documenta evidence, available in the em 10 in or anisation's/ lace of stud 's records?	
	Em lo ment/student screenin	
	o ID with hoto ra h	Yes ☑ No ☐

o two references	Yes ☑ No ☐
o verification of ermission to work/stud in the UK	Yes ☑ No ☐
o ex loration of an a s in em lo ment	Yes No
Evidence of current rofessional re istration	Yes No N/A
Evidence of ualifications	Yes o
Occu ational health screenin / clearance	Yes 0 C]

Is the named individual on a fixed term contract or is thecontra t end imminent? Yes No
Please indicate current contract end-date Date: I O q/ 2018.

Si ned: [illegible]		Date:	O m (
Name: Rachel	[illegible]	Job Title:	Operations
Or anisation: Inimersi	of Birmi	De artment: Medicalt	
Address: Medical	Building.	aston ; Birmingh	
Tel No:	Email:		

Please return the form to the researcher.

Section 6 - Instructions to applicants To be com leted b Researcher	
Please indicate which of the followin documents are attached to this Research Pass o	
Current curriculum vitae, including details of qualifications, training and professional registration (please use the template C.V. at http://www.rdforum.nhs.uk/docs/template cv.doc)	No
Researcher's copy of criminal record disclosure. NB where research involves regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), the disclosure must include confirmation of a check against the appropriate ISA barred list(s).	Yes ☑ No ☑ N/A ☐
Evidence of occupational health screening / clearance	Yes ☑ No ☑
Appendix — List of projects and amendments	Appendix numbers: N/A C]

Please send the completed form and original documents to the Lead R&D office. The completed form and original documents will be returned to you. This package of documents will be used to validate your completed Research Passport form. You may then, and where relevant, provide the Research Passport to other NHS organisations.

You must inform all NHS organisations that have received this Research Passport of any changes to the information supplied above. Failure to do so may result in withdrawal of your honorary research contract or letter of access. As part of the quality control procedures for the Research Passport, random checks on the accuracy of the information held on this Research Passport may be made.

Section 7

This section should be completed by HR in the Lead NHS organisation, only if additional checks are undertaken

The following additional checks have been completed:	
Having confirmed that the necessary additional pre-engagement checks have been completed, I am satisfied that the above named researcher is suitable to carry out the duties associated with their research activi outlined in this Research Pass ort.	
Si ned:	Date:
Name:	Job Title:
Or anisation:	De artment:
Email:	

Section 8 - For Office Use Only

This section should be completed by the NHS R&D office that received the initial application. The NHS R&D office must countersign and date retaine photocopies of the documents. The grey section must be completed before the form is returned to the pplicant.

CV reviewed?	Yes No	Training?	yes No	
Evidence of qualifications?	Yes NO	Appendix pages reviewed?	Numbers:	
Professional registration details reviewed?	Yes C] No N/A	ccupational health clearance reviewed?	yes NO C] N/A	
Criminal record disclosure reviewed?	Yes ☑ No ☐ N/A ☐	Date of disclosure: ure: 17 AUGUST 2017 Disclosure No: 001584522607		
For regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), did the criminal record disclosure confirm a satisfactory check against the appropriate ISA barred list(s)			Yes No N/A	
Enter Electronic Staff Record Number (if issued): N/A				
Confirmation of valid search ort: Ending Passport: OC4c) 2020 Project specific Three-yearDate: ☑ Other EndDate				
Signed:		Date:		
Name: DONNA ALLIN				

BIRMINGHAM AND SðL/HUUC MENTAL HEALTH	NHS Organisation Name and contact details
THE BARBERRY RESEARCH AND INNOV HT7ð/U/ 25 VINCENT DRIVE EDGBASTON, BIRMINGHAM B15 2FG	ÊðWDÐ71ð —ads-T
Date Honorary Research Contract/letter of access issued (delete as appropriate)	

If required, this section should be added to the Research Passport Form and completed by each NHS R&D office receiving the valid Research Passport. The original Research Passport form and documents should be returned to the applicant.			
Has the Research Passport been validated by a Lead NHS organisation and is this validation acceptable to this NHS organisation? Yes C] NO			
CV reviewed?	Yes NO C]	Training?	Yes C] NO Cl
Evidence of qualifications?	Yes NO	Appendix pages reviewed?	Numbers:
Professional Registration details reviewed?	Yes ☐ No ☐ N/A ☐	Occupational health clearance reviewed?	Yes No N/A
Criminal record disclosure reviewed?	Yes ☐ No ☐ N/A ☐	Date of disclosure: Disclosure No:	
For regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012, did the criminal record disclosure confirm a satisfactory check against the appropriate ISA barred list(s)			Yes No N/A
Checked Electronic Staff Record: Yes NO C] N/A			
Signed:		Date:	
Name:			
NHS organisation name and contact details:			
Date honorary research contract/letter of access issued (delete as appropriate)			

Passport Appendix. List of projects and amendments

Appendix Number: 1.

If you are applying for a three-year Research Passport, please use this section to enter details of projects and activities that will be covered by this Research Passport. Once you have a validated Research Passport, you may add details of subsequent projects during the three years that this Research Passport is valid.

If you are applying for a project-specific Research Passport, but need to add further sites to the project, please enter the details below.

Whenever you add further details, the full Research Passport and accompanying documents must be submitted to the relevant NHS organisations.

Title:		*Start Date:*	*End Date:*
NHS organisation(s):	*Dept(s):*	*Proposed research activities:*	*Manager in NHS organisation:*
Birmingham & Solihull Mental Health Foundation Trust.	Perinatal Mental Health Services	Interviews with patients	
Central & North West London NHS Foundation Trust.	Perinatal Mental Health Services	Interviews with patients.	

Amendments to the Research Passport

Please state what these are, e.g. they might be a change in name or employment details, or a change in research activities.

Please check with the NHS organisation where you are undertaking your research if you are unsure whether you will need to submit new evidence of pre-engagement checks on a new Research Passport form, which will need to be validated by the NHS organisation(s) hosting your research.

Date	Old Details	New Details	Office use only NHS contact details and si nature

To add more projects please copy this page or download further blank pages. Each appendix page should be numbered.

For office use only:

A photocopy of the appendix should be retained whenever any amendments or additions to the appendix are made.

Appendix 14.

Clinical Clearance

Occupational Health Services
The University of Birmingham
13 Pritchatts Road
Edgbaston
Birmingham B15 2QU

PRIVATE & CONFIDENTIAL
Addressee Only

Date: 21 September 2017

Our Ref: 0001187749

CLINICAL CLEARANCE

Post reference number (if known):

Name: Miss Harpreet Kaur Sihre

DOB:

Post: Student - PG

Department: Institute Of Applied Health Research HPPRIM

I confirm that, in accordance with the 2007 Guidelines for Clearance of New Healthcare Workers, you have been cleared to work in the NHS.

Signature: _____ Date: _____

Verified
21 SEP 2017
Occupational Health

Sophie Gask
Occupational Health Adviser
RGN, Diploma in Professional Studies (Occupational Health)

Appendix 15.

DBS Enhanced Certificate

STRICTLY PRIVATE AND CONFIDENTIAL

Enhanced Certificate

Page 1 of 2

Disclosure & Barring Service

DBS Fee Charged

Certificate Number

Date of Issue: 17 AUGUST 2017

Applicant Personal Details

Surname:

Forename(s):

Other Names:

Date of Birth:

Place of Birth:

Gender:

Employment Details

Police Records of Convictions, Cautions, Reprimands and Warnings

NONE RECORDED

Information from the list held under Section 142 of the Education Act 2002

NONE RECORDED

DBS Children's Barred List information

NONE RECORDED

DBS Adults' Barred List information

NONE RECORDED

Other relevant information disclosed at the Chief Police Officer(s) discretion

NONE RECORDED

Enhanced Certificate

This document is an Enhanced Criminal Record Certificate within the meaning of sections 113B and 116 of the Police Act 1997

THIS CERTIFICATE IS NOT EVIDENCE OF IDENTITY

Continued on page 2

Disclosure and Barring Service, PO Box 165, Liverpool, L69 3JD Helpline: 03000 200 190

© Crown Copyright

Appendix 16.

Study Advertisement

UNIVERSITY OF BIRMINGHAM

INSTITUTE OF APPLIED HEALTH RESEARCH

Birmingham and Solihull Mental Health NHS Foundation Trust NHS

Research participants needed!

Study Full Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK.

What is the study about?

- To explore your experiences of living with a severe postnatal psychiatric illness
- [redacted]

your severe postnatal psychiatric illness.

Who can participate?

- Participant is South Asian Female
- Participant is 18 years or above
- Participant is able to speak sufficient English.

What is involved?

- Participate in a one-to-one, face-to-face in-depth interview about your experiences of living with a severe postnatal psychiatric illness and experiences of Perinatal Mental Health services, care and support
- The interview can take place at your home or a preferred location
- Any travel and/or childcare cost will be covered, if required The interview will aim to last 1 hour and will be recorded.

ALL INFORMATION WILL REMAIN *PRIVATE* *CONFIDENTIAL* AND *ANONYMOUS*

If you have any questions or if you are interested in participating in this study, please ask a member of staff on the Mother and Baby unit. A member of staff will refer you to the researcher after you have been discharged from the Mother and Baby unit.

Advertisement Material_Version 2_20-11-2017

Appendix 17.

Study Recruitment Script

Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK:
A qualitative study protocol

SHORT STUDY TITLE: The lived experiences of severe postnatal psychiatric illness

IRAS Project ID: 220825

Telephone call to potential participants:

- The potential participant identified by a member of the clinical team, will either still be under the care of the services or discharged from the services.
- A member of the clinical team will make the telephone call to the potential participant.
- During this initial telephone call, the clinician will advise the potential participant about a "health research" study about experiences and invite them to partake.
- They will be informed that their participation will involve a face-to-face interview with the researcher that will last one hour.
- The interview can take place at their home, the Trust, the University of Birmingham, or a preferred location of their choice.
- The potential participant will also be told that their information will remain private and confidential and anonymous.
- If the potential participant expresses an initial interest, they will be asked to provide verbal consent for their contact details to be referred to the researcher. They will then be informed that the researcher will be in contact. They will be given several options for the researcher to contact them i.e. contact via post, email, telephone or in person.

Appendix 18.

Letter of Invitation to Participant

Trust address

Name and Address of potential participant < insert >

Date < insert >

Dear < insert name of potential participant >

We are writing to invite you to participate in a research study that is being conducted by a researcher from the University of Birmingham as part of their PhD project.

The study is about the lived experiences of postnatal psychiatric illnesses in South Asian women and also experiences of Perinatal Mental Health services. Your story about your illness will be highly valued for this area of research for the South Asian community and for service provision.

Your participation in the research study would involve an interview with the researcher that will aim to last approximately 1 hour. You will have the option for the interview to take place at your home, the NHS Trust or a quiet location of your choice. Any travel and/or childcare cost will be covered, if required. The interview will be audio-recorded to help with analysing the interview. All of the information you provide will remain **private and confidential** and **anonymous**.

If you decide you want to take part in this research study or wish to find out more information, please complete and return the Consent to Contact Form (please find enclosed). This will allow the researcher to contact you.

We thank you in advance for your time and co-operation and look forward to hearing from you in the near future.

Yours Sincerely,

Appendix 19.

Consent to Contact Form

Study Short Title: Lived experiences of severe postnatal psychiatric illness

IRAS ID: 220825

Version 2 (19-11-2017)

Consent to Contact Form (IRAS ID: 220825)

Study Full Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study

Chief Investigator: *Dr Qulsom Fazil*

Researcher: *Harpreet Kaur Sihre*

A research team at the University of Birmingham are carrying out a study about the lived experiences of severe postnatal psychiatric illnesses in South Asian women and experiences of Perinatal Mental Health Services.

If you are interested and wish to find out more about the study please provide your verbal consent to contact to a member of the clinical team and/or print your name, contact details and signature on the next page. Please note that signing this form does not mean you have agreed to participate in the study. It just allows a researcher to contact you and discuss the details of the study with you.

Participant Contact Details

Please complete your preferred contact details below:

Contact by letter	**Address:** …… …… …… **Postcode:** ……
Contact by telephone	**Contact number:** ……
	When would you prefer to be contacted? *(please circle below)* Morning / Afternoon / Evening / Don't mind
	May we leave a voicemail message? *(please circle)* Yes / No
Contact by email	**Email address:** ……

Name of Participant	Date	Signature
……	……	……
Name of Researcher taking consent	Date	Signature
……	……	……

Consent to Contact Form_Version2_19-11-2017

Appendix 20.

Letter of Invitation to Participant (Sent in the Post)

Trust address

Name and Address of potential participant < insert >

Date < insert >

Dear < insert name of potential participant >

We are writing to invite you to take part in a research study that is being done by a researcher at the University of Birmingham as part of their PhD. The study is about health research in South Asian women.

Your participation in the research study would involve an interview with the researcher that will aim to last approximately 1 hour. You will have the option for the interview to take place at your home or a quiet location of your choice. Any travel and/or childcare cost will be covered, if required. The interview will be audio-recorded to help with analysing the interview. All of the information you provide will remain **private and confidential** and **anonymous**.

If you want to take part in this study or wish to find out more information, please telephone contact the person below and give your consent for your contact details to be given to the researcher (see contact details below).

Contact	Dr Jelena Jankovic
Telephone	Tel: < insert >

We thank you in advance for your time and co-operation and look forward to hearing from you in the near future.

Yours Sincerely,

Appendix 21.

Participant Information Sheet

PARTICIPANT INFORMATION SHEET (IRAS ID: 220825)

Introduction

We are a group of researchers from the University of Birmingham and we would like to invite you to take part in the research study. Before you make your decision, it is important to understand why the research is being done and what your participation in the study will involve. Please take time to read the following information carefully.

Please ask us if there is anything that is not clear or if you would like more information. You have at least 24 hours to decide whether or not you want to take part in this research study.

Study Full Title:

Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study

Chief Investigator: Dr Qulsom Fazil
Researcher: Miss Harpreet Kaur Sihre

What is the aim of the study?

The aim of this research study is to explore South Asian women's experiences of their mental illness after having a baby and their experiences of the care and treatments they received for their mental illness. We want to understand these experiences to improve the services for women like yourself. You have been identified as having a mental illness after childbirth so your story will be very useful for our research study and you will be helping the South Asian community. All information that you provide will remain **private and confidential** and **anonymous**. Your name or details will **not** be identified.

What would taking part in the study involve?

You will be taking part in an interview with the researcher which will take approximately 1 hour. The researcher will ask you questions about your experiences of your postnatal mental illness and experiences of the treatment and care you received. If you agree, the interview will be recorded to help with the analysis. The interview can take place at your home, the NHS Trust, the university or another place of your choice. Any travel and/or childcare cost will be covered, if required.

What are the possible benefits of taking part?

In taking part, your story will help researchers to learn more about your experiences and increase the research in this area. If you take part, your experiences will also help to improve services for women from South Asian backgrounds like yourself. This study has not been done before and your involvement will be highly respected and important to us.

What are the possible disadvantages and risks of taking part?

The research study has been designed to not cause any risks or harms for you. But there could be psychological risks and risks to your confidentiality.

- *Psychological risk*

Recalling a distressful or traumatic experiences may be upsetting for you. If you feeling upset or distressed during the interview, you will be given the option to pause and continue when you feel ok. If you feel you no longer want to continue, you will have the opportunity and right to withdraw at any given time.

You will also be provided with a list of support services that may be helpful should the above occur.

- *Risk to confidentiality*

Your personal information gained during the research will remain **private and confidential**. However, in situations where you express feelings or harm, suicide or harm to others, the clinical team or your GP will be informed for your personal safety.

Further supporting information

What if something goes wrong?

Complaints – if you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions (See further information and contact details). If you remain unhappy after speaking with the researchers and wish to make a formal complaint, you can do this by contacting The University of Birmingham, Institute of Applied Health Research. Details can be found below:

The Institute of Applied Health Research

College of Medical and Dental Sciences
University of Birmingham
Edgbaston
Birmingham
B15 2TT
Tel: +44 (0)121 414 3344

What will happen if I want to withdraw from the study?

You have the right to leave the study at any point before or during the interview takes place. However after 2 weeks of your interview taking place, you will not be able to request for your data to be deleted from the study.

Will my information be kept confidential?

All of your information will be kept **anonymous** and **confidential** within the research team. None of your information will be re-used with others in future research. The data generated from the study interviews will be stored and protected on the University network and only the researcher will have access to this data. Data will be stored and archived on the University of Birmingham's Research Data Archive for 10 years. This data will remain **anonymous**. The researcher, Harpreet Kaur Sihre will be carrying out the interviews, transcribing and analysing the interviews.

What will happen to the results of the study?

Your information is being collected for a PhD study and will be discussed as part of the student's thesis. Because of the importance of sharing research and new knowledge and understandings, the findings of this research study will be published in journal articles and findings may be presented at relevant conferences and events. However, confidentiality will be maintained and **ALL** types of data collected will remain **anonymous** throughout the study. Your name and details will **not** be revealed.

Who is organising and funding this study?

This research is self-funded by the researcher.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by XXX Research Ethics Committee.

Consent process

After reading this Participant Information Sheet, you will need to decide whether or not you want to participate in this study. Consent will be obtained in writing by the researcher before the interview. You will receive a copy of the Consent Form.

Further information and contact details

For further information about this research study or if you wish to take part, please contact the researcher Harpreet Kaur Sihre:

Researcher Name	**Harpreet Kaur Sihre**
Address	**Institute of Applied Health Research** College of Medical and Dental Sciences Murray Learning Centre, Room 125 University of Birmingham Edgbaston Birmingham B15 2TT
Telephone	TBC
Email	

If you wish to seek advice to concerns or queries about the research study, please contact the person below:

Name	**Patient Advice & Liason Service (PALS)**
Contact	Birmingham and Solihull Mental Health NHS Foundation Trust Trust Headquarters Unit 1, B1 50 Summer Hill Road Birmingham B1 3RB Telephone: 0800 953 0045 Text: 07985 883 509 Fax: 0121 301 1301 Email: bsmhft.customerrelations@nhs.net

Name	**Patient Advice & Liason Service (PALS)**
Contact	Central and North West London NHS Foundation Trust, Stephenson House, 75 Hampsted Road, London, NW1 2PL Tel: 0203214 5700

Thank you for taking time to read this Information Sheet.

Participant Information Sheet_Version 3_24-11-2017

Appendix 22.

Interview Schedule

INTERVIEW SCHEDULE

Study Full Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study

Interviewer: Harpreet Kaur Sihre

Interviewee:……

Date: ……..…

Location of interview:……

Interview start time: ____:____ Interview end time: ____:____

Hello…

I would just like to check with you if it is ok that I record this interview? It is easier for my memory to record the interview so I don't have to write everything down. But I will be taking some notes during the interview. Are you happy for me to start recording the interview?

Thank you for agreeing to take part in the study. As I mentioned I'm doing my PhD at the University of Birmingham about South Asian women's lived experiences of their postnatal psychiatric illness and their experiences of Perinatal Mental Health services.

There are a few things I would like to go through, before we start the interview, if that is ok with you?

Description of the study

Your participation in the study will involve this interview, which will aim to last up to 1 hour.

I would now like to collect some information about you.
(Complete Demographic Information Sheet_Version 1)

Also, just to reassure that no-one but the research team will have access to the data.

If we can just go through the Interview Consent Form (Version 1)
(Read out the consent form and ask the participant to print name, sign and date)

Is there anything else you would like to go through before we start the interview? Any questions?

Opening interview questions

- So can you tell me about yourself before you had your baby? Could you describe a typical day?

- How was your pregnancy?

- And how are you feeling today?

- Have you always lived here in England? When did you move? How did you feel? What caused you to move to England?

- Do you have friends?

Section 1: To explore South Asian women's lived experiences of severe postnatal psychiatric illnesses

1. Diagnostic history

So let's talk about how you became ill after having your baby…

- Can you tell me what was happening to you when you first thought you might be ill?
- What kind of symptoms were you experiencing? What were you thinking?
- Can you describe what your behaviour was like? What was going on in your mind then? How did that feel in your body?
- Was anything happening to you that was worrying you?
- Had you experienced anything like this before?
- Did you know what sort of illness it was?

Could you tell me when you realised that you had an illness?

- Who told you? How did you feel? What was your initial reaction?
- Can you explain what happened?
- Did you have any idea about these symptoms before?
- What happened? Did you see a doctor?
- Did you have anyone with you at the time?

Did you tell anyone about it?

- How did they react when you told them? Family/doctor/friends?
- Were they supportive when you told them?
- How do you think other people saw you when you told them? Was it openly talked about?
- Did you feel you could talk openly about it?

2. Understanding of the illness

So going back to your symptoms, do you know what diagnosis you were given?

Could you tell me what is your understanding of your illness?

- Did you feel you knew enough about it?
- Were you given information about it?

3. Illness beliefs and perceived causes

What do you believe your illness is?

- What does it mean to you?
- What does your illness represent?
- Where do you believe it came from?
- Do you have another name or expression for it?

What do you think caused your illness?

- Can you identify any particular experiences or events that may be related to your illness? E.g. work, family, culture, religion?
- Why do you think your illness started when it did?

Are there any other causes that you think played a role?

- Is there anything that happened during/before/after pregnancy?

4. Lived experiences of a severe postnatal psychiatric illness

So, let's talk about your experiences about what living with your illness was like?

- How did it feel? What were you thinking?

How did your illness affect areas of your daily life? Can you describe what a typical day was like for you?

- What are the main difficulties your illness have caused you?
- How did your illness affect your Social/Work/Home life?
- Were you able to cope by yourself?
- Did you need help? From whom?
- Were you able to look after your baby?
- What would you call a good day? What would you call a bad day?

What do you think this illness does to you as a person?

Has you illness changed the way you look at life in general?

Do you have any concerns or feelings about the future?

Is there anything you would like to share about how your life has changed since your diagnosis?

5. The journeys, pathways and process of referral and admission

So, I would like to talk about your experiences when you first went to seek help.

What symptoms did you have to make you go and get help?

- How did you feel about having spoken to the doctor?

- Did the doctor explain what was happening to you?

How did you feel when you needed specialist Perinatal Mental Health care?

- Did you know about specialist care for women like yourself?

- How long did it take until you had your first contact with specialist services? Too long, short?

- Do you think this treatment was the best option for you? What kind of treatment do you think you should receive?

How did you feel when they said you needed to go to hospital with your baby?

- Could you describe a typical day at hospital for you?
- Did your family/friends visit?

6. Experiences of Perinatal Mental Health Services and support networks

I would now like to talk to you about your experiences of the treatment you received.

- What sort of treatment did you receive and how did you feel about this?
- Were you able to follow the treatment plan ok?
- What was good about the care you received?
- What was bad about the care you received?
- Do you think the services meet the needs of South Asian women?
- Can you suggest any improvements in the care they provide to women with a similar illness to you?

What was your relationship like with the doctors and nurses?

- Can you describe how you felt about the way they looked after you?
- Did you feel you were able to talk the health professionals?
- Did they understand you ok?
- Did you experience anything stopping you from seeking support?
- Did they understand your culture?

Did you receive support from your family and friends?

- Did you feel you could talk to them openly about your illness?
- How did they react to finding about your illness?
- Did you feel you received enough support?

How did this help you cope with your illness?

Was there anything else you yourself did?

- What did you do to help you overcome your illness?
- Is there anything else you did yourself to cope with your illness?
- (Formal, Traditional, Religion, Spiritual)

After going through this experience, what advice might you give other women who are experiencing a similar illness?

Closing Questions

- How do you feel after talking to me about your experiences?

- Do you have any questions that you would like to ask me?

- Would you like to take part in the focus group with similar women like yourself?

Examples of further probes

- Can you tell me a little more about…?
- What was it like?
- How did it feel?
- What did you think then?
- How did you…?
- What has changed?
- What is the same?
- How do you feel about this?
- Can you tell me a little more?
- What did this do for you?

Appendix 23.

GP Notification Letter

Miss Harpreet Kaur Sihre
The Institute of Applied Health Research
College of Medical and Dental Sciences
University of Birmingham
Edgbaston
Birmingham
B15 2TT
Telephone: XXX
Email

GP Name and Address < insert >

Date < insert >

Dear Dr. <insert name>

Full Study Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study

Your patient ……. was invited to participate in a study and has consented to participate. I am doctoral researcher at the Institute of Applied Health Research, University of Birmingham and this study is part of my PhD. The research objectives are to explore South Asian women's lived experiences of their severe postnatal psychiatric illness and to understand South Asian women's experiences of Perinatal Mental Health services, care and support.

Your patient has been provided with a Participant Information Sheet (please find enclosed), which explains the nature of study, what is involved of their participation, their participation is entirely voluntary, that they are free to withdraw from the study at any time and any benefits and potential risks/burdens involved. Your patient has also provided both verbal and written informed consent for their participation in the research study.

Your patient's participation will involve a one-to-one, face-to-face, in-depth interview that will aim to last 1 hour.

Permission has been received from your patient to inform you of their participation in this research study.

This study has received approvals from XXX.

Should you have any questions or require further information about this research, please do not hesitate to contact me.

Yours Sincerely,

Harpreet Kaur Sihre

GP Notification Letter_Version2_05-11-2017

Appendix 24.

Informed Consent Form

Study Full Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English Speaking South Asian women, living in the UK: A qualitative study

IRAS ID: 220825

Researcher: Harpreet Kaur Sihre

Participant identification code:……..……

PARTICIPANT CONSENT FORM (IRAS ID: 220825)

Please tick box

1. I confirm that I have read the **Participant Information Sheet** 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. ☐
3. I understand that quotes from the interview may be used in research reports, however personal information will be removed and quotes will remain anonymous so that it is not possible to identify me. ☐
4. I agree to my General Practitioner being informed of my participation in the study. ☐
5. I agree and consent to take part in this study. ☐

Name of Participant	Date	Signature
……	……	……
Name of Researcher taking consent	Date	Signature
……	……	……

Appendix 25.

Safety Protocol

Protocol for Managing Disclosure of Risk: BSMHFT/CNWL patients

This protocol directs the practice of all researchers/staff members working on the South Asian mothers with severe postnatal psychiatric illness qualitative study.

Study Full Title: Understanding the lived experiences of severe postnatal psychiatric illnesses in English speaking South Asian women, living in the UK: A qualitative study

IRAS ID: **220825**

Researcher/staff members	
Researcher	**Harpreet Kaur Sihre**
Care Coordinator	
Care Coordinator Team member(s)	
Duty Worker	

Rationale

During contact with a member of the research team, a participant may indicate an intention to harm themselves and/or others. Alternatively, they may provide information to the effect that a child or other vulnerable person may be in danger. Additionally, the participant may experience high level of stress or emotional distress. Any information of this nature **must** be acted upon.

At the beginning of the study, the participant will be verbally informed and provided with written information in the Participant Information Sheet that what is discussed is private and confidential, except if they disclose information to the effect that a child or other vulnerable person may be in danger. In such situations the staff member/researcher has a legal duty to breach confidentiality. The particular setting within which risk is disclosed (i.e. hospital ward or community) will determine the specific actions to be taken.

Participant under the care of BSMHFT/CNWL

Community participants: Face-To-Face

Before the interview, the researcher must inform a colleague that they have arrived safely at the location of the interview. The researcher must also inform a colleague when the interview has finished and left the location safely.

In the case that the individual indicates intention to harm themselves or others the action taken is to remind the participant of the researcher's legal duty to break confidentiality when risk is identified (as already outlined prior to the commencement of the study) and contact the appropriate agents, depending on the participants level of intent and immediacy. All risks identified in the community will be to be recorded on the Trusts's electronic patient records. The researcher will contact the participant's Care Coordinator (depending on the level of risk and immediacy this contact may be immediate or directly after the interview) who will record the details on the patient's electronic notes system.

Imminent risk to themselves and/or others

If an imminent risk is identified, i.e. the individual reports that they intend to harm themselves/others at that moment and is in possession of the means to carry out that harm, immediate action must be taken. The session must be stopped, the researcher should leave the property if they do not feel safe, and must then phone the police (999).

In a situation when a participant begins to engage in self-harm behaviour (e.g. cutting, ligaturing etc.), the researcher must immediately stop the session, phone an ambulance (999), commence first-aid or resuscitative interventions if necessary and not leave the participant until the ambulance staff have taken over.

Non-Imminent risk to themselves and/or others

However, if the individual reports that they may harm themselves or others and the risk is not imminent / they do not have the means to carry out that harm, action by the researcher may involve continuing with the session in light of the information discussed and reviewing how they are feeling at the end of the interview, or stopping the interview.

The researcher must ensure the participant's Care Coordinator is phoned following the interview. If at all possible, the participant will be encouraged to work in collaboration with the researcher (unless there are circumstances that would contraindicate, e.g. risk to safety of staff). Such as, the individual may be given the option of phoning the Care Coordinator themselves in the presence of the researcher or staying in the room whilst a call is made. Alternatively, the individual may choose to wait in a safe place, such as an adjoining room.

The researcher must ensure the Care Coordinator or other relevant agent knows about the risk – a message on the Care Coordinator's answerphone will not suffice. If the researcher cannot speak to the Care Coordinator, they should speak to another individual from the Care Coordinator's team, the Duty Worker for the appropriate Mental Health Team or their GP. If these agents are not available or if the researcher is in doubt, s/he should phone the ward.

Based upon the telephone discussion with the Care Coordinator (or with a member from the Care Coordinator's team), the researcher must act on any part of the action plan generated that involves action on their part (e.g. accompanying the participant to A&E).

Risk to child and/or other vulnerable person

If the individual indicated that a child / other vulnerable person are at imminent risk, the researcher must phone the police (999).

If the individual indicates that a child / other vulnerable person are at non-imminent risk or the researcher is unsure whether they are at risk, the Care Coordinator must be phoned. If this is not possible the Trusts's Child and Adult Safeguarding Team must be contacted. The participant must be informed that these agents are being contacted (unless there are circumstances that would contraindicate e.g. risk to safety of staff).

All community incidents will be followed up with an email written by the research (Harpreet Sihre) advising of the incident and informing that patient records have been updated and naming the person who was requested to update the records.

Psychological distress

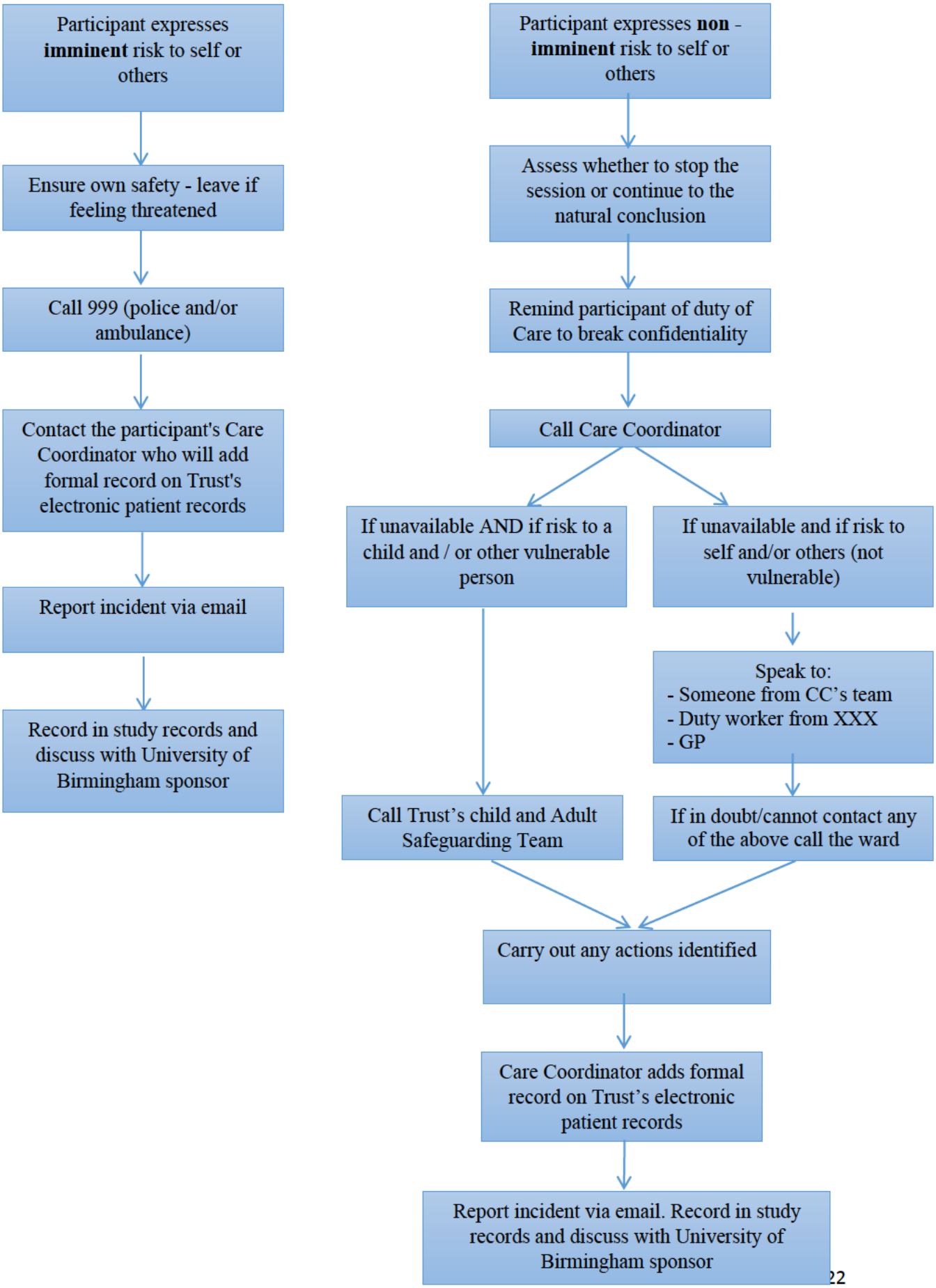
On arrival at the location of the interview, the researcher will use their own judgement to terminate the interview if the participant seems too unwell to partake. If during the interview the participant begins to experience high level of stress or emotional distress and/or exhibits behaviours that are suggestive that the interview discussion is too stressful (such as uncontrollable crying) they will be provided the opportunity to pause the interview. If the participant feels able to carry on, the interview will resume or they will have the option to rearrange the interview for another day. However, if the participant does not wish to continue, they have the right to withdraw from the study.

The researcher is not a health professional, so will not offer immediate support or assess mental status of the participant. The researcher will have access to a list of community support services that will be provided to the participant.

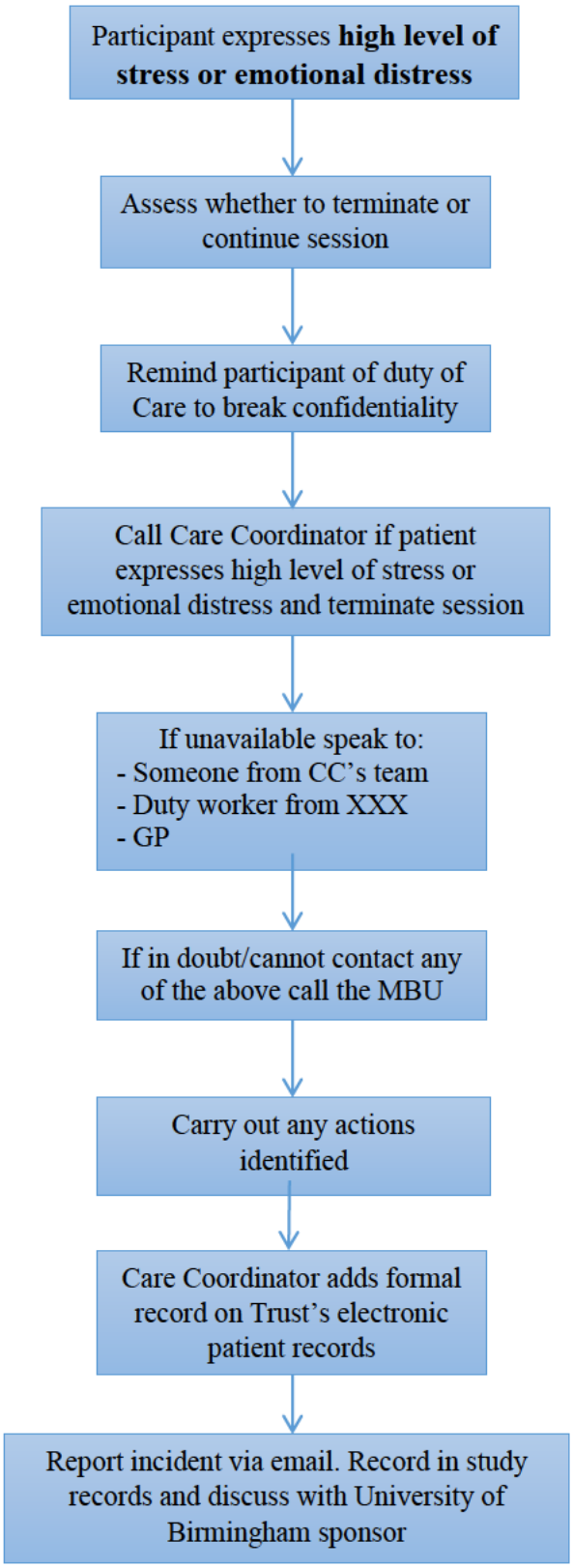
If in a situation where the researcher feels the participant is too unwell to partake or the participant shows signs of high level of stress or emotional distress during the interview, the researcher must ensure the participant's Care Coordinator is phoned. A message on the Care Coordinator's answerphone will not suffice. If the researcher cannot speak to the Care Coordinator, they should speak to another individual from the Care Coordinator's team, the Duty Worker for the appropriate Mental Health Team or their GP. If these agents are not available or if the researcher is in doubt, s/he should phone the ward.

Based upon the telephone discussion with the Care Coordinator (or with a member from the Care Coordinator's team), the researcher must act on any part of the action plan generated that involves action on their part.

FLOWCHART OF ACTIONS FOR COMMUNITY PARTICIPANTS: FACE-TO-FACE



FLOWCHART OF ACTIONS FOR COMMUNITY PARTICIPANTS: FACE-TO-FACE



Participants no longer under the care of BSMHFT/CNWL: Face-To-Face

Before the interview, the researcher must inform a colleague that they have arrived safely at the location of the interview. The researcher must also inform a colleague when the interview has finished and left the location safely.

In the case that the individual indicates intention to harm themselves or others the action taken is to remind the participant of the researcher's legal duty to break confidentiality when risk is identified (as already outlined prior to the commencement of the study) and contact the appropriate agents, depending on the participants level of intent and immediacy. The researcher will contact the participant's General Practitioner (GP) (depending on the level of risk and immediacy this contact may be immediate or directly after the interview) who will record the details on the patient's electronic notes system.

Imminent risk to themselves and/or others

If an imminent risk is identified, i.e. the individual reports that they intend to harm themselves/others at that moment and is in possession of the means to carry out that harm, immediate action must be taken. The session must be stopped, the researcher should leave the property if they do not feel safe and must then phone the police (999).

In a situation when a participant begins to engage in self-harm behaviour (e.g. cutting, ligaturing etc.), the researcher must immediately stop the session, phone an ambulance (999), commence first-aid or resuscitative interventions if necessary and not leave the participant until the ambulance staff have taken over.

Non-Imminent risk to themselves and/or others

However, if the individual reports that they may harm themselves or others and the risk is not imminent / they do not have the means to carry out that harm, action by the researcher may involve continuing with the session in light of the information discussed and reviewing how they are feeling at the end of the interview, or stopping the interview.

The researcher must ensure the participant's GP is phoned following the interview. If at all possible, the participant will be encouraged to work in collaboration with the researcher (unless there are circumstances that would contraindicate, e.g. risk to safety of staff). Such as, the individual may be given the option of phoning the GP themselves in the presence of the researcher or staying in the room whilst a call is made. Alternatively, the individual may choose to wait in a safe place, such as an adjoining room.

The researcher must ensure the GP or other relevant agent knows about the risk – a message on the GP answerphone will not suffice. If the researcher cannot speak to the GP, they should speak to another individual from the GP practice, or whoever else is involved in the woman's care plan (this information will be established prior to the interview).

Based upon the telephone discussion with the GP (or with a member from the GP Practice), the researcher must act on any part of the action plan generated that involves action on their part (e.g. accompanying the participant to A&E).

Risk to child and/or other vulnerable person

If the individual indicated that a child / other vulnerable person are at imminent risk, the researcher must phone the police (999).

If the individual indicates that a child / other vulnerable person are at non-imminent risk or the researcher is unsure whether they are at risk, the GP must be phoned.

All incidents will be followed up with an email written by the research (Harpreet Sihre) advising of the incident and informing that patient records have been updated and naming the person who was requested to update the records.

Psychological distress

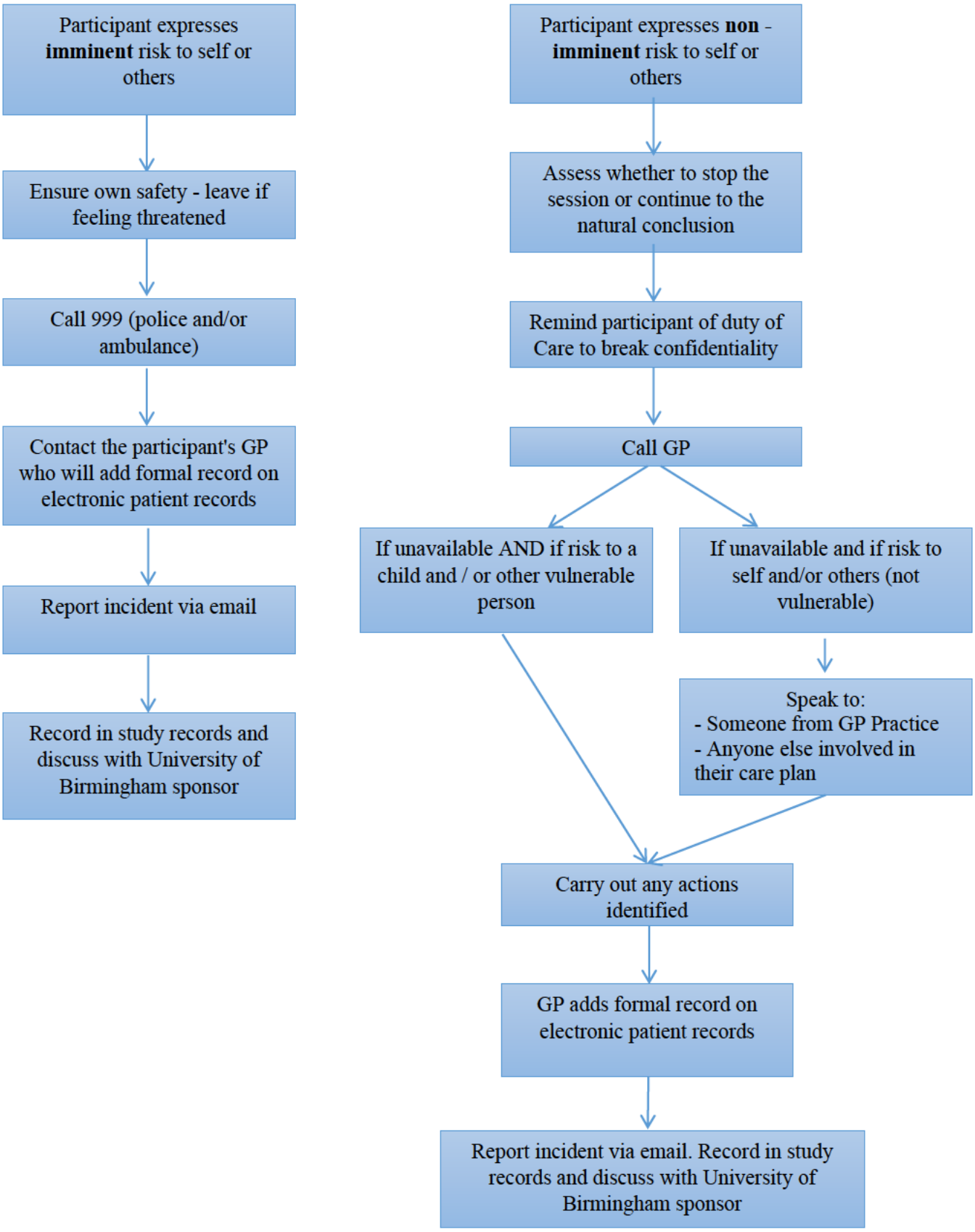
On arrival at the location of the interview, the researcher will use their own judgement to terminate the interview if the participant seems too unwell to partake. If during the interview the participant begins to experience high level of stress or emotional distress and/or exhibits behaviours that are suggestive that the interview discussion is too stressful (such as uncontrollable crying) they will be provided the opportunity to pause the interview. If the participant feels able to carry on, the interview will resume or they will have the option to rearrange the interview for another day. However, if the participant does not wish to continue, they have the right to withdraw from the study.

The researcher is not a qualified health professional, so will not offer immediate support or assess mental status of the participant. The researcher will have access to a list of community support services that will be provided to the participant.

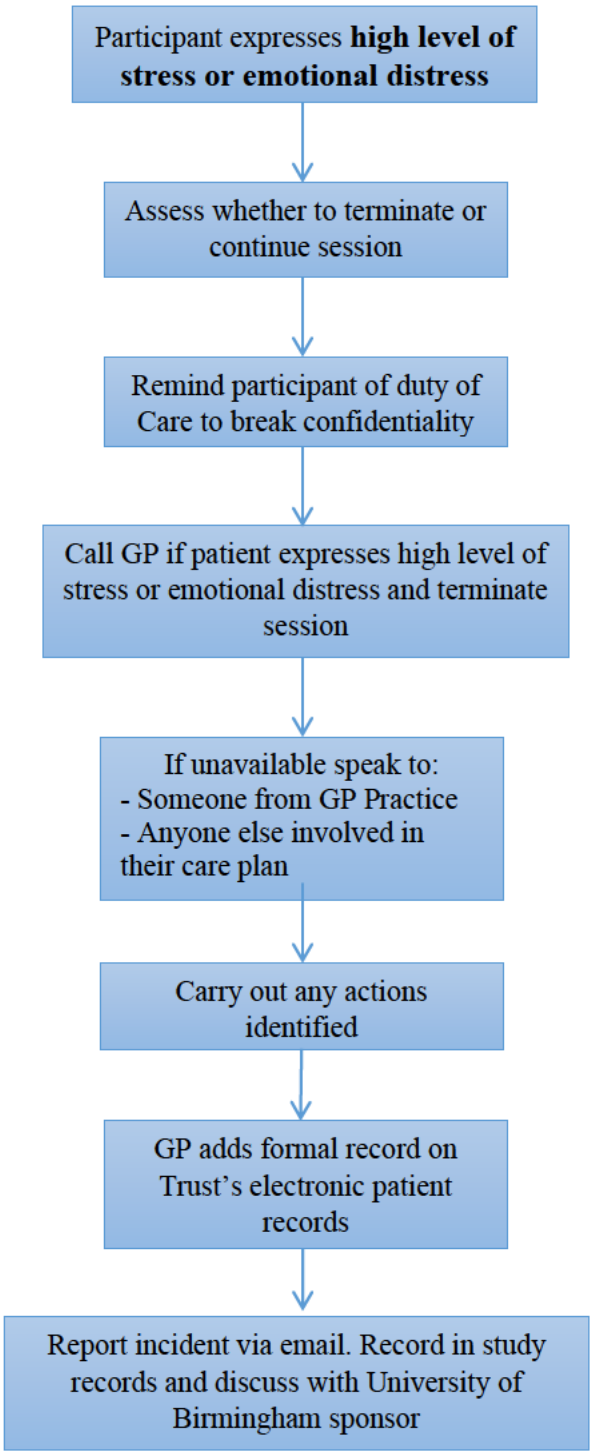
If in a situation where the researcher feels the participant is too unwell to partake or the participant shows signs of high level of stress or emotional distress during the interview, the researcher must ensure the participant's GP is phoned. A message on the GP's answerphone will not suffice. If the researcher cannot speak to the GP, they should speak to another individual from the GP practice or whoever else is involved in their care plan (this information will be established prior to the interview).

Based upon the telephone discussion with the GP (or with a member from the GP Practice), the researcher must act on any part of the action plan generated that involves action on their part.

FLOWCHART OF ACTIONS FOR PARTICIPANTS NO LONGER UNDER THE CARE OF BSHMFT/CNWL: FACE-TO-FACE



FLOWCHART OF ACTIONS FOR PARTICIPANTS NO LONGER UNDER THE CARE OF BSHMFT/CNWL: FACE-TO-FACE



Participant discloses a crime

If the participant or someone else has committed a crime, then the researcher must phone the Care Coordinator/GP. After a discussion with the Care Coordinator/GP it may be necessary to phone the police (999). All actions must be recorded on the Trust's electronic patient records. It may also be advisable for the researcher to seek legal advice if the crime is reported to the police.

Details of risk

If a participant you are working with expresses ideas of harm to self or others these are the useful factors to consider and pass on to the Shift Lead / Qualified Member of the Nursing Team (in-patients or Care Coordinator / Community Mental Health Team / GP.

- Ideation (e.g. frequency, intensity, duration)
- Plans / Intent
- Access to means to carry out plans
- Timeframe

If details of these factors are provided to the researcher, these details **must** be recorded in the Trust's electronic patient records.

The researcher MUST ensure that ALL information and actions are taken, including telephone calls and discussions with ward staff.

LIST OF USEFUL CONTACTS

University of Birmingham Details:

Dr Qulsom Fazil (Chief Investigator & Academic Supervisor)	Dr Qulsom Fazil (QF), Institute of Applied Health Research, University of Birmingham Email:
Professor Paramjit Gill (Academic Supervisor)	Professor Paramjit Gill (PG), Warwick Medical School, Warwick University Email:
Dr Antje Lindenmeyer (Academic Supervisor)	Dr Antje Lindenmeyer (AL), Institute of Applied Health Research, University of Birmingham Email:
Dr Sean Jennings (Sponsor)	Dr Sean Jennings (SJ), Research Support Group, University of Birmingham Email: researchgovernance@contacts.bham.ac.uk

Ward Contact Details:

WARD NAME	MANAGER	TELEPHONE

West Midlands Police (non-emergency)
101

Appendix 26.

An example of initial noting from each transcript

Interviewee	Erm and then. So he was born on the Thursday and then on the Tuesday he was really concerned. We had a chati, so you know when people come over, family and I was just a bit erratic and we took him to A&E because we were a bit concerned about his, so there was a lot lots of stuff going on. repetitions.	↳ language variation - cultural/ethnic Chati - family gathering Erratic Lots of stuff going on Concerned about baby "He" -> where are women's voices? Changes to "We"	Postnatal cultural traditions Infant health
Interviewer	Hmm...		
Interviewee	He was breastfeeding, initially when I was breastfeeding him, tried it, you know it wasn't working and had a lot of issues trying to start breastfeeding as well. Erm there was so much going on at that point of time erm *pause* it felt really stressful. And obviously it was the first kind of child in our family, like my parents, first grandchild so I guess it was all new and everything erm..yh and then on the, on the Thursday night, no Friday night sorry, I I couldn't sleep. After I had him I was only having like 2 to 3 hours sleep the whole day for about a week. Erm and then on Thursday I said look I can't breastfeed him I need to have rests, so let me rests this day, still couldn't sleep that day and then on Friday I was trying to sleep, I was erm and then I think I went in to some sort of, like a dream but it almost felt really real! ↳ happens successfully without problems.	Breastfeeding difficulties - stressful Lots of stuff going on. First child in family - all new. Sleeping difficulties - 'still' - ongoing Scrambling for a cause ↳ calm/peaceful adjective "Like a dream" - but "felt really real!" ↳ exaggeration - phrase - simile Hesitation indicators. Hyperbole - exaggeration.	Breastfeeding difficulties Causation ↳ Stress. Sleeping difficulties.
Interviewer	Ok...		
Interviewee	And I don't know what happened, and I don't have any memory from Friday afternoon-ish until erm Monday afternoon, that whole kind of 3 and a half days 4 days I really don't know what happened.	Loss of memory -> metaphorical. ↳ in the past mental capacity	
Interviewer	Yh		
Interviewee	But in that, in that time I was admitted into hospital so, I think on that Friday my husband was really concerned then he went to my GP which is just round the corner. Then my dad, obviously because it's quite a taboo in, in Asian families you know, so he was like no no no there's nothing wrong with her, she's fine, she'll be alright, we don't want, we don't want anything to happen, we don't want	Hospital admission Husband concerned - help seeking Taboo - cultural - social world Husband Vs Dad - conflict - male dominant Dad speaks on behalf of family.	Help-seeking behaviour ↳ medical attention. Taboo -> family reputation. Stigma.

Reputation of family ← Repetition of "we don't want"

"You know"
↳ request interviewer to confirm that she shares interviewee opinion / attitude.

7

Interviewer	Mmhmm		
Interviewee	They were good, but they were not culturally sound	Good, but not culturally sound	Lack of cultural competency. Experience of care.
Interviewer	And could you expand on that? In what ways?		
Interviewee	There was another South Asian with me, and we have few issues, South Asian issues, cultural issues	Issues - South Asian issues - cultural issues "We" - cultural group - ethnic segregation.	Identity Cultural identity
Interviewer	Mmhmm		
Interviewee	They didn't know about it. She was suffering there for three months, and then I came there and told them this is the reason why she is thinking such a way	Team unaware. "We" vs "They" -> different groups	Lack of cultural competency Identity.
Interviewer	Right		
Interviewee	In the cross discussion, I told them about it		
Interviewer	Sure		
Interviewee	And she was able to come out of it after she really really received that		
Interviewer	And what cultural needs did you need at the hospital that they weren't culturally sound with?		
Interviewee	First they need to know the culture, they need to study, they need to have a, a, a, this uh anthropology subject -> essential	Need to know the culture "They" Anthropology subject -> the team	Lack of cultural competency More educated on culture.
Interviewer	Right		
Interviewee	Because there are things in this culture which are very very unique, the South Asian culture	Things in the South Asian culture -> "very very" unique -> repetition - emphasis	Experience of care. Cultural identity
Interviewer	And this is why I'm doing this piece of research		

Interviewee	Erm and no matter what I did, nothing made me happy, I was, this overpowering feeling of er depression anxiety and all those thoughts just erm I just couldn't get rid of them	Depression and anxiety Nothing made her happy	Experience of symptoms. ↳ thoughts.
Interviewer	Mmhmm		
Interviewee	24/7 from day till night until I fell asleep and when I woke up from sleep er again I feel like oh another day of struggle and dragging myself doing things	Recurring cycle. -> Metaphorical -> to move with great difficulty	Experience of symptoms.
Interviewer	Mmhmm		
Interviewee	And obviously my parents my parents were home so they helped me, my mum helped me with the baby a lot otherwise I wouldn't have been able to look after the baby at all *laughs*	Help from parents with baby. Unable to cope as mother -> doubt?	Family support.
Interviewer	Mmhmm		
Interviewee	Ermm		
Interviewer	And how did your parents react to it when they found out?		
Interviewee	Yh everyone was really upset then erm er everyone just wanted to get me better and they they felt sad seeing me like this, seeing their eldest eldest child going through this uh this suffering and no one in my family in my whole in my both sides of my family mum's and dad's family no one had this had this in their it's only me so that made me feel even more convinced that I must be some er unlucky one, just unfortunate why me not anyone else *laughs* but just me. But before I was I was normal, I was functioning well, I was doing job full-time, I studied, I did degree, I went to university did everything er but all of a sudden, just this depression just strikes me it's like what what's wrong	Family reactions - upset. Feels unjustified - questioning. Singled out - victim - isolated. Scrambling for a cause Previous self - normal Metaphorical - "strikes me" - harshness ↳ hit forceably. ↳ unwelcome phenomenon ↳ occur suddenly with harmful effects.	Others' perception. Causation factor. Identity
Interviewer	Yh		

	really ill I'll start swearing and calling people names and telling people off feeling like you know I'm authoritative and I have a role to play and I have to tell people what to do a bit like a preacher	Authoritative Preacher -> Non medical symptoms	Experience of symptoms.
Interviewer	Ok		
Interviewee	Erm yh		
Interviewer	And why do you think you became superstitious and spiritual in your beliefs?		
Interviewee	That's I dunno why but that's always what happens in every heightened I think because it's linked to you know my day to day you know life I do er you know read the Quran and you know you know I'm into spirituality and you know religion etc and I think that becomes heightened and distorted when I'm in an episode	Religion and spirituality becomes heightened during an episode ↳ part of everyday life. ↳ becomes distorted. Her illness as an "episode". - her recognition of illness.	Experience of symptoms. ↳ Religion/ spirituality.
Interviewer	Ok, right		
Interviewee	Yhh and doing things my way thinking what I'm doing is right and others are wrong ocd I remember washing hand washing all my clothes and the babies and not feeling pain and now when I I feel the pain after that now because at that time because I'm mentally so erm I feel so strong or mentally so so powerful my physical nature I don't think about and I don't realise I'm physically for example my legs are aching because I'm mentally so strong and so strong minded about things it's only until afterwards I feel the pain now and now I	She is morally right. ↳ Omnipotence. Mentally powerful. so strong. Insensitivity to pain. ↳ emphasis "so" ↳ repetition. Physical pain	Experience of symptoms.

Interviewee	There was no attached, because she wasn't attaching	Attaching - physical + emotional?	Breastfeeding difficulties.
Interviewer	Mm		
Interviewee	There's nothing happening		
Interviewer	Mm		
Interviewee	And she was crying and I was scared and I felt as soon as that happened I'm a bad mother, I'm a bad mother and then I had so many people come, the house was full of people. I gave birth on the 31st and the first weekend we came home the house was full and it was eid as well, the house was packed with people that day and then his family came and they were like oh you know you gotta breastfeed her you know you gotta do this and my head was like erm ok I was really out of it, I've had no medication, and they told me to start medicating and I still hadn't taken it and I was really really tired and I was like you know what I'm either gonna cry or I'm gonna scream. So I just went upstairs, I held my stomach because I was in agony I went upstairs, I shut the door and I just screamed my head off and they actually heard me do that and I screamed and then my partner came upstairs and he goes what happened? I said I want everyone to go, I want everyone to go cuz this is just the next day, I want everyone to go and he goes what happened, what happened?i said look I don't need to be told what I need to be doing and what not, I just don't wanna do anything right now, I've just come home and I	Bad mother -> repetition. ↳ failed to feed child. emphasis consequence Pressure to breastfeed "you gotta" -> demanding. ↳ expectation ↳ cultural? Scream or Cry -> Cathartic? for her. Metaphorical expression "screamed my head off" ↳ impact of scream. She wanted to be alone with baby.	Breastfeeding difficulties. Consequence of illness Cultural expectations. Experience of symptoms