

**Portfolio Volume 1: Major Research Project**

**The Experiences and Understanding of Psychological Distress in  
the Pre- and Post-Natal Period Among Sikh Punjabi Women  
Living in the UK.**

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## **ABSTRACT**

There is increasing interest in the NHS to better cater to diverse needs. However, the literature exploring the perinatal mental health (PMH) experiences of specific ethnic groups is scarce. This is the first study to explicitly explore Sikh Punjabi women's stories of perinatal psychological distress, and how they make sense of and navigate their experiences.

Semi-structured narrative interviews were conducted with four Sikh Punjabi women, born in the UK, between the ages of 30-40, and had given birth within the last ten years.

Using narrative analysis, three main storylines (Stories of Changes; Stories of Challenges; Stories of Growth) and seven sub-storylines (Self as (new) mother; Faith versus medical narratives; Making sense of motherhood; Stories of the unspeakable; Stories of resolution; Collective recovery; Stories of transformation) were identified across the accounts. Key narrative themes included maternal guilt, self-blame, stigma, shame, and social isolation. The model of perinatal psychological distress is proposed.

Three out of four mothers spoke about having experienced thoughts of ending their own life. None received adequate professional support. The findings indicate that racially minoritised mothers that require perinatal support are not receiving it. This implies that we have a long way to go before the ambitions set out in the NHS long-term plan for the provision of inclusive perinatal support are achieved.

Improvements are required across perinatal and related settings. Recommendations and suggestions informed by the participants accounts are offered, including ideas for addressing barriers to help-seeking and resources for staff training. Future research ideas are proposed.

## **ACKNOWLEDGEMENTS**

*“you are one person*

*but when you move*

*an entire community*

*walks through you”*

*Rupi Kaur (2020)*

This thesis is in loving memory of my mother.

I thank my participants, research consultants, and everyone else from the Punjabi community that gave me their time and trusted me with their precious stories. I hope that I have done your stories justice.

For their endless support, I thank my family, friends and supervisors Dr Lizette Nolte and Dr Nic Horley.

Finally, I would like to thank God.

(I sincerely apologise should any errors have been made in this thesis through translating or communicating concepts from Satguru Sri Guru Granth Sahib Ji.)

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## TERMINOLOGY AND LANGUAGE

| <b>Term</b>         | <b>Meaning</b>  |
|---------------------|---|
| <i>Ang</i>          | An arm of the Sri Guru Granth Sahib Ji. In some literature, ang is translated to mean a “page”, which is a colonial translation.                      |
| <i>Atma</i>         | Soul.   |
| <i>Bani</i>         | Hymn.   |
| <i>Chardi kala</i>  | Optimism/high spirit.   |
| <i>Desi dawai</i>   | Natural remedy.   |
| <i>Dukh</i>         | Pain/suffering.   |
| <i>Ek Onkar</i>     | God/the Creator/Oneness with everything.  |
| <i>Gurbani</i>      | Holy scripture/compositions.  |
| <i>Gurdwara</i>     | Door to the teacher. Sometimes referred to as a Sikh place of worship; however, this is a colonial translation.                                       |
| <i>Gurmat marg</i>  | The spiritual path.   |
| <i>Gurmukh</i>      | God-centred and humble.   |
| <i>Haumai</i>       | Ego/pride.  |
| <i>Hukam</i>        | The will of God (Kalra et al., 2012).   |
| <i>Izzat</i>        | Learnt complex rules that one follows in order to protect family honour and keep their position in the community (Gilbert, Gilbert & Sanghera, 2004). |
| <i>Jap Ji Sahib</i> | Morning Sikh prayer.  |
| <i>Karam</i>        | Actions performed in previous births manifesting their consequences in the present birth.   |
| <i>Kala tikka</i>   | The cultural practice of drawing a black dot to ward off <i>nazar</i> . This practice is not rooted in Sikhism.                                       |

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|  |  |
|--|--|
| <b><i>Maya</i></b>                     | Untruth. An illusion that distracts one away from God (Dhillon, 1988).   |
| <b><i>Manmukh</i></b>                  | Self-centred.  |
| <b><i>Miri-piri</i></b>                | <i>Miri</i> meaning temporal power and <i>piri</i> meaning spiritual power (Sikh Research Institute, 2021).                                    |
| <b><i>Nazar</i></b>                    | Evil eye. Not a theological found in Sikhism but a cultural explanation to the causes of mental health distress (Lindridge, Hogg & Shah, 2004) |
| <b><i>Sangat</i></b>                   | Active Sikh gathering and community. In some literature, sangat is translated to mean a congregation; however, this is an oversimplification.  |
| <b><i>Sansar</i></b>                   | Cycle of transmigration.   |
| <b><i>Sewa</i></b>                     | Sewa refers to selfless service which Sikhs are encouraged to perform (Singh & Singh, 2016).   |
| <b><i>Shabad</i></b>                   | Prayers.   |
| <b><i>Sikh</i></b>                     | Disciple or student.   |
| <b><i>Sri Guru Granth Sahib Ji</i></b> | The final eternal guru. In some literature, the SGSS is translated to mean a holy book; however, this is a colonial translation.               |
| <b><i>Punjab/Panjab</i></b>            | Derived from Persian – ‘ <i>Panj</i> ’ and ‘ <i>ab</i> ’, meaning ‘five rivers’ (B. Singh & Singh, 2019). A state in North-West India.         |
| <b><i>Punjabi/Panjabi</i></b>          | A person from the land of the five rivers.   |



## ABBREVIATIONS

| <b>Abbreviation</b> | <b>Explanation</b>   |
|---------------------|--|
| <b>APA</b>          | American Psychological Association                                       |
| <b>BAME</b>         | Black, Asian and Minority Ethnic   |
| <b>BME</b>          | Black and Minority Ethnic  |
| <b>BPS</b>          | British Psychological Foundation   |
| <b>CFI</b>          | Cultural Formulation Interview   |
| <b>DSM-5</b>        | Diagnostic and Statistical Manual of Mental Disorders –<br>Fifth Edition |
| <b>IAPT</b>         | Improving Access to Psychological Therapies                              |
| <b>ICD-10</b>       | International Classification of Diseases - Tenth Revision                |
| <b>MBU</b>          | Mother-Baby Unit   |
| <b>PMH</b>          | Perinatal Mental Health  |
| <b>PPD</b>          | Perinatal Psychological Distress   |
| <b>SGGS</b>         | Sri Guru Granth Sahib Ji   |
| <b>UK</b>           | United Kingdom   |
| <b>WHO</b>          | World Health Organisation  |

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## CHAPTER ONE: INTRODUCTION

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This thesis explores four Punjabi mothers' accounts of psychological distress during the perinatal period using narrative analysis. Over the course of this thesis, I hope to answer the following question:

*How do Sikh Punjabi mothers narrate their sense making and sense of self in relation to having experienced perinatal psychological distress?*

I will begin this thesis by outlining the context in which this research is situated. I will then consider my relationship to the topic and epistemological position. This will be followed by definitions of key terms used throughout this report, information about the prevalence and recognition of perinatal mental health (PMH) difficulties in the UK, and the main models for understanding PMH. Finally, I provide an overview of the relevant literature in relation to this topic and the rationale for this research.

### **1.1 The current context**

This study took place between March 2020 and September 2021 during the COVID-19 pandemic. An international survey revealed that 60% of Punjabi respondents reported a decline in their self-rated mental wellbeing from before Covid-19 and lockdown to during Covid-19 and lockdown (Taraki, 2020). Furthermore, research examining the public discourse of women pre- and post-birth during Covid-19 reveals that women have experienced heightened distress (related to a high-risk external environment); despair and anticipatory grief (due to deprivation of social and family support, and bonding rituals); and altered family and support relationships; guilt-tampered happiness (Eysenbach et al., 2020).

As well as Covid-19, this research is also situated during an intensified Black Lives Matter movement, triggered by the murder of George Floyd in May 2020, which sparked widespread

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discussions and debates around structural inequalities and racial discrimination. This was shortly followed by news of a reform of India's Agricultural Laws (which was passed in September 2020 and repealed in November 2021). Whilst recruitment and screening for this project began in August 2020, there was widespread concern amongst many about the effect of the new regulations on the India's farming community. Those living in Punjab (and Punjabi people internationally) have been particularly concerned as Punjab is an agrarian state and the agriculture laws pose a threat not only to farming but also to the ancestral lands. In protest, a tractor march took place in January 2021, uniting the Punjabi community and beyond. During the farmers' movement, gross human rights violations have been committed against farmers and their families. Public discourse popularised an image of the Sikh community as violent. The events have reopened the intergenerational scars of the Punjabi Sikh community, who are still recovering from the tragic events of 1947 and 1984 (see Tatla, 2006).

Interviews took place between November 2020 and March 2021. During this time, India was described as breaking the world record for most new coronavirus cases in a week (Bhowmick, 2021).

## **1.2 My relationship to the topic**

*"Contemplate and reflect upon knowledge, and you will become a benefactor to others."*

*(SGGS, Ang 356)*

My interest in this topic stems from listening to a Punjabi woman describe the difficulties she experienced after giving birth and the incongruence between her understanding of her own emotional pain versus the views of the professional(s) that were involved in her care. After working in mental health settings in England and Punjab, India, I have come to learn that there is limited research and literature exploring Punjabi people's understandings and experiences of mental health but also motherhood.

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Further inspiration for this thesis originated from a role in which I made home visits and provided support to parents and infants in the community. Upon commencing the doctorate, I learnt that the team I had been a part of which provided invaluable perinatal care and assistance to marginalised families had been closed due to shortages in funding.

During this research, I had been working in a community perinatal service for my final year specialist placement. The experience highlighted to me the narrow focus of PMH care and the dominant approaches which are rooted within the Western concepts of motherhood and recovery.

To address the gaps that I have identified and work towards more culturally appropriate perinatal care and support for marginalised communities such as the Punjabi community, I hope to understand and learn from Punjabi mothers' narratives and give space to their views and opinions in this report.

As a Sikh Punjabi woman interviewing Sikh Punjabi mothers as part of this research, I consider it imperative to think and reflect upon my own identity and context in relation to this research. In narrative analysis, stories are understood to be told in relation to the listener and the narratives as co-produced during social interactions. As an "insider" researcher (Dwyer & Buckle, 2018), holding "active membership" (as a Sikh Punjabi woman) but not "core membership" (I am not a mother in the same respect), I acknowledge that I will have an influence on what is shared by participants in this research. The data will be a product of transcreation as certain narratives, language and emotions are shared (or not shared) as a direct result of my presence and/or responses in the interviews. Not to mention, the interviews will be conducted in English and Punjabi. This allows for context to be offered to the Punjabi terminology used and the layers of meaning to be honoured as opposed to a literal translation from Punjabi to English which can result in a loss of meaning or significance. Given the impact



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of colonisation on Punjab's education, agriculture and social institutions (see Singh & Singh, 2019), it feels particularly important to give space to the Punjabi language, meaning, and ways of being to avoid furthering oppression by exporting or replacing aspects with Western concepts.

### **1.3 My theoretical position**

Epistemology concerns how we “know, think and decide” (Bateson, 1979a, p228). My own epistemological stance has shaped and influenced this research from beginning to end. This research is written from two positions:

Firstly, the critical realist ontological position. This position assumes that our data can tell us something about reality, but it does not view this data to be directly mirroring reality (Harper, 2012). From this position, it is assumed that participant's experiences of psychological distress during the perinatal period did occur and therefore did exist.

Secondly, the social constructionist epistemological position. This position posits that participant's accounts might be serving a range of interpersonal and societal functions as they are situated within social, historical, and cultural contexts (Harper, 2012). From this position, participant's narratives of emotional pain can be understood and conceptualised in different ways depending upon the contexts in which they are situated.

### **1.4 Language**

For ease of reading, this thesis is written predominantly from a third-person perspective; however, my personal reflections have been interwoven and are written in first-person perspective.

Within this report, the terms ‘psychological distress’, ‘emotional distress’ and ‘mental health difficulties’ are used interchangeably to refer to the emotional experiences of mothers during the perinatal period. These terms were selected after consultation with experts by experience

but also influenced by the researcher's personal preference (see section '**1.5.2 Perinatal psychological distress**' for further information).

It is acknowledged that some mothers may prefer the use of diagnostic terms (Forde et al., 2019). At certain points in this thesis, clinical terminology (e.g., 'postnatal depression') is used but with caution as they carry heavy socio-cultural connotations and exclude individual and cultural perspectives. Furthermore, it is acknowledged that there are no literal translations of English mental health terminology in the Punjabi language. This is because mental health terminology is bound to the context of professional psychiatric theory and practice, originating in the West.

This thesis attempts to decolonise PMH to give space to individual and cultural perspectives but to also work towards further building our knowledge and understanding of existing terms and concepts within the mental health field (otherwise introducing terms such as 'perinatal psychological distress' could go onto carrying the same sociocultural connotations as the original term 'mental health problem').

The terms 'ethnic diversity' and 'racially minoritised' (Milner & Jumbe, 2020) are used throughout this thesis rather than 'ethnic minority', 'BME' (Black and Minority Ethnic) or 'BAME' (Black, Asian and Minority Ethnic). This is because from a social constructionist position, minoritisation is understood to be a social process shaped by power and groups that have been (consciously and unconsciously) minoritised by people that benefit from dominance in the social hierarchy (Milner & Jumbe, 2020). Therefore, the aforementioned terms can be problematic. They lack specificity, many do not identify with the terms, and they do not account for power.

## **1.5 Definition of key terms**

### **1.5.1 Perinatal**

According to the ICD-10 (WHO, 1993), perinatal is defined as the period of time from twenty-two completed weeks of gestation to seven days after birth. The perinatal period within perinatal services refers to pregnancy and the first 12-months post-childbirth (NICE, 2018). The perinatal period is framed as a time during which mothers are vulnerable to physical, psychological and social complications because of the effects of pregnancy and childbirth (Kowalenko et al., 2000).

### **1.5.2 Perinatal psychological distress**

Due to lack of consensus within the scientific community, several definitions of ‘psychological distress’ (Laporte & Aita, 2021), ‘perinatal distress’<sup>1</sup> (Wenzel & Kleiman, 2015), and ‘maternal distress’<sup>2</sup> (Raphael-Leff, 2018) exist. In line with the social constructionist stance and in effort to promote conceptual clarity, within this thesis, the term ‘perinatal psychological distress’ (abbreviated to ‘PPD’ for the purpose of this thesis) is used to refer to a state of emotional suffering during the perinatal period (Arvidsdotter et al., 2016; Button et al., 2017). This provides an opportunity to notice and give space to cultural nuances that may otherwise be missed if using strict diagnostic criteria.

Psychological distress is said to occur during difficult or unusual experiences that may be associated with mental health difficulties or psychiatric diagnoses (Cromby, Harper & Reavey, 2013). In the perinatal literature, it is often associated with symptoms of depression and anxiety. However, the symptoms of depression and anxiety do not qualify as an operational

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<sup>1</sup>Perinatal distress is defined as the experience of depression and/or anxiety during pregnancy within the first postpartum year (Wenzel & Kleiman, 2015).

<sup>2</sup> Maternal distress is attributed to various causes but usually defined as postnatal depression (Raphael-Leff, 2018).

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definition of psychological distress but rather refer to depression and anxiety (Laporte & Aita, 2021). Therefore, in this thesis, PPD is understood as manifesting during common human experiences (such as pregnancy, birth or up to one-year post-birth) during which the demands placed on the mother exceed the resources that the mother can mobilize, thereby placing the mother in a precarious situation that results in the felt experience of PPD.

### **1.5.3 Punjabi**

‘Punjab’ is derived from Persian – ‘*Panj*’ and ‘*ab*’, meaning five rivers (B. Singh & Singh, 2019). Punjab is a state in the North-West of India. The official language is Punjabi, which is an Indo-Aryan language. Whilst a variety of dialects exist, Majhi is the main and standard dialect of Punjabi.

Punjabi literally translates to a person from the land of the five rivers (Singh, 1999). In 1849, the British conquered Punjab. In 1947, Punjab was reorganised which resulted in a partition of the Punjab into two: East Punjab (India) and West Punjab (Pakistan). Punjabi refers to someone whose heritage originates from Punjab in India and/or Pakistan. According to a census of the Punjab in India (Census of India, 2011), 57.69% of the population are Sikhs, followed by 38.49% of Hindus and 1.93% of Muslims.

### **1.5.4 Sikhism**

To be a ‘Sikh’ means to be a disciple or student (Singh, 2008). Sikhism is a monolithic faith (believing in the Oneness of God) that originates from around 15<sup>th</sup> century AD Punjab from the teachings of Guru Nanak Dev Ji, the first Sikh Guru, and his nine successors. The tenth Guru is the Shri Guru Granth Sahib Ji (SGGS), which holds all the teachings of the gurus.

Sikhs form part of the global classification of ‘South Asian’. Sikhs have historically been listed as of ‘Indian’ ethnicity; however, not all Sikhs identify as Indian. In preparation for the UK

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Census in 2021, many Sikhs rejected identification with ‘Indian’ and petitioned to be identified as a separate ethnicity under ‘Sikh’ (see Jhutti-Johal, 2018). Sikhism is the world’s fifth largest religion, with the largest diasporic communities in the UK, Canada, and USA (Kaur, 2020). Approximately 0.8% of the UK population is Sikh, making it the fourth largest religion in the UK (National Office for Statistics, 2011).

### **1.5.5 Mother**

For the purpose of this thesis, the term ‘Sikh Punjabi mother’ is used to refer to mothers that have given birth to a child, personally identify as Sikh and whose family lineage can be traced back to the Punjab.

The high regard given to women and mothers in Sikhism can be seen in the hymns in the SGGS which include the use of sexual symmetry (Kaur & Moghal, 2014) (e.g., “*God is our mother and our father*” – SGGS, Ang 1223) and the empowering tone with which the role and function of women is communicated (e.g., “*Without woman, there would be no one at all*” – SGGS, Ang 473).

Throughout this research project, I have been mindful of not only Punjabi mothers’ strengths but also the challenges that they have historically faced and continue to face both culturally and socio-politically. Early in the research process I was aware of the limitations around using the term ‘mother’. Much research has looked at motherhood from a white, western perspective and this limits our understanding of the experience of motherhood for different ethnic groups. Motherhood is complex and multi-faceted, and mothers are not homogenous in their perceptions of motherhood (Bhopal, 1998). Consequently, I have adopted to use the term Sikh Punjabi mother in this thesis to represent the layers of complexity and cultural nuances that come with being a *maa* (mother) from a Sikh Punjabi background.

### **1.5.6 Migration**

Migration refers to the process of going from one country, region, or place of residence to settle in another (Bhugra & Becker, 2005). It is estimated that the global Sikh population is between 23 to 25 million people, of which 1.5 million or more reside outside of India (Myrvold & Jacobsen, 2016). During the twentieth century, Sikhs began to settle in parts of Europe, including England. This was often for economic reasons.

Acculturation refers to the changes people experience from being in contact with other cultures (Graves, 1967 cited in van Oudenhoven & Eisses, 1998). According to Berry et al (1992 cited in van Oudenhoven & Eisses, 1998), there are four potential responses of minority members to a dominant group. Assimilation: the strategy chosen by a minority member who wishes to join the dominant society and to whom it is not important to maintain their culture and identity. Integration: which is said to be used by the minority member who wishes to maintain their ethnic identity, but who considers contact with the dominant society to be of value. (Bowskill et al (2007) state that integration has often been considered the idealized response of minority members.) Marginalization: which is when the minority member loses cultural and psychological contact with both their traditional culture and the larger society (either by exclusion or withdrawal). Lastly, separation: when the minority member wishes to maintain their ethnic identity and minimizes contact with the dominant group. These occur as a dual process, whereby on an individual level, one experiences changes in their behavioural repertoire and on a group level, whereby there are changes in social structures and cultural practices (Berry, 2005).

### **1.5.7 Identity**

In this thesis, it is assumed that identities are co-constructed, multiple and in perpetual movement, moving through successive phases of definition and redefinition rather than being a unitary, enduring, or fixed entity. An intersectional approach (Crenshaw, 2021) has been

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applied for considering and conceptualising the identity of Sikh Punjabi mothers. Intersectionality would suggest that intersecting factors such as their gender, ethnicity, and religion come together, impact one other and influence ways of being, experiences and stories. The issue of Sikh identity has caused debate within Sikh studies (Takhar, 2012). Some Sikhs prefer to identify as ‘Punjabi’, or as ‘Afghan\* Sikh’ (\*depending upon their country of residence), whilst others consider their ethnic group and/or religion as ‘Sikh’ (see Jhutti-Johal, 2018).

### **1.6 Prevalence of perinatal psychological distress**

Around 10%-20% of women during pregnancy and/or in the first postpartum year are reported to experience psychological difficulties (Smith et al., 2019). However, women from Asian ethnic backgrounds are twice as likely to experience adverse pregnancy outcomes (Garcia et al., 2015). In the UK, relatively few PMH studies have been conducted with ethnically diverse women and therefore limited statistics exist on outcomes in the UK. The research that does exist suggests that women of ethnic diversity experience significantly higher levels of psychological morbidity in the perinatal period that may become chronic (Edge, 2011; Onozawa et al., 2003) yet they have significantly lower access to community mental health services and higher percentages of involuntary admissions in comparison to White British women (Jankovic et al., 2020; Prady et al., 2016).

The King’s Fund (2006) report that there is evidence to suggest that the NHS is not catering well to Britain’s diverse population. Higher levels of dissatisfaction with NHS services have been found amongst Pakistani, Indian, and Bangladeshi respondents compared with the White majority. Woolett & Dosanjh-Matwala (1990) found that when Asian women in East London were asked about their childbirth experiences, a significant part of their accounts concerned their experiences in the postnatal wards, including indications of tensions between mothers and

staff. Further research has found that Asian women in Tower Hamlets received little or no emotional support once home because the roles of professionals were understood solely in terms of physical care (Parvin, Jones & Hull, 2004).

Mothers and family members of ethnically diverse backgrounds have different needs and expectations to their white counterparts (Edge, 2011). They belong to different cultural, ethnic, linguistic, and socio-political groups. Family structures and relationships vary, and they have differing levels and expectations of education and work. Some live among social and material deprivation (Edge, 2011) and/or experience discrimination (Wallace et al., 2016). Many face inequity in accessing and receiving appropriate support, early detection, type of intervention and outcome (Anderson et al., 2017; Prady et al., 2016). These diverse needs are said to be largely unmet by perinatal services which focus more on language and translation (Edge, 2010). By focusing on language and translation, assessment and physical health care is assisted but women's wider cultural needs are not accommodated which obstructs their care. Tseng et al (2005 cited in Rathod et al., 2015) suggests the need to consider not only technical adjustments (e.g., mode and manner of therapy) and practical adjustments (e.g., societal factors that impact on client's experiences) but also theoretical modifications (e.g., concepts of self and ego boundaries, defence mechanisms and coping) and philosophical reorientation (e.g., world view, beliefs, and attributions to distress).

### **1.7 Recognition of perinatal mental health difficulties in the UK**

It is estimated that in the UK, only 40% of women experiencing what is classified as postnatal depression are diagnosed. Of those recognised, only 60% receive treatment; only 40% receive adequate treatment, only 30% of those are identified as "recovered" and 3% as achieving "full recovery" (Bauer et al., 2014). (It is important to note that these figures would be less for women from ethnically diverse backgrounds.)



Without appropriate support, PMH difficulties can result in adverse psychological, social, parenting and employment outcomes for women. They can also negatively impact the unborn or developing baby, thereby increasing the risk of premature birth, stillbirth, physical, behavioural, emotional and/or educational problems as well as impaired mother-baby interactions (Coussons-Read et al., 2013). Furthermore, partners of pregnant women and/or mothers who are struggling with their mental health might themselves also experience emotional distress (Burgess, 2011; Paulson et al., 2016).

PMH difficulties have a huge impact on society. The London School of Economics and Centre for Mental Health (Bauer et al., 2014) estimate that in England, lack of timely access to adequate mental health care costs the NHS about £1.2 billion and society about £8.1 billion for each one-year cohort of births. In comparison, it would cost only an extra £280 million a year to bring the whole pathway of PMH care up to the level and standards recommended in national guidance (Bauer et al., 2014).

As part of the NHS long-term plan (The Mental Health Task Force, 2016; NHS England, 2019), additional funding was released for PMH services to ensure that by 2023/2024 more women can access evidence-based care and support. The funding has been used to expand inpatient mother and baby units (MBUs), specialist community PMH teams (to include parent-infant interventions and psychological provision through Improving Access to Psychological Therapies (IAPT)); to upskill and expand existing workforces as well as to better integrate care systems (Centre for Mental Health, 2021; National Collaborating Centre for Mental Health, 2018). As part of the expansion, it was agreed that care packages will be rolled out across maternity units (National Maternity Review, 2017) and partners of mothers experiencing mental health difficulties need to be offered a comprehensive mental health assessment and sign-posted to professional support if needed (NHS, 2018).

There is evidence to suggest that the changes outlined in the above documents have not been implemented to the same extent across the UK. The Centre for Mental Health (2021) states that there have been cuts to some services for women and families and a decrease in investment in related services due to austerity measures. PMH service users report missed opportunities to identify problems at an early stage and offer pro-active support (King's Fund, 2016).

A rapid evidence review of Covid-19's impact on mothers (Centre for Mental Health, 2021) indicates that Covid-19 has led to a decrease in mental wellbeing amongst women during the perinatal period and that the impact has been unequal. The impact of Covid-19 on ethnically diverse communities has brought to attention existing health inequalities as ethnic groups are at increased risk of morbidity and mortality if they contract the virus (Turienzo et al., 2021). Data on pregnant women admitted to hospital with Covid-19 between March 2020 and April 2020 reveals that half were from Black, Asian, and other ethnically diverse groups (Knight et al., 2020). This is striking considering that the population of England and Wales is about 86% White in comparison to 7.5% Asian, 3.3% Black and 3.2% Mixed and Other ethnic groups (Office for National Statistics, 2011).

A seminal paper by Johnson and Nadirshaw (1993) highlighted that there is a common perception that members of the South Asian community do not access mental health services due to fear of stigma or preference to keep issues within the family. These pervasive assumptions and stereotypes have contributed to less than satisfactory service provision for minoritised communities. Katbamna et al (2004) write that immediate family members are often the main source of support in South Asian households; however, the hidden nature of informal caregiving means that changes in the circumstances of carers and their relative experiencing difficulties is often overlooked. Whilst extended family members provide some support, this can be sporadic and not always dependable (Katbamna et al., 2004).

Reports state that many perinatal services do not offer specific provisions for ethnic minority women and where services exist, they tend to focus on interpretation and translation rather than culturally informed individualised care (Edge, 2011). Redshaw and Henderson (2016) found that Asian and older women are less likely to be asked and to be offered support antenatally and that this is even more evident in the postnatal period. They propose that the inverse care law is operating, whereby the women most in need of support and treatment are least likely to be offered it.

### 1.8 Models for understanding perinatal mental health

In this section, I outline the main models and interventions used for understanding and supporting mothers experiencing psychological distress during the perinatal period.

**Table 1.** Models for understanding PMH

| Perspective |  |
|-------------|--|
| Western     | Cognitive behavioural model (Wenzel, 2011)<br>Psychodynamic model and psychoanalytic literature (Bibring, 1959; Mahler & LaPerriere, 1965; Pines, 1972; Winnicott, 1956)                       |
| Alternative | Cultural formulation interview (APA, 2013; Fernandez, 2009)<br>Biopsychosocial-spiritual model (Hatala, 2013)  |
| Sikh        | Sikh Life-Stress Model (Sandhu, 2005)<br>Cycle of transmigration (SGGS)<br>Sikh model of the person, suffering and healing (Sandhu, 2004)<br>Sikh spiritual model of counselling (Singh, 2008) |
| Feminist    | Intensive mothering (Hays, 1996)<br>Feminist mothering (Ruddick, 1984)   |

### **1.9.1 Western models**

The transition to motherhood is marked by a combination of neurobiological and psychosocial changes. Whilst there is increasing evidence for the psychosocial factors involved in the perinatal period; the medical and psychiatric literature emphasise the biological aspects and frequently overlook the psychosocial factors.

#### **1.9.1.1 The cognitive behavioural model**

The cognitive behavioural model was developed by Dr Aaron Beck (1979) and refined by Dr Judith Beck (2011). It conceptualises cognitions (in particular, the meaning we make of situations) as playing a central role in our emotional, behavioural, and physiological reactions rather than the situation, stressor or trigger making us feel a certain way.

Wenzel and Kleiman (2015) produced a cognitive behavioural model of perinatal distress. The model outlines that people have genetic, neurochemical, psychological and environmental vulnerabilities that predispose them to experience emotional distress. These vulnerabilities are likely to be activated and expressed in times of life stress whereby we experience automatic thoughts (unhelpful beliefs) that influence our emotions and consequent behaviour, and vice versa.

#### **1.9.1.2 The psychodynamic model and psychoanalytic literature**

The psychodynamic model was developed by Dr Sigmund Freud and further developed by other theorists. Within the psychoanalytic literature, the psychological distress experienced during pregnancy and motherhood has long been recognised (see Blum, 2007). It has been described as a bio-psycho-social crisis which, under favourable conditions, can lead to personal maturity (Bibring & Valenstein, 1972; Bjelica et al., 2018).

Becoming a parent is regarded as a transitional stage (Erikson, 1959) and motherhood, by some, as potentially one of the most enriching stages of the life cycle (“when is one nearer to feeling

like God than when creating a new life?" - Pines, 1982, p311). Motherhood is considered a special state, during which 'primary maternal preoccupation' takes place (Winnicott, 1956). Primary maternal preoccupation refers to the development and manifestation of a state of heightened sensitivity experienced by mothers during pregnancy, which increases towards the end of pregnancy and lasts for a few weeks post-birth. It is a period during which intra-psychic changes take place (Pines, 1982) that enable a mother to adapt delicately and sensitively to her infant's needs (Winnicott, 1956). This allows the mother to provide a 'good enough' maternal environment, in which the mother is usually attuned (but not always) to what the child needs (Winnicott, 1963). This provides a facilitating environment and the maternal act of 'holding' (Winnicott, 1960; 1965). Winnicott (1956) recognised that primary maternal preoccupation is not experienced by all mothers, as some will have concerns outside of motherhood which they may not abandon or not be able to abandon. Due to there being little room for primary maternal preoccupation, some may find the mothering function difficult to achieve.

The first pregnancy is regarded as a time of stress for a new mother (Pines, 1972). From a psychodynamic perspective, new mothers undergo the task of 'separation-individuation' (Bibring, 1959; Mahler, 1979; Pines, 1972), which refers to specific developmental challenges that result in psychic reorganization, or as Mahler, Pine and Bergman (1977) termed it, psychological birth. During pregnancy, mothers experience a shift from being an independent single unit to an irreversible mother-infant dyad (Lapsley & Stey, 2010). As the child is born, there is a shift from baby's symbiotic union with mother to an individuating one. Mothers might experience a loss of symbiosis and/or relief from it (Mahler & LaPerriere, 1965).

The mother is confronted with the task of achieving a new adaptive position, both within her inner world and the outer world: a state of maturation as resolution of the relational tension between agency and communion takes place (Lapsley & Stey, 2010; Pines, 1972). Over the process, mothers will identify as a child of one's own mother as well as a mother distinct from

one's own parent (Raphael-Leff, 2018). During this process, uneasy conflicts belonging to past developmental states can be revived as one experiences a temporary regression to their primary identification with their own mother. One's self and object representation of their mother could be of mother as life giving or as a frightening figure. Depending upon the representation, this will either facilitate or conflict with the development of the mothers own maternal identity.

### **1.9.2 Alternative models**

The Cultural Formulation Interview (CFI), proposed in the DSM-5 (APA, 2013) and developed in North America, provides a framework for conceptualising and exploring psychological distress. The CFI outlines five areas for consideration when offering support: the cultural identity of the individual, cultural explanation(s) of their experience, cultural factors related to their psychosocial environment and level(s) of functioning, cultural elements of the relationship between the individual and professionals, and cultural considerations for assessment and intervention (Fernandez, 2009). One study in Pune, India (Paralikal et al., 2015) found that clinicians made little or no distinction about the value of the CFI; however, the patients valued the use of the CFI (some more so than others, depending upon the extent of their distress). Further research is required into the value and effectiveness of the framework.

The biopsychosocial-spiritual model (Hatala, 2013) is an extension of the biopsychosocial model (Engel, 1977; Gatchel, 2004). The model provides a holistic frame for understanding and addressing health as it outlines four domains (biological, psychological, social, and spiritual) that are said to interact and influence one's health and wellbeing. Spirituality concerns a person's relationship with transcendence (Sulmasy, 2002). It was previously seen as an independent domain, but the model proposes that spirituality interacts with one's biology, psychology, and social domains as it influences the meaning and purpose within health experiences not to mention influences coping (e.g., reading from sacred texts) and help-seeking (e.g., prayer and meditation).

### 1.9.3 Sikh perspectives

The Sri Guru Granth Sahib Ji (SGGS), completed in 1604, refers to pain/suffering, grief, sadness, worry, happiness, and anger. There are many references to emotional experiences, some are described (*chindaa* – worry) (e.g., SGGS, Ang 1019) whilst others are expressed through metaphors (e.g., *fahee faathay mirag ji-o dookh ghano nit ro-ay* – like a deer caught in the trap, they suffer in terrible agony; they continually cry out in pain (SGGS, Ang 23)). From a Western medical perspective, these experiences may be conceptualised as referring to the experiences of anxiety and depression (see Kalra, Bhui & Bhugra, 2013).

The Sikh Life-Stress Model (Sandhu, 2005) is based on the idea that we are driven by our ego's<sup>3</sup> desire to fulfil four core human needs which are interlinked and pursued simultaneously. These include security (*surakhia*), love (*prem*), respect (*izzat*), and freedom (*azaadi*). According to Sikhism, a major source of suffering (*dukh*) is caused by the perception that the ego is our authentic centre (Sandhu, 2005). From this position, we experience a tendency towards ego-centredness when our ultimate goal in life is to experience unity with *Ek Onkar* (God/the Creator/Oneness with everything). The path of being ego-oriented (*manmukh*) forms the theoretical foundation of the Sikh Life-Stress Model, known as the circle of suffering (*dukhan ka chakr*) (Sandhu, 2005).

The Sikh model of the person, suffering and healing (Sandhu, 2004) has been summarised into table 2. Suffering is attributed to being bound to the cycle of transmigration (*sansar*), which is influenced by internal and external forces (Kaur, 1985 cited in Sandhu, 2004). Internal forces include *karam* (the actions performed in previous births manifesting their consequences in the present birth). By following the spiritual path (*gurmat marg*) one can change their destiny. External forces include the familial and social environment, and the way in which the ego relies

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<sup>3</sup> The concept of the ego in Sikhi refers to the experience of “I” (Sandhu, 2008).

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on worldly experiences, roles, and attachment to experience security and validation (*maya*) (Sandhu, 2004).

**Table 2.** Summary of the Sikh model of the person, suffering and healing (Sandhu, 2004).

| <b>Part</b>    | <b>Meaning</b>   |
|----------------|--|
| Spiritual self | Cosmic essence that unifies all diversity.   |
| Consciousness  | Dynamic spheres of awareness: <ul style="list-style-type: none"> <li>❖ Awake state (mind generates information about phenomena through the sense organs).</li> <li>❖ Dream state (sense and motor organs are at rest).</li> <li>❖ Deep-sleep state (mind is in absolute stillness).</li> <li>❖ Consciousness totally absorbed in the spiritual self (absorbed in the spiritual self).</li> </ul> |
| Hidden record  | Unconscious sphere that stores impressions that have accumulated through the cycles of transmigration.   |
| Mind           | <ul style="list-style-type: none"> <li>❖ Sensory perception</li> <li>❖ Memory</li> <li>❖ Intellect</li> <li>❖ Empirical ego</li> </ul>   |
| Physical body  | Regarded as the vessel for the spiritual self.   |

Sikh belief posits that whatever happens in our life is as per the will (*hukam*) of God (Kalra, Bhui & Bhugra, 2013). Kalra, Bhui and Bhugra, (2013) suggest that the emphasis on *dukh* being like a gift from God may be one of the factors why some people today do not seek professional help on time. When considering mental health, some Sikhs may refer to concepts such as the evil eye (*nazar*) or spirit possession (*atma ka kabza*). It is important to note that



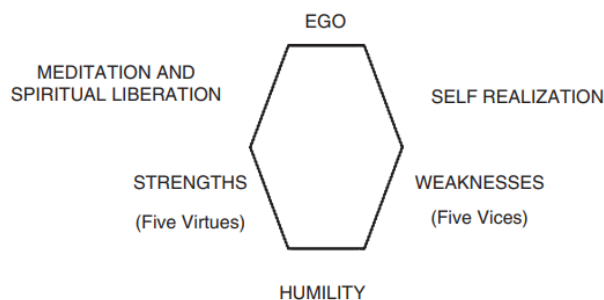
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these explanations are not theological ideas found in Sikhism but are cultural explanations to the causes of mental health distress (Lindridge, Hogg & Shah, 2004).

Sikhism teaches to take the spiritual path; to realise the true nature of the self and its connection with *Ek Onkar* and transcend *karam*. Therefore, the process of healing for a Sikh requires a holistic approach as one works towards the realization of the spiritual self (Singh, 1990 cited in Sandhu, 2004) and a state of *chardi kala* (optimism/high spirit). Within Sikhism, there is also acknowledgement of the socio-political context. The miri-piri doctrine was laid down by Guru Nanak Dev Ji in his *bani* (hymn) and Guru Hargobind Ji who donned two swords: one of *miri* (temporal power), and the other of *piri* (spiritual power) (Sikh Research Institute, 2021). This made clear the role that the Sikh society was to play: to resist and confront injustice, wherever it takes place (Mann & Singh, 1992).

The Sikh spiritual model of counselling was developed by Singh (2008) (see figure 1). The model outlines six steps to spiritually liberate oneself from *haumai* (ego/pride) and become *gurmukh* (God-centred and humble), not *manmukh* (self-centred). The steps include: to understand what and how our ego affects us, to address our ego, to reflect upon the five thieves (lust, anger, greed, wordly attachment and pride) and consider which one is relevant, and to counter the ego and accept humility. The model is designed for clinical use and, in line with Sikhi, suggests practicing the five virtues. These include speaking the truth, finding contentment, developing one's patience, having faith, and practicing compassion.

**Figure 1.** The Sikh spiritual model of counselling by Singh (2008)



#### 1.9.4 Feminist perspectives

Motherhood is a contested concept. Simone de Beauvoir, a prominent feminist and midwife, argued that women are encouraged to see motherhood as the essence of their life and the fulfilment of their destiny when in fact maternity is a means of maintaining a woman's inferior social and economic status (Pateman, 1988; 1989 cited in Neyer & Bernardi, 2011). Traditionally, pregnancy, childbirth, and child-rearing have allowed women to gain recognition in a patriarchal society that acknowledges their value when they reproduce (Oliver, 2010). Still today, in some cultures, if a woman is childless, there are social and cultural consequences as it remains the path to achieving womanhood (see Balen & Bos, 2009).

The ideology of 'intensive mothering' prescribes women to be perfect mothers (Hays, 1996). It is based on the premise that mothers are the preferred caretakers of children and must put their children's needs first. Research shows that such pressure to be a perfect mother is positively related to parental burnout (Meeussen & Laar, 2018). It is argued that the linkage between motherhood and nature is historically, socially, legally, politically, and philosophically created (see Neyer & Bernadi, 2011). Furthermore, feminists propose that framing motherhood as nature denies that motherhood is in fact work and legitimizes the subordination of women.

Refraining from motherhood and motherly work for some is a means of resistance against these systems (Neyer & Bernadi, 2011). Others propose that it is the social construction of motherhood that is burdensome and overbearing rather than motherhood itself. In line with ‘feminist mothering’, motherhood can be a rewarding expression of conscience (Green, 2009) as women can use their experiences of motherhood to challenge and transform unacceptable dominating patriarchal constructions of motherhood and mothering practices (Rich, 1986; Green, 2009).

### **1.10 Assessments and interventions used in the NHS**

Currently, this is an ever-expanding area, and it is beyond the scope of this thesis to go into detail and review every intervention for PMH difficulties. Perinatal services have traditionally been focused on offering support to the mother; however, in line with the five-year forward plan, access is being expanded to include support for fathers, co-parenting and more family and parent-infant interventions (Howard & Khalifeh, 2020).

CBT is the main psychological intervention used in perinatal services for supporting mothers experiencing forms of PPD (see table 3). This can be accompanied by psychiatric medication. Extensive literature exists looking at the biological factors involved in the perinatal period and this lends itself to the suggested interventions, which can include “offer an antipsychotic” (“if the pregnant woman develops mania or psychosis and is not taking psychotropic medication”) and to *consider* psychological interventions (CBT or family intervention) (NICE, 2014; NICE, 2014). This is despite acknowledgement by the field that the suggested intervention options can have adverse outcomes for the woman, foetus or baby, not to mention that medications are under researched (Lynch et al., 2019; NICE, 2014).

Holmes (2000) argues that as modern medicine has advanced, this has resulted in a loss of meaning within our clinical work. Evidence-based medicine is criticised for applying the

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scientific method without giving enough consideration to the historical and sociological forces shaping a person's reality (Holmes, 2000)

**Table 3.** NICE (2014; 2018) guidelines for antenatal and postnatal mental health

| <b>Perinatal mental health difficulty</b> | <b>Recommendation</b>  |
|---|--|
| Depression and anxiety disorders          | <p>High intensity psychological therapy such as CBT. This may be combined with medication.</p> <p>Medication (a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or serotonin-norepinephrine reuptake inhibitor (SNRI)) if the service-user (1) expresses preference for medication, (2) declines psychological intervention, or (3) has limited response to high intensity psychological intervention.</p> <p>Electroconvulsive therapy (ECT) for pregnant women with “severe depression” (NICE, 2014, p38), if physical health or foetus considered to be at risk.</p> |
| Bipolar disorder                          | <p>CBT, interpersonal therapy (IPT) and/or behavioural couple's therapy.</p>   |

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|  |  |
|--|--|
| <p>Post-traumatic stress disorder (resulting from traumatic birth, miscarriage, stillbirth, or neonatal death)</p> | <p>Trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR).</p>   |
| <p>Mania or psychosis</p>  | <p>Offer antipsychotic.</p> <p>CBT or family intervention if already diagnosed with psychosis (or schizophrenia) who become pregnant.</p> <p>Electroconvulsive therapy (ECT) for pregnant women with “mania”, or “catatonia” (NICE, 2014, p38), if physical health or foetus considered to be at risk.</p> |
| <p>Woman experiencing mental health difficulties and planning a pregnancy</p>                                      | <p>Preconception counselling.</p>  |

The NICE guidelines (2014) also mention that professionals must provide culturally relevant information on mental health difficulties in pregnancy and the postnatal period. This is a challenge considering that professionals are expected to provide services to populations for whom they have not received any culturally relevant training (Sehgal et al., 2011). Not to mention, the assessments and interventions used in the NHS are predominantly based on Western frames of understanding and research involving White British participants. Attempts have been made to cross-culturally adapt tools. For example, the Hospital Anxiety and

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Depression scale has been translated into Punjabi (see Lane et al., 2007). It is argued that significant adaptations are needed to the delivery of interventions and therapeutic process to make empirically supported treatments more culturally appropriate (Whaley & Davis, 2007).

There is increasing emphasis on cultural competence within the NHS. E-learning resources have been created with the aim of supporting NHS staff to develop their cultural competence skills. However, the content of these videos largely appears to focus on general information and statistics (see ELFH, 2022) and less so on specific knowledge, beliefs, values, attitudes, and practices of diverse populations. Whilst the latter can be difficult to accomplish, given the degree of diversity within society, it can be argued that teams hold some responsibility to inform themselves to a reasonable degree about the demographic and culture of the local community they have a role in supporting.

Alongside this aim for cultural competence, there is increasing interest in adopting a stance of cultural humility within practice (Kelsall-Knight, 2022). Cultural humility might involve staff consciously attempting to understand their service-user's identities but also their own identities as practitioners and how they may be informing how the service-user is experienced and understood (Khan, 2021). Whilst some may adopt an either-or approach (i.e., cultural competence or cultural humility), the author sees merit in utilising a both-and approach which encompasses educating oneself and engaging in self-reflection.

### **1.11 Summary**

We need culturally sensitive care pathways and support in perinatal and related services. It would help improve health outcomes and address racial and ethnic health disparities. To achieve this, we need a better understanding of the perinatal needs of women of ethnic diversity.

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Whilst the literature looking at the PMH experiences of Punjabi women is scarce, there is growing literature on the PMH experiences of women of Indian heritage. Given the geographical link and cultural similarities between the Punjabi community and wider Indian community, it would be useful to summarise and critically consider what is currently known about the perinatal experiences of women of Indian heritage. Therefore, the next section explores the literature exploring this topic.

## SYSTEMATIC LITERATURE REVIEW

In this section, the literature that is relevant to the research question will be reviewed. This chapter will provide an overview and critical evaluation of the existing research that relates to the PMH of women of Indian heritage. To the author's knowledge, there has been no previous systematic review of the literature looking at the perinatal experiences from the perspectives of Indian women.

### 1.12 Aims and scope

The aim of this systematic review was to summarise and synthesise the relevant literature to answer the following question:

*What is currently known about the perinatal experiences of women of Indian heritage?*

#### 1.12.1 Review strategy

A search was conducted to confirm that a systematic review of the selected research question has not already been conducted. This allowed for familiarising with the existing literature and identifying gaps in research. Thereafter, a preliminary search was conducted to identify the terms most frequently used to refer to papers relating to the research question. The search terms identified and used for conducting the systematic search are outlined in table 4.

**Table 4.** Search terms used for conducting the systematic review

| Category   | Classification term   |
|------------|---|
| Women      | Wom* OR Wom?n OR Female   |
| Maternal   | Maternity OR Matern* OR mother*   |
| Experience | Narrative OR stor* OR meaning* OR sense* OR understand* OR belief OR idea OR account* OR experience* OR description OR symptom* OR cop* |
| Perinatal  | Prenatal OR Perinatal OR Postnatal OR Postpartum  |



Indian | India\* OR Punjabi

The first set of searches were conducted in May 2020 and the final searches were conducted in August 2021. This was to capture any developments in the literature since the original searches were undertaken. A combination of the outlined search terms was used. The systematic search was conducted using Pubmed, Scopus and Ovid to review the databases from 1960<sup>4</sup> to 16 August 2021. In addition, Google Scholar was used to supplement the search. ‘Mental health’ was initially included as a search term but later removed because it was producing a vast number of unrelated search results. On some databases, ‘NOT COVID-19’ had to be added to further narrow the search results. Lastly, reference lists and grey literature<sup>5</sup> were scanned for relevant articles (see ‘supplementary hand searches’ in **Figure 2**). This led to a snowballing approach<sup>6</sup> of gathering additional relevant literature.

Once papers had been identified and duplicate papers removed, the titles were reviewed for relevance to the research question. This was subsequently followed by a review of the abstracts of the remaining papers. This left 21 papers for in-depth review and finally 9 papers for the systematic review (see figure 2 for Prisma flow diagram). Throughout the process, relevance was determined using the eligibility criteria (see table 5). The quality of each article was also assessed (see appendix A).

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<sup>4</sup>Pre-1960 papers were excluded to fine tune the search results as from the 1960s onwards, there was renewed interest and advancements in the perinatal field in the UK (Dunn, 2007).

<sup>5</sup> Unpublished manuscripts and commissioned reports.

<sup>6</sup> One or more sources are used to lead the researcher to more sources (Stangor, 2007).

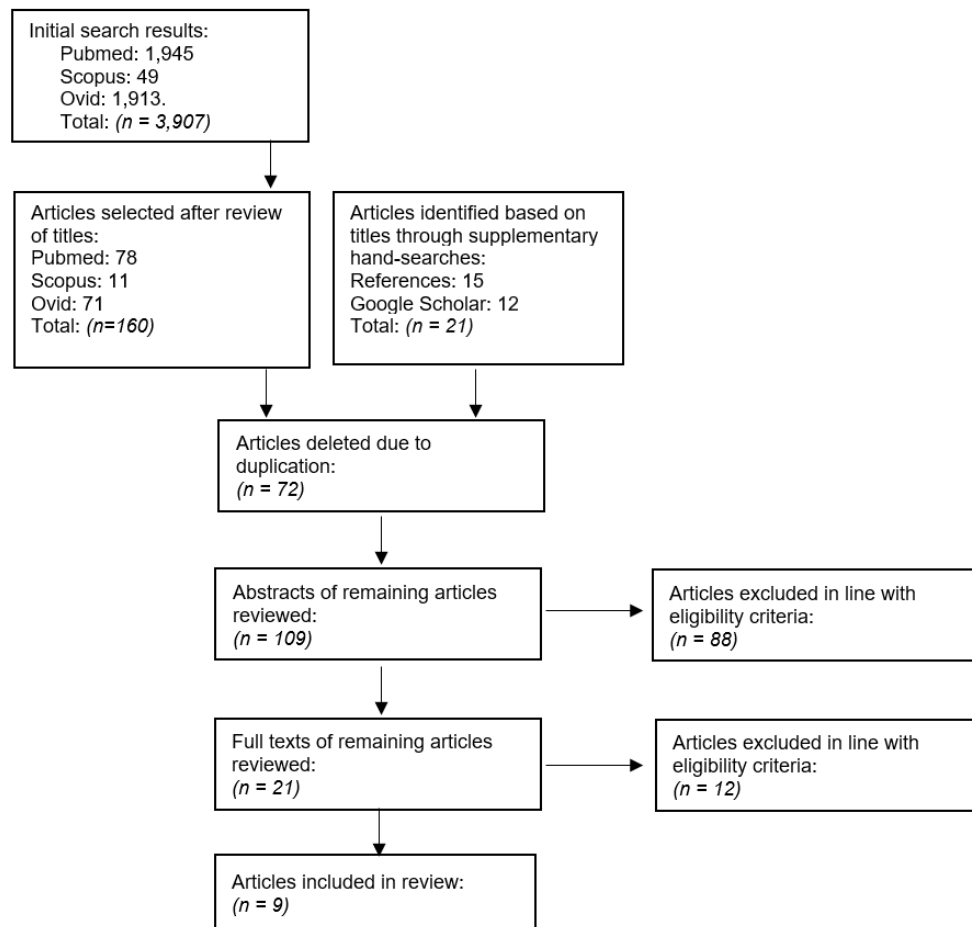
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**Table 5.** Eligibility criteria

| <b>Reasons for inclusion</b>  | <b>Reasons for exclusion</b>  |
|---|---|
| Published in English.   | Not published in English.   |
| Published in 1960 onwards.  | Published before 1960.  |
| Article focused on women's mental health during the perinatal period.                   | Article unrelated.  |
| Article predominantly on the experiences and understanding of women of Indian heritage. | Population unrelated.   |
| Self-report data on perinatal experiences.  | Data only from care givers, key informants, or healthcare professionals; intervention evaluation or service evaluation. |
| Qualitative, mix methods or quantitative with a qualitative component.                  | Pure quantitative methodology as the review is interested in exploring women's qualitative perinatal experiences.       |
| Reported data from an empirical study.  | Review paper.   |
| Peer reviewed articles.   | Not peer reviewed.  |

The full process is illustrated in figure 2.

**Figure 2.** Prisma flow diagram of the systematic literature review process (Page et al., 2021)



### 1.12.2 Overview of literature review

This review is based on data from 734 mothers of Indian heritage living in the UK, India, Australia, and Canada. Two studies included Indian women plus other ethnicities. (Critical consideration and rationale for the inclusion of these studies is in section ‘**1.12.7 Critical review**’.) The oldest article was published in 2002 and the most recent article was published in 2020.

**Table 6.** Summary of systematic review papers

What is currently known about the perinatal experiences of women of Indian heritage?

| Author, year and title  | Aims  | Country                          | Sample  | Languages   | Design   | Outcomes and key conclusions  | Comments<br>(L = limitation.<br>S = strength.)  |
|---|---|----------------------------------|---|---|--|---|---|
| Wittkowski et al (2011)<br><br>The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study | To better understand the experience of PND in South Asian mothers living in Great Britain.  | Greater Manchester, UK           | Five Indian women, one, Bangladeshi woman, and four Pakistani women   | Out of the five Indian mothers: three spoke English and Urdu, one spoke English and Punjabi and one spoke English and Gujarati. | Interviews.<br><br>Grounded theory approach  | 1. Three categories identified:<br>➤ Internalising misery<br>➤ Others will judge me, and I feel like I am on my own<br>➤ I talk to my health professional, and they don't understand<br>2. Coping strategies: faith/religion, time out, remaining positive and seeking more family support.   | L: faith?<br>L: from which area of India?<br>S: main researcher and participants identified as Asian British.<br>S: rich findings with quotes.<br>S: Tentative model for post-natal depression in South Asian mothers proposed.   |
| Goyal et al (2020)<br><br>Psychiatric morbidity, cultural factors, and health seeking behaviour in perinatal women:                       | The study was undertaken due to the limited literature on explanatory models of postpartum psychosis (PP) among patients and caregivers in India. | Bangalore and neighbouring areas | 123 women provided quantitative data<br><br>27 women provided qualitative data<br><br>80% of the mothers identified as Hindu. | Local terms used but language not stated.   | Cross-sectional study<br><br>Cultural formulation interview.<br><br>Mix methodology:<br><br><sup>7</sup> Independent (unpaired) samples T-test and Chi-square/Fisher's exact test.<br><br>Participant responses and verbatim included. | 1. Emotional/behavioural words used to describe the problem.<br>2. Perceived cause: 33.3% pregnancy/physical health, 29.6% interpersonal stress, 22.2% psychological attribution. Other responses: witchcraft and destiny.<br>3. Helpful support: social support (70.3%) followed by spiritual support (25.9%) and faith healing (3.7%).<br>4. Moderating factors: religion and social support.<br>5. Barriers to help-seeking: stigma, financial problems, busy work schedule, family commitments and poor accessibility of health care facilities.<br>6. Help-seeking influenced by: trust, easy availability and | L: language?<br>L: largely urban sample, age 18-25, most were antenatal<br>L: researchers have not shared the steps taken in between collecting qualitative data and performing quantitative analysis.<br>S: participant language used to describe and understand PMH experiences.<br>S: demonstrated usefulness of cultural formulation interview in obtaining information about the influence and impact of culture on PMH. |

<sup>7</sup>Goyal et al (2020) collected data from mothers using scales and the cultural formulation interview. They performed a t-test and chi square. They did not specify the steps taken in between these two stages.

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|   |   |   |   |   |  |   |  |
|---|---|---|---|---|--|---|--|
|   |   |   |   |   |  | accessibility, recommendations, and belief in supernatural.   |  |
| Iyengar, Pelto & Iyengar (2016)<br><br>Huwa Rog, Parhej and Desi Dawai: women's perceptions of postpartum maternal morbidity and care in Rajasthan, India | To better understand how women and their families perceive postpartum health problems, and to understand their concepts of prevention of postpartum illness.  | Rajasthan, India                                | 81 women<br><br>+ some family members<br><br>+ nine female key informants (senior woman, traditional birth attendants, village health workers, midwife) | Hindi   | Open-ended interviewing, followed by semi-structured interviews.<br><br>Ethnography based mixed methods. | 1. Huwa rog: postpartum health problems.<br>2. Desi dawai: preventative medicine as part of parhej (postpartum precautions).<br>3. Focused on "cold" and "hot" as causes of illness.<br>4. Observance of restrictions.  | L: age? Faith?<br>L: no audio recordings of interviews.<br>S: produced an explanatory model of <i>huwa rog</i> and <i>parhej</i> which provides keys for understanding women's behaviours in relation to health problems in the postpartum period.<br>S: participant language used to describe and understand PMH experiences. |
| Thippeswamy et al (2015)<br><br>What is in a name? Causative explanatory models of PP among patients and caregivers in India                              | To address the lacunae in understanding explanatory models of postpartum psychosis.   | Bangalore and nearby areas                      | 123 women<br><br>+ care givers<br><br>77% identified as Hindu   | Local terms used but name of language not stated. | Open-ended interviews using the Short Explanatory Model Interview (SEMI).<br><br>Content analysis.       | 1. Names used for postpartum psychosis:<br>➤ specific to postpartum period, mental illness/psychosocial factors,<br>➤ supernatural,<br>➤ physical forces<br><br>2. Causes:<br>➤ psychosocial causes<br>➤ interpersonal problems (strained relationships with spouse and/or in-laws.<br>➤ gender of baby (pressure to have a male infant)<br>➤ death of first child<br>➤ supernatural<br>➤ physical causes<br>➤ personality factor<br>➤ spiritual and religious causes | L: language? faith?<br>S: produced explanatory models for experiences conceptualised as postpartum psychosis.<br>S: participant language used to describe and understand PMH experiences.  |
| Rao, Dahlen & Razee (2020)<br><br>Indian migrant women's experiences of motherhood and postnatal support in Australia: a qualitative study                | To explore experiences of motherhood and postpartum support of Indian migrant mothers. To identify postpartum health needs and socio-cultural barriers and explore postnatal model of care that could contribute to promoting their postnatal mental wellbeing. | Originally from India. Immigrated to Australia. | 11 women (not diagnosed with perinatal mental health problems)  | Fluent English.                                   | Semi-structured interviews.<br><br>Thematic analysis.  | Four categories identified:<br>➤ Role of social support in postpartum care,<br>➤ Support from health services,<br>➤ A psycho-emotional journey within sociocultural expectations<br>➤ Struggling to bridge two cultures   | S: perinatal demographics included.<br>S: detailed findings including quotes from participants.<br>L: faith?<br>L: born in India - mother tongue?<br>L: from which region of India?  |

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|  |  |   |   |   |   |  |  |
|--|--|---|---|---|---|--|--|
| <p>Patel, Rodrigues &amp; Desouza (2002)</p> <p>Gender, poverty, and postnatal depression: a study of mothers in goa, India</p>  | <p>To examine the aetiological role of risk factors recognised to be relevant to the onset of postpartum depression in developed societies, as well as those that reflect poverty and gender inequality faced by women in India.</p> | <p>Goa, India</p>   | <p>270 mothers</p> <p>89% identified as Hindu</p> | <p>Spoke either Konkani, Marathi, Hindi or English.</p> | <p>Questionnaires, histories, and semi-structured interview.</p> <p><sup>8</sup>Two tailed tests.</p> | <p>Risk factors for occurrence and chronicity of depression:</p> <ul style="list-style-type: none"> <li>➤ problems with breast-feeding,</li> <li>➤ infant hospital admission,</li> <li>➤ sadness about infant's gender,</li> <li>➤ economic deprivation,</li> <li>➤ poor marital relationship and domestic violence,</li> <li>➤ birth of female child,</li> </ul>  | <p>L: researchers have not shared the steps taken in between collecting qualitative data and performing quantitative analysis.</p> <p>L: first-time mother? Faith?</p> <p>S: a variety of methods were used to collect comprehensive data (questionnaire, scales and semi-structured interview).</p> <p>S: implications and recommendations offered.</p> |
| <p>Grewal, Bhagat &amp; Balneaves (2008)</p> <p>Perinatal beliefs and practices of immigrant Punjabi women living in Canada.</p> | <p>To describe new immigrant Punjabi women's perinatal experiences and the ways that traditional beliefs and practices are legitimized and incorporated into the Canadian health care context.</p>                                   | <p>From Punjab, India. Living in British Colombia, Canada</p> | <p>15 mothers</p> <p>Faith not mentioned.</p>     | <p>Punjabi</p>  | <p>Interviews.</p> <p>Naturalistic qualitative study.</p>   | <p>Three categories identified:</p> <ul style="list-style-type: none"> <li>➤ The pervasiveness of traditional health beliefs and practices related to the perinatal period,</li> <li>➤ The important role of family members in supporting women during the perinatal experiences,</li> <li>➤ The positive and negative interactions women had with health professionals in the Canadian health care system.</li> </ul> | <p>L: states that language posed a barrier for women who did not speak English but does not state the women's primary language.</p> <p>S: shared culture between interviewer and participants.</p> <p>S: interviews conducted in participants own language (Punjabi).</p> <p>S: detailed methodology.</p> <p>S: recommendations offered.</p>             |

<sup>8</sup>Patel, Rodrigues & Desouza (2002) collected data using scales and histories. They performed univariate comparisons and multivariate logistic regression analysis. They did not specify the steps in between these two stages.

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

|  |   |   |   |  |  |   |   |
|--|---|---|---|--|--|---|---|
| <p>Mccauley et al (2020)</p> <p>'Good health means being mentally, socially, emotionally, and physically fit': women's understanding of health and ill health during and after pregnancy in India and Pakistan: a qualitative study.</p> | <p>To explore what women consider health and ill health to be, in general, and during and after pregnant. Women's views on how to approach screening for mental ill health and social morbidities were also explored.</p> | <p>New Delhi, India and Islamabad, Pakistan</p> | <p>130 Indian women (60) and Pakistani women (70) living in urban settings.</p> | <p>India-Hindi and Pakistan-Urdu.</p>              | <p>Focus group discussions and key informant interviews.</p> <p>Thematic framework analysis.</p> | <p>Health:</p> <ul style="list-style-type: none"> <li>➤ lack of disease, good energy levels, supportive family environment.</li> </ul> <p>Ill health:</p> <ul style="list-style-type: none"> <li>➤ physical symptoms/disease; tension, abusive/stressful home environment.</li> </ul> <p>Health during and after pregnancy:</p> <ul style="list-style-type: none"> <li>➤ nutritious diet, medication, rest, extra care, peaceful home.</li> </ul> <p>Barriers:</p> <ul style="list-style-type: none"> <li>➤ lack of enquiry, unacceptable to discuss, repercussions if discussed, "they can ask but what can they do?", concerns around confidentiality.</li> </ul> | <p>S: detailed demographic information.</p> <p>S: detailed findings.</p> <p>S: research team reviewed the data to ensure inter-rater reliability and critiqued themes and subthemes and discussed discrepancies and reached consensus.</p> <p>L: participants were attending secondary level healthcare and therefore may not be generalisable to women that do not access support.</p> |
| <p>Raman et al (2014)</p> <p>My mother... my sisters... and my friends: sources of maternal support in the perinatal period in urban India.</p>  | <p>To explore wide ranging sources of support that the maternal-infant dyad need or expect throughout the perinatal period in urban India.</p>  | <p>Bangalore</p>                                | <p>36 mothers</p>   | <p>Kannada, Hindi, Tamil, Telugu, and English.</p> | <p>Semi-structured interviews and ethnographic fieldwork.</p> <p>Thematic analysis.</p>          | <p>Five categories identified:</p> <ul style="list-style-type: none"> <li>➤ Importance of women's own mother,</li> <li>➤ My place (ooru),</li> <li>➤ Female support network,</li> <li>➤ Role of husband,</li> <li>➤ The ambivalent role of the family.</li> </ul>   | <p>L: Age? Faith? First time mothers?</p> <p>S: shared language between researchers and participants.</p> <p>S: in-depth interviews conducted, lasting between 1.5 to 3 hours.</p>  |

### **1.12.3 Data synthesis**

In this review, each article has been discussed individually and themes identified across the literature to explore the overall question:

*What is currently known about the perinatal mental health experiences of women of Indian heritage?*

In respect of this, the review aims to consider:

1. The experiences and understanding of perinatal mental health amongst women of Indian heritage.
2. The traditional health beliefs and practices of women of Indian heritage in relation to the perinatal period.
3. The factors that influence the help-seeking behaviours of women of Indian heritage in relation to perinatal mental health.

### **1.12.4 Method of data synthesis**

Thematic synthesis is a process drawing on techniques from thematic analysis to synthesise and analyse qualitative research (Thomas & Harden, 2008). Thematic synthesis was used in the current systematic review to combine the studies exploring Indian women's perinatal experiences and extract the findings. The findings were coded line-by-line which summarised the data and allowed for translation of concepts from one study to another. Similarities and differences between the codes were considered and incorporated into the write up to highlight points of connection and disconnection between studies. Due to the number of codes identified and the richness of the data, the studies are presented individually to not compromise on the depth of the findings and to avoid over-simplifying the findings.



### ***Desi dawai (natural remedy) and Parhej (precautions)***<sup>9</sup>

Iyengar, Pelto and Iyengar (2016) interviewed six women in Rajasthan, India who were identified to have experienced '*huwa rog*' (postpartum illness). Some of their family members were also interviewed along with nine female key informants. Mothers' descriptions of *huwa rog* included physical symptoms such as pain and weakness (see table 6). *Huwa rog* was understood by key informants to be caused by violating *parhej* ((postpartum) precautions). Two themes were noted in the mothers' accounts: '*desi dawai*: preventive medicine as part of *parhej*' and 'observance of restrictions on work'. *Parhej* included avoiding going outside during the postpartum period, avoiding work, avoiding sour foods and to ingest *desi dawai* (natural remedies) after childbirth, including *sonth* (dried ginger), *ajwain* (carom seeds) and *gond* (tree gum). *Desi dawai*s were described as varying in their degrees of '*garami*' (heatness), which was considered important for initiating lactation, providing strength, and mending the body. The authors concluded that health interventions can be enhanced by professionals having a good knowledge of local relevant explanatory models, such as the humoral system (the idea that good health is maintained through equilibrium of hot and cold) as it can be a factor accounting for the acceptance or rejection of professional support (see Kanani et al., 1994<sup>10</sup>; Nichter, 1989).

### ***Chilia (40 days of rest)***

Grewal, Bhagat and Balneaves (2008) interviewed 15 first-time immigrant mothers from Punjab, India in British Columbia, Canada. They noted three categories in the mothers'

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<sup>9</sup> Headings are based on what the author considers to be the key finding(s) of each study.

<sup>10</sup> Some women rejected iron folic acid tablets in antenatal care because of their supposed "heatiness" as well as other negative qualities (Kanani et al., 1994).

accounts: ‘the pervasiveness of traditional health beliefs and practices related to the perinatal period’, ‘the important role of family members in supporting women during the perinatal experiences’, and ‘the positive and negative interactions women had with health professionals in the Canadian health care system’.

Like Iyengar, Pelto and Iyengar’s (2016) findings, traditional health beliefs and practices noted in Grewal, Bhagat and Balneaves’ (2008) study included a balanced diet in the form of foods believed to have “hot effects” (because “cold foods” were believed to cause imbalance in a woman’s body after labour), creating positive energy (through prayer, keeping an image of Guru Nanak, visiting the Gurdwara to receive blessings, hanging neem leaves, tying black thread or placing a black dot on the baby to ward of *najjar* (evil spirits)) and practicing *chilia* (resting for 40 days). Mothers had certain expectations of care from hospital staff as they had planned to practice *chilia*. They described feeling abandoned, forced to take on activities before they felt ready, and their experiences of pain/fatigue as not acknowledged by staff. Grewal, Bhagat and Balneaves (2008) concluded that nurses are ideally placed to support mothers through adapting cultural practices in ways that uphold traditional beliefs whilst recognising the inaccessibility of some ritual material in Canada.

***“I go and talk to my health professional, and they don’t understand me”***

Wittkowski et al (2011) interviewed 10 South Asian mothers (five of which were of Indian heritage) about their experiences understood as postnatal depression within Greater Manchester, UK. Mothers referred to their experiences as “postnatal depression”, “tension” (p486) or as unknown. The authors noted three categories in the mothers’ accounts: ‘internalising misery’, ‘others will judge me, and I feel like I am on my own’ and ‘I talk to my health professional, and they don’t understand me’. ‘Internalising misery’ included difficulty understanding their own thoughts and feelings following childbirth, cultural and religious

suppression of difficult thoughts and feelings, and somatisation<sup>11</sup>. The category ‘Others will judge me, and I feel like I am on my own’ involved feeling isolated and desperate for support but not knowing who to turn to. ‘I go and talk to my health professional, and they don’t understand me’ referred to discrimination and stigmatisation, language and communication barriers, and lack of cultural and religious sensitivity. This connects with Grewal, Bhagat & Balneave’s study (2008), in which Punjabi mothers described struggling with language barriers in antenatal classes. Wittkowski et al (2011) conclude that services need to improve their accessibility for South Asian mothers, including raising awareness of the services available to women but also by offering quality translation and interpretation services to women.

### **Intergenerational conflict**

Goyal et al (2020) assessed 27 women in North India using the Cultural Formulation Interview (CFI) (APA, 2013). They noted that the mothers perceived the cause of their difficulties to be pregnancy/physical health, interpersonal stress, and psychological in nature. Some mentioned witchcraft and destiny. Other factors included marital discord, gender of the infant (however, unlike the papers previously mentioned, this paper was not explicit about male gender preference) and family issues (termed “intergenerational conflict” (p55). The latter finding overlaps with Wittkowski et al (2011) and Grewal, Bhagat and Balneave (2008). In Wittkowski et al (2011), family were described as helpful but also as having a significant negative effect on the mothers’ mental health (due to “intergenerational incongruity” (p488)). In Grewal, Bhagat and Balneaves (2008), female elders (mothers and mothers-in-law) often

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<sup>11</sup> Somatisation was not expanded upon or defined by Wittkowski et al (2011). It can be conceptualised from several different perspectives. The most common explanation is the experience of psychological distress in the form of physical symptoms. However, the phenomenon is often oversimplified when applied to non-Western cultures (see Busaidi, 2010).

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offered women advice, which was experienced as overwhelming by the women, especially if it conflicted with the advice of health professionals (e.g., what foods to eat and safe positions for lying down whilst pregnant).

Furthermore, Goyal et al (2020) found that religion was the most common coping strategy and there was emphasis on self-coping. This also resonates with the findings of Wittkowski et al (2011), in which mothers' accounts included coping by taking time out for themselves, remaining positive and turning to religion. Help-seeking behaviour was influenced by trust, easy availability and accessibility, recommendations (by significant others) and belief in the supernatural. Barriers to seeking help included stigma, family commitments and poor accessibility of health care facilities. Goyal et al (2020) conclude that these barriers need to be held in mind when planning preventative and intervention maternal programs.

### **Male child preference**

Patel, Rodrigues and DeSouza (2002) interviewed 270 mothers in Goa, India before and after childbirth. They noted that the risk of postnatal depression in mothers who had experienced marital violence was significantly greater if the infant was a girl and significantly lower if the infant was a boy. The results allude to male infant preference which is supported by the literature (Jayachandran & Kuziemko. 2011; Pande & Malhotra, 2006; Puri et al., 2011), including the articles in this review (Grewal, Bhagat & Balneaves, 2008<sup>12</sup>; McCauley et al., 2020<sup>13</sup>).

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<sup>12</sup> Families are described to have celebrated the birth of a child, particularly first child or a boy, by giving gifts and money.

<sup>13</sup> For a small number of women, there was some discussion regarding male gender preference as a cause of stress and tension.

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Interestingly, an overview of the data shows that mothers with a female infant were slightly less unhappy (relative risk of 2.4) about their infant's gender (and more likely to already have had a female child (2.4)) compared to mothers with a male infant who were slightly more unhappy about their infant's gender (relative risk of 2.6) (and less likely to already have had a female child (0.9)). The findings warrant unpacking, and it would be useful to have qualitative excerpts alongside the data to better understand the mothers' preferences.

The authors concluded that preference for male children may make pregnancy a stressful experience for some Indian women and that for those with a female child, the stress may be even greater due to wanting a male infant next. Some mothers may be blamed for the birth of a female child, which can increase the risk of marital violence. The authors propose parent counselling to address gender preference. Although it is uncertain whether counselling would address the issue of gender preference as it is deeply rooted in Indian society, not to mention barriers exist to receiving adequate mental health support in India (Shidhaye & Kermode, 2013).

### **More than 30 different names for postpartum psychosis**

Thippeswamy et al (2015) completed a short explanatory model interview with 123 women diagnosed with postpartum psychosis in Bangalore and nearby areas. In the mother's accounts, they noted four categories of names used to refer to postpartum psychosis and eight causative models of what the cause of postpartum psychosis was perceived to be. There were more than 30 different names used to refer to postpartum psychosis (see table 6). Causative models included: (1) mental illness (also noted by McCauley et al., 2020), (2) psychosocial stressors, (3) supernatural such as speculation of black magic or possession by evil spirit (also noted by Goyal et al., 2020), (4) do not know, (5) physical factors such as cold (also noted by Iyengar, Pelto & Iyengar, 2016), (6) personality, (7) spiritual and religious, and (8) heredity.

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This was the only paper in which heredity was identified as an explanation for PMH difficulties. The second most common causative model included psychosocial stressors such as strained relationships with spouse and in-laws, which is consistent with the findings of Goyal et al (2020) and Raman et al (2014). The authors concluded that explanatory models influence help seeking, and despite the medical model being the dominant framework used for understanding postpartum psychosis in healthcare services, it only accounted for one third of the explanatory models of the mothers.

The authors state that 50% of the participants had a psychiatric history and that the findings indicate poor awareness of mental illness in the community. However, it could be argued that this is a eurocentric view. The wide variety of explanatory models used by the women in the study emphasises the complex bio-psycho-social-spiritual layers of these women's mental health experiences that have been framed as postpartum psychosis. The study highlights an inadequacy in terms of providing a culturally sensitive service to women of Indian heritage as existing services do not attend to two thirds of women's understandings of PMH.

### **Cultural clash**

Rao, Dahlen and Razee (2020) completed semi-structured interviews with 11 migrant women of Indian heritage living in Canberra, Australia. They found four themes across the mother's accounts: 'the role of social support in postpartum care', 'support from health services', 'a psycho-emotional journey with socio-cultural expectations', and 'struggling to bridge two cultures'. 'The role of social support' referred to friends, family, and healthcare professionals. Extended family, particularly women's mothers, arrived to provide support to allow the women to focus on looking after their baby. When the support person left and the husband returned to work, women reported feelings of "shock" and "stress" in relation to being alone (p482).

Consistent with the findings of Grewal, Bhagat and Balneaves (2008<sup>14</sup>), McCauley et al (2020), and Patel, Rodrigues and DeSouza (2002)<sup>15</sup>, women in the study who gave birth to male babies had more positive experiences of motherhood than women who gave birth to female babies. Women wanted to have more pregnancies in the hope of a baby boy. The theme ‘struggling to bridge two cultures’ connects with Wittkowski et al (2011) who reported that culture and in-laws dictated a domesticated role for the mothers following the birth of a child which conflicted with the mother’s expectations of themselves and their situation. Wittkowski et al (2011) termed this “cultural clash”. The authors concluded that lack of public knowledge about what child and family services can offer is a gap that needs addressing.

***“They can ask but what can they do?”***

McCauley et al (2020) interviewed 130 pregnant women, 60 of which were Indian women from New Delhi, India. They noted from the accounts that mothers’ concepts of ill health consisted of ‘physical symptoms/medical disease’, ‘stress/tension’, ‘domestic violence’, and ‘alcohol abuse in the family’ (i.e., physical, mental, and social components).

Mothers described a lack of enquiry from healthcare professionals about the mental and social components and that it would be beneficial to speak if feeling “stressed”/“under tension” (p6). Barriers included that the issues are personal, that healthcare providers do not have the time and/or cannot help. Some discussed the possibility of repercussions such as not being allowed to access care again if they disclosed information.

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<sup>14</sup> Families are described to have celebrated the birth of a child, particularly first child or a boy, by giving gifts and money.

<sup>15</sup> Whilst the data suggests that mothers with a female infant were slightly less unhappy compared to mothers with a male infant, the data suggests that having a female infant increased the relative risk for marital violence.

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The authors concluded that there is a window of opportunity to provide adapted and relevant support to women as they increasingly access care during and after pregnancy. This should include being asked questions in relation to their mental health. One mother is quoted as saying, “They can ask but what can they do?” (p7) and confidentiality was highlighted as important. Mothers should be informed about the limits of confidentiality, of the options available to them and what these options may look like.

### **Female network and natal home**

Raman et al (2014) completed in-depth interviews with 36 mothers from Bangalore, India. They noted five themes in the mother’s accounts: ‘Importance of women’s own mothers’, ‘My place (ooru)’, ‘Female support network’, ‘Role of husband’, and ‘The ambivalent role of the family’. ‘Importance of women’s own mothers’ was described as a standalone theme and as universal across all themes. Women spoke of relying on their mothers for support, advice, presence, and help. Their mother and natal home was constructed as a buffer for when things were not easy with their husband’s and/or in-law’s (referred to as “in-law tension” (p134). Women spoke about staying at their natal home, which was a culturally appropriate place to be during the perinatal period. To not have an available mother or to be geographically too far away from one’s natal home was commented upon with sadness and as difficult.

The women spoke about being supported by their female network; they did not mention their husbands unless asked about them, and neither did they mention health-care professionals. These findings differ to Rao, Dahlen and Razee (2020), in which women highlighted the importance of healthcare professionals. Raman et al (2014) concluded that relevant services need to support women’s access to social and support networks, especially those for whom the support network is scarce.



### 1.12.5 Summary of review

This review systematically examined nine identified studies (Grewal, Bhagat & Balneaves, 2008; Goyal et al., 2020; Iyengar, Pelto & Iyengar, 2016; McCauley et al., 2020; Patel, Rodrigues & Desouza, 2002; Raman et al., 2014; Rao, Dahlen & Razee, 2020; Thippeswamy et al., 2015; Wittkowski et al., 2011) reporting on the perinatal experiences of women of Indian heritage.

In summary, the perinatal experiences of Indian women included struggling to bridge two cultures, the presence of difficult thoughts and feeling abandoned, isolated, desperate (for help), overwhelmed (by conflicting advice) and stressed/tension. A variety of frames were used by the women to understand their experiences. Many understood their perinatal experiences to be a response to psychosocial stressors (such as cultural clash/cultural incongruity, male infant preference, marital discord, in-law tension and/or lack of social support), of physical caution (such as cold temperatures) and/or the supernatural (black magic or evil spirits). Other explanations included that the experience was a form of “mental illness”, personality, cultural/religious suppression, or heredity.

Traditional health beliefs and practices during the perinatal period included taking *desi dawais* (natural remedies), *chilia* (40 days of rest after childbirth), avoidance of excessive work and cold temperatures, visiting one’s natal home, support and advice from female network (especially one’s own mother and mother-in-law), and receiving gifts and money after having a baby (especially for the first-born or male child). Help-seeking was influenced by what was understood to be the cause of the experience.

Barriers to accessing support included lack of inquiry by professionals, the belief that the issue is personal (and therefore inappropriate to discuss with professionals), concerns around confidentiality, repercussions of disclosure, discrimination, stigmatisation, family

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commitments, lack of knowledge about what support is available, poor accessibility of services, language and communication barriers, and lack of cultural and religious sensitivity.

The authors suggestions for professionals and services working with this population include familiarisation with knowledge of relevant explanatory models, such as the humoral system. Working towards understanding cultural and religious beliefs and practices and supporting mothers with respect of these. To raise awareness in the community about perinatal services and to offer quality translation and interpretation services to women accessing services along with culturally sensitive interventions that consider the complex bio-psycho-social-spiritual layers of Indian women's experiences. Women should be informed about the limits of confidentiality, of the options available to them and what these options may look like. Local support should be considered where necessary which can support women to access wider female social and support networks.

#### **1.12.6 Quality evaluation**

Tracy's (2010) criteria for assessing quality in qualitative research was used to assess the quality of the papers included in the systematic literature review (see appendix A). The framework presents eight criteria that act as markers of high quality qualitative methodological research. These include (1) worthy topic, (2) rich rigour, (3) sincerity, (4) credibility, (5) resonance, (6) significant contribution, (7) ethical, and (8) meaningful coherence.

Each of the articles included in the systematic review have been considered in turn (see table 6) against each of the eight criteria. A high standard of quality was noted across the nine studies, especially with regard to the criteria: worthy topic, resonance, significant contribution and meaningful coherence. However, there were some areas of weakness in relation to the criteria: sincerity (lack of self-reflexivity and transparency about challenges) and ethical (no mention of ethics or limited information relating to ethics). Additional areas of weakness included rich

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rigour (insufficient demographic data and missing date/time in the field), and credibility (lack of member reflections and no consultation with additional researchers and/or experts by experience).

No relationship was observed between quality and design or year of publication. It was noted that the two quantitative papers with a qualitative component (Goyal et al., 2020 and Patel, Rodrigues & Desouza, 2002) scored the lowest on the quality measures; however, this is understandable as Tracy's (2010) criteria is designed for pure qualitative research. Despite the low scores, the two papers were included because they contribute to the literature on what is known about the perinatal experiences of women of Indian heritage. Furthermore, there is no empirical evidence to justify excluding papers based on low-quality scores (Carroll & Booth, 2015). Lastly, a quality measure for quantitative research was not employed as the two papers (Goyal et al., 2020 and Patel, Rodrigues & Desouza, 2002) lacked information about how the qualitative data was converted for quantitative analysis.

### **1.12.7 Critical review**

This review provides an up-to-date systematic overview of the articles identified that explore the perinatal experiences of women of Indian heritage. One strength is that the quality of the articles used in the review have been assessed using Tracy's (2010) criteria. The review is further strengthened by the richness and depth of the data retrieved, and by the inclusion of papers written in different countries which have looked at Indian women's perinatal experiences.

It must be noted that two of the papers included in the review explored not only the experiences of Indian mothers but also Pakistani ( $n=74$ ) and Bangladeshi mothers ( $n=1$ ). It can be argued that there are commonalities between the three cultures. Furthermore, the authors of the two

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papers reported no distinct differences in emerging themes or subthemes from women from India, Bangladesh, or Pakistan.

While most papers reported whether the women were first-time mothers or second-time mothers, not all papers did. Additionally, whether the women followed a particular faith, and their primary language was not recorded in all the papers. This adds difficulty in determining the degree of heterogeneity in the sample and applicability to particular sub-groups within the Indian ethnicity based on linguistic differences and religious frames of understanding and perinatal practices. This highlights a limitation and lack of specificity in cultural awareness and sensitivity in the literature. Specificity in perinatal research is important because it brings forward important areas for consideration and opportunities for new and more effective ways of supporting women of diverse backgrounds (Gopalkrishnan, 2018).

### **1.12.7 Rationale**

The existing literature explored the perinatal experiences and understanding of women of Indian heritage. It has become apparent that there exists a significant lack of research on the perinatal experiences of Punjabi women and even fewer studies on the perinatal experiences of Sikh women.

One article included in the systematic review explored the perinatal experiences of Punjabi women in Canada (Grewal, Bhagat & Balneaves, 2008). They reported rich perinatal beliefs and practices (e.g., diet, lifestyle, rituals, and family support), some of which differ to the findings of studies conducted with mothers of broader Indian heritage (for example, the ways in which mothers/families created a spiritual environment at home).

The author knows of no research to date which has explicitly given space to the perinatal experiences of Sikh and/or Punjabi mothers in the UK. There exists a large Punjabi population in the UK (UK Government, 2020). Punjabi women are said to have higher rates of depression

compared to their white counterparts (Bhui et al., 2004) and at high risk for perinatal distress (Sanghera et al., 2015). Furthermore, Sikh women are said to be vulnerable to emotional distress because of the role and status that they typically have in society (British Sikh Report, 2018).

There is increasing interest in the NHS to better cater to diverse needs (The King's Fund, 2006). This is outlined in the NHS long-term plan (NHS England, 2019; The Mental Health Task Force, 2016) which argues for improvements in cultural accessibility and suitability of services to address the differences in outcomes for mothers and babies from minoritised backgrounds.

It is encouraged that staff be open and curious, demonstrating cultural humility<sup>16</sup> and acknowledge differences and their own bias and assumptions in order to better attend to the needs of diverse populations. However, it is also encouraged that staff develop an understanding of the specific sub-groups in the community they work in. Services need to become more skilled at considering culturally nuanced approaches, meaning making and understanding, and ways of responding (Khan, 2021).

A gap exists in our understanding of Sikh Punjabi women's perinatal experiences, views and preferences, and the role of social and cultural factors in defining post-partum care. Through considering this, we might be able to strengthen the capacity for professionals to better meet diverse perinatal needs and fine-tune the care and support that is being offered. The paucity of research relating to Sikh and/or Punjabi mothers perinatal experiences provides a robust rationale for the present study.

In conclusion, notwithstanding that some research has looked at Indian women's perinatal experiences, there is still a gap in the literature and our current knowledge regarding Sikh

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<sup>16</sup> Cultural humility refers to being curious, respectful, and demonstrating a degree of openness to reflect and learn (Foronda et al., 2016).

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Punjabi mothers' health beliefs and practices and how they make sense of their perinatal experiences.

### **1.12.8 Research aims**

To begin to address the gap in the existing literature relating specifically to Sikh Punjabi women's perinatal experiences, the main research question is:

*How do Sikh Punjabi mothers narrate their sense making and sense of self in relation to having experienced perinatal psychological distress?*

## CHAPTER TWO: METHODOLOGY

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In this section, I have outlined the methodology of the study, the rationale for using narrative analysis, and detailed the procedure employed. This is followed by consideration of the quality controls employed and key ethical issues.

### **2.1 Design**

This is a cross-sectional study conducted from March 2020 to September 2021. Retrospective interviews were conducted, and narrative inquiry was used to explore how mothers from a Punjabi background narrate their sense making and sense of self in relation to having experienced PPD.

### **2.2 Narrative analysis**

The term ‘narrative’ refers to a story that tells a sequence of events that is significant for the narrator or their audience (Moen, 2006). A narrative often includes a protagonist, antagonist, and third-party witnesses (Meza, 2018).

Narrative analysis refers to a family of qualitative research methods (see table 13) that are used to interpret texts that have a storied form (Reissman, 2008). Each narrative analysis method is suited to different research questions and has a different focus, but they can be combined to capture the different layers that may be involved in the construction of narratives (Frost, 2009).

Caine et al (2018) describe narrative analysis as both phenomenon and methodology for understanding experience. This is because narrative inquiry explores the context of the story telling (i.e., the situation, including the way in which the story is embodied in institutional and social practices) and the way in which the interaction between teller and listener (real or imagined) shapes the story (Greenhalgh et al., 2005; Greenhalgh, 2016) Of equal importance

are the consumers of the stories as they may construct different meanings from the same story (Earthy & Cronin, 2008).

There exists a branch of narrative research termed 'feminist narrative analysis'. This relates to narrative methods exploring women's lives and what stories can and are told by, for and about women. It concerns how narratives are read or heard, and how the narrators of narratives might be constrained and/or liberated by the stories they tell (Woodiwiss et al., 2017).

### **2.3 The rationale**

Narrative inquiry was selected because this study seeks to explore how Sikh Punjabi mothers narrate their sense making and sense of self over the perinatal period (from pregnancy to birth) in relation to having experienced perinatal psychological distress. As there is limited research on this topic, it was considered important to use a research approach that emphasises detail, depth, and richness.

Qualitative methods (particularly Interpretative phenomenological analysis and Narrative analysis) that privilege an in-depth focus on individual experience were viewed as most appropriate for answering the research question over methods that take a broader and less individualised approach (e.g., Grounded theory or Thematic analysis). However, narrative inquiry allows for the personal dimensions of experience over time to be captured. The time and temporal components found in narrative inquiry are fundamental in this research to examine the storying and sensemaking processes in an ever-changing context (Dawson & Sykes, 2019).

This is another important feature: narrative analysis considers the relationship between individual experience and one's (cultural) context (Clandinin & Connelly, 2000). As the story is told from an individual's point of view (and the individual may share why they did not tell the story in a particular setting), it provides unique insights into that person's (or cultural



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group's) world and how they interpret it, but also about the societal constraints on racially minoritised groups (Greenhalgh, 2016).

Narrative inquiry uses storytelling to uncover nuance (Wang & Geale, 2015), which fits well with the Punjabi art of oral storytelling as a traditional means of communicating information (see Mir, 2006). This can be seen in Bollywood and Punjabi cinema, in which the form of storytelling differs in both form and in content compared to Hollywood (Naithani, 2008).

The advantage of using narrative inquiry in health research is that stories can capture tacit knowledge since individual stories are situated in broader meta-narratives (Greenhalgh, 2016). This provides an opportunity to understand communities and cultures. When the collected knowledge is shared with health care organizations, it can bridge the gap between explicit, codified, and formal knowledge (e.g., guidelines around pregnancy, birth, and mothering) and informal, uncodified knowledge (e.g., informal support systems and ways of managing), thereby allowing for culturally appropriate care to be provided.

Whilst narrative analysis considers the contextual links in the construction of narratives, it does not consider individual self-contained stories (for example, salient events or key moments). Nor does it treat life stories as whole accounts or consider stories' relations to reality (Esin et al., 2014). However, there is a social justice element to narrative inquiry. Clandinin and Connelly (2000) describe how our engagement with participants influences our lives and the lives of participants, and that as we live alongside our participants and retell their stories of experience in research, this sometimes allows for institutional narratives to be shifted.

## **2.4 Procedure**

### **2.4.1 Consultations**

Expert by experience involvement refers to research conducted in collaboration with members of the public (NiHR, 2018). In this study, a number of women from ethnically diverse

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backgrounds (that self-identified as having experienced PPD) were recruited from an existing service-user panel and social media as research consultants on this project. This is in line with the good practice guidelines for research (NiHR, 2013) which advises that several service users should be involved in a research project as it allows for multiple perspectives on a given topic, share of burden, and not asking any one person to speak on behalf of any group or community.

The research consultants in this study participated in discussions around where and how to advertise for the study and language in relation to the advertisement, project website and interview schedule. The consultants shared what would encourage versus discourage them from participating in research. In accordance with their feedback, advertisements were placed on Instagram, which were shared by social influencers and peer-support groups for mothers. The advertisement and documents referred to Punjabi mothers as many shared that they identify as Punjabi as opposed to South Asian or Indian. Open-ended questions were formulated as part of the interview schedule to guide areas of discussion. This was in response to discussions which suggested that the community have a varied understanding of mental health terminology.

#### 2.4.2 Inclusion and exclusion criteria

**Table 7.** Inclusion criteria with rationale

| <b>Inclusion criteria</b>   | <b>Rationale</b>   |
|---|--|
| Age 18 or above at the time of recruitment.                         | To recruit women of childbearing age, and able to consent to participation in the research.  |
| Identify as Punjabi and speak English and at least minimal Punjabi. | To capture cultural nuances, including linguistic concepts. However, it was seen as important to conduct the interviews mainly in English and some Punjabi. Conducting the interviews in only English would have compromised the degree to |

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|   |  |
|---|--|
|   | which cultural nuances can be expressed by participants and received by the interviewer.   |
| Experienced psychological distress during the perinatal period. Do not need to have accessed mental health services or have a diagnosis/to have been diagnosed.   | It is plausible that the recovery experiences of women that have experienced psychological difficulties prior to pregnancy may differ from the experiences of women with psychological difficulties that arose during the perinatal period.  |
| Children required to be a minimum of six months of age.   | If the participant has children younger than six months of age, the focus of the interview will be on the perinatal experiences connected to the child aged six months or older. This is to allow the mother enough time to have processed her experience and be able to reflect on it in the interview. |
| Be willing to share some of their motherhood journey experiences and feel safe enough to do so. Those experiencing psychological distress and seeking help at the time of the study were excluded from the study. | To prevent psychological harm.   |

### 2.4.3 Recruitment

Advertisements for the study were placed on the research project website, on social media accounts developed for research purposes, relevant newsletters (Centre for Sikh and Panjabi Studies and Sikh Press Association), websites (Action for Postpartum Psychosis) and online forums (mumsnet.com). The project was also shared and discussed live on a national radio station (BBC Three Counties Radio) during a special on maternal mental health, which the researcher was invited to contribute to.

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Mothers interested in taking part were asked to make contact via email or phone to arrange a time to speak. It was noted that many women got in contact to express their appreciation for the study and provide feedback about the current system (see table 8).

**Table 8.** Feedback received during recruitment phase about the study and the system

|  |   |
|--|---|
| Feedback about the study   | <i>“Overdue”; “important”; “starting much needed conversations”; “challenging stigma”; “I feel acknowledged”; “we don’t normally do this”; “in our culture this is a taboo”; “I didn’t know new mothers go through this so it’s good to share”<sup>17</sup></i>   |
| Feedback about the system (including family and health services) | <i>“Insensitive”; “intricacies not understood”; “not a lot of support in the community for us”; “just have to solve [issues] yourself”; “made me feel worse that no one could help”; “doctors will give antidepressants, that’s all they’re gonna do”; “I was alone – antidepressants won’t solve it”; “they (professionals) weren’t recognising what’s wrong – they were not the right people”; “no one checked or understood”; “they’re (family) not emotional”</i> |

Whilst many women expressed interest in participating in the study, not everyone responded when invited to attend screening to determine eligibility. This was reflected on in the supervisory team and seen as a finding in itself. It was noted that the significant concern about

<sup>17</sup> Quotes are in bold and italicised for ease of reading.

PMH and appreciation for the study expressed by many women did not lead to them personally coming forward to take part in the research. While it is not possible to know for sure why the women made this choice, it was speculated that this might possibly indicate the significant stigma surrounding mental health and the taboo of speaking openly about such experiences and/or the significant distrust in professionals as expressed in the responses above. This highlighted the importance of the study and the research team proceeded with new commitment and passion.

Screening began with discussions regarding the rationale, potential advantages, and disadvantages of taking part and participant rights. Demographic information was collected from those interested in proceeding, which was followed by a brief survey to ascertain perinatal history (appendix F). Women were deemed eligible to participate if during screening they were noted to be sharing detailed/relevant stories without too much prompting; not experiencing high degrees of associated distress and responded in time to be interviewed. These women were informed of eligibility and emailed a copy of the information sheet and consent form (appendix D and E). Upon receipt of a completed consent form, an online interview was arranged at a mutually agreed date and time.

It was noted that many women attended the telephone screening but not all of them responded to or accepted the invitation to attend the interview. It was noticed that during screening that most women shared that it was the first time they were telling their story to anyone. Some women presented as tearful whilst for others it brought up feelings of anger and injustice (in relation to motherhood, being a woman/wife/daughter(-in-law) in a Punjabi family) and frustration with society/professionals/services. It is possible that the screening session provided what felt like a safe space to be heard in confidence and express feelings whereas the interview (which unlike the screening session was recorded) did not feel safe enough or as comfortable to participate in.

**Table 9.** Stages of the recruitment process

| <b>Stage</b>   | <b>Number of women</b> |
|--|------------------------|
| Responses  | 50+                    |
| Requested further information to take part                             | 30                     |
| Did not reply  | 16                     |
| Underwent screening to determine eligibility                           | 14                     |
| Did not meet eligibility criteria                                      | 3                      |
| Meet eligibility criteria  | 11                     |
| Did not respond or declined the interview                              | 4                      |
| Interviewed as part of the study                                       | 4                      |
| Not interviewed due to limitations in scope and timeframe of the study | 3                      |

#### **2.4.4 Modifications**

The study originally focused on a) Punjabi women of all faith backgrounds and b) their experiences that some may frame as postpartum psychosis.

The first modification to the study included broadening the focus of the research from postpartum psychosis to maternal mental health, thereby encompassing all forms of psychological distress. This modification was made due to the overwhelming response from Punjabi mothers during the recruitment and screening process stating that they would like to take part in the study; have experienced psychological difficulties, and do not culturally relate to the term postpartum psychosis, nor to the criteria for postpartum psychosis (which was based on the guidance set out on the NHS website as postpartum psychosis is not classified as a distinct entity with its own set diagnostic criteria). Therefore, in reflection with the supervisory team, it was deemed that a medicalisation of distress would not be a fit for Punjabi women, many of whom reported that they had not accessed mental health services. The decision was

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consequently made to allow women to self-identify as having experienced perinatal distress, while using the screening conversation to consider their experiences in relation to the inclusion and exclusion criteria. This allowed the beginning of a co-construction of meaning that aligned with the women's own understanding and meaning making.

The second modification included shifting the focus of the study from Punjabi women of all faith backgrounds to Punjabi women that follow the Sikh faith. This was because despite sharing the advertisement on various platforms, all the participants that expressed interest in taking part in the study identified as Sikh. It also became clear that cultural and faith-informed meaning-making of perinatal distress were closely connected and interwoven in ways significant to the women coming forward.

I wondered if it was because of my own identity as a Sikh and/or the platforms that agreed to share my advertisement, that all the participants that expressed interest in taking part in the project identified as Sikh Punjabi women. Had there been more time or opportunity to work in-person in the community, I would have visited faith and community centres to engage with members of the Punjabi community to aid recruitment. However, there is a possibility that conducting research with participants of different faith backgrounds could have introduced differences that dilute the findings.

The responses/emotion from the Sikh Punjabi community demonstrated to me how many stories remain untold and unspoken when it comes to mental health, let alone maternal mental health. I noticed that when clinical language was used by the women, they often used the terms 'depression' and/or 'anxiety'. This was the case even when in the Western diagnostic framework sense, their experiences would be considered as aligning with the criteria for diagnoses such as 'postpartum psychosis' or 'post-traumatic stress disorder'. This raises questions about why many of the Punjabi mothers identified with the terms 'depression' and

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‘anxiety’. Is it because their understanding of the clinical terms versus that of professionals differs or did ‘depression’ and ‘anxiety’ feel safer and less threatening because the topic of mental health is still too much of a taboo? This will be considered further in the strengths and limitations section in chapter four.

## **2.5 Ethical considerations**

Ethics approval was obtained from the University of Hertfordshire (protocol number: aLMS/PGT/UH/04228(2)) (appendix H). All four interviews were conducted online. The guidelines for online working were reviewed and adhered to (BPS, 2020; 2020; 2021).

### **2.5.1 Consent and confidentiality**

Participants were provided with an information sheet containing full details of the project and a consent form (appendix D and E) after the telephone screening was completed. They were offered an opportunity to ask questions about the research or researcher. Participants were required to verbally reinstate consent at the start of the interviews confirming that they agree to participate in the study, to be interviewed and recorded, and analysed for the purpose of the research project. It was also explained that individuals have the right to withdraw from the study at any stage up until the point at which the data has been fully analysed.

Participants were informed that any personally identifiable information will be anonymised and about the limits of confidentiality. Audio recordings of the interviews were made using an encrypted audio recording device. In accordance with APA and BPS regulations, recordings were securely stored on the university OneDrive and will be destroyed once the researcher has completed her studies.

### **2.5.2 Potential emotional distress**

It was acknowledged that during the interviews, which explored experiences of psychological distress during motherhood, individuals who have had difficult experiences may



feel discomfort or upset. Participants were encouraged to inform the researcher if they experienced any distress or upsetting feelings during participation and reminded of their right to skip a question, request a break, or withdraw from the study. They were provided with contact details for sources of support that they could access (appendix J). The professional transcriber was offered a debrief as some of the interview content was emotionally heavy.

### **2.5.3 Online interviews**

All interviews were conducted remotely, which raised ethical considerations around confidentiality and emotional distress. The BPS (2020; 2020; 2021) guidelines on working with people via online video platforms were consulted and adhered to. Participants were encouraged to find a space where they felt safe and able to share what they wished to share in relation to the interview questions. Furthermore, participants were informed that they could not be overheard as no one else would be in the same room but also, the researcher would be wearing headphones throughout the interview.

All the mothers conducted the video interviews from home. Some were seen to be double-checking that their door was closed and spoke quietly at times to prevent being overheard by anyone. I wondered to what extent conducting the interviews remotely influenced what participants felt able to share. However, all mothers confirmed that they were happy to participate remotely and felt safe to proceed. They also mentioned that participating remotely was convenient as they were able to care for their young children as and when needed.

## **2.6 Participants**

### **2.6.1 The sample**

Four Sikh Punjabi mothers of childbearing age were recruited (all through the social media recruitment pathways) and interviewed as part of the study. They each had between one to two

children. See table 10 for further details (personally identifiable information has been changed or removed for confidentiality purposes).

It is important to note that three out of four of the participants had sons. It is possible that gender may have impacted the study as the literature suggests a male infant preference in the South Asian community and a higher incidence of psychological distress reported by mothers of female infants (Grewal, Bhagat & Balneaves, 2008; McCauley et al., 2020; Patel, Rodrigues and DeSouza, 2002).

**Table 10.** Details of the final participants

| <b>Participant pseudonym</b> | <b>Age range</b> | <b>Gender</b> | <b>Country of birth</b> | <b>Children</b>   |
|------------------------------|------------------|---------------|-------------------------|---|
| Harmeet                      | 30 - 40          | Female        | UK                      | Two sons, both under five years of age.                 |
| Gurpreet                     | 30 - 40          | Female        | UK                      | One daughter under five years of age.                   |
| Charan                       | 30 - 40          | Female        | UK                      | One son and one daughter, both under five years of age. |
| Amarleen                     | 30 - 40          | Female        | UK                      | Two sons, both under 10 years of age.                   |

## 2.6.2 Data collection

The interviews were conducted and recorded on Zoom and using an audio recording device. The interview schedule (appendix G) contained questions and prompts; however, participants were encouraged to share what they would like to share about their experiences. This is in line with narrative interviewing which aims to provide the opportunity to prioritise the story teller's perspective (Anderson & Kirkpatrick, 2016) and participants are regarded as collaborators rather than as informants guided by the agenda of the researcher (Altork, 1998 cited in Moen, 2006).

The interview began with an open-ended question asking who is in their family. This was not only to set the scene but to build rapport by putting participants at ease before asking about their perinatal experiences (which may be uncomfortable). This was followed by questions inquiring about a range of topics (see table 11).

**Table 11.** Narrative interview topics

| No. | Topic area                                       |
|-----|--|
| 1   | Family   |
| 2   | Experience of motherhood (before, during, after) |
| 3   | Understanding and sense making of experience(s)  |
| 4   | Coping   |
| 5   | Response(s)                                      |
| 6   | Identities                                       |
| 7   | Help seeking                                     |
| 8   | Resources  |
| 9   | Current context                                  |

It is important to note that all interviews lasted nearly three to four hours. The first hour functioned as rapport building, setting the scene (as mothers shared their family context and

timeline of events) and establishing a mutual understanding of terms relating to their perinatal experience(s). The second hour involved mothers sharing much more personal information and further details in relation to their perinatal experience(s). The third/final hour involved reflecting on their perinatal (and interview) experience and learning. Some mothers had their young children in the background during the interviews. During interactions with their children, mothers involved the researcher (who was referred to as “*massi*” (mother’s sister) by some participants to their children). These interactions further extended the length of the interviews.

This impacted on the study pragmatically in several ways. During the interviews itself, the interactions needed to be thoughtfully and ethically managed by the researcher (for example, by offering the women breaks if needed, the researcher working hard to listen and stay present as the women told their stories, and scheduling in another date to finish the interview if the interview was not completed in the allocated time).

Furthermore, while guidance for narrative analysis studies emphasises small sample sizes (Sandelowski, 1996; Sullivan & Forrester, 2018), the context of the length of the interviews was a further factor in deciding, in collaboration with the supervisory team, to end data collection after four interviews. It was felt that given the amount of data collected from the long interviews, further interviews would have become difficult to manage within the scope of the current study. Again, within the supervisory team, the length of the interviews was seen as a finding in itself, possibly indicating the extent of the stigma, and the need to establish trust and rapport before sharing what were previously untold stories.

Once the interview was complete, there was a debrief session which reminded participants of their right to withdraw and provided contact details for any questions, concerns or support required. They were sent a debrief sheet (appendix J) via email.

## **2.7 Data analysis**

### **2.7.1 Transcribing the stories**

Transcription involved two stages. A professional transcriber (a White Western woman) was used in the first stage of transcription to create a basic draft of text. This was utilised due to the length of the interviews and time constraints of the project. The professional transcriber signed a confidentiality agreement, agreeing to maintain absolute confidentiality and destroy any data upon providing the completed transcripts (appendix I). As the transcriber was not from a Sikh or Punjabi background, it was agreed before the data was shared that spaces could be left where Punjabi was used.

The second stage of transcription was completed by the researcher (a Sikh Punjabi woman), which involved carefully listening to the audio recordings while following the draft transcripts. Cultural and faith-related nuances and aspects of speech and action (including words, phrases, meanings, and expressive utterances) were edited and added. This was important given that the project seeks to explore the language Sikh Punjabi women use to construct their identities and narrate their perinatal experiences.

### **2.7.2 Language considerations**

As the method of narrative analysis involves working with words and language is central in all stages of the research process, recommendations for enhancing the validity of cross-English qualitative research (van Nes et al., 2010) were considered and applied where possible to minimise Punjabi sayings and concepts being lost in translation when converted into English (see table 12).

**Table 12.** Recommendations for enhancing the validity of cross-English qualitative research

(van Nes et al., 2010)

|   | <b>Recommendation applied</b>   |
|---|---|
| 1 | Stay in the original language as much as possible.  |
| 2 | Avoid the use of one-word translations which oversimplifies concepts.   |
| 3 | Discuss possible wordings and linguistic translations with others including research consultants to co-consider the best translation. |

### 2.7.3 Analysing the stories

Narrative analysis covers several methods and therefore no definitive guidance for performing narrative analysis exists (Watson & Mcluckie, 2020). The narrative analysis framework outlined by Esin (2011) (a summary of which can be found in table 13) was used in this study, in addition to the auto-ethnographic model (Hayano, 1979), because it offers a clear framework for conducting narrative analysis.

**Table 13.** The models of narrative inquiry used in this research

| <b>Model of narrative inquiry</b>                  | <b>Focus of the model</b>  |
|--|--|
| <b>Content</b><br>Thematic model (Reissman, 2008)  | The content of stories - <i>what</i> is said and the themes around <i>which</i> stories are told.  |
| <b>Structure</b><br>Structural model (Labov, 1972) | The structure of stories – <i>how</i> a story is told and what language is used to make a story persuasive.<br><br>The way it's organised, including the temporal elements, units, stanzas, strophes, and parts. |

|  |  |
|--|--|
| <p><b>Performance of narratives</b></p> <p>Performative model (Reissman, 1993; Mishler, 1995; Denzin, 2001)</p>                  | <p>The contextual features that <i>shape</i> the construction of narratives. How the meaning is collaboratively created through interaction between storytellers and listeners/(real/imagined) audience(s). Involves analysis of pauses, interruptions, and topic chaining.</p>  |
| <p><b>Reflexivity</b></p> <p>Auto-ethnographic model (Hayano, 1979)</p>  | <p>The use of personal experiences and knowledge to describe and interpret cultural experiences, language, beliefs and practices of one’s “own people” (Adams et al., 2017). Narratives cannot be fixed in definition or meaning (Goodson, Antikainen, Sikes &amp; Andrews, 2016). When narratives are being described “they are changing; some forms are dying out and new ones are coming into being” (Rosen, 1998, p.20).</p>   |
| <p><b>Gendered dimensions</b></p> <p>Feminist narrative analysis (Fraser, 2004; 2008 cited in Fraser &amp; Macdougall, 2017)</p> | <p>Recognising the historical tendency to marginalise women’s experiences and accounts of experiences. Analysing the way that language can be used to normalise (or resist) gender stereotypes and express (dis)approval. Examine clichés, adages, and conventional turns of phrase to consider how people, interact with others and different aspects of themselves (using language symbolically and metaphorically) (Fraser, 2004; 2008 cited in Fraser &amp; Macdougall, 2017).</p> |

Transcripts were studied individually whilst listening to the audio recording of the interview. This stage was repeated numerous times and allowed for re-familiarising with each interview and forming a holistic sense of each interview. In line with Riessman (2005) and Smith & Sparkes (2008), transcripts were examined line by line and the content, structure, and context of the narratives was considered as well as the performative, interactive and rhetorical aspects. By considering the context, structure (beginning, middle and end), language and presentation of the narratives along with how my own self influenced the narratives, the multiple layers involved in the construction of the narratives was able to be captured and individual accounts were produced.

As described in Ward & Delamont (2020), as I became immersed in the data, a sensitivity to nuance developed. Reoccurring concepts and meanings became apparent. An analytical approach suggested itself which led to the production of the collective storylines.

#### **2.7.4 Reflexivity**

Reflexivity in research refers to thinking about oneself: to recognise and take responsibility for one's own situatedness within a research project and consider the effect one may have on the research process and findings (Berger, 2015; Dodgson, 2019). Having a reflexive approach in qualitative research is encouraged (Ortlipp, 2015). Without it, one increases the risk of unconscious bias influencing what the researcher sees and values within the results (Buetow, 2019).

To maintain a reflexive approach in the study, a research diary (appendix M) was kept. This stimulated thoughts, brought to conscious awareness thoughts and allowed thoughts to be tracked (Watt, 2015). It allowed meaningful connections to be made between theory and practice and prompted critical reflection (of personal history, values, ideas, feelings,



assumptions, preferences, and positions). Extracts have been included in this write-up to ensure that the research process is as transparent as possible.

### **2.7.5 Quality of the research**

The quality of narrative research depends on the degree to which the study is trustworthy (Loh, 2013). To determine trustworthiness, quality procedures are required.

Tracy's (2010) eight criteria for excellent qualitative research has been utilised as a framework to ensure quality research (see appendix N). In this study, there was no member checking with the participants because it does not necessarily fit with the study methodology. In narrative inquiry, the researcher owns their interpretations and sees the interpretations as co-constructed, rather than as a truth that has been 'found' or 'discovered'. Additionally, each participant had already offered over 4-5 hours of their time in total (in the form of the screening survey plus research interview). However, the findings were shared with an expert by experience (who identified as ethnically diverse and with lived experience of perinatal distress). Furthermore, the research supervisors were consulted to further determine the plausibility of the research claims. Moreover, peer validation was used, whereby consultations were held with a fellow final year doctoral student that was familiar with the research approach, themes and theories that were applied to the interview texts. Lastly, audience validation was used whereby the findings and conclusions of the study were shared with the primary intended users and readers in the form of a community perinatal team.

## CHAPTER THREE: RESULTS

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In this chapter, I provide an overview of the interpretation and discussion of the individual accounts (section 3.2) followed by the collective storylines (section 3.3) by Punjabi mothers who identified as having experienced PPD. This reflects the research question:

*How do Sikh Punjabi mothers narrate their sense making and sense of self in relation to having experienced perinatal psychological distress?*

### 3.1 Overview of participants

Four Punjabi mothers were interviewed. They all identified as British, Punjabi and Sikh.

### 3.2 Individual stories

In this section, I present summaries of the individual accounts. This includes how mothers storied their experiences (with consideration of the structural, temporal, and performative elements of their accounts) and how they constructed their identities in relation to the PPD. (Direct quotes are in bold and italicised for ease of reading. See appendix K for transcription symbols.)

#### 3.2.1 Harmeet (in her 30s)

Harmeet told a quest narrative<sup>18</sup> (Frank, 1995) from her home whilst simultaneously caring for her child. She was an engrossing narrator who told a flowing and growing narrative about her perinatal experiences. Her account was full of maternal health knowledge, traditional Punjabi figures of speech and references to her Sikh faith.

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<sup>18</sup> Quest narrative (Frank, 1995) involves the protagonist setting out on a long challenging journey to reach what becomes most important to them (Booker, 2015).

Harmeet's story started at a logical beginning: when she found out that she was pregnant for the first time. She told a nonchronological narrative and seemed purposeful in sharing that as a teenager she had been told that she could not conceive. This invited me to feel surprised, which aligned with Harmeet's felt experience at the time as she described that she had felt "*shock*" and "*so excited*" that she did not mentally prepare for post-pregnancy.

Harmeet swiftly went onto describing the second birth as "*love at first sight*" and her "*body doing everything that it should have done*", which implied that the first birth had not been in line with Harmeet's expectations. She then returned to speaking about her first pregnancy, which was "*really easy*" and repeated that she "*didn't actually focus on the end result*". It seemed that this information was important to understanding what had happened next. Norrick (2000) suggests that repetition heightens the dramatic effect of storytelling and stresses the teller's evaluation of the story.

Harmeet continued that her birthing experience "*went so the other way*" in comparison to her cousin's experience, which gave me a foreboding sense of an upcoming 'black moment'<sup>19</sup> and created suspense as to what had happened next. It seemed that Harmeet's cousin's birthing experience (which would be considered a 'normal birth'<sup>20</sup>) had led to certain expectations. Harmeet told a story about her expectations versus her body's performance during delivery ("*I expected to firstly, have a vaginal birth... I felt that my body had let me down... I've done an injustice to my child*"). This first 'black moment' in the story - and the use of intensifiers ('*I was so shocked*' and '*that really weighed heavy on me*') - seemed to communicate her

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<sup>19</sup> Carter (2007) refers to dark or difficult events in stories as "black moments".

<sup>20</sup> Prosser et al (2018) define normal birth as without induction of labour, epidural, spinal and/or general anaesthesia, an assisted vaginal birth (with forceps and/or ventouse) or caesarean section, or an episiotomy.

felt disappointment in herself and her body, and connected with the Cartesian model (body/self) that permeates the foundations of the perinatal field (see Carter, 2010; Goldberg, 2002).

She appeared to draw on normative societal expectations of motherhood as she described vaginal births as *“the way it’s supposed to be”*. She was knowledgeable about the advantages of a vaginal birth and seemed to communicate maternal guilt<sup>21</sup> in connection to having had a c-section<sup>22</sup> (*“(son) was dealt a really shitty hand (.) because of me not being able to do what I needed to do... I felt like I’d already failed him... before he’d even taken his first breath”*). She continued, *“what followed after that was even worse”* which signified escalating events and upcoming tests in the quest. Harmeet was admitted into a high dependency unit and her child into intensive care, during which she struggled to care for herself and her son. She positioned herself as a *“failure”* because *“the ideology of a mother is, she’s there for you through the bad times, she’s the one person”*. Harmeet seemed to present two discrete identities: the ‘unexpected mother’ and the ‘bad mother’.

Harmeet appeared to construct her journey with PPD as a spiritual experience that allowed for her spiritual emergence (Crowley, 2006). The midpoint events in the narrative saw Harmeet *“somewhere else, in between somewhere”*, where she would *“think someone had come over and spoken with me and that wasn’t the case”* and see *“the lights on and the lights would not be on”*. She attempted to rationalise by drawing on alternative narratives (*“being vulnerable and exposed, maybe just made me vulnerable and exposed to other areas too (spirits)”*). Her use of *“maybe”* suggested possibility, not certainty, in this alternative theory.

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<sup>21</sup> Maternal guilt refers to guilt in relation to one’s perceived inability to live up to cultural ideals of the “good mother” which is embedded in intensive mothering discourse (Collins, 2021).

<sup>22</sup> C-section refers to a caesarean delivery, whereby babies are delivered through an incision (Mathai, Hormeyr & Mathai, 2013).

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

However, she spoke with conviction and constructed herself as “*privileged*” to have had this experience.

Her family attempted to support her using prayers: a traditional healing resource in Sikhism. She sought a biological explanation for how she experienced the prayers and conveyed it as an experience that was beyond her control (“*I know what the shabad (prayer) was saying but my understanding of it at that point was what my brain wanted to hear and chose to understand*”). She described hearing “*you’ve been given a diamond* (she interpreted this as referring to her son) *and I’m going to take it from you*”. Perhaps out of fear of blasphemy, she explained “*I can’t believe↓ I’m using the word demonic to Gurbani* (holy scripture/compositions)... *nothing evil could come out of that pureness*”.

She shared restitution narratives (“*I read about what postnatal (depression) is, and then I was ticking a:ll of the boxes*”), and explained that “*unless it’s a medical condition*” she prefers “*homeopathic treatment*”, which is a recognised and controversial system of medicine in India (see Prasad, 2007). Harmeet reflected on her journey, indicating that it has been a spiritual experience (“*I had to go through muddy waters to get to where I am today, and I feel like I am on a higher vibration because of it*”). Her choice of analogy seemed to convey the extent of how challenging the journey has been for her and elicited empathy within me. I responded with validation.

Harmeet was driven to share her story, stating “*I don’t know who or when but one day this conversation will help somebody. I’m doing my bit. If I’m doing my bit then it was worth↑ going through that*”.

### 3.2.2 Gurpreet (in her 30s)

Gurpreet told a chaos narrative<sup>23</sup> as the storyline appeared to zigzag and lack coherence at times (Booker, 2015; Frank, 1995). She spoke from her bedroom where she would not be overheard, which suggested a need for privacy when talking about mental health. She was a mindful narrator; her story seemed emotionally contained in comparison to the screening session, during which she had been tearful (and described the experience as *“emotionally cathartic”*). Her account was full of small stories and paradoxical elements about family life, cultural traditions and felt expectations. Her story highlights some of the prevailing ideas about gender roles and off-spring sex preferences in the Indian community (Khan, Mustafa & Ali, 2017; Mathu, 2008; Pande & Astone, 2007).

Gurpreet’s story began with the date on which she got married. She revealed that she became pregnant soon after. She described the pregnancy as a *“shock”* and mentioned *“fear”* of comments about becoming pregnant so soon. This spoke to the natural progression of life but also fear of judgement. Upon being asked by people if she was excited, she narrated her reply as *“I’m just worried about the actual birth”* (*“I wasn’t worried about the after”*). She shared having felt *“happy... but detached”*. This was mirrored in the way she narrated her motherhood story in the interview.

Upon learning that she had a baby girl, it seemed that Gurpreet had hoped for a male child (*“I don’t know if I felt deflated”*). She explained *“(on mother’s side) there’s been stories about boys being favoured”* and *“(on husband’s side) there are still very anti-girl comments”*. She narrated having asked her mother if it was okay to have had a girl, perhaps as a form of reassurance seeking.

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<sup>23</sup> In a chaos narrative, the plot depicts endless turmoil (Frank, 1995).

Gurpreet told a story about struggling to bond with her daughter and spoke to dominant discourses around motherhood and the traditional concept of the maternal instinct<sup>24</sup> (“*I held her for a few minutes(.) didn’t really feel anything... didn’t have that oh my god, crying or whatever. And then I was so keen to pass her onto my husband*”). She contrasted this with the master narratives<sup>25</sup> on mothering and how mothers are portrayed in the media (“*you see... ‘like when I held her, I just felt an outpour of love...’ – I didn’t feel that*”). She questioned whether there was something wrong with her.

She positioned herself as “*not maternal*” and compared herself to her mother-in-law (“*your typical mother hen*”), whom she described as “*Very warm, very affectionate, very soft(.) and, you know, smiling... always wanting to hug, always wanting to kiss and play*”. She constructed her mother-in-law as the ideal mother whilst dismissing herself as non-maternal<sup>26</sup>. There appeared to be a sense of Gurpreet judging herself as less than.

The account conveyed a self/body disconnect as Gurpreet described “*I did display happiness, and I was↑ happy, but I didn't feel it within myself*”. Her frequent use of intensifiers (“*really hard*”) provided strength to her words and conveyed the level of difficulty she had experienced. Upon disclosing the PPD to her husband, she shared “*he doesn't believe in that, mental health issues*”. This conveyed a sense of invalidation and dismissal which drew me into an ally position.

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<sup>24</sup>The maternal instinct is a controversial idea suggesting that women have an innate predisposition towards motherhood (Gustafsson et al., 2013).

<sup>25</sup> Master narratives are descriptive and prescriptive. They tell members of a group how to act (Lindemann, 2019).

<sup>26</sup> Non-maternal mother is a concept seen in the literature and arts, used to refer to mothers that do not have what is considered to be natural to women: the mothering instinct.

She attributed her feelings to the gender of her baby. It appeared that Gurpreet drew on internalised gender discourses around the cultural value attached to having a male son and she conveyed a sense of inner conflict in relation to acknowledging this as she frequently self-corrected her talk about her preference for a male child. For example, she began *“if it was a boy”* but stopped herself, switching to *“we can't imagine not having her (daughter)”*. She returned, *“but if it was a boy, maybe I felt like there would have been a weight off my mind”*. She added, *“A weight that no one had put on me, I feel, but kind of was put on me<sup>↑</sup>”*. This paradoxical statement was followed by additional paradoxical statements, indicating the presence of implicit but dominant and heavy societal expectations (of women) and values. I began to make notes to aid my processing and hoped that my notetaking would not result in a relational disconnect. The order of the narrative suggested that Gurpreet was trying and struggling to make sense of the cultural norms that she was embodying. There seemed to be shame or fear of negative judgement as she explained *“it's really, really bad to think like this”* and provided an example of being *“progressive”* (in which she had advocated for another woman). In a conscious attempt to convey safety and support our rapport, I stopped notetaking to soften my demeanour/the interview.

Halfway through the interview, Gurpreet briefly left informing me that she had a low battery. I wondered if sharing her perinatal difficulties with me may have felt difficult or uncomfortable as when she re-joined, she had switched her video off. Although it was possible that this was a personal preference as her voice sounded contained. During PPD, she described having felt *“low”* and *“suicidal”*. She had images of herself *“getting hit by a bus”* or *“by a car”*, which were triggered by her daughter being *“happier with other people”*. She asked *“would I put it down as a mental health problem? Probably not”* because *“I feel like I've overcome it”*. This suggested that Gurpreet understood mental health difficulties as more long-term or permanent. She later reflected *“I could have been going through postnatal depression”*. It appeared that



Gurpreet was attempting to understand her experience and the hesitance or reluctance to frame her experience as a mental health problem could be linked to stigma which amongst minoritised communities can be associated with fear, avoidance or rejection of mental health difficulties (Gary, 2005).

Gurpreet told stories about meeting healthcare professionals and there appeared to be a recurring theme around the need for privacy and invalidation. She shared that her mother-in-law was present whenever her health visitor came. She visited her GP and despite “*blatantly crying*”, the GP “*just offered me a leaflet*”. The order of this narrative pulled me in. I felt struck by her attempt to seek-help and her display of emotion having been dismissed. She appeared to reject the inadequate help and enact power, stating “*I actually didn’t even bother reading it (leaflet), I just binned it.*”

Gurpreet told a restitution narrative (Frank, 1995) as she described “*working*” on herself and “*forcing*” herself to “*just love her (daughter)*”. I felt disappointed that Gurpreet did not receive the support she was entitled to and that she was confronted with a dichotomous choice as the onus was placed on her: “*either I carry on as I am or I just have to dig deep*”.

She was driven to share her story in the hope that it “*will be of help*” to others.

### 3.2.3 Amarleen (in her 30s)

Amarleen shared an account of personal suffering from the loft in her home where she would not be overheard, which implied a need for privacy. Amarleen told a chaos narrative that grew in detail and emotion, and I was positioned as a passive listener for much of the story. Her story illustrated the impact of postnatal mental health on family life and the challenges faced by mental health professionals requiring support for their own mental health. Amarleen’s account was full of long stories about family dynamics, cultural traditions, and considerations around the language used to talk about PMH.

After sharing with me some initial stories about life during COVID-19, she delved into the story about *“the worst experience”* of her life. Tearfully, Amarleen positioned herself as changed and made clear that the story she was about to tell me is not the mother she is today. I wondered if Amarleen felt worried about being judged negatively.

She described feeling *“really traumatised”* by the birthing experience because *“no one had ever gone anywhere like in that vicinity, except obviously my partner”*. It appeared that Amarleen was not fully informed or understood the procedure that the midwife had conducted on her. There was a sense of having felt violated (*“The fact that somebody had touched me down there...”*) and this violation having been required as part of the process (*“obviously I’d consented to it, of course, this was for my, my baby”*). Amarleen’s talk connected with ideas around the birthing woman being treated as a Cartesian body, i.e., separate from her body, rather than as an embodied woman and being treated as a lived body (Goldberg, 2002).

The story moved onto her experiences after childbirth (*“They (family) passed the baby around. I didn’t even know where the baby was at one point”*). This suggested lack of control but also distance between mother and baby as Amarleen said ‘the baby’, not ‘my baby’ which communicates ownership (Priest et al., 2016). She described feeling *“a lot of pressure”* during her stay in hospital due to having many visitors (*“maybe to give money<sup>27</sup>”*).

Amarleen described her PMH experience as *“a rollercoaster”*, whereby the main difficulty was *“the depression side”* and *“becoming very, really anxious”*. She considered the possible cause(s), describing *“underlying kind of mental health issues”/“personality traits”*. Amarleen moved onto drawing on psychosocial narratives (*“dynamics really changed (with mother-in-law)”*). She appeared to convey internalised blame as she described *“my PD traits started kind of coming out”* which resulted in Amarleen being *“kicked out (of the house)”*. At this point,

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<sup>27</sup> *Shagun* is a money gift and blessing given during auspicious moments.

she presented an identity of a mental health practitioner that is able to identify the traits that are conceptualised as a personality disorder. She later expressed that she prefers to say, ***“I struggle with regulating my emotions”*** because ***“that describes it better”***. It appeared that Amarleen was dipping in and out of different frames of understanding as she attempted to make sense of PPD. She returned to medicalising her distress, almost dismissing herself, as she closed with the reflection, ***“or I am a PD, and I just don’t want to admit it”***.

She spoke about the challenges of being a daughter-in-law and a new mother in a Punjabi household – ***“cooking, cleaning, all of that stuff... bearing in mind, my baby’s like three months old”***. She positioned herself as bullied, having been subject to regular criticism (***“I had stopped breastfeeding because I was told (by mother-in-law) so much that (child’s name) wasn’t growing”***). Amarleen described having experienced self-doubt about her parenting ability and a sense of not being a good enough mother. I felt flooded by Amarleen’s fast pace and the degree of intricate details she was providing. I noticed that I repeated questions more often than I did in the other interviews in my attempt to contain the interview. It is possible that this may have impacted Amarleen’s account.

After her second child, she ***“had thoughts of just ending things”*** because ***“things would be better if like, we just weren’t here”***. Her repeated use of the word ‘just’ emphasised the absoluteness and extent of her experience. She presented an identity of staff member that supports others and a reluctance to be in the position of service user that requires support. I wondered if the reluctance originated from or was exacerbated by her previous experience of invalidation by family and professionals.

Amarleen storied the way she took back control and exerted agency (***“I just took it in my own hands and... yeah, therapy on myself”***). Amarleen positioned herself now as an advocate, actively involved in being the change she wants to see (***“I’m just glad we’re moving forward”***

*as like, just a community and just looking at kind of, yeah, supporting others with this as well”).*

### 3.2.4 Charan (in her 30s)

Charan told a succinct restitution narrative<sup>28</sup> (Frank, 1995) from her living room whilst caring for her youngest child. She remained steady in tone and pace throughout but often switched from first-person perspective to second-person prose, which can be a form of introducing distance between one’s emotions and storytelling (Priest et al., 2016). Her story illustrates the way that healthcare services can be experienced and the impact of social isolation on new mothers.

Charan’s story began when she was pregnant and felt *“really excited”*. She reflected upon what she had not considered whilst pregnant (*“You<sup>2</sup> don’t think about, you<sup>2</sup> know, what happens when you<sup>2</sup> have that child and how difficult it’s going to be being a first-time mother”*). I felt engaged and provided space for Charan to proceed as I awaited the upcoming black moment (Carter, 2007).

Charan narrated being induced early as *“quite stressful”*. There appeared to be an element of self-blame as she shared having asked herself, *“is this my fault?”*. Further self-blame was conveyed as Charan described wanting *“the best”* for her child and asking, *“Have I done something that’s affecting that?”*. This connects with the prevalent ideology of maternal blame<sup>29</sup>. After birth, Charan storied herself as *“OK for the two weeks”*; however, when her husband returned to work, she would *“stare out the window”* and watch people pass-by (*“oh my God, that used to be my life”*). Charan’s account conveyed sadness over the changes in her

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<sup>28</sup> Restitution narrative (Frank, 1995) tells the story of a body being restored to wellness. Restitution narratives are based on the belief that health is, can and should be restorable (Estey-Burtt, 2013).

<sup>29</sup> Maternal blame is based on the ideology that often assumes the mother is at fault (Chess, 1982).

identity, autonomy, and independence ('public world losses') (Mauthner, 1999) after having a baby. She presented an identity of the invisible mother (De Vries, 2017) ("***nobody thinks about the<sup>3</sup> mother and their<sup>3</sup> emotions once they've<sup>3</sup> had a baby because... it's all about the<sup>3</sup> baby's wellbeing***"). Her account conveyed a sense of having felt ignored/neglected, which reflects the physical nature of having a baby whereby the pregnant body is obvious, but the postpartum woman is less visible (Benson & Wolf, 2011).

Charan storied the impact of "***added pressure***" from her family ("***telling you<sup>2</sup>, you<sup>2</sup> should do this, you<sup>2</sup> should do that***"). She described how she began to feel "***really worried***" about not being able to cope with her baby. Charan constructed her husband as a buffer against the criticism. She seemed to be demonstrating agency as she purposely shared "***I'd chosen to breastfeed***", a task which is often synonymous with being a 'good mother' (Marshall et al., 2007). Her family were constructed as sharing misinformation ("***you're not drinking enough milk, so how do you know you're producing enough?***") and Charan became reluctant to seek their support.

She recalled her negative experience of health services: "***They just sent me a letter and said, we did a blood test... These are the consequences...***". The letter was "***so blunt***", particularly "***the word 'disease'***". She described how she "***cried***" because she thought it was "***something really major***". Her and her husband "***researched it together***" and found "***it's quite common apparently***". This reflects a pattern in women's health, whereby many health difficulties and women's experiences of suffering are normalised, despite causing women difficulty and ill health (see Bullo, 2018; Shaheed, 2017).

Charan described how she would "***cry a lot***" and identified that this was not usual for her. Charan appeared to not consider this emotional side of herself as a part of her *real* self ("***I didn't know if I was going to be able to go back to being myself***"). Her talk highlighted a

wider issue around lack of education about how mothers may feel after childbirth but also a reluctance to accept vulnerability. Charan presented herself as a successful woman; a problem solver, and her perinatal experience as a problem to solve (*“I’ve got to find the answer quickly, got to fix that issue quickly”*). Charan brought her husband into the story explicitly (*“we’d talk... come up with a little plan”* because *“we were experiencing it together”*) which created a strong sense of his presence in the story and their collective efforts towards recovery. She accepted her husband’s support because *“he wasn’t going to judge”*, something she had experienced from her family and expected from professionals and the community.

Subtle themes of misogyny and patriarchy arose as Charan shared that she would not want help from the Asian community due to fear of negative judgements (*“We’re already perceived in a way that’s, you<sup>2</sup> know, you’re<sup>2</sup> not capable”*). Charan’s use of collective pronouns resulted in me feeling seen as more than a researcher, but as a part of the in-group of Punjabi women that have shared experiences. I noted how Charan reflected on having *“never struggled with anything”* before and the challenges of motherhood which resulted in her thinking *“I’m a bit of a failure, really”*. Whilst having exceptionally high standards can lead to overly critical self-evaluations (Frost, Marten, Lahart, & Rosenblate, 1990), it appeared that Charan had internalised the negative judgements and was internally hearing what she was worried about hearing from the community. Charan moved onto the topic of her faith, which she constructed as her healing resource (*“(Sikhi is) not judgemental, it doesn’t have these negative stereotypes”* and therefore *“I can find strength there”*).

Towards the end of the interview, Charan referred to the part of her that had experienced PPD as *“a ghost”*, perhaps suggesting the extent to which vulnerability was unwelcome. Charan frequently offered suggestions and ideas for improving PMH services which suggested awareness of her immediate and future audience.

### 3.3 Collective storylines

In this chapter, I have considered the narratives of each mother collectively and represented the points of connectedness and differences across the accounts, with particular consideration given to aspects of identity and sense-making of PPD. The narratives have been summarised into stories and sub-stories with relevant theory and research interwoven.

**Table 14.** Selection of experiences reported by the participants of PPD

|                               |                            |                                  |                         |                           |
|-------------------------------|----------------------------|----------------------------------|-------------------------|---------------------------|
| <i>“Suicidal”</i>             | <i>“Lights flickering”</i> | <i>“Imagining conversations”</i> | <i>“Seeing shadows”</i> | <i>“Detached”</i>         |
| <i>“Flat feeling”</i>         | <i>“In a dark place”</i>   | <i>“Not regulated”</i>           | <i>“Disappointed”</i>   | <i>“Overwhelmed”</i>      |
| <i>“Tearful”</i>              | <i>“Traumatised”</i>       | <i>“Very scared”</i>             | <i>“Depressed”</i>      | <i>“Dread”</i>            |
| <i>“Obsessional thoughts”</i> | <i>“Worried”</i>           | <i>“Panicky”</i>                 | <i>“Jittery”</i>        | <i>“High alert state”</i> |

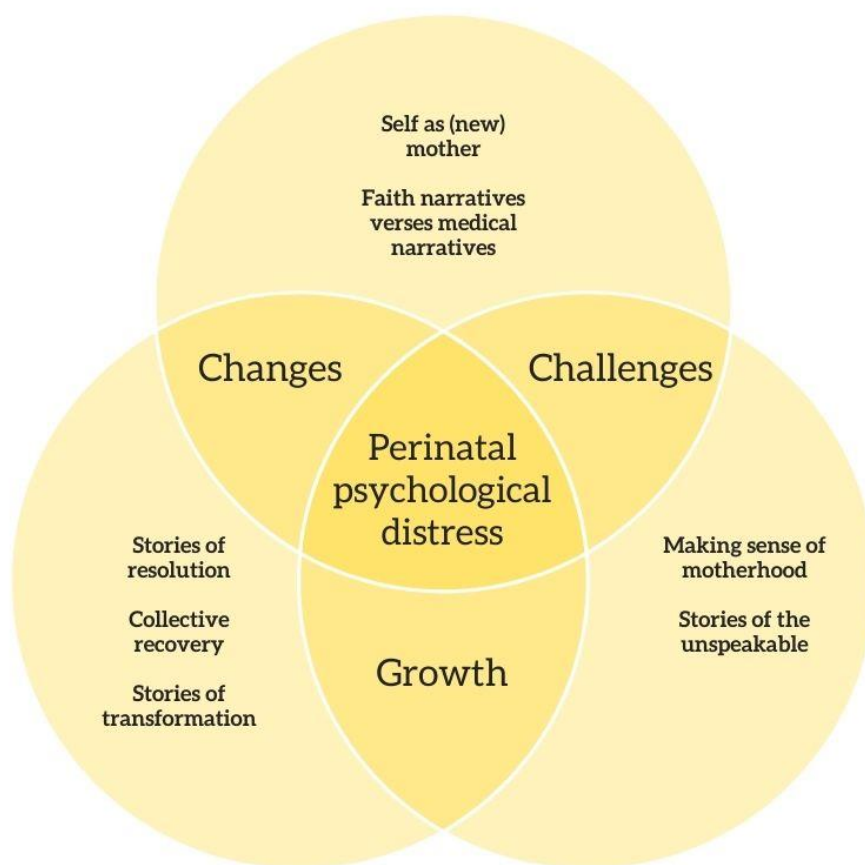
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**Table 15.** The main stories and sub-stories

| Story  | Sub-story   |
|--|---|
| <p><i>“I’ve never had this feeling before”</i>: Stories of change</p>                  | <p><i>“What kind of woman am I – what kind of mother am I?”</i>: Self as (new) mother.</p> <p><i>“I was on a different vibration”</i>: Faith narratives versus medical narratives.</p>                    |
| <p><i>“I don’t know what I’m doing”</i>: Stories of challenges</p>                     | <p><i>“Bond but no bond”</i>: Making sense of motherhood.</p> <p><i>“Hide everything.”</i>: Stories of the unspeakable.</p>   |
| <p><i>“I allowed myself to grow and get strength from this”</i>: Stories of growth</p> | <p><i>“I was able to find the tools to use”</i>: Stories of resolution.</p> <p><i>“We went through postnatal together”</i>: Collective recovery.</p> <p><i>“I’m woke”</i>: Stories of transformation.</p> |



**Figure 3.** The model of perinatal psychological distress which details the main stories and sub-stories in diagrammatic form



### 3.3.1 “*I’ve never had this feeling before*”: Stories of change

Change appeared to be a defining feature of becoming a mother and being a mother. All four Sikh Punjabi mothers spoke about motherhood as bringing new responsibilities, unexpected (or lack of) feelings, and shifts in family dynamics and societal expectations (beneficial and/or otherwise). They spoke of normative motherhood identities and trajectories; about their expectations of motherhood not aligning with their experiences of motherhood and feeling pressure (from their family and community) to mother in a particular way.

#### 3.3.1.1 “*What kind of woman – what kind of mother am I?*”: Self as (new) mother

PPD was storied by the participants as navigating questions around identity and what it means to be a (new) mother in a Sikh Punjabi family (“*who am I?*” – Charan). Some

participants spoke about not being or feeling ‘maternal’ (“*that glowing warm feeling you’re supposed to feel*” - Gurpreet) and described feelings of guilt associated with what they considered to be a lack of innate maternal instinct. They narrated how they acted (“*I just kind of did the role of what a mother is expected to do*” – Gurpreet) or practiced being a mother (“*being a mother didn’t come naturally, I really had to work for it*” - Harmeet) and that it required time (“*the overwhelming feeling of love didn’t hit me until at least I’d say three, four months down the line*” - Gurpreet). Some distinguished maternal instinct as driving a desire for “*the best for my child*” but how to do so as requiring experience (“*figure it out as you go along*”) because “*nobody tells you* (how to nurse and encourage milk production)” (Charan). Professionals and groups were constructed by the participants as not providing enough information about what to expect after childbirth, particularly in relation to how mothers can feel and sources of support.

Learning to mother was spoken about alongside receiving support and (often contradictory) suggestions from family members, especially from mothers-in-law. For example, Amarleen was told to stop breastfeeding and start her four-month-old baby on formula milk. Family support was constructed as “*a double-edged sword*” by Gurpreet who explained that it “*did help me*” but “*made me feel like I can’t cope*”. Themes of agency were identified across all the narratives. Participants expressed lack of control when referring to their experiences of PPD, but also described mechanisms of informal social control (Wardak, 2019) that dominated decision making on how to navigate experiences of PPD. Examples of informal social control included elders in the family (Gurpreet’s mother-in-law advised her not to talk to a doctor), culture/tradition (Gurpreet was encouraged to rest for 40 days), and community (Amarleen spoke about gender stereotypes in the community). The cultural practice of “*don’t go out for 40 days*” after giving birth is to allow mothers to rest and recuperate (Gatrad, Jhutti-Johal & Sheikh, 2005). For some participants this was experienced as being “*trapped indoors*”

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(Amarleen) and it was during this rest period that **“it (PPD) all kind of started”** (Charan). For other participants, there was already a sense of **“there wasn’t something right”** (Gurpreet) but **“it was more apparent at home”** (Harmeet).

In Indian culture, the involvement of immediate relatives and friends is a part of the social order (Choudhry, 1997). It appeared from the interviews that family involvement for most participants was at times unhelpful as they described experiencing **“controlling behaviour”** (Amarleen) or **“criticism”** (Charan) which became internalised. For example, Charan was told that perhaps she is not producing enough milk. This manifested as feelings of **“pressure”** and the belief that **“I’m not good enough. Not being a good mom”**. However, Harmeet’s account differed as she spoke about lack of support. Her in-laws live in Punjab, and she contrasted living in the UK to living in the *pind* (village), where **“everything is around the house and the farm”**. This connects with the African proverb ‘it takes a village to raise a child’, which in essence captures childrearing in Punjab. Harmeet spoke about the perceived benefits of family support, conveying a sense of loss over not having had this experience.

Participants constructed themselves as career women with busy social lives pre-motherhood. This was in sharp contrast to motherhood. Participants narrated changes in their identity/role, social life, body, but also their ambitions (**“You give up some of your aspirations... you may settle for positions that you may have before thought, actually, I would have gone higher”** - Amarleen). These losses conveyed a sense of personal sacrifice for their children. Some participants’ shared stories of joy about returning to work. This indicated the value they placed on being a mother alongside having a career, which conveyed the multifaced nature of the participants’ identities and further paradoxical aspects of self that co-exist.

In Punjab, and across India, motherhood is respected but also idealised (Krishnaraj, 2010). Borovska (2015) writes about the myth of the ‘good mother’. According to the myth, the ‘good

mother' knows what the best way of rearing is, as soon as a child is born, because maternity is the natural role of the mother. When mothers do not conform to this myth, they are viewed by society and/or perceive themselves to be unnatural (Borovska, 2015). All mothers positioned themselves in relation to these discourses. For example, Harmeet talked about not feeling able to comfort her child "*the way a mother would*". She consequently constructed herself as "*a failure of a mother*". The accounts reflected normative societal expectations and discourses about the female body/self (Carter, 2010), such as what is a normal birth and what being a good mother looks/feels like.

### 3.3.1.2 "*I was on a different vibration*": Faith narratives versus medical narratives

PPD was constructed by the mothers using a combination of narratives. For some participants, it was either/or (such as medical, or spiritual) whilst others adopted a both-and approach (such as medical and spiritual). It was noted that there seemed to be less preparedness around these stories, suggesting that these stories may be less told.

All participants initially told problem saturated stories (Freeman, Epston & Lobovits, 1997). Despite having each experienced similar but different mental health experiences, at the outset participants storied their experiences using similar medical narratives and terminology. This is demonstrated in the quotes below, whereby it can be seen that all participants constructed their experiences using the word "*depression*".

Harmeet: "*I had postnatal depression*".

Gurpreet: "*I could have been going through postnatal depression*".

Amarleen: "*it was more the depression side... everything would just make me panic and make me kind of feel really anxious!*"

Charan: "*it probably was postnatal depression, but I didn't want that depression*".

Participants appeared to be drawing on ideas and forms of lay knowledge (Bury, 2001) in the form of common diagnostic statements to interpret and communicate about their experiences of PPD. These classic illness narratives (Kalitzkus & Matthiessen, 2009) are based on the medical model of understanding health and conveyed a sense of something beyond self-control (*“Why haven’t I got control of my body, why?”* – Harmeet).

When narrating a different event or description of PPD, participants shifted to drawing on alternative narratives in the form of grand narratives (i.e., metanarratives providing sociocultural understandings of health - Kalitzkus & Matthiessen, 2009) (see table 16). For example, Harmeet drew on medical narratives when in the story she introduced her experiences as *“hallucinations”* (*“Something more to do with the hormones than my actual mental state”*). However, she appeared to reconsider her interpretation (*“I don’t know if they were hallucinations”*) and shifted to (what some may consider to be supernatural) alternative narratives as she constructed her experiences of seeing *“shadows”* of *“someone”* that others could not see or hear as *“spirits”*.

**Table 16.** Selection of narratives used by participants

| <b>Participant</b> | <b>Dominant narrative</b>            | <b>Position</b> | <b>Grand narrative</b>   |
|--------------------|--------------------------------------|-----------------|--|
| Harmeet            | Medical (depression, body, hormones) | Either-<br>or   | Faith/Sikh narratives  |
| Gurpreet           | Medical (depression)                 | Both-<br>and    | Faith/Sikh narratives<br><br>Psychological (personality theory, male child preference)<br><br>Social/cultural (family dynamics, male child preference) |

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|          |  |               |   |
|----------|--|---------------|---|
| Amarleen | Medical (depression, anxiety, trauma, personality disorder, sleep deprivation) | Either-<br>or | Psychological (emotion dysregulation, trauma)<br>Social (family dynamics)               |
| Charan   | Medical (depression, hormones)   | Both-<br>and  | Psychological (personality theory)<br>Social (family dynamics)<br>Faith/Sikh narratives |

Grand narratives appeared to be used when participants were narrating aspects of stories that were personally meaningful and significant to them or moments of ambiguity that appeared to be better captured by a particular meta-narrative, perhaps dependent upon whether it was attributed to the body, mind, or soul (see Virk, 2018). For example, Harmeet drew on dominant medical narratives to explain a sudden and difficult to understand change (*“it’s hard to go, literally, one day you’re fine and then a couple of days later... you are a completely different person”*). She drew on counternarratives informed by historical discussions (*“my grandma used to tell me all the time, there are spirits”*) and her interpretation of the SGGS. During which, she made a distinction between spirits and the supernatural (*“we don’t really believe in the supernatural... we do talk about spirits and spirits do roam the earth... it is written in text (SGGS)<sup>30</sup>”*). Gurpreet and Amarleen rejected the concept of spirits, commenting that *“It’s*

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<sup>30</sup>The *Reht Maryada* (Sikh code of conduct) instructs to not engage in superstitious observations (Shiromani Gurdwara Parbandhak Committee, 2009). *“Bhooṭ”* (evil nature spirits) and *“parayṭ”* (ghosts) are mentioned in the SGGS (e.g., Ang 134; 1029; 1150). Due to the lack of literature on this topic, as part of this study, conversations were held with members of the Sikh community in Punjab and England. The responses have been grouped into three themes: (1) references to spirits/ghosts are metaphors for evil. Sikh scriptures focus only on present earthly duties, (2) spirits/ghosts are a mystery, and (3) spirits/ghosts exist plus personal experience of spirits/ghosts.

*not my religion. We don't believe in this*" (Amarleen). This highlighted variation in religious and spiritual beliefs amongst the participants.

Faith (Sikh) narratives also included mention of destiny<sup>31</sup> ("*if it happens, it happens. Up to God kind of thing*" – Gurpreet) and fate<sup>32</sup> ("*jo likhya*" (whatever is written is meant to be) – Harmeet). Fate and destiny narratives imply some form of belief in divine control. This can have a stress-buffering role (DeAngelis, 2018; DeAngelis & Ellison, 2018) as for some, this can manifest as perceived lack of personal control (Wu, Chen & Ng, 2020) and responsibility over events.

As well as medical narratives, participants drew on psychological narratives including personality theory ("*I'm not a confident person... I feel my personality probably had a lot to do with it as well*" – Gurpreet) and the concept of emotion dysregulation ("*I struggle with regulating my emotions... or I am a PD at points in my life and I just don't want to admit it or whatever it might be*" – Amarleen).

Participants' meta-narratives conveyed a sense of uncertainty, limited education about emotional changes during the perinatal period, but also maternal blame. Maternal blame appeared to be a key narrative theme across the accounts as mothers described themselves as "*failed*"/"*failure*" (Harmeet and Charan), "*shit mom*" (Amarleen), and "*I shouldn't have let myself get to that*" (Gurpreet). The accounts reflected wider discourses around mothers often being blamed for already-complex responsibilities that comprise mothering (Chess, 1982; Jackson & Mannix, 2004), which is said to be a patriarchal strategy (Watts, 2019) that upon internalisation can manifest as self-blame.

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<sup>31</sup> Destiny refers to the choices one makes given the limitations.

<sup>32</sup> Fate refers to what is predetermined and cannot be changed.

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Amarleen, Gurpreet and Charan gave insights into their social situations, including the impact of complex family dynamics on PPD. Participants spoke of declining further family support to avoid negative feedback from their elders, which resulted in further social isolation. For some, this exasperated the PPD (“*that's when I started to get really emotional*” – Charan) whilst for others it offered respite as they returned to their natal home (“*I'd removed myself from the situation... and that was that*” - Amarleen).

As participants navigated different frames of understanding PPD, their accounts presented a juxtaposition of dominant Western narratives and non-Western narratives inextricably interwoven, which either alleviated or perpetuated self-blame.

### **3.3.2 “*I don't know what I'm doing*”: Stories of challenges**

Mothers talked about the changes that came with motherhood, including the challenges associated with becoming a mother, and specifically, difficulties that manifested as PPD. These related to difficulty bonding with baby, seeking a (maternal) role model and barriers to accessing help.

#### **3.3.2.1 “*Bond but no bond*”: Making sense of motherhood**

The accounts detailed the closeness and distance between the mothers and their babies' post-partum (see table 17). Most participants spoke of the contradictory paradox (termed the existential crisis of motherhood by Arnold-Baker (2020)) of shock and/or fear with happiness at learning that they were pregnant.

Some participants spoke of struggling to bond with their babies' post-birth (see table 16) and the impact of these early experiences on their parent-child relationships. Their narratives conveyed the reciprocal nature of PPD, in the way that they described PDD as affecting their sense making and ability to parent, which impacted parent-child relationship, that, in turn,



contributed to further distress. For example, Harmeet talked about the detachment between her and her baby after what was a difficult birth (“*I was just like...Just, just take him away from me. I can't do anything for him.*”) and attributed present day challenges to his early years (“*although I love him immensely now, um, to comfort him, I struggle*”).

Other participants also positioned themselves in relation to these discourses. For example, Amarleen spoke about the “*rejection*” her son endured during her experiences of PPD and the consequent “*damage*” to him. These narratives can potentially be accounted for by the popular concept of the critical period for bonding, which emphasises that early mother-infant bonding benefits later development and relationships. The concept of bonding and critical period is said to be responsible for considerable parental anxiety (Redshaw & Martin, 2013). Research suggests that early contact between mother and baby can be supportive but the data for long-term relationship gains is less than substantial (Myers, 1984; Redshaw & Martin, 2013).

**Table 17.** Participant’s descriptions of their bond with their baby

| <b>Participant</b> | <b>Parent-infant bond</b>   |
|--------------------|---|
| Harmeet            | <i>“wasn’t created”</i>   |
| Gurpreet           | <i>“really struggled to bond”</i><br><i>“(now) really attached”</i> |
| Amarleen           | <i>“lost some bonding”</i>  |
| Charan             | <i>“strongest bond”</i>   |

Participants narrated that their (perceived) lack of bond with their children was influenced by their expectations of motherhood which was, in turn, based on lack of experience with infants, family over-involvement and/or male child preference. Ambivalence about having a daughter was storied by Gurpreet who narrated that their bond had required time. This speaks to social discourses and normative cultural expectations about the perceived benefits of male offspring

within the Punjabi community (Agarwal, 2003; Ghuman, 2012) but also the myth of parental love at first sight, both of which contribute to ideals of what is considered acceptable.

Meanwhile, Harmeet narrated that she felt like she had failed her child and that she would spend the rest of her life trying to make up for being *“a failed mother”*. Similar sentiments were shared by Amarleen who tearfully described herself as a *“shit mom”*. Participants narratives reflected the literature (see Carson et al., 2017) around internalised discourses about how women ‘ought to’ behave during childbirth and post-partum, but also conveyed a long-lasting impact of PPD: a sense of (unintentionally) having wronged one’s child and feeling indebted to them, to compensate for lost moments.

Ambivalent stories that depict the mother as a ‘unit’ (comprising of biological mother plus family, particularly the mother-in-law) seemed important to the mothers. This is consistent with understandings of the collectivist nature of Punjabi families (Galdas et al., 2011), whereby cohesion and interdependence are promoted. Gurpreet and Amarleen described the presence of their mothers-in-law either during delivery or post-birth and their ongoing involvement over the postpartum period, as leading to feelings of being replaced (*“spending more time with her grandmother. She (baby) is not to know that I'm her mother”* – Gurpreet) and undermined (*“I was told so much that (baby) wasn't growing, (baby) wasn't this, even though there was proof”* – Amarleen). Charan’s narrative differed as she described her in-laws as *“more supportive”* (they would *“hold baby”* and *“make food”*) than her own parents who were constructed as providing *“criticism”*. All participants narrated being a part of a multigenerational family and how they incorporated the advice of their elders’ versus rejected or challenged ideas, which provided (sometimes uncomfortable) opportunities to find their preferred identity and parenting style as a new mother.

The sub-narrative about identifying or not identifying with one's own mother and its potential impact on bonding came up for some of the participants. For Amarleen, this was about wanting to parent differently (and provide children with a different parenting experience) whilst for Gurpreet it was about wanting a different experience to that of her mother. Stories about seeking a maternal role model were told by Amarleen who wants to 're-write the script' (Rivett & Street, 2009) ("*I wouldn't want to be a mom like my mom, and I wouldn't want to be a mom like my mother-in-law*"). She described identifying with parents in films and social media from which she would draw ideas and inspiration. Conversely, Gurpreet attributed her desire for a male child to not wanting the "*same fate*" as her own mother who lives alone, which Gurpreet stated would not be the case if her mother had had a son (because "*my brother would be with her, with his wife*"). It appeared that Gurpreet drew on internalised gender discourses around the cultural value attached to having a son and stereotypes of mother-son relationships.

Narratives included descriptions of seeking connections and informal support in the form of community baby groups and Gurdwara-run play groups. Within Sikhism, fellowship of the *sangat*<sup>33</sup> is of importance as it is believed to provide spiritual togetherness and correspond to the preservation of wellbeing, which is supported by the literature on the benefits of social support (e.g., Thoits, 1995). However, mothers storied their experiences of mother-baby groups and Gurdwara-run play groups as unhelpful during PPD as the groups communicated what is (considered) normal which contributed to feeling "*different*" and "*worse*" (Harmeet) about both themselves (as mothers) and their relationships with their babies.

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<sup>33</sup>*Sangat* means an active Sikh gathering and community. The fellowship of the *sangat* is of importance in religious practice as in *sangat* "*His inner being is not touched by anger or dark energies at all*" (SGGS, Ang 29).

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Harmeet (referring to herself in second prose): “*you're<sup>2</sup> either in the in crowd or you're<sup>2</sup> not...*

*You<sup>2</sup> could tell that, you know, your<sup>2</sup> kid was the only kid that didn't know every bit of the*

*Jap Ji Sahib<sup>34</sup>*”.

The above quotes convey a sense of feeling judged and alienated in social groups, which mirrors participants' experiences with their families and professionals. Furthermore, the groups were constructed as not providing enough information or opportunity to connect with other mothers and receive peer support (“*no one else I can talk to or ask, oh have you had this?*” – Charan). This communicates the degree to which support felt inaccessible for these participants and the extent of their social isolation during the postnatal period.

### **3.3.2.2 “Hide everything.”: Stories of the unspeakable**

Stories of discouragement from speaking with health professionals about PPD appeared to be a central narrative theme across the accounts. Participants spoke about censoring information when speaking with health professionals. The discouragement from speaking openly about their experiences of PPD appeared to come from inside (family members) and indirectly from outside sources (professionals and the community).

Participants positioned themselves as distrustful and cautious of health professionals. This related to fear of (negative) judgement, of information being documented, of their child(ren) being taken away, and of being given a mental health diagnosis and/or offered psychiatric medication. Perhaps as a result, participants spoke about not having accessed professional support for PPD. This was linked to either fear of being recognised by professionals, the presence of mothers-in-law during appointments, being discouraged by family members and the “*taboo*” (Amarleen) nature of mental health in the Punjabi community.

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<sup>34</sup> *Jap Ji Sahib* is a prayer.

Harmeet: *“we don’t do depression, we don’t do um depression medication, we’re not about that”*.

Shame and stigma seemed to be underlining these barriers (*“I was worried about what people would think or say”* (a common worry/saying in Punjabi households) - Amarleen). Charan talked about how *“everything gets swept under a rug”* in Sikh Punjabi families (*“that’s our culture, right? Hide everything”* - Amarleen). PPD was constructed as an untold and untellable experience; something that is hidden in plain sight to uphold *izzat*<sup>35</sup>. This is demonstrated further by the advice that participants had received from their mothers:

Harmeet: *“she goes, “No, you’re not okay but you’ve got all of us around you. You don’t want any more drugs pumped into your body. You do not need to be going to more appointments. We’re all here, we will work through it together”*.

Gurpreet: *I told my mom, and my mom essentially was like, “Just, um, don’t go to the doctor, just leave it... deal with it within yourself”*.

Harmeet’s mother’s advice demonstrates a collective family approach to PPD (see section ‘3.3.2.1 *“Bond but no bond”*: Making sense of motherhood’ and ‘3.3.3.2 *“We went through postnatal together”*: Collective recovery’ for collectivist theory) whilst Gurpreet’s mother’s advice demonstrates a self-management approach. Both have the common theme of PPD being managed internally without external support. Research suggests that external support has the potential to buffer the effects of strained interactions which relates to psychological wellbeing (Walen & Lachman, 2000). However, to go against their elder’s advice risked the potential to *“rock the boat (with family)”* (Harmeet) which risked losing family support. This connects with understandings of the South Asian identity, whereby the self is positioned within the

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<sup>35</sup>*Izzat* refers to learnt complex rules that one follows in order to protect family honour and keep their position in the community (Gilbert, Gilbert & Sanghera, 2004).

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family system and power is established hierarchically (Paiva, 2008), and sometimes this inherited level of power determines level of personal agency. This is further complicated for South Asian women who are symbolised as the carrier of family honour and fear of bringing dishonour inhibits behaviour (Gilbert, Gilbert & Sanghera, 2004).

All participants narrated wanting external support (“*I wanted to talk to someone, I wanted to cry*” – Harmeet), but the challenge of facing a multitude of barriers to help-seeking (see table 18).

**Table 18.** Participant’s explanations for not disclosing personal experiences of PPD to professionals

| <b>Participant</b> | <b>Explanations for non-disclosure</b>  |
|--------------------|---|
| Harmeet            | Mental health diagnoses and medications considered to be unacceptable<br>Professionals considered to be inauthentic and uncaring<br>Preference for clinician of same ethnic background to aid sociocultural understanding of PPD<br>Discouragement by elders<br>Fear of child being removed |
| Gurpreet           | Cultural norm of staying silent<br>Discouragement by elders due to fear of diagnosis and damage to reputation   |
| Amarleen           | Cultural norm of staying silent   |

|        |   |
|--------|---|
|        | <p>Fear of being recognised by colleagues</p> <p>Provided with a leaflet from her GP and no follow-up</p> <p>Professionals perceived as uncompassionate and jumping to conclusions</p> <p>Fear of documentation and information sharing</p> |
| Charan | <p>Taboo nature</p> <p>Professionals considered to be judgemental and patronising in tone, language, and demeanour</p> <p>Uncomfortable with being asked too many questions</p> <p>Fear of documentation</p>                                |

Charan constructed talking to a professional as “*like a door you don't want to go through*”. This conveyed a sense of fear or anxiety, of something unknown. The extent to which services felt inaccessible for these women was conveyed as they narrated having had thoughts of ending their own lives and/or them and their baby’s life, and not feeling able to disclose this vital information to professionals. Amarleen tearfully described learning about a suicide in a previous generation in her family. This conveyed a family history of emotional distress and an intergenerational pattern of remaining silent because narratives about mental health are stories of the unspeakable.

Charan ***“if you sensed that that person is being a bit reserved, then at least think that maybe they’re being reserved because they’re afraid”.***

The accounts connect with the theory of ‘self-silencing’ (Jack, 1991 cited in Emran et al., 2020): of not sharing certain thoughts and feelings to uphold the family’s need for intimacy and safety because outside support seems uncertain and unsafe. Although it was noted that self-silencing was not done consistently as some participants did share some information with professionals about the PPD (***“I said yes, I am having, um, not normal thoughts and things like that”*** – Harmeet) which suggested a need to be heard and helped. However, information was limited (***“She (GP) said, are any of them suicidal? I outright lied. I said no. I said, me and my baby are safe”*** – Amarleen) or incorrect (***“I was giving the wrong answers deliberately”*** – Gurpreet) which consequently did not result in an offer of support. The extent of self-silencing was conveyed as participants talked about no one else other than themselves knowing the full details of their experience of PPD. Therefore, it is possible that participants felt unable to share some aspects of their experiences of PPD in the interviews.

Participant’s constructed disengagement from health services as linked to health professionals not being relatable, asking ***“too many questions”*** (Charan) in an impersonal manner (***“tick box exercise” - Harmeet***), and dismissing emotional distress by providing leaflets and not asking open questions (***“she (GP) was like, “Well, would you say you’re depressed?” And I said, “I don’t know. Like, what is depression?”*** - Gurpreet). Participants perceptions of professionals as lacking compassion is consistent with previous perinatal studies on ethnic women’s experiences of perinatal support and care (e.g., see Edge, 2011).

All participants reflected on the language and approach used by professionals, particularly medical terminology, which, for some, assumed shared understanding. This appeared to amplify thoughts and feelings around not knowing and not being a good enough mother. Participants storied disengaging from services at this point in their accounts. Unfortunately,



disengagement can reinforce narratives in services (Johnson & Nadirshaw, 1993) that South Asian mothers do not want support for PPD, when in fact the women most in need of support and treatment are less likely to be offered it (Redshaw & Henderson, 2016).

Amarleen's narrative differed to the other participants. Amarleen works in mental health and agreed to be referred to talking therapies after the birth of her second child after initially refusing professional support. Interestingly, her decision to accept support was attributed to her husband, who was positioned as encouraging and actively involved in the process. Participants appeared to construct professional support as not feeling culturally appropriate and lacking consideration of their gender (role), religion, and ethnicity, which participants felt was central to their experiences. The narratives imply a need for improving access and engagement in healthcare services through the provision of more culturally sensitive care and support.

### **3.3.3 “I allowed myself to grow and get strength from this”: Stories of growth**

Across the narratives, often located at the end of the story, participants spoke about what their experiences of PPD had allowed for. They described recovery as a process of re-discovery of the self, a collective gain for the family, and an opportunity for personal transformation.

#### **3.3.3.1 “I was able to find the tools to use”: Stories of resolution**

Most participants storied recovery as a process that was suddenly activated internally, which allowed for resolution to follow. This can be seen in the quotes below:

Gurpreet: *“one day something just clicked... I know I have to be here for my mom and my daughter... so I either continue as I am, or I just have to dig deep”.*

Charan: *“it’s almost like a switch flicked and that’s where I was able to find the tools to use that I would term my ‘old self’”.*

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Amarleen: *“I think I then realised that I couldn’t do that to [husband], I couldn’t. It’s not fair on the kids, they haven’t even had a life like, and who am I to take that away from them. I couldn’t go because I’m the only one who could do the best job for them”.*

In recounting these narratives (Frank, 1995), most participants constructed recovery as a choice and positioned themselves as active agents, consciously involved in decision making and facilitating their own recovery journeys by finding tangible solutions. Overall, methods that do not involve external support were sought (see table 19) for the reasons outlined in section 3.3.2.2.

**Table 19.** Participants strategies for coping and/or resolution

| <b>Participant</b> | <b>Forms of coping and/or resolution</b>  |
|--------------------|---|
| Harmeet            | Faith (scripture, prayers)<br>Behavioural (avoid sad or dramatic melodies)<br>Cultural (burn chillies, throw salt, throw lemons into river, draw <i>kala tikka</i> <sup>36</sup> on baby)   |
| Gurpreet           | Behavioural (acting opposite to the feeling)<br>Family (child-care)   |
| Amarleen           | Behavioural (self-help materials, mindfulness, avoiding mother-in-law, social media)<br>Faith (prayers)<br>Self-care (sleep hygiene)<br>Medical (medication)<br>Family (stayed at natal home for a small period after childbirth, child-care, sent texts to husband during times of need) |
| Charan             | Faith<br>Cognitive (taking stock of feelings, catching and processing the negative thoughts, consider positive aspects)<br>Behavioural (scheduling and completing tasks, avoiding birth parents, social media)<br>Self-care (reading)<br>Family (speak with husband)                      |

<sup>36</sup>*Kala tikka* refers to the cultural practice of drawing a black dot to ward off *nazar*. This practice is not rooted in Sikhism.

Solutions often comprised of behavioural techniques (e.g., smile more, challenge thoughts, schedule activities and gradually increase level of difficulty). In line with previous research (Raggatt et al., 2018), participants storied social media, blogs, and apps as sources of inspiration, despite mentioning that posts can be unrealistic (“*seeing all these moms like looking amazing, doing the flipping fitness while the kid is doing like homework*” – Amarleen) and sources of stress.

Gurpreet recounted that having no one to speak to about PPD influenced her choice of solution. Meanwhile, Charan, recounted that she would read self-improvement articles (not necessarily related to motherhood) and find “*little tests*” to occupy herself (whilst breastfeeding) to build “*mental strength*” as she defined personal growth as “*learning new things*”. Charan presented a productive identity (Buzzanell & Liu, 2005) and her account reflects normative cultural preferences and expectations in British Sikh Punjabi families where there is often an emphasis on the importance of education and being successful (Thandi, 2018). It also reflects wider societal discourses and pressure on women (in the context of patriarchy, inequality and discrimination – Becker, 2015; Rana et al., 1998) to demonstrate productivity, which represents an arbitrary standard for measuring self-worth.

Stories of participants becoming empowered and taking agency as they became their own therapists featured across the narratives. This can be seen in a quote from Amarleen’s interview: “*I just kind of just took it in my own hands and did my little, yeah, therapy on myself*”. However, unlike therapy where there can be space to consider paradoxical emotions and thoughts, for these mothers it seemed that there was no room for alternatives. Gurpreet described “*forcing*” herself to “*try to be happier, try to smile and to just love her (baby)*” in hope of “*faking it till I make it*”. This ‘*just get on with it*’ attitude and performing the role of

mother (until the internal conflict resolves) offered participants a practical solution but dismissed their core phenomenological experience. This connects with previous research conducted with the Punjabi community in the UK (Takhar et al., 2019), which found that for some Punjabi people, mental health problems are viewed as a character failing or not a 'real' problem which can lead to individual's repressing the core issue. This form of dismissal is demonstrated in a quote from Gurpreet who described ***"I just kind of compartmentalised my inner views and feelings"*** because ***"It's not given as much seriousness as a physical injury"***.

Despite participants using various frames to understand their experiences, for many their healing resources comprised of their faith. For example, Harmeet narrated that her belief in fate supported her through PPD: ***"this is not how it's going to be for me forever... it will be fine in the end"***. She seemed to demonstrate *chardi kala*: ***"if you're having bad times, good times will come"***. Meanwhile, Charan found strength in Sikhi because unlike society, ***"it's not judgmental, it doesn't have these negative stereotypes"***. It appeared that faith and *Gurbani* fulfilled Charan's values for equality and compassion and functioned in the form of providing her with validation and peace. Amarleen, who identified as Sikh during screening but in the interview described herself as an Atheist since her sibling's ill health, shared that she prays daily. This demonstrated that despite having a complex relationship with her faith, she continued to find solace in it.

Another tool that mothers began to use to manage the PPD was to start talking about their experiences. All participants described talking with their family members, especially their husbands, but towards the end of the accounts some participants described talking with people outside of their family. Charan constructed reflecting on and talking about PPD to be a source of ***"strength"***. Meanwhile, Amarleen described talking about PPD at work as an opportunity to challenge cultural norms. This demonstrated an act of resistance against being silenced (see section ***'3.3.3.2 "We went through postnatal together": Collective recovery'*** and ***'3.3.3.3 "I'm***

*woke*”: **Stories of transformation**’). However, participants appeared unable to share the full details. For example, Amarleen talked about her mother not knowing that she takes psychiatric medication. This implied that participants felt more able to position themselves in their preferred (individual) identities in spaces outside of the family (collective identity) context (Epp & Price, 2008).

### 3.3.3.2 “*We went through postnatal together*”: **Collective recovery**

Participants storied PPD as an experience that affected the whole family. They narrated how experiences of PPD had initially negatively affected “*family bonds*” (Harmeet, Amarleen and Gurpreet), particularly their relationships with their mothers-in-law and/or babies. However, towards the end of their narratives, participants described the positive impact of PPD on their family:

Harmeet: “*We’re definitely stronger now than we’ve ever been*”.

Amarleen: “*I think, that is a massive up, and just us like as a family, like family bonds*”.

Participants appeared to convey a sense of collective recovery (Fullilove & Hernandez-Cordero, 2006), in which the recovery process involves the family unit and recovery is a result of changes in the family system (Engel, 1977). This is important considering that perinatal services often work with the mother and/or mother and baby, not with the whole family. Further, the outcome of recovery was constructed as a collective family gain. The idea of recovery as a collective family gain connects with the concept of familial collectivism in Indian family systems (Chadda & Deb, 2013), whereby strong interdependent ties exist between family members, and self-reliance is encouraged, the results of which are considered to benefit the whole family.

Recovery ideas are primarily based on Western European and North American models around the notion of something being wrong (Beresford, 2015) and the need to overcome “symptoms” (Beresford, 2015; Onken et al., 2007). It was noted in the present study that participants did not use the term recovery but instead constructed the resolution of PPD as forms of personal development (see table 20). Two participants spoke about recovery as a bodily experience, a recoupling of body and self. This connects with female body/self-conceptualisations in perinatal work whereby women are linguistically split into two entities: the body in labour versus the self as mother (Carter, 2010).

**Table 20.** Descriptors used by participants to convey recovery

| <b>Participant</b> | <b>Terms used that convey personal development</b> | <b>Body-self conceptualisations</b>   |
|--------------------|--|---|
| Harmeet            | Growth   | There were no examples of body-self conceptualisations.                               |
| Gurpreet           | More understanding                                 | <i>“Trying to become more positive changed my brain ...changed my body behaviour”</i> |
| Amarleen           | Achieved   | <i>“Feeling that you fit in your body again”</i>                                      |
| Charan             | Strength<br>Confidence                             | There were no examples of body-self conceptualisations.                               |

These excerpts from the interviews suggest that recovery was understood to be a form of renewal and transformation of the self from an illness identity to an identity marked by meaning

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and personal development. Perhaps loss-to-hope narratives reflect the enactment of defence mechanisms whereby painful feelings are rationalised for the purpose of survival.

It appeared that relationships with significant people had taken on a special intensity during motherhood. Husbands were constructed as either actively involved in providing emotional and practical support or as passively involved (*“he didn't really push on it like, you know, “Have you called the doctor?” or, “Let me call the doctor”* - Gurpreet). Towards the end of the accounts, participants shifted from narratives of conflict, power and control between themselves and their elders to talking about family togetherness and collaboration:

Gurpreet: *“when you live in a family, there's always going to be moments, issues, but we overcome them”*.

Amarleen: *“you have to look after your elders, no matter what they're like”*.

Some participants expressed gratitude for the help and support their parents and in-laws had provided. This implied forgiveness and personal duty towards their family. It also conveyed not only collectivism but elder respect (Chadha, 1995).

Participants shared stories about ripples of change triggered by their experiences of PPD. For example, Harmeet's father has begun to give talks on PMH in local Gurdwaras to raise awareness and understanding, whilst her mother has accepted that *“You don't hide things like postnatal”*. This juxtaposes the narratives mentioned in section 3.3.2.2. about self-censoring or silencing stories about their mental health.

### **3.3.3.3 “I'm woke”: Stories of transformation**

A strong feature towards the end of the accounts was personal transformation after PPD. Participants drew upon faith, social comparisons, and the self-development literature in what appeared to be an attempt to form meaning of their experiences and lives. Participants reflected



upon how their sense of self had changed. This included descriptions of feeling **“woke”**, **“more compassionate”**, and accepting the **“small wins”**, which corresponds with recent recovery ideas about discovering/rediscovers aspects about oneself and building a meaningful life (Thornton & Lucas, 2011).

Stories were shared of self-transcendence. Participants’ experiences appeared to have brought about a sense of interconnectedness with others (a form of oneness<sup>37</sup>) (**“it’s not about just one person, it’s about the collective”** – Harmeet) and intrapersonal expansion (Reischer et al., 2021) as they seemed to adopt an accepting attitude toward their past (perinatal) experiences and future. Some participants talked about restoration of a part of themselves (**“I had to find an element of my old self and pull that”** – Charan, and **“feeling that you<sup>2</sup> fit in your body again”** - Amarleen) whilst others described an evolution of the self (**“if it doesn’t kill you, it makes you stronger”** – Harmeet, and **“I’m still who I was, just there’s a new added element”** - Charan). This somewhat reflected dominant restitution narratives<sup>38</sup> (Frank, 1995) but it was noted that participants did not mention restoration or renewal of health.

Talk about resolution and/or evolution of the self was not consistent as participants also offered elements of chaos narratives (Frank, 1995). This was in the form of talking about aspects of their perinatal experiences that remained unresolved and difficult to accept:

Harmeet: **“I almost grieve the relationship with (child’s name) that I would have had”**.

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<sup>37</sup>Oneness refers to an attribute based on “1”. “1” is what is invoked when Sikhs refer to the Divine, the Creator. Oneness is the Sikh vision of the divine in all (Sikh Research Institute, 2020) and is symbolized by the symbol *Ik Onkar* (Virk, 2018).

<sup>38</sup>Restitution narrative (Frank, 1995) denotes an end, a solution or resolution to the problem with hope and promise returning to its original state (Nosek et al., 2012).

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Gurpreet: *“if I do look back, it will just forever be marred with a tinge of sadness that I felt like that... how could I ever feel like that for my daughter”*.

Amarleen: *“I still feel traumatised about it”*.

The above quotes suggest that although participants shared stories of transformation, the transformations were complex as whilst some aspects of PPD had resolved, there remained residual elements. Participants’ overall narrative accounts conveyed a sense of disappointment in services and corroborated the need for timely and culturally appropriate support. Participant accounts also substantiate alternative recovery narratives as integration of their PPD experiences and the blossoming of meaningful transformations did not require participants to be free of all internal distress.

Despite residual elements, some transformation stories were embellished with downward social comparisons (Krause & Weber, 2018) as experiences and circumstances were contrasted with those whom participants considered to be worse off.

Harmeet: *“One woman, she had a baby, uh, same day as me. The baby didn’t get oxygen for six minutes... me and my child had sepsis and meningitis. We both came out fine, and she could have a child who’s brain damaged for the rest of its life”*.

There appeared to be an element of participants exhibiting acceptance of their experiences and/or circumstances and demonstrating contentment (a virtue in Sikhism - Sandhu, 2004). Within Sikhism, it is believed that by developing one’s conscious awareness, one can release the ego from self-defeating impressions that have built up (Sandhu, 2007). Constructing their narratives using downward social comparisons and practicing contentment appeared to function as a way of alleviating emotional pain. Participants described that it *“put things in perspective”* (Harmeet) and *“it does make you appreciate”* (Gurpreet).

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For all participants, stories of transformation led to discussions about their hopes and aspirations during which participants conveyed a sense of feeling responsible for reform in the field of PMH (“*Why are we as youngsters not challenging this?*” – Amarleen). Participants constructed themselves as activists and storied their efforts to contribute to change. For example, Amarleen now works in PMH supporting mothers and Harmeet expressed a desire to volunteer to help mothers. Through their own lived experiences, participants appeared to regain control by negotiating a meaningful role and identity for themselves through *sewa*<sup>39</sup> and asserting their responsibility to live by the *miri-piri* concept. This activist spirit is reflected within wider discourses and the community whereby millennial Sikh females are increasingly engaging actively in issues that matter to them (Takhar, 2018).

Participants appeared to internalise personal agency and develop a self-narrative in which they viewed themselves as influential and having power within. Through this way of storying their experiences of PPD, the expected audience (parents and service providers) were offered a narrative of resilience and hope.

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<sup>39</sup> Research on helping others suggests that giving can have health benefits (see Brown et al., 2003).

## **CHAPTER FOUR: RELEVANCE, IMPLICATIONS AND CONCLUSIONS**

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### **Overview**

In this chapter, I provide a summary of the analysis and discussion with reference to the relevant literature. This is followed by consideration of research fidelity to the quality criteria, and the strengths and limitations of the study. Lastly, implications and research dissemination are explored, followed by suggestions for future research.

### **4.1 Revisiting the research question**

The purpose of this study was to address the following research question:

*How do Sikh Punjabi mothers narrate their sense making and sense of self in relation to having experienced perinatal psychological distress?*

In chapter three, summaries of the four individual accounts and seven collective storylines were provided with the relevant literature and theory interwoven. In this section, aspects of these are revisited below and considered in conjunction with the literature covered in the systematic literature review.

### **4.2 Summary of findings**

Participants narrated their sense-making of PPD using a combination of narratives as they initially presented themselves in their accounts as new mothers and situated themselves in-between two distinct cultures: Western (British Asian) and non-Western (Sikh Punjabi and as second-generation immigrants). Choice of narrative(s) was dependent on the nature of their perinatal experience(s) and personal understanding of their experience(s), which was, in turn, informed by their socio-cultural context.

As participants narrated their experiences of PPD, they initially told problem saturated stories (Freeman, Epston & Lobovits, 1997) in the form of classic illness narratives (Kalitzkus & Matthiessen, 2009). Similar to the findings of Wittkowski et al (2012), mothers in the present study used the term depression to capture their perinatal experiences, despite the quality of their emotional experiences having differed considerably and uncertainty around whether their experience was biologically based. Participants narrated theories of biological causation including changes in hormones during the postpartum period. This reflected the degree to which participants have been socialised to the (dominant) medical model of health (Meza, 2018). This is in sharp contrast to Thippeswamy et al's (2015) findings in India who found that only one third of mothers drew on medical narratives. It is possible that this is due to regional differences, as mothers in the UK are more widely exposed to Western discourses which can result in a side-lining of traditional health knowledge (Tripathi & Sinha, 2013).

Research suggests that South Asian patients, particularly Punjabi people, are likely to 'somatise' emotional distress (Anand & Cochrane, 2005; Krause, 1989). Unlike Wittkowski et al (2012), aspects of somatisation were not identified across the accounts in the present study. However, the use of medical narratives by participants did appear to connect to body/self-conceptualisations (see Carter, 2010 & Virk, 2018) and not having felt in control of the PPD. Medical narratives potentially functioned as alleviating felt responsibility and self-blame for the experiences and perceived consequences of PPD.

Similar to Thippeswamy et al (2015) and Mccauley et al (2020), participants used more than one explanatory model when speaking about PPD. For certain aspects of PPD, participants shifted to drawing on the following meta-narratives (Greenhalgh, 2016): faith/Sikhi, spirituality, psychological, and social. Choice of meta-narrative appeared to relate to aspects of stories that felt personally meaningful or significant to participants or seemed to be better captured by the alternative narrative(s). At this point, participants either rejected the initial

medical narrative (adopting an either-or position) or held onto multiple perspectives (adopting a both-and position), using Western (eurocentric and psychiatric) and non-Western ideas (religious, spiritual and/or cultural). This finding corresponds with Jhutti-Johal (2012), who also found that Sikh participants resorted to drawing on a number of belief systems to explain and manage experiences of emotional distress. However, in the present study, participants appeared to attempt and struggle to bridge their two cultures. This coincides with the findings of Rao et al (2020) and Wittkowski et al (2012), conveying an element of cultural clash and uncertainty about the emotional changes they had experienced during the perinatal period.

In line with the systematic literature review (Goyal et al., 2020; Wittkowski et al., 2012), some participants drew on faith and spirituality as an explanatory model and/or coping strategy. Across the accounts, faith and spiritual narratives were similar yet different as there was variation among participant's religious/spiritual beliefs. Participants shared stories of self-transcendence as they connected with the idea of oneness and drew on the concepts of destiny and fate which connects with Sikh beliefs in equality and divine control. Perhaps this had a stress-buffering role for participants (DeAngelis, 2018; DeAngelis & Ellison, 2018) as it can suggest a lack of personal control, power, and responsibility for events. Although some argue that there is an element of moral responsibility in destiny (Chan et al., 2019), which is in line with Sikh doctrine, whereby it is believed that the universe obeys *hukam*<sup>40</sup>, but that God offers people agency and choice to live a moral life (Singh, 2019).

Similar to Mccauley et al (2020), psychological narratives (personality theory and male child preference) and social narratives (complex family dynamics, experiences of mother-baby groups and Gurdwara run playgroups) were also drawn upon by participants when narrating about PPD. Unlike Goyal et al (2020) and Patel et al (2002), participants in the present study

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<sup>40</sup>*Hukam* refers to the will of God (Kalra et al., 2012).

did not report marital disharmony and only one participant reported male child preference (note: three out of four of the participants had sons). Husbands were constructed as either actively involved (researching PMH and/or encouraging help-seeking) or passively involved (not fully understanding PMH and/or not encouraging help-seeking). In line with the work of Rao et al (2020), supportive husbands appeared to make a difference in the sense of sharing the emotional and physical burden that came with the experience of PPD.

In the present study, there was mention of in-law tension (Raman et al., 2014) and intergenerational incongruity (Goyal et al., 2020), particularly in relation to having received conflicting advice about breastfeeding. This links with Patel et al's (2002) work who found that breastfeeding-related issues were risk factors for PMH difficulties. This aligns with the culture conflict hypothesis which is regarded a dominant explanation for distress amongst British South Asian women (Anand & Cochrane, 2005). However, the key role of gender cannot be ignored. Participants conveyed experiences of expectations, pressure, blame and isolation in connection to being a young Sikh Punjabi woman.

Themes of power and agency appeared and reappeared throughout the accounts as participants narrated how their mothers-in-law had taken over childcare. Similar to Raman et al (2014) and Grewal et al (2008), participants told ambivalent stories about motherhood as a family experience and the role of mother being depicted as a 'unit' (biological mother plus family members, particularly the mother-in-law). Family support was referred to as a "*double edge sword*" (Gurpreet) as participants faced criticism from parents and/or parents-in-law about their personal style of mothering. This seemed to result in participants socially withdrawing and experiencing further social isolation, which for some participants exasperated the PPD.

Similar to Grewal et al (2008) and Raman et al (2014), participants described a sense of cultural disconnect when attending community groups and their unfilled needs for connection with

other mothers. Experiences of being (or feeling) negatively judged and alienated (by family, professionals, and the wider community) seemed to have become internalised, manifesting as the belief *'I'm not good enough/I'm not a good mom'*. Across the narratives, maternal blame (Chess, 1982) was a key narrative theme as participants conveyed maternal guilt (Collins, 2021) and shame for their perceived lack of maternal instinct.

Participants narrated stories of the unspeakable. This included that they had experienced thoughts of ending their own lives during PPD but had not felt able to disclose this information to health professionals. In the present study, participants positioned themselves as distrustful and cautious of health professionals but also as dismissed by them during their time of need. The finding resonates with previous studies which have also found that South Asian mothers want support but feel misunderstood and abandoned by professionals, as well as isolated and unsure about who to turn to (Grewal et al., 2008; Wittkowski et al., 2012). In Mccauley et al (2020), mothers felt that healthcare providers do not have the time and/or cannot help them.

Underlining the barriers appeared to be shame and stigma (a finding which connects with Goyal et al., 2020) but also fear of the unknown and undefined consequences to which participants attached negative connotations. This seemed to be the case for all participants, including a participant that works in mental health. PPD was constructed as an untold and untellable experience; something that is hidden to uphold *izzat*. This corresponds with the literature, in which shame and honour are considered risk factors for distress in Sikh women (British Sikh Report, 2018). Previous research with South Asian women shows that PMH is considered a part of one's "personal life" (Mccauley et al, 2020, p7). As South Asian women are symbolised as the carrier of family honour, fear of bringing dishonour inhibits their behaviour(s) (Gilbert, Gilbert & Sanghera, 2004). In the present study, PPD was narrated as being managed internally, without external support (via a collective family approach or through self-management, which corresponds with Goyal et al., 2020). However, external contexts (outside of the family



(collective identity) context) were constructed as allowing participants to position themselves in their preferred (individual) identities.

Towards the end of the accounts, participants told restitution narratives (Frank, 1995). They narrated recovery as a process that was suddenly activated internally, which allowed for resolution to follow. Recovery was constructed as collective recovery which referred to a family experience comprising of growth, achievement, strength, understanding and confidence as a mother and as a unit. During this stage in the accounts, family support was re-storied as supportive with emphasis on family togetherness and collaboration. This conveyed the complexity of family relationships, but also elder respect (Chadha, 1995).

Furthermore, talk about restoration and/or evolution of the self was spoken of alongside elements of chaos narratives, which included residual elements of PPD (e.g., maternal guilt). This corresponds with recent ideas about recovery which have moved away from the traditional biomedical model (see Thornton & Lucas, 2010). Choice of explanatory models sometimes but not always linked to help-seeking and the resources utilised to resolve the PPD. Main coping strategies included behavioural strategies (e.g., trying to behave differently, avoiding sad melodies and scheduling activities), self-care (sleep hygiene), and faith-based (prayer and referring to scripture). As they narrated quest narratives (Frank, 1995), participants demonstrated *chardi kala* and in line with the *miri-piri* concept, conveyed an activist spirit as they spoke about having started or planning to perform *sewa* in the field of PMH. Participants also mentioned choosing to break the silence about their personal experiences of PPD (although this was limited with certain details still being excluded). Participants offered narratives of resilience and hope and developed a self-narrative in which they viewed themselves as influential.

### **4.3 Quality assessment**

Tracey's (2010) eight 'big tent' criteria for quality in qualitative research was used as a framework to inform and guide the research design for the current study (see section '2.7.5 Quality of the assessment' and appendix N).

#### **4.3.1 Strengths of the research**

One strength of this study is that four lengthy interviews (of 3 hours or more) per participant were completed as part of this research. This allowed for developing rapport and trust (including transparency from the researcher with regards to the motivation behind the research), provided time for participants to carefully consider their thoughts and feelings, and thereby collate detailed authentic accounts. This connects with a further strength of the study, which was the shared culture and religion between the researcher and participants. This allowed for participants to move between speaking English and Punjabi, to draw on religious and cultural discourses, to best capture and communicate about their experiences and understandings of PPD. Participants shared that for them, being interviewed by someone of the same community aided the research process. It is important to note that it is possible for shared culture to create an "illusion of sameness" (Pitman, 2002, p285). To avoid assuming shared understandings, participants were encouraged, where possible, to expand and share their personal interpretations of the concepts/terminology they were using. Additionally, the researcher kept a reflective diary throughout the research process (to consider which aspects belonged to her versus the participants) and held consultations with the research team and research consultants as well as members of the Sikh Punjabi community who were recruited via word of mouth.

A key strength of this study is that the stories shared by the participants had been constructed as untold and (prior to the study) untellable. Their accounts have highlighted the degree of distress experienced and endured without the assistance and support of health professionals.

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The accounts demonstrate the heavy limitations of PMH services in the UK in relation to inequity and inequality in the use of PMH care. Participants kindly offered suggestions for service improvements. Their suggestions have been honoured and included in section ‘**4.5 Implications**’.

#### **4.3.2 Limitations of the research**

It is important to note that the present study had a small sample, consisting of four second generation Sikh Punjabi women between the ages of 30 to 40. Whilst common narrative threads were identified across the narratives, they may not reflect the wider female Sikh Punjabi community’s sense-making and identity constructions around PPD.

Furthermore, full socio-demographic information was not collected, including finances, religiosity<sup>41</sup>, class, and caste<sup>42</sup>. The importance of asking about religiosity became apparent during the interview stage as one participant (Amarleen) identified as Sikh during screening but shared in the research interview that whilst she was brought up in a religious household, she now identifies as an Atheist. Such demographics have the potential to influence experiences, understanding and management of PPD. Although, one could argue that identity is complex (Sikh religious identity versus Sikh ethnic identity) and can change depending upon life circumstances.

A further limitation of the study includes that the research was conducted amidst the COVID-19 pandemic during which in-person recruitment was not possible. As this study largely

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<sup>41</sup>Religiosity can be defined as *Amritdhari* Sikhs (“baptised” Sikhs) and *Sahajdhari* Sikhs (practicing but “non-baptised” Sikhs).

<sup>42</sup>Caste was not inquired about because Sikhism is an egalitarian faith which denounces the caste system as it is considered to be a form of oppression. However, caste identity and caste-based stereotypes are constructed in society (Jaspal, 2011; Jaspal & Takhar, 2016).

involved recruiting participants online using social media, it is possible that the study may only have accessed a small proportion of the Sikh Punjabi community, especially given the digital divide caused by internet poverty (Kelly, 2020). This is considered further under the section **‘4.7 Future research’**.

The potential influence of shame and stigma on the content offered by participants as part of their narrative accounts cannot be ignored. For example, it was noted in one interview that certain details (in connection to the behaviour of a mother-in-law) were initially being omitted in comparison to how readily the same information had been offered during the initial telephone screening. In the interview, the participant reported that they could not remember what had happened next in the story. Perhaps the participant(s) felt the need to censor narratives due to the interview being audio and video recorded, to avoid becoming tearful again, ambivalence about sharing personal information, or they had simply forgotten. Later, in the interview, the participant shared the missing detail which corresponded with the account provided during screening. Due to time constraints, I was unable to clarify the study findings with the participants and I am mindful that “our narratives about others’ narratives are our worldly creations” (Reissman, 1993, p15).

It was very important to me that I represented the women’s stories as closely as was possible (whilst holding in mind that I was shaping the stories throughout) and more specifically, that I captured and reflected in my writing the complexity of the distress experienced by the women. Therefore, in my writing there are shades of light and darkness interwoven. This can be seen more clearly in the final main story of **‘I allowed myself to grow and get strength from this: Stories of growth’**, whereby aspects of resolution, growth and development is described alongside residual distress and difficulties that the women still face. I was committed to making my critical realist social constructionist position transparent in this research. Therefore, the shades of light and darkness in my writing are potentially intentional as I was consciously

attempting to stay connected with the complexity of the PPD and not simplify the experiences, and to cast a spotlight on the need and importance to invest in and improve understanding and support for minoritised women. Traditional research approaches would argue that such closeness to a topic and experience is a limitation but from a critical realist social constructionist position, it would be considered a strength.

#### **4.4 Significance**

This is the first study to explicitly explore Sikh Punjabi women's experiences of PPD and how they make sense of and navigate their experiences. Thus, the findings contribute qualitative data to an area of limited research.

Existing research shows that perinatal services are underutilised by South Asian women but also, that perinatal services do not offer specific provisions for racially minoritised women. To improve access of perinatal services and offer more culturally inclusive perinatal care, decolonisation research initiatives such as this study aid the process. Whilst it is acknowledged that the findings of this study are based on a small sample, they are informed by the Sikh Punjabi mothers lived experiences of PPD which have included significant distress, social isolation, lack of professional support and thoughts of ending their own/baby's lives. Therefore, this study is of importance as it gives space to these mothers' perinatal experiences, biopsychosocial-spiritual care needs, and barriers to help-seeking (see section '**5.5 Implications**' for more detail).

Since the completion of the present study, further (informal) research initiatives have been identified on social media platforms, which seek to explore and encourage conversations around mental health and PMH experiences of the Sikh Punjabi community. It has been noted that the narrative themes, stories, and sub-stories identified in the present study correspond

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with the social media posts by Sikh Punjabi women in which they narrate their views and experiences.

#### **4.5 Implications**

The findings indicate that improvements are required across clinical, community and related perinatal settings. Albeit important, it is beyond the scope of this thesis to consider the potential changes required on a wider political level.

Based on the findings of the present study (screening and interviews), and drawing on the literature, alongside having worked in a community PMH service and spoken with Sikh Punjabi mothers in the community, the below suggestions are proposed to staff working in relevant settings.

#### **Tune into language and frames of understanding**

In the present study, participants narrated how professionals frequently used medical terminology and assumed both understanding of terms and aspects of their experiences. Professionals were constructed as going into textbook mode (Harmeet) and following tick-box lists (Charan). It is suggested that professionals conduct holistic assessments to allow space for Sikh Punjabi service-users to consider and narrate biopsychosocial-spiritual narratives, cultural identities (see Holliday, 2010), and intergenerational trauma (see Tatla, 2006). As stated by Holmes (2000, p96), we need to “attend as closely to the patient’s story and context”. The content of appointments should be tailored to the person in the form of weaving in their language and frames of understanding and (where possible) incorporation of their preferred healing resources.

### **Discuss the resources before handing them over**

Participants reported that they did not know about the emotional changes that can take place during the perinatal period and there appeared to be strong ideas around maternal instinct and what being a good mother in a Punjabi family looks like. It is suggested that professionals share information with mothers-to-be about how they may feel during the perinatal period. Sources of support need to be provided so that mothers can access advice and build connections with other mothers in the local community. If information regarding support is provided to mothers, it is important to check with service-users if they would access the discussed sources of support. Similar to Edge (2011), one participant reported feeling dismissed when given leaflets without any conversation about the content of the leaflet. Culturally-adapted leaflets can be useful (see Bhugra & Hicks, 2004), but should be discussed with service-users prior to being handed-out and only given to the service-user if they consider it to be relevant.

### **Speak about stories of the unspeakable (sensitively)**

It was mentioned by participants that they faced many barriers to seeking help which manifested as tears, lying and/or silence in appointments. Participants narrated that professionals “*shut-off*” (Harmeet)/“*switch-off*” (Charan) which resulted in disengaging from services. If a service-user is not forthcoming with information in an appointment, it is suggested that professionals consider asking a yes or no question about whether there is something important to them that they feel unable to talk about, and whether they might require more time (or something else) before they are ready to disclose the information. Professionals should clarify where information will be stored and who will have access to the information as concerns about trust and confidentiality have also been identified in previous studies as a key barrier to help-seeking (Gilbert et al., 2004; O’Mahony & Donnelly, 2007).

### **Is the support supportive?**

Participants described a general lack of responsiveness and follow-up by health visitors and general practitioners (GPs). One participant narrated “*breaking down in tears*” (Gurpreet) in a GP appointment, which resulted in being given a leaflet about postnatal depression whilst another participant weaned herself off Sertraline medication (Amarleen). Recommendations state that professionals should offer a combination of support including support groups and befriending (RCGP, 2017), review appointments should be discussed and planned to allow for monitoring (NICE, 2014), and if there are concerns about risk, professionals should assess whether the woman has adequate social support and is aware of sources of help (NICE, 2014).

Additionally, some participants, although not all, narrated that they would have liked the option to see a professional of the same cultural background to aid the process. This points towards the importance of a collaborative and empowering approach and open communication with women, ensuring they are well-informed and have agency in identifying what will best meet their needs but also are aware of their rights and that they can request further information and permission to be touched. Other participants expressed that they would have preferred professionals to include their partners in their care and support. For the latter, professionals may wish to consider talking with new fathers and providing fathers with information (about pre- and post-pregnancy changes) and the option to access support for themselves and/or in relation to how best to support the mother during the perinatal period.

### **Access to care is important but what about service delivery?**

Staff in perinatal-related services are encouraged to practice cultural humility (Foronda et al., 2016) so that they are better placed to notice and respond to the cultural nuances of service users’ experiences and expressions and provide culturally sensitive services. However, it is also encouraged that staff in perinatal-related services be reasonably culturally competent



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(Tseng et al., 2005 cited in Rathod et al., 2015; Khan, 2021), whereby they hold *some* knowledge of cultural practices and beliefs of local ethnically diverse groups in the community. Clinicians hold a responsibility to educate themselves to a degree about cultural and faith practices, and should be continually striving to be better informed, so as to offer sensitive and suitable services, whilst still seeing service-users as the experts of their experience.

Staff training by trained Sikh Punjabi mental health professionals is strongly encouraged to decolonise perinatal practice and improve access and service-provision for Sikh Punjabi women. Some suggestions for resources to share in training include, but are not limited to, the models outlined in table 21.

**Table 21.** Suggested resources for clinical work with Sikh Punjabi mothers

| <b>Stage<sup>43</sup></b> | <b>Resource</b>   |
|---------------------------|---|
| Assessment                | The model of perinatal psychological distress (figure 3)  |
|                           | The cultural formulation interview (APA, 2013; Fernandez & Diaz, 2002)                          |
|                           | Social graces (Burnham, 2012)   |
|                           | LUUUT model (Pearce & Pearce, 1990)   |
| Formulation               | The biopsychosocial-spiritual model (see Hatala, 2013)  |
|                           | The Sikh model of counselling (see Singh, 2008)   |
|                           | The Sikh model of the person, suffering and healing (see Sandhu, 2004)                          |
| Intervention              | The Sikh model of counselling (see Singh, 2008)   |
|                           | The Sikh model of the person, suffering and healing (Sandhu, 2004)                              |
|                           | Framework for culture competent psychotherapy (Tseng et al., 2005 cited in Rathod et al., 2015) |
|                           | Framework for cultural humility (Lekas, Pahl & Lewis, 2020; Khan, 2021)                         |

<sup>43</sup>In clinical practice, assessment sessions may act as both assessment and intervention, and vice versa. Stages have been set out here for ease of communication.

Review | The model of perinatal psychological distress (figure 3)

### **We need to address mental health stigma in the community**

Across the accounts, there appeared to be instances of public stigma and self-stigma (Latalova et al., 2014). Participants constructed mental health as a “*taboo*” (Charan), consisting of negative stereotypes (e.g., family members assumed that mental health interventions are delivered in an “*institution*” - Amarleen) and stigmatising language (e.g., “*pagal*”<sup>44</sup> - Amarleen), which corresponds with the findings of Memon et al (2016).

Furthermore, participants appeared to convey guilt and shame over having experienced PPD and the perceived negative consequences of PPD. Initiatives are required in the community (Byrne, 2000), perhaps in Gurdwaras and family centres, where trained Sikh Punjabi mental health professionals and Sikh Punjabi experts by experience can together provide, or support in the provision of, holistic and culturally sensitive PMH education and information packages (for staff and the community), as well as a safe space for women and families to engage in discussions and questions about PMH and options for support. It is encouraged that within these spaces, professionals interweave opportunities to address and challenge myths and negative stereotypes, and not only normalise mental health distress but humanise the experience using a compassionate approach that makes clear that stigma is a social injustice that deeply harms individuals and concerns us all (Corrigan, Roe & Tsang, 2011).

### **Spirituality and religion within clinical psychology**

The variety of explanatory models used by the women in the present study emphasises the complex bio-psycho-social-spiritual layers of these women’s perinatal experiences, which

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<sup>44</sup> *Pagal* in Punjabi means crazy/mad.

were neglected by services and professionals, thereby impacting access and engagement with services. Best practice guidance (Department of Health, 2009) encourages clinicians to consider the spiritual and religious needs and beliefs of service-users, stating that it can contribute to wellbeing. Yet despite such guidelines, clinical psychology has been slow in recognising that as part of good practice clinicians should be addressing the spiritual and religious concerns of their service-users. There exists a lack of training and guidance within the profession on how clinical psychologists can effectively engage in and incorporate dialogue and reflection about spirituality and religion into clinical practice in a way that feels constructive and manageable. The present study highlights the need for the field of clinical psychology to improve training and guidance in this area.

#### **4.6 Dissemination**

The study was discussed on a radio interview to raise awareness about PMH and the support that is available to mothers. Individuals were directed to visit the study website which included contact information for sources of support. The findings of the study have also been presented and discussed at a community perinatal service team meeting, which comprised of predominantly White British professionals (psychology staff, psychiatrists, nurses, nursery nurses and social workers). After sharing the study findings, one staff member reflected on their experience of working with Punjabi patients and concluded that they think that Punjabi patients “do not understand mental health”. There was a sense of unfamiliarity with the idea that Punjabi patients may experience and/or describe mental health experiences differently to their white counterparts, and that sometimes some experiences and/or understanding may be best captured using Punjabi which can be difficult to translate accurately into English. Further staff responses included acknowledgement that their perinatal service is accessed largely by White British service-users and uncertainty around how to improve access for racially minoritised mothers. One doctor shared that they frequently handed out leaflets to service-users

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and had not considered the need to jointly review the leaflets and offer the opportunity to ask questions.

The presentation left me with questions, which I have shared as they may be useful for perinatal teams to consider (see figure 4).

**Figure 4.** Questions for perinatal teams

- ❖ Where is race and culture set out as a clear agenda in this service?
- ❖ How is the team attempting to increase access to the service for racially minoritised women?
- ❖ How is the team going about attempting to provide culturally sensitive care and support to racially minoritised women?

Further plans for dissemination include publication in a peer reviewed journal, sharing research summaries with Sikh Punjabi mental health organisations and perinatal (and related) services, and presentation of the research findings at the Life of Medical Science's 2022 research conference at the University of Hertfordshire.

To account for the limited literature on this topic, the model of perinatal psychological distress (figure 3) along with the grab sheet (appendix O) has been produced to encourage consideration of the research findings within perinatal settings. There are hopes for further resources to be co-produced with mothers from Sikh Punjabi backgrounds with experiences of PPD. Resources will be informed by the current research project and an extension of the current research project which is currently in discussion with scholars. Ideas for additional resources include a) information about how Sikh Punjabi mothers may feel during the perinatal and postpartum period, b) how and where culturally sensitive mental health advice and support can be accessed, c) self-help materials, and c) a myth busting resource that outlines the limits of confidentiality but also mothers' rights with regard to procedures and being touched.

#### **4.7 Future research**

Firstly, as the current study is based on a small sample, future research could include a national survey to determine the extent to which the findings are representative of Sikh Punjabi mothers in the UK.

Secondly, it is striking that three out of four participants interviewed in the present study spoke about having experienced thoughts of ending their own life. Not one participant disclosed their thoughts and distress to professionals. The resolution of their distress followed sudden internal activation of drive and hope. The findings indicate that racially minoritised mothers that require perinatal support are not receiving it, and this has been previously documented by Redshaw and Henderson (2016) and widely discussed in the South Asian community following the death of Nima Bhakta, a new mother that ended her own life after struggling with her mental health postnatally. It seems that we have a long way to go before the ambitions set out in the NHS long-term plan for the provision of inclusive perinatal support are achieved.

Research shows that mothers that end their own lives during the perinatal period often have been found to have had no active intervention (Howard & Khalifeh, 2020). Therefore, it is imperative that future research expands on the present findings, particularly the sub-story 'Stories of the unspeakable'. This could help inform how Sikh Punjabi mothers would wish their appointments to be framed so that they feel able to not only access support but benefit from it, which in turn, would benefit the infant and family.

#### **4.8 Conclusion**

Minoritised women and their babies are more likely to die during childbirth or within the first year of their baby's life compared to white women and their babies in the UK (PHE, 2020; Birth Rights, 2022). There is an urgent need to improve health outcomes for the groups these women represent.

The present study highlights the barriers to better health outcomes for women and babies from Sikh Punjabi backgrounds, and there are implications for both community and health services. Throughout this chapter, important changes have been outlined, including to speak with women about stories of the unspeakable (sensitively), to assess whether women have adequate support and are aware of additional sources of help, and ensure that women are aware of their rights.

It is hoped that by addressing the barriers to help-seeking and supporting services to become more culturally sensitive and confident in working with diversity, health outcomes for Sikh Punjabi women can be improved. This research is a step towards beginning to address these issues.

#### **4.9 Final reflections**

Whilst working in a PMH service during my final year of doctoral training, I noticed a lack of ethnic diversity amongst service users accessing the community service versus the inpatient unit. I also noticed an absence of culturally informed assessments, resources, and interventions for those that did access the community service. In addition, race and ethnicity were scarcely mentioned during MDTs and case discussions, and these demographics were frequently not recorded in patient records. I was left wondering to what degree my experience of the service reflected the experiences of racially minoritised women.

During this research I have felt struck by the tears and frustrations expressed by the Sikh Punjabi women that came forward and shared (some for the first time) their stories of PPD with me over the course of this study. Their accounts felt raw and pained. I hope during our time together that they felt heard. I am left thinking about the women that disengaged from the study, had not felt able to contact me and/or are no longer with us whose perinatal stories will remain untold.

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The process of completing this study has been a transformative experience for me personally. I have valued the opportunity to embed myself in a topic that is under researched. It has felt like a positive contribution to the field of perinatal mental health but also the Punjabi community, and a step towards addressing inequities in accessing health services. Over the course of this study, I have gained insight into the barriers to help-seeking that Punjabi women and families face. The project has left me not only with a greater sense of openness and sensitivity to cultural nuances, but it has strengthened my determination and confidence to meaningfully engage with and integrate issues of diversity into my day-to-day clinical practice to improve access and outcomes for minoritised people. I feel motivated to use this study as a platform to conduct further research in this area, to disseminate the findings in community, clinical and academic spaces, and encourage and support multidisciplinary teams to reflect on and engage with these important issues.

My clinical work alongside this research study has stressed to me the need for innovation and change in perinatal (and related) services in the UK to shift the stuckness and work towards offering more inclusive care and support that bridges the existing policy-practice gap. Perinatal services and clinicians are invited to be responsive and carefully consider the diverse needs of racially minoritised women that they have a duty of care towards.

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## **APPENDICES**

## Appendix A: Full systematic review quality assessment (Tracy, 2010)

### Key:

| Score | Meaning              |
|-------|----------------------|
| 0     | Absent               |
| 0.5   | Somewhat present     |
| +     | Present              |
| ++    | Sufficiently present |

| Article  | Worthy topic?                                    | Rich rigour?  | Sincerity?  | Credibility?   | Resonance?  | Significant contribution?   | Ethical?  | Meaningful coherence?  |
|--|--|---|---|--|---|---|---|--|
| Wittkowski et al., (2011). The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study. | ++<br>Relevant, timely, significant, interesting | +<br>Appropriate theoretical constructs. Sample outlined. Context and recruitment process not mentioned. Data collection and analysis process is clear. | ++<br>Self-reflexivity included in methodology section and challenges.    | +<br>Thick description, concrete detail. No triangulation with participants or EbE but consulted with research team. | +<br>Naturalistic generalisations. Transferable findings.   | ++<br>Significant contribution conceptually, theoretically, practically, morally.                                     | +<br>Ethical standards adhered. Mention of procedural ethics <sup>45</sup> and some relational ethics <sup>46</sup> . | ++<br>Achieved aim. Method and procedure fit the goal. Connection with literature.                                 |
| Goyal et al., (2020). Psychiatric morbidity, cultural factors, and health seeking behaviour in perinatal women:                        | ++<br>Relevant, timely, significant, interesting | ++<br>Sample outlined. Date and time in field mentioned. Data collection, recruitment process and analysis process is clear.                            | +<br>Lack of self-reflexivity. Transparency about methods and challenges. | +<br>Description in table (verbatim included). Text is mainly telling what the data                                  | +<br>Transferable findings: participant language used to describe and understand difficulty; considerations around barriers to care and | +<br>Contributes to literature on conceptualisations of difficulty and help seeking among mothers of Indian heritage. | +<br>Ethical standards adhered. Brief mention of procedural ethics.   | +<br>Achieves aim. Uses methods and procedures that fit the goals. Connects with some literature. Implications and |

<sup>45</sup> Procedural ethics refers to formal approval procedures (Reid et al., 2018; Tracy, 2010).

<sup>46</sup> Relational ethics refers to awareness of researcher actions on others (Reid et al., 2018; Tracy, 2010).

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|   |  |   |   | showing<br>(quantitative form).  | what kind of help<br>would be useful.  |   |  | recommendations<br>missing.   |
|---|--|---|---|--|--|---|--|---|
| Iyengar, Pelto & Iyengar (2016)<br>Huwa Rog, Parhej and Desi Dawai: women's perceptions of postpartum maternal morbidity and care in Rajasthan, India | ++<br>Relevant, timely, significant, interesting | +<br>Sample outlined but some demographic data missing. Date and time in field mentioned. Recruitment process vaguely mentioned. Data collection and analysis process outlined.   | +<br>Lack of self-reflexivity. Transparency about methods and challenges.   | ++<br>Description in table (verbatim included). Semi-structured interview followed by in-depth case interview and collected data with regard to identified theme.  | ++<br>Transferable findings: participant language used to describe and understand difficulty; considerations around cultural beliefs and behaviour patterns.               | ++<br>Contributes to literature on cross-cultural models of health and illness.   | ++<br>Ethical standards adhered. Mention of procedural ethics and exiting ethics whereby some participants were referred on to access support. | ++<br>Achieves aim. Uses methods and procedures that fit the goals. Connects with literature. |
| Thippeswamy et al., (2015)<br><br>What is in a name? Causative explanatory models of PP among patients and caregivers in India                        | ++<br>Relevant, timely, significant, interesting | +<br>Appropriate theoretical constructs. Sample outlined (except whether first mother or faith). Context and recruitment process mentioned. Data collection process is described but paper mentions content analysis and thematic analysis – unclear. | 0.5<br>Lack of self-reflexivity. Some transparency about methods but lack of limitations and challenges.            | ++<br>Open ended interview used with women and care givers. Description and verbatims included. Lack of member reflections but mentions that themes were discussed and finalised with other researchers. | ++<br>Transferable findings: participant language used to describe and understand experiences; considerations around explanatory models and association with help seeking. | ++<br>Contributes to literature on cross-cultural models of postpartum psychosis which is under-researched.   | +<br>Ethical standards adhered. Mention of procedural ethics.  | ++<br>Achieves aim. Uses methods and procedures that fit the goals. Connects with literature. |
| Rao, Dahlen & Razeq (2020)<br><br>Indian migrant women's experiences of motherhood and postnatal support in Australia: a qualitative study            | ++<br>Relevant, timely, significant, interesting | +<br>Appropriate theoretical constructs. Sample outlined (except whether first mother or faith). Date and time in field mentioned. Context, recruitment process and data collection clearly outlined.   | ++<br>Self-reflexivity and use of reflection as part of research process. Transparency about method and challenges. | ++<br>Semi structured interview used with women. Description and verbatims included. Lack of member reflections but mentions that themes were discussed and finalised with other researchers.            | ++<br>Transferable findings and highlights areas for important consideration of professionals.   | ++<br>Significant contribution conceptually, theoretically, practically, morally around experiences of motherhood, challenges and needs.                        | +<br>Ethical standards adhered. Mention of procedural ethics.  | ++<br>Achieves aim. Uses methods and procedures that fit the goals. Connects with literature. |
| Patel, Rodrigues & Desouza (2002)<br><br>Gender, poverty, and postnatal depression: a study of mothers in goa, India                                  | ++<br>Relevant, timely, significant, interesting | ++<br>Appropriate theoretical constructs. Sample outlined (except whether first time mother or faith). Date and time in field mentioned. Context, recruitment process   | +<br>Lack of self-reflexivity in paper. Transparency about method but no mention of challenges.                     | 0<br>Semi structured interview used with women. No description or verbatim. Lack of member reflections. Interpretation of the  | +<br>Useful findings. Not directly transferable but indirectly transferable.   | +<br>Useful contribution to the literature around gender bias in Indian society, and gender-based factors and postnatal depression in women of Indian heritage. | +<br>Ethical standards adhered. Mention of procedural ethics.  | +<br>Achieves aim. Connects with literature.  |

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

|   |  |  |  |   |   |  |   |   |
|---|--|--|--|---|---|--|---|---|
|   |  | and data collection clearly outlined.  |  | data outlined in the paper.   |   |  |   |   |
| Grewal, Bhagat & Balneaves (2008)<br><br>Perinatal beliefs and practices of immigrant Punjabi women living in Canada.   | ++<br>Relevant, timely, significant, interesting | +<br>Relevant theoretical constructs, Date, and time in the field missing, some information about sample (missing information: their religion, gender of infant)             | +<br>Mentions backgrounds of interviewers and who reviewed tapes and transcribed the data. Lack of self-reflexivity. Transparency about method and challenges. | +<br>Thick description of results with concrete examples. Lack of member reflections.   | ++<br>Evocative representations, Naturalistic generalisations. Transferable findings  | ++<br>Significant contribution conceptually and theoretically. Only paper looking at perinatal mental health of Punjabi women.   | +<br>Ethical standards appear to have been adhered. No mention of ethics. | ++<br>Achieves purpose. Method and procedure fit the goal. Meaningfully connects with literature. |
| McCauley et al., (2020)<br><br>'Good health means being mentally, socially, emotionally, and physically fit': women's understanding of health and ill health during and after pregnancy in India and Pakistan: a qualitative study. | ++<br>Relevant, timely, significant, interesting | ++<br>Relevant theoretical constructs. Date and time in the field missing. Detailed demographic information.   | 0.5<br>Very briefly mentions background of interviewers. Lack of self-reflexivity. Transparency about method and briefly comments on challenges.               | ++<br>Thick description of results with concrete examples. Lack of member reflections. Data reviewed by different researchers and then the themes were reviewed by the research team. | ++<br>Evocative representations, Naturalistic generalisations. Transferable findings. | ++<br>Significant contribution conceptually and theoretically. Lack of literature looking at health and ill health.  | +<br>Ethical standards adhered. Brief mention of procedural ethics.       | ++<br>Achieves purpose. Method and procedure fit the goal. Meaningfully connects with literature. |
| Raman et al., (2014)<br><br>My mother... my sisters... and my friends: sources of maternal support in the perinatal period in urban India.  | ++<br>Relevant, timely, significant, interesting | +<br>Relevant theoretical constructs. Date and time in the field stated. Demographic information included but no mention of age range, faith and whether first time mothers. | 0.5<br>Lack of self-reflexivity. Transparency about method but no mention of challenges.   | +<br>Thick description of results with concrete examples. Lack of member reflections.   | ++<br>Evocative representations, Naturalistic generalisations. Transferable findings. | ++<br>Significant contribution conceptually and theoretically. Produced model detailing sources of support accessed by Indian women at points in time over the perinatal period. | +<br>Ethical standards adhered. Brief mention of procedural ethics.       | ++<br>Achieves purpose. Method and procedure fit the goal. Meaningfully connects with literature. |
| <i>T</i> =  | 18 out of 18                                     | 12 out of 18   | 9.5 out of 18  | 13 out of 18  | 15 out of 18  | 16 out of 18   | 10 out of 18  | 16 out of 18  |



**Appendix B:** Recruitment advert created for social media

# ARE YOU A PUNJABI MOTHER WILLING TO TAKE PART IN A STUDY?

After giving birth, did you feel confused? Did you hear, see, feel or smell things that were not there? Did you have racing thoughts or new beliefs which in that moment could not be true?

If you experienced any of the above, we would be keen for you to be part of our study. The study involves a 60 minute interview about your experiences and views. The conversation will be confidential and you are only required to share what you feel comfortable sharing.

This study is being undertaken to advance an improvement in how maternal mental health is understood and treated as well as how to effectively tackle the stigma within the community.

PLEASE GET IN TOUCH WITH JASDEEP IF YOU WOULD LIKE TO TAKE PART OR IF YOU WOULD LIKE TO KNOW MORE ABOUT THE STUDY.

JASDEEP (PRINCIPAL INVESTIGATOR, IS A TRAINEE CLINICAL PSYCHOLOGIST WORKING IN THE NHS):  
JG18ACF@HERTS.AC.UK  
07840 459 855

**University of  
Hertfordshire UH**

This study has been reviewed by the University of Hertfordshire ethics board and is part of my Doctorate in Clinical Psychology. Protocol no: aLMS/PGT/UH/04228(1).

# Project Maternal

A study exploring maternal mental health within  
the Punjabi community in the UK.

|  |      |       |         |            |     |  |
|--|------|-------|---------|------------|-----|--|
|  | Home | About | Support | Contact us | 🐦 @ |  |
|--|------|-------|---------|------------|-----|--|

## ARE YOU A **PUNJABI** MOTHER WILLING TO TAKE PART IN A STUDY?

**After** giving birth, did you feel confused? Did you hear, see, feel or smell things that were not there? Did you have racing thoughts or new beliefs which in that moment could not be true?

If you experienced any of the above, we would be keen for you to be part of our study. The study involves a 60 minute interview about your experiences and views. The conversation will be confidential and you are only required to share what you feel comfortable sharing.

This study is being undertaken to advance an improvement in how maternal mental health is understood and treated as well as how to effectively tackle the stigma within the community.

PLEASE CONTACT JASDEEP IF YOU WOULD LIKE TO TAKE PART OR IF YOU WOULD LIKE TO KNOW MORE ABOUT THE STUDY.

JASDEEP (PRINCIPAL INVESTIGATOR, IS A TRAINEE CLINICAL PSYCHOLOGIST WORKING IN THE NHS):  
JG18ACF@HERTS.AC.UK  
07840 459 855

**University of Hertfordshire UH** This study has been reviewed by the University of Hertfordshire ethics board and is part of my Doctorate in Clinical Psychology. Protocol no: aLMS/PST/UH/D4228(7).

### Can I take part?

Are you based in the UK? After giving birth, did you have any of the experiences listed in the advert? Did you give birth more than a year ago? If so, you may be eligible to take part. You can contact me through the details provided in the advert above or click [here](#) to leave me a message.

### What will the study involve?

This study will involve arranging a time for us to speak in confidence about your experiences and views. You are only required to share with me what you feel comfortable sharing. Your participation would take around one hour. I can speak with you over the phone or using Skype at a date and time most convenient for you.

# Project Maternal

A study exploring maternal mental health within  
the Punjabi community in the UK.

[Home](#)

[About](#)

[Support](#)

[Contact us](#)

[Twitter](#) [Instagram](#)

## For support, there are some organisations and resources listed below that you can access:

### Your GP

Please consider contacting your GP if you are feeling low or anxious.

### Psychological Therapies

If you think that you may benefit from engaging in a talking therapy (such as cognitive behavioural therapy), then you may wish to consider self-referring to your local psychological therapies service, or asking your GP to refer you.

To find your nearest service, you can search on the NHS choices webpage:

[https://www.nhs.uk/Service-Search/Psychological-therapies-\(APT\)/locationSearch/10008](https://www.nhs.uk/Service-Search/Psychological-therapies-(APT)/locationSearch/10008)

### NHS Choices

If you're worried about an urgent medical concern, call 111 and speak to a fully trained adviser.

Website: <https://www.nhs.uk/pages/home.aspx>

Helpline: 01135 250 000

### Samaritans

This is a 24/7 free and confidential helpline for anyone experiencing any emotional distress.

Freephone: 08457 909 090

Website: [www.samaritans.org](http://www.samaritans.org)

### PaNDAS

For peer-to-peer support for you, your family and your network.

Website: <https://pandasfoundation.org.uk/>

Helpline: 08001 981 776

### Tommy's

For a team of in-house midwives who offer free support and information at any stage of pregnancy and after birth.

Website: <https://www.tommys.org/>

Email: [midwife@tommys.org.uk](mailto:midwife@tommys.org.uk)

### Maternal Mental Health Alliance

For guidance on Covid-19 and maternal mental health.

Website: <https://maternalmentalhealthalliance.org/news/mmba-members-offer-reassurance-amid-coronavirus-outbreak/>

### Baby Buddy by Best Beginnings

You can download the Baby Buddy app for a free interactive pregnancy and parenting guide.

Download here:

<https://www.bestbeginnings.org.uk/baby-buddy>

### Cysters

This is a charity offering information and support around reproductive health and mental wellbeing. Cysters run community projects including chai and chat meetings.

Website: <http://cysters.org/>

### Action on Postpartum Psychosis

For information about treatment and recovery.

Website: <https://www.apo-network.org/what-is-pp/getting-help/>

Please note that Project Maternal is in no way affiliated with any of the above organisations.

## Appendix D: Participant information sheet

### INFORMATION SHEET

**Project Maternal: A study looking at Punjabi mothers lived experiences of psychological distress during the perinatal period.**

**Research team: Jasdeep Kaur Grewal, Lizette Nolte and Nic Horley**

You are invited to take part in this research study about maternal mental health within the Punjabi community. This study is being undertaken as part of a Doctorate in Clinical Psychology qualification at the University of Hertfordshire. The study is being led by Jasdeep Kaur Grewal (Trainee Clinical Psychologist). The following information outlines what the study involves. Please take the time to read this information sheet carefully before you decide to participate. If you have any questions or would like further information, please do not hesitate to contact Jasdeep on the details provided at the end of this information sheet.

#### 1. What is this study about?

This study is about listening to Punjabi mothers who have had some of the experiences listed in the purple box below during and/or after pregnancy. Therefore, this study is open to mothers that identify with the experiences listed. If you accessed mental health services at the time of your experiences, your experiences may (or may not) have been diagnosed. **Please note:** having a diagnosis is not necessary to take part in this study.

#### What is 'psychological distress'?

Psychological distress is a state of emotional suffering. It refers to the different kinds of difficult or unusual experiences that may be associated with mental health problems or psychiatric diagnoses (such as depression and anxiety).

#### Experiences can include:

- Feeling low, worried, or confused,
- New beliefs which in that moment could not be true,
- Hearing, seeing, feeling or smelling things that others could not hear, see, feel or smell,
- Very busy mind or racing thoughts,
- Trouble sleeping or not feeling the need to sleep,
- Feeling suspicious of other people's motives,
- Dark thoughts or urges

#### 2. What is the purpose of this study?

Mother-baby units and community perinatal services aim to be as helpful as possible. The purpose of this study is to hear the experiences and opinions of mothers that have had experiences that may or may not have been diagnosed as postpartum psychosis. A key aim of this study is to increase our knowledge and understanding of Punjabi maternal mental health and Punjabi mothers' views on services and support.

#### 3. Do I have to take part?

You are under no obligation to take part in this study. Participation is entirely voluntary. If you do decide to take part, you will be asked to sign a consent form after confirming that you have read this information sheet. Agreeing to take part in this study does not mean that you have to complete the study. You have the right to withdraw from the study up until the point of when data has been analysed. You will not need to give a reason to withdraw your data from the study. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment, care or support that you may be receiving.

#### 4. Are there any age or other restrictions that may prevent me from participating?

To take part in this study, you will need to be over the age of 18; identify as Punjabi; speak English and have a minimal understanding of Punjabi; identify with some of the experiences outlined in section 1; be willing to share some of your motherhood journey experiences and feel safe enough to do so. Please know that what you share and how much you share would be entirely your choice and you can decline to answer a question.

#### 5. How long will my part in the study take?

If you decide to take part in this study, the interview will take about 60 minutes in total. The interview will be held over the phone or online using Skype at a date and time convenient for you.

#### 6. What will the study involve?

The first stage of the study involves a brief telephone call during which you will be asked a couple of background

questions (such as your age, number of children, etc). The second stage of the study involves an interview which will last between 60 to 120 minutes. The interview consists of a few questions about your motherhood journey and your views and opinions on treatment and support. After the interview, there will be a debrief which provides you with the opportunity to share how you found the interview. The debrief also reminds you of your right to withdraw from the study and provides you with contact details should you later have any questions or concerns relating to the study.

**7. What are the benefits of taking part?**

The study will provide Punjabi mothers with the opportunity to share their experiences and views of services. It will provide us with a greater understanding of the needs and expectations of Punjabi mothers. This information may be used to inform services, training and resources offered at mother-baby units, perinatal services and beyond.

**8. What are the possible disadvantages of taking part?**

During the interview you will be asked some questions about your experience(s) of psychological distress and support during your motherhood journey. Although none of the interview questions should cause you any stress, there is a possibility that individuals who have had difficult experiences may feel some discomfort. If participation in this research causes you any distress or upsetting feelings, you are encouraged to inform the researcher. You are reminded of your right to request a break or withdraw at any point of the study. You may wish to contact immediate sources of support such as your family, friends, GP or a therapist.

**For support, there are some organisations and resources listed below that you can access:**

**Your GP**

Please consider contacting your GP if you are feeling low or anxious.

**Psychological therapies**

If you think that you may benefit from engaging in a talking therapy (such as cognitive behavioural therapy), then you may wish to consider self-referring to your local psychological therapies service, or asking your GP to refer you. To find your nearest service, you can search on the NHS choices webpage.

**Website:** [https://www.nhs.uk/Service-Search/Psychological-therapies-\(IAPT\)/LocationSearch/10006](https://www.nhs.uk/Service-Search/Psychological-therapies-(IAPT)/LocationSearch/10006)

**NHS Choices**

If you are worried about an urgent medical concern, call 111 and speak to a fully trained adviser.

**Website:** <https://www.nhs.uk/pages/home.aspx>

**Helpline:** 01138 250 000

**Action on Postpartum Psychosis**

For information about treatment and recovery.

**Website:** <https://www.app-network.org/>

**Samaritans**

This is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress.

**Freephone:** 08457 909090

**Website:** [www.samaritans.org](http://www.samaritans.org)

**PaNDAS**

For peer-to-peer support for you, your family and your network.

**Website:** <https://pandasfoundation.org.uk>

**Helpline:** 08081 961 776

**Tommy's**

For a team of in-house midwives who offer free support and information at any stage of pregnancy and after birth.

**Email:** [midwife@tommys.org.uk](mailto:midwife@tommys.org.uk)

**Website:** [www.tommys.org/](http://www.tommys.org/)

**Maternal Mental Health Alliance**

For guidance on Covid-19 and maternal mental health.

**Website:** <https://maternalmentalhealthalliance.org/news/mmha-members-offer-reassurance-amid-coronavirus-outbreak/>

**Baby Buddy by Best Beginnings**

You can download the Baby Buddy app for a free interactive pregnancy and parenting guide.

**Download here:** <https://www.bestbeginnings.org.uk/baby-buddy>

**Cysters**

This is a charity offering information and support around reproductive health and mental wellbeing. Cysters run community projects including chai and chat meetings.

**Website:** <http://cysters.org/>

**Please note that this project is in no way affiliated with any of the organisations listed above.**

**9. How will my taking part in this study be kept confidential?**

Any personally identifiable information will be removed from the data collected during the interview and you will be provided with a pseudonym to ensure anonymity.

**10. What will happen to the data collected within this study?**

- Your data will be stored in accordance with the Data Protection Act 1998. We confirm that only the research team will have access to your data. Your data will be anonymised, and you will be assigned a pseudonym. Your information and interview will be used solely for research purposes as outlined in this information sheet.
- Any audio recordings of interviews will be destroyed once the study is completed (expected date: August 2021). Your demographic data and the transcription of your interview will be retained for a maximum duration of 5 years after the study has been completed; however, this information will be anonymised and not personally identifiable.
- Research findings will be submitted as part of a Doctorate in Clinical Psychology research project at the University of Hertfordshire. In addition, we may write up an article for publication in a journal or for mainstream media and/or present the findings as part of training or conferences; however, again no participant will be personally identifiable.

**11. Who has reviewed this study?**

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH protocol number is aLMS/PGT/UH/04228(1).

**12. Factors that might put others at risk**

Please note that if, during the study, any medical conditions or non-medical circumstances (such as unlawful activity) become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

**13. Who can I contact if I have any questions or concerns?**

If you would like further information or would like to discuss any details personally, please get in contact with me (Jasdeep Kaur Grewal, Trainee Clinical Psychologist) by email: [jg18acf@herts.ac.uk](mailto:jg18acf@herts.ac.uk). Alternatively, you may contact my research supervisor, Dr Lizette Nolte: [l.nolte@herts.ac.uk](mailto:l.nolte@herts.ac.uk).

Although we hope it is not the case, if you have any concerns or complaints about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar  
University of Hertfordshire  
College Lane  
Hatfield  
Herts  
AL10 9AB

Thank you very much for reading this information and for giving consideration to taking part in this study. Your time is appreciated.

Kindest regards,



Jasdeep Kaur Grewal  
Trainee Clinical Psychologist  
[www.projectmaternal.com](http://www.projectmaternal.com)

## Appendix E: Participant consent form



### CONSENT FORM:

**Project Maternal: A study looking at Punjabi mothers' lived experiences of psychological distress during the perinatal period.**

I, the undersigned [*please give your name here, in BLOCK CAPITALS*]

.....  
of [*please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address*]

.....  
hereby freely agree to take part in the study entitled 'A study looking at Punjabi mothers' lived experiences of postpartum psychosis'. UH Protocol number: aLMS/PGT/UH/04228(1).

1. I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in the study.

2. I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3. In giving my consent to participate in this study, I understand that voice recording will take place and I have been informed of how this recording will be used and stored.

4. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5. I understand that my participation in this study may reveal findings that could indicate that I may require advice and support. In that event, I will be informed and advised to consult my GP and I acknowledge that, following discussion, I may be required by the University to withdraw from the study. If, during the study, evidence comes to light that I may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study.

6. I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

## Appendix F: Telephone screening protocol, demographic survey, and screening questions

**STAGE ONE:**

**University of Hertfordshire UH**

**TELEPHONE SCREENING PROTOCOL**

**Title: A study looking at South Asian mothers' lived experiences of perinatal psychological distress**

**Participant number:** .....  
**DATE:** .....  
**OUTCOME:** .....

**Introductions:**

- My name, role, and institution
- Check if now is a good time to speak
- Explain what the call is about:  
*e.g., thank you for showing interest in taking part in my study that is looking at Punjabi mothers' experiences and views.*

**Survey:**

- Check that they are still interested in taking part in the study and ask what brought them to this research.  
*e.g., Are you still interested in taking part?  
Out of interest, what makes you interested in taking part?*
- Provide further information:  
*e.g., What will happen now is that I will go through a brief questionnaire with you to determine whether you meet the study criteria.*
- *If you do meet the study criteria, I will send some information to you by email. In the study, you will be asked a couple of questions about your motherhood journey. The information you give me will be used purely for this study; it will not be used elsewhere. Data will be kept anonymous and confidential. If you do take part, you can withdraw at any point.*
- *Would you like to go ahead with the questionnaire?*

**Assessment of eligibility:**  
*e.g., To take part in the study, there are some routine questions that I need to ask you. Are you:*

- 18 or over
- Speak English and Punjabi
- Punjabi by origin and identify as Punjabi
- Experience of/or formal diagnosis of postpartum psychosis
- Minimum of one year since onset of postpartum psychosis
- No historical diagnosis of schizophrenia or psychosis prior to childbirth
- Child minimum of one year of age
- Not currently experiencing psychological difficulties or distress or seeking to access services

**What is postpartum psychosis?**  
Postpartum psychosis is a term given to experiences a woman may have after giving birth. The experiences can include:

- New beliefs which in that moment could not be true;
- Hearing, seeing, feeling or smelling things that are not there;
- High mood with loss of touch with reality or severe confusion;
- Having a very busy mind or racing thoughts.



**STAGE TWO:**

**University of  
Hertfordshire UH**

**DEMOGRAPHIC SURVEY AND SCREENING QUESTIONS:**

**Title: A study looking at South Asian mothers' lived experiences of postpartum psychosis**

1. How old are you?
2. How would you describe your gender? (Please specify):
  - Male
  - Female
  - Non-binary
  - Transgender
  - Gender fluid
  - Other:
3. What is your work status?
4. What is your education level?
5. Were you born in or out of the UK?  
*If inside: were your parents born in or out of the UK? / Whereabouts?*
6. How would you define your religion? (Please specify):
  - Buddhist
  - Christian
  - Hindu
  - Muslim
  - Sikh
  - Other:
7. What is your relationship status? (Please specify):
  - Single
  - Married
  - Divorced
  - Widowed
  - Cohabiting
  - Other:
8. How many children do you have?
9. What are your children's ages?
10. Had you experienced any mental health problems before pregnancy? / Accessed services? /  
Diagnosis?
11. How was your mental health postnatally?
12. Did you have any of the following experiences after giving birth:
  - Excited or elated.
  - Depressed, anxious, or confused.
  - Excessively irritable or changeable in mood.

- New beliefs which in that moment could not be true.
  - Hearing, seeing, feeling or smelling things that are not there.
  - High mood with loss of touch with reality.
  - Severe confusion.
  - Being more talkative, sociable, on the phone an excessive amount.
  - Having a very busy mind or racing thoughts.
  - Feeling very energetic or agitated and restless.
  - Having trouble sleeping, or not feeling the need to sleep.
  - Behaving in a way that is out of character or out of control.
  - Feeling paranoid or suspicious of people's motives.
  - Feeling that things are connected in special ways or that stories on the TV or radio have special personal meaning.
  - Feeling that the baby is connected to God or the Devil in some way.
  - I am not sure and I am willing to speak with the researcher directly.
  - Other:
13. Did you access mental health services? Yes/no
14. If yes, broadly speaking, who was your treatment provider? (for example, Mother-baby unit)
15. Did you receive a diagnosis of postpartum psychosis? Yes/no
16. Months/years since onset of postpartum psychosis:
17. Are you currently accessing mental health services or taking medications?
18. If yes, broadly speaking who is your treatment provider? (e.g. Community Mental Health Team)
19. If you are happy to take part in the study, please provide your email and/or telephone number so that the research team can contact you:

Thank you for completing this survey.

**STAGE THREE:**

**If the eligibility criteria is met:**

e.g. Before you decide whether to take part, I would like to email you some information which provides full details about the study. Are you happy for me to email information to you?

- Confirm email address.

You should receive the information sheet and consent form via email within the next few days. Please take the time to read the information carefully and discuss it with others if you wish. Do not hesitate to ask me anything that is not clear or for any further information you would like to help you make your decision. If you are happy to take part, please complete the consent form provided and email it to me on [jg18acf@herts.ac.uk](mailto:jg18acf@herts.ac.uk).

- Confirm a day and time that you will call the person back to commence stage two.

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

## Appendix G: Interview schedule



### INTERVIEW SCHEDULE:

Title: A study looking at Punjabi mothers' lived experiences of perinatal psychological distress

Participant number: .....

DATE: .....

OUTCOME: .....

| Points for framing the interview  | Tick |
|---|------|
| <ul style="list-style-type: none"> <li>• Hi ..... Introduce self.</li> <li>• Before we start, I need to <b>press record</b>. (Zoom recording is a backup. Dictaphone is the main copy. Remind: confidential and anonymised. Ask for consent.</li> <li>• Thank you so much for kindly agreeing to speak with me today about your motherhood journey as part of my research. I have some questions in front of me to guide our conversation, but it is only a guide. I encourage you to tell me what you would like to share about your experiences.</li> <li>• This will take about <b>1 hr-2hr</b>. We can take a break at any point, and we can stop at any point if you need to.</li> <li>• If a question feels uncomfortable, please do let me know. You only need to answer and share what you feel comfortable sharing.</li> <li>• You may find that some of my questions today ask about things you have already told me about in our last phone call. It would be <b>really helpful</b> if you could talk to me about it again because we have more time and space for it but also as this conversation is being recorded it means I can listen to it again and make sure I don't miss anything important.</li> <li>• Remind: right to withdraw and do not have to give a reason. This is up until the results are analysed.</li> <li>• Questions?</li> <li>• Ready to start?</li> </ul> |      |



|     |  |  |
|-----|--|--|
| 1)  | Tell me who you live with and who is in your family?   | Context/family and others                    |
| 2)  | Can you tell me the story of your motherhood journey?<br>Do you remember anything else about this?<br>What was happening before/during/what happened after that?   | Experience of motherhood                     |
| 3)  | What moments would you say have been the ups and downs of motherhood?<br><br>Can you tell me more about these moments?   | Experience of motherhood                     |
| 4)  | Can you remember when you first heard the term "psychological health" or "mental health"?<br><br>What has informed your understanding of...<br><i>Tell me more about that.</i><br>Do you remember ever having heard about anything similar before (even if it was called something different?)<br>Did anything happen to change how you understand this? | Understanding and sense making of experience |
| 5)  | Can you tell me about your experiences and when you first noticed that something was different?<br>Can you tell me more about that?<br>What did you notice?<br>Can you describe what happened?   | Understanding and sense making of experience |
| 6)  | How did you make sense of your experience at the time?<br>What was your understanding of what was happening and why?   | Understanding and sense making of experience |
| 7)  | What did you do?   | Coping                                       |
| 8)  | Who else noticed?<br>What did they notice?<br>How did they respond?<br>What happened then?   | Response                                     |
| 9)  | Can you tell me about how it affected you?   | Identities                                   |
| 10) | What do you think you have gained and/or lost through your experience of motherhood and mental health (over time)?   | Identities                                   |
| 11) | Who did you turn to for help?<br>Can you tell me about when you first had contact with them: where you were, what you told them and how you explained this?  | Help seeking                                 |
| 12) | What sort of help were you wanting?<br>What was your experience of help?<br>How did you feel about this and their reactions at the time? What about now?   | Help seeking                                 |
| 13) | Could you tell me about your relationship(s) with helping professionals? (GP etc)<br>How did you find their involvement?<br>How did you/do you find the language used by them?<br>What kind of impact did/does this language have on you?  | Help seeking                                 |
| 14) | What did you do to find strength?  | Resources                                    |
| 15) | Tell me about family life now.<br>How would you describe your relationship with your partner/baby/family/wider community/faith?  | Context/family and others                    |
| 16) | What was the experience of this interview like for you?  | Feedback                                     |
| 17) | Is there anything else that you would like to mention about your motherhood journey?   | Other  |
|     | We've come to the end of the interview.  |  |

**DEBRIEF:**

Thank you for participating in the study. I hope you have found it interesting and have not been upset by anything we have discussed. How are you feeling?

I will email a debrief document to you today, which contains my contact details and a contact for the university should you want to get in contact with myself or the University for any reason. It also has information about services that offer support.

If at any stage, you can choose to withdraw the data you have provided today – you can do so. You do not have to give a reason for withdrawing.

Questions? Happy to finish there?

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

## Appendix H: Ethical approval confirmation letter

**University of  
Hertfordshire UH**

**HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA**

### **ETHICS APPROVAL NOTIFICATION**

**TO** Jasdeep Kaur Grewal  
**CC** Lizette Nolte  
**FROM** Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair  
**DATE** 06/01/2021

---

**Protocol number:** aLMS/PGT/UH/04228(2)

**Title of study:** A study looking at Punjabi mothers lived experiences of psychological distress during the perinatal period.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

**Dr Nic Horley**

**Modification:** Amended study title and additional workers.

#### **General conditions of approval:**

Ethics approval has been granted subject to the standard conditions below:

**Original protocol:** Any conditions relating to the original protocol approval remain and must be complied with.

**Permissions:** Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

**External communications:** Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

**Invasive procedures:** If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

**Submission:** Students must include this Approval Notification with their submission.

**Validity:**

This approval is valid:

From: 06/01/2021

To: 01/09/2021

**Please note:**

**Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.**

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

**Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.**

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

**Failure to report adverse circumstance/s may be considered misconduct.**

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

## Appendix I: Confidentiality agreement for transcription services

**This agreement is between myself, Jasdeep Kaur Grewal (Doctoral Student/Researcher at University of Hertfordshire), and [REDACTED] (Transcriber at [REDACTED])**

You agree, as part of your services as a Transcriber, that you will keep all information sent to you confidential and that it shall not be used or circulated for any purpose other than what we have agreed, i.e. – for transcription for research purposes.

You agree that after sending me the final transcripts, you will delete the files and email(s) I sent the recordings through to you.

### **TERMS**

It is agreed as follows:

1. In this agreement:
  - a. "GDPR" means Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, so far as this Regulation is applicable in England and Wales and including as amended, extended or re-enacted from time to time in England and Wales;
  - b. "Data Protection Act" means the Data Protection Act 2018 including as amended, extended or re-enacted from time to time;
  - c. "Data Protection Legislation" means the Data Protection Act and the GDPR;
  - d. "Personal Data" means personal data within the meaning of GDPR Art 4.1, for which the Researcher is a data controller, and the Transcriber is a data processor.

### **Confidentiality**

2. The Transcriber acknowledges that over the course of providing transcription services, they may become privy to information about the affairs of the Researcher and/or research participants that is privileged and confidential. The Transcriber therefore undertakes in consideration of the research project that when providing transcribing services, they will maintain absolute confidentiality over all information which they receive, will not convey any such information to third parties and will not copy or distribute data that contains such information. Upon completion of the transcription, the Transcriber may be required to hand over any notes made during the service.

### **Data Protection**

3. The Transcriber will process the personal data only on documented instructions from the Researcher, including with regard to transfers of personal data to a third country or an international organisation, unless required to do so by Union or Member State law to which the Transcriber is subject; in such a case, the Transcriber shall inform the Researcher of that legal requirement before any processing, unless that law prohibits the provision of such information on important grounds of public interest.
  - a. The Transcriber will maintain appropriate technical and organisational measures to protect Personal Data against accidental, unauthorised or unlawful destruction, loss, alteration, disclosure or access ("Data Breach").
  - b. The Transcriber will notify the Researcher, without undue delay, of any non-trivial Data Breach that may adversely affect the Personal Data or have an impact on the Researcher.
4. At the choice of the Researcher, the Transcriber will delete or return all the Personal Data to the Researcher at the end of providing transcription services.

**Signed:** *JasdeepKaurGrewal (23/04/21)*

**Signed:** [REDACTED] (23/04/21)



## Appendix J: Debrief form



**Project Maternal: A study looking at Punjabi mothers lived experiences of psychological distress during the perinatal period.**

Thank you for participating in Project Maternal: A study looking at Punjabi mothers' lived experiences of psychological distress during the perinatal period. We hope that you have found it interesting and have not been upset by any of the topics discussed.

**If you have found any part of this experience to be distressing or you wish to speak to one of the researchers, you can contact me at:**

Jasdeep Kaur Grewal (Trainee Clinical Psychologist, University of Hertfordshire):  
[jg18acf@herts.ac.uk](mailto:jg18acf@herts.ac.uk)

**Alternatively, you may contact my research supervisor:**

Dr Lizette Nolte (Clinical Lecturer, University of Hertfordshire): [l.nolte@herts.ac.uk](mailto:l.nolte@herts.ac.uk)

**There are also some organisations listed below that you can contact:**

**Your GP**

Please consider contacting your GP if you are feeling low or anxious.

**Psychological therapies**

If you think that you may benefit from engaging in a talking therapy (such as cognitive behavioural therapy), then you may wish to consider self-referring to your local psychological therapies service, or asking your GP to refer you. To find your nearest service, you can search on the NHS choices webpage.

**Website:** [https://www.nhs.uk/Service-Search/Psychological-therapies-\(IAPT\)/LocationSearch/10008](https://www.nhs.uk/Service-Search/Psychological-therapies-(IAPT)/LocationSearch/10008)

**NHS Choices**

If you are worried about an urgent medical concern, call 111 and speak to a fully trained adviser.

**Website:** <https://www.nhs.uk/pages/home.aspx>

**Helpline:** 01138 250 000

**Action on Postpartum Psychosis**

For information about treatment and recovery.

**Website:** <https://www.app-network.org/>

**Samaritans**

This is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress.

**Freephone:** 08457 909090

**Website:** [www.samaritans.org](http://www.samaritans.org)

**PaNDAS**

For peer-to-peer support for you, your family and your network.

**Website:** <https://pandasfoundation.org.uk>

**Helpline:** 08081 961 776

**Tommy's**

For a team of in-house midwives who offer free support and information at any stage of pregnancy and after birth.

**Email:** [midwife@tommys.org.uk](mailto:midwife@tommys.org.uk)

**Website:** [www.tommys.org/](http://www.tommys.org/)

**Maternal Mental health Alliance**

For guidance on Covid-19 and maternal mental health.

**Website:** <https://maternalmentalhealthalliance.org/news/mmha-members-offer-reassurance-amid-coronavirus-outbreak/>

**Baby Buddy by Best Beginnings**

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

You can download the Baby Buddy app for a free interactive pregnancy and parenting guide.

**Download here:** <https://www.bestbeginnings.org.uk/baby-buddy>

**Cysters**

This is a charity offering information and support around reproductive health and mental wellbeing. Cysters run community projects including chai and chat meetings.

**Website:** <http://cysters.org/>

**Please note that this project is in no way affiliated with any of the organisations listed above.**

**Right to withdraw**

At any stage, you can choose to withdraw the data you have provided. You do not have to give a reason for withdrawing and this will not affect any support you are accessing or entitled to.

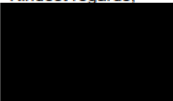
**If you would like to make a complaint or have any concerns:**

If you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, you can write to the University's Secretary and Registrar at the following address:

*Secretary and Registrar  
University of Hertfordshire  
College Lane  
Hatfield  
Herts  
AL10 9AB*

Thank you very much for reading this information and for taking part in this study.

Kindest regards,



Jasdeep Kaur Grewal  
Trainee Clinical Psychologist

**Appendix K:** Transcription symbols (adapted from Jefferson, 2004)

| Symbol          | Example  | What the symbol represents   |
|-----------------|--|--|
| [ ]             | <i>A: Okay. [overlap]<br/>B: [overlap]</i>         | Indicates overlapping talk.  |
| =               | <i>A: Okay. What about<br/>=<br/>B: Also</i>       | Indicates no gap or pause in between speaker change.                             |
| (.)             |  | Indicates a brief interval.  |
| (1.2)           |  | Indicates time in seconds between end of a word and the start of the next word.  |
| Underlining     | <u><i>I know</i></u>                               | Indicates emphasis.  |
| ::              | <i>I fe::el okay</i>                               | Indicates prolongation of word.  |
| ↓↑              |  | Shift in pitch to higher pitch or lower pitch.                                   |
| Capital letters | <i>It ACTUALLY made me feel worse</i>              | Indicates words that are louder than the surrounding speech by the same speaker. |
| ◦ ◦             | ◦ <i>I didn't have help</i> ◦                      | Indicates speech that is softer than the surrounding speech by the same speaker. |
| “ ”             | <i>My mom said, “no, that won't be necessary”.</i> | Indicates imitation or quoting someone else.                                     |
| (xxx)           | <i>He is (xxx)</i>                                 | Indicates inaudible speech.  |
| hhh             | <i>It was hard... hhh</i>                          | Indicates in-breath or breathiness.  |
| [ ]             | <i>I struggled to breastfeed [name]</i>            | Indicates deliberately removed text.   |

The experiences and understanding of psychological distress in the pre- and post-natal period among Punjabi women living in the UK.

Additional symbols used in the analysis process:

|          |                                       |   |
|----------|---------------------------------------|---|
| <u>2</u> | <i>you</i> <sup>2</sup>               | Used to indicate switch to second person prose.   |
| <u>3</u> | <i>their</i> <sup>3</sup>             | Used to indicate switch to third person prose.  |
| ( )      | <i>She then (mother-in-law) would</i> | Used to indicate added text to convey who/what the participant is referring to and/or when a participant speaks in Punjabi. |

**Appendix L:** Interview transcript and sample of analysis (included with permission from participant)

|        |                       |
|--------|-----------------------|
| Pink   | Content               |
| Orange | Structural elements   |
| Blue   | Performative elements |

|   |  |
|---|--|
| <p><b>Gurpreet:</b> Yeah, I mean, the thing is(.) <b>I think I'm feeling it now(.)</b> like, like my mom, she's one of six. <b>So</b> my mom... <b>I've always said to my mom, it's funny, isn't it, how nan and grandad stopped the moment they had a boy,</b> so it was girl, girl, girl, girl, girl and then my Mama was the very last one. <b>And then(.) I was born and in terms of myself(.) like my grandmother didn't have that many, wasn't very partial towards me↑, whereas all the other daughters who had sons↑, again like, you know, she's given them a lot of love and I've kind of just been on the outside↑.</b> And even now, when my <b>uncle's</b> had a boy, like(.) my mom said to me that, um, they actually made comments, like, "Oh, (<sup>Punjabi</sup>: let there be a boy, let there be a boy)" So, it, I guess, (xxx), and <b>I do feel like if I did have another girl... It's strange↑, because I genuinely don't think there is any difference in boy and a girl,</b> like I've always said, <b>I want my daughter to, to grow up strong, confident.</b> I don't want her to rely on <b>no man,</b> you know. But again, you just... I, <b>I feel like I fall back to those typical Indian stereotypes↑.</b> Um, so <b>for example, my mom right now, she's on her own,</b> if she, if I had a brother, chance is, I would probably be like, she won't be on her own, my brother would be with her, with <b>his</b> wife. You know, when we↑ grow older, <b>again, it's, it's really↓ really bad to think like this,</b> but when we grow older and if we only have her, we'll kind of be on our own↑. I don't know <b>hhh</b> it's... Like, for me↑ foremost, it's I want to give her a <b>sibling</b> so she doesn't grow up to be on her own, like I↑, I want her to have sibling support. <b>Ideally, I would want it to be a boy</b> because then <b>I do feel like there'd be unspoken pressure off me.</b> No one has said it to me, but I feel like it↑. I don't know if this makes sense, <b>you're probably thinking I'm like really mental</b> (laughs) but I don't know-</p> | <p><b>Structure:</b> narrative swiftly moves onto the topic of gender.<br/> <b>Content:</b> family stories about gender. identifying with family members experiences of also having a baby girl first and trying again for a baby boy.<br/> <b>Performative:</b> "you know" may suggest that G is assuming that I understand/relate to her as a Sikh Punjabi female.<br/> <b>Structure:</b> narrative is moving back and forth between G stating that she has no personal gender preference to having a gender preference (for a baby boy).<br/> <b>Content:</b> clash between modern feminist views and traditional gender role stereotypes.<br/> <b>Performative:</b> constructs self as Indian and holding majority views from Indian culture.<br/> <b>Content:</b> provides example of her own mother who has one daughter. Appears to be identifying with mother.<br/> <b>Structure:</b> returns to male gender preference.<br/> <b>Content:</b> G mentions pressure on her to have a male child and appears unsure where this pressure is stemming from. Internalised cultural discourses and expectations?<br/> <b>Performative:</b> appears to struggle to make sense of gender preference. Constructs self as "mental" and projects it onto me as if I hold this view of her.</p> |
|---|--|

### Appendix M: Reflective diary extracts

|   |
|---|
| <p>Date: April 2020<br/>Stage in research: Research proposal<br/>Entry: Due to COVID-19, I will largely be recruiting online instead of through the community which I had hoped to do. Who will my adverts reach vs not reach? Which stories will be told, and which stories will remain untold?</p>  |
| <p>Date: November 2020<br/>Stage in research: Screening<br/>Entry: Overwhelming response to the adverts. I have received direct messages, emails, texts, and phone calls from Punjabi mothers that either wish to take part, are undecided but want to share their experiences (some for the first time) and/or want to say thank you for conducting this research. The adverts have worked to raise awareness and create conversations but what next? For those that will proceed to seek support, are communities/organisations/services equipped to respond to the diverse needs of these women?</p>   |
| <p>Date: June 2021<br/>Stage in research: Research analysis<br/>Entry: Theme appearing of being maternal vs not being maternal. Perhaps maternal in a different way? What happens when different cultures (British, Sikh and Punjabi), each with their own distinct different gender roles and societal expectations, come together?</p>  |
| <p>Date: September 2021<br/>Stage in research: Research analysis<br/>Entry: Endings<br/>Most accounts conveyed a sense of resolution and (positive) transformation(s) after PPD but with some residual conflict. This led me to be curious about how Punjabi stories traditionally end. In Singh (2018), stories by eminent female Punjabi writers are reviewed. Interestingly, the stories are described as about “struggle, emotional turmoil, unfinished dreams and social rejection”; have “extremely dark or bleak endings” but “unmistakable depictions of vigour and celebration of life” in the background. I see parallels between the descriptions of the stories and the accounts of my participants. What does this tell me about the lives of Punjabi women?</p> |

## Appendix N: Quality assessment of present study

| Worthy topic?  | Rich rigour?   | Sincerity?  | Credibility?   | Resonance?   | Significant contribution?  | Ethical?  | Meaningful coherence?  |
|--|--|---|--|--|--|---|--|
| Significantly under researched topic, relevant given NHS long term plan, timely, significant, and important contribution | Appropriate theoretical constructs. Epistemological and ontological position outlined. Sample demographics provided. Context in which research is situated is shared. Recruitment process clearly outlined. Data collection and analysis process and steps are shared. | Self-reflexivity included in introduction, methodology and discussion. Researcher's identification as a Sikh Punjabi woman has been shared. | Thick description with concrete detail using direct quotes. No triangulation with participants (as it does not align with narrative analysis) but consulted with research team, EbE and Punjabi community and cross-checked findings with social media posts by Sikh Punjabi women. Furthermore, research diary was used to maintain reflexive position. | Naturalistic generalisations. Findings with clinical significance. Relevant to a variety of settings including clinical, community and related settings. | Findings correspond with previous research. Begins to address gap in research. Using the findings, the model of perinatal psychological distress has been proposed along with a grab sheet based on the stories, themes and suggestions from participants. Findings have been presented to a community perinatal service which prompted discussion and debate. | Ethical standards adhered. Mention of procedural ethics, situational ethics, ethical relationships, and ethical issues in exiting the study (Reid et al., 2018; Tracy, 2010). | Achieved aim. Method and procedure fit the goal. Connection with literature. Suggestions are practical and applicable. |

**Appendix O:** Grab sheet based on the model of perinatal psychological distress

