

Middlesex University Research Repository

An open access repository of

Middlesex University research

<http://eprints.mdx.ac.uk>

Sattar-Jenkins, Anita (2019) Motherhood and the absence of maternal support: an exploration amongst Asian women. DCPsych thesis, Middlesex University / Metanoia Institute.

Final accepted version (with author's formatting)

This version is available at: <http://eprints.mdx.ac.uk/28731/>

Copyright:

Middlesex University Research Repository makes the University's research available electronically.

Copyright and moral rights to this work are retained by the author and/or other copyright owners unless otherwise stated. The work is supplied on the understanding that any use for commercial gain is strictly forbidden. A copy may be downloaded for personal, non-commercial, research or study without prior permission and without charge.

Works, including theses and research projects, may not be reproduced in any format or medium, or extensive quotations taken from them, or their content changed in any way, without first obtaining permission in writing from the copyright holder(s). They may not be sold or exploited commercially in any format or medium without the prior written permission of the copyright holder(s).

Full bibliographic details must be given when referring to, or quoting from full items including the author's name, the title of the work, publication details where relevant (place, publisher, date), pagination, and for theses or dissertations the awarding institution, the degree type awarded, and the date of the award.

If you believe that any material held in the repository infringes copyright law, please contact the Repository Team at Middlesex University via the following email address:

eprints@mdx.ac.uk

The item will be removed from the repository while any claim is being investigated.

See also repository copyright: re-use policy: <http://eprints.mdx.ac.uk/policies.html#copy>

MOTHERHOOD AND THE ABSENCE OF MATERNAL SUPPORT:

AN EXPLORATION AMONGST ASIAN WOMEN

Anita Sattar-Jenkins

Middlesex University and Metanoia Institute

Research Thesis submitted in partial fulfillment of the degree of:

**Doctor of Counselling Psychology and Psychotherapy by Professional
Studies (DCPsych)**

September 2018

Word Count: 43,908

ABSTRACT

Aim: Only few existing studies focus on Motherhood and the absence of maternal support. This research investigated the life experiences of Asian women who had given birth to their first-born child at a time when they did not have maternal support.

Design: Baby clinics were targeted and Health Visitors selected candidates that fulfilled the criteria to participate in the research. Ten participants comprising of Asian women were recruited and participated in an interview about their experience of giving birth to their first child at a time when they were not in contact with their maternal family.

Method: Interviews were transcribed, analysed and categorised using the qualitative method of Interpretive Phenomenological Analysis (IPA). A meeting was set up for the participants to review the transcripts and the data was coded into themes.

Key findings: Results highlighted four themes which emerged that affected the wellbeing of the mother and baby. The first theme was the cultural expectation of support and these findings were of significant interest from the viewpoint of inbuilt parental relationships and the way they develop as well as the discovery of feelings of inadequacy arising because of communication difficulties. The second theme was the newness of being supported by their husband which was a new experience for them and questioned their role as a mother and their ideas about the assumed responsibilities for women in an Asian culture. The third theme was the emotional and physical impact of having a baby which was an area that appeared to be out of their awareness and came as a surprise to them in the aftermath of the baby's arrival. The fourth theme was pre and post-natal experiences of having a baby in the NHS and this identified a number of strategic

changes which could be implemented to identify women at risk due to the absence of maternal support.

Conclusion: The potential significance of my results, which considered Asian women in this context, indicates that the NHS could adopt preventative measures to ensure these women are identified as vulnerable and do not continue to fall short of maternity services. In order for professionals to 'signpost' their patients appropriately they need to be skilled up to understand the needs of these women. This research highlights the need for women from other cultures to be able to expect a level of understanding from Healthcare professionals in relation to their specific situations and to have an awareness of the particular difficulties that women face when they do not have maternal support.

CONTENTS

ABSTRACT	2
CONTENTS	4
ACKNOWLEDGMENTS.....	8
1.0 INTRODUCTION	10
1.1 My Interest in this area.....	10
1.2 Integrated Mother/Culture.....	10
1.3 The Research Focus.....	12
1.4 My experience as an Allied Health Professional (AHP)	12
1.5 Holding a dual lens.....	13
2.0 LITERATURE REVIEW.....	14
2.1 Introduction	14
2.2 Contemporary research	14
2.3 The role of family in motherhood	21
2.4 Cultural experiences of women treated in Healthcare	23
2.5 The transition to motherhood	28
2.6 The emotional development in the newborn infant.....	35
2.7 Specific research questions.....	41
3.0 RESEARCH DESIGN.....	43
3.1 Design	43
3.2 Methodology – choosing an IPA approach	48
3.3 Sample Size	50
3.4 Recruitment and inclusion criteria:	51
3.5 Coding and identifying themes	53
3.6 Insider Researcher and the middle ground.....	55
3.7 Trustworthiness and planning	58
3.8 Potential Contribution to the Field of Maternal Well Being	62
4.0 PLANNED RESEARCH IN THE NHS	67
4.1 Berkshire Research Ethics Committee (REC) Approval	67
4.2 Clinical Governance	69

4.3 Sampling Issues	70
4.4 Description of Proposed Sample.....	70
4.5 Table 1 - Health Visiting Clinics in East Berkshire.....	72
4.6 Locating the Participants.....	72
4.7 Data Collection.....	74
4.8 Table 2 - Candidates selected by Health Visitors and invited for an interview. 76	76
4.9 Interview Structure	77
4.10 Subjectivity.....	78
4.11 Analysis of the Interviews	79
4.12 Reflexivity	81
4.13 Review of the transcripts.....	82
4.14 Cultural Issue on Interviewing	83
4.15 Phase Two – Validating the transcripts	85
4.16 Thames Valley Mental Health Conference.....	86
5.0 RESULTS	87
5.1 Interview Data.....	87
5.2 Demographics.....	88
5.3 Identifying Themes based on participant experiences.....	90
5.4 Grouping the data into themes	91
5.5 Detailed table of themes derived from the data.....	93
5.6 Cultural expectation of support.....	96
5.7 Newness of being supported by their husband.....	110
5.8 The emotional and physical impact of having a baby.....	117
5.9 Peri and post natal experiences in the NHS.....	130
5.10 Mother and child interaction	144
5.11 Forms of support.....	145
5.12 Reflexive Practice.....	146
6.0 DISCUSSION.....	147
6.1 Findings from My Research:	147
6.2 Cultural Expectations.....	148
6.3 Importance of Maternal Relationships	150
6.4 The role of the father	152

6.5 Change of a family structure	152
6.6 Feeling Excited and Apprehensive.....	153
6.7 Potential onset of Postpartum Depression	154
6.8 Neonatal Behavior	156
6.9 Reflection on methodological tensions in the NHS	157
6.10 Breast-Feeding and the Breast is best campaign	157
6.11 Chila – A Period of Confinement.....	159
6.12 Important Contributions from my Research	160
6.13 Policy and Strategy Implications	163
6.14 Taking My Research Findings Forward	164
6.15 Potential scope	166
7.0 MOVING FORWARD	167
7.1 Suggestions	167
7.2 Multicultural Deficits	171
7.3 Limitations of the Study.....	171
7.4 Conclusion	174
8.0 REFERENCES	180
9.0 APPENDICES.....	201
9.1 Research Ethics Committee (IRAS) Version 2.0.....	A1
9.2 CV (on line) Form	A2
9.3 Application to Research Ethics Committee.....	A3
9.4 Proposal.....	A4
9.4 Candidate Information Sheet	A5
9.5 Candidate Demographic Sheet	A6
9.6 Candidate Consent Form	A7
9.7 Participant Questions	A8
9.8 Participant Debriefing Information	A9
9.9 Co-Sponsor Joint Agreement	A10
9.10 Research Passport	A11
9.11 Research Ethics Approval	A12

9.12 Research PresentationA13
9.13 Interview Transcript (with codes and categories)A14 - A18

ACKNOWLEDGMENTS

To those in Berkshire NHS Foundation Trust who enabled my pathway to access this research, the strategic Lead, Health Visitors, and ten participants who brought this research alive and allowed me to be a part of their journey into motherhood.

My research supervisor Professor Vanja Orlans for her attention to detail, inspiring challenges, wealth of knowledge, endless support, constant belief in my research idea, encouraging me to see the light at the end of tunnel and for “never giving up on me”.

Finally, to my parents, brothers and sisters, nephew and nieces who are never far from my thoughts. Being born into an Asian family rich in its cultural heritage allowed me to find my own sense of self and belonging and integrate myself as a British born Asian. This journey would never have started if it were not for the circumstances that led me to this situation, a situation that continues to shape who I am today.

This research project is dedicated to:

My family, especially my daughter Jasmine without whom this journey would never have begun, my husband Stephen for his constant support, encouragement and endless patience and my friend David Cory for his expertise and countless hours of proof reading.

In memory of my father whose love of conversations sparked my passion for therapy.

1.0 INTRODUCTION

1.1 My Interest in this area

My interest in this area is borne out of my own life experience in which I had my first child at a time when I was not in contact with my birth family. However, by revisiting a therapy space of my own I now understand the very basis for this research topic stands upon the grounds through which I left home. This feeling fueled my desire to better understand the experience of other women when they give birth to their first-born child without any maternal support.

My relationship to this area of interest is borne out of my own life experience “In the field of counselling psychology and psychotherapy many doctoral candidates choose to focus on a topic that has some personal meaning for them, knowing this connection will develop and grow over time and keep them engaged in what can sometimes be a difficult and lonely process” (Etherington 2004: 179). I have always reflected on my experience of becoming a new mother at a time when I was not in contact with my own birth family and wondered whether other Asian women have had a similar experience to mine.

1.2 Integrated Mother/Culture

Whilst the situation surrounding my experience is unique the experience of giving birth without maternal support is an experience shared by women across the world. My experience was one in which I was rejected and therefore not allowed to access my family for support. In a wider context this occurs as generations move

forward and more people move abroad for better job prospects. Alternatively they flee their country of origin through civil war or invasions and as a result the likelihood of maternal support being a practical option is going to decrease. Hence my research highlights a very important experience and voices what it is like to become a mother without maternal support. Some of the research recognises that Asian women tend to rely on support, advice and guidance from their own families. However there still remains very little written about this experience of women giving birth at a time when they do not have maternal contact.

I have questioned how Asian women in particular cope with the experience of being brought up by migrant parents in the UK or Asian parents in their own country and then immigrate to the UK and deal with the complexity of parenting their newborn child in a western society without the support of their birth parents.

There has been a significant amount of research conducted which focuses on pre and post-natal experiences. In my research topic I am interested in mothering, maternity services, attachment and how society tackles the issue of cultural diversity in maternity services. My research seeks to understand the actual life experience of women during the time they became a mother without maternal support from their own mother. I am interested in how this experience shaped their experience of mothering their new born baby and my passion is to give this experience a voice.

My particular focus of research is the experience of Asian women because this is a particular ethnic group whose experiences I can relate to. I hope my research will continue to inform other professionals in the field of maternity services when considering the multicultural experiences and needs of women.

1.3 The Research Focus

I want to understand a woman's experience of giving birth to her first child without the support of her maternal family and to gain insight into her lived life experience of this. I want to know what the quality of her relationship with her maternal family is like. As a child I grew up with a sense of community support and a sense of feeling cared for. I would like to understand what the word "support" means to a woman in this context. It is my own early upbringing and the culture that I was brought up in that leaves me with a sense that in the Asian community women are respected as sisters, wives and mothers. I would therefore like to understand women's experience of the cultural importance of a mother. My experience of giving birth in an NHS setting leaves me questioning if there is anything about the women's experience that would facilitate a shared understanding amongst professionals in the field of maternal wellbeing.

1.4 My experience as an Allied Health Professional (AHP)

I have worked in the NHS as an AHP for over 18 years. My personal experience of embarking on the journey of motherhood combined with my working history in the NHS sparked my passion for the research topic and has allowed me the interface

of working in the front line as an NHS professional and brought me into contact with the issues faced by patients. This facilitated the opportunity to apply for NHS ethical approval, contact the relevant professionals in my area of interest, work with the Health Visitors to conduct the research and enable my access to the NHS library which aided my literature search. I view my various roles within different NHS services as empowering through which I have gained substantial work experience across a multitude of services acquiring knowledge, skills and an understanding of the areas of expertise in different NHS contexts. All of this richness informs my understanding to conduct this research and goes on to inform me as an evolving practitioner.

1.5 Holding a dual lens

My research seeks to contribute to the NHS work setting in maternity services and informs strategic considerations of provisions they make in the future. In particular it clarifies the practice of antenatal care and postnatal care in terms of service delivery. Having worked as an AHP I have been in a privileged role of conducting research and understanding a patient's experience of receiving care. This combined with my experience as a patient who has received care from maternity services. This unique combination gives me a dual lens that informs my research as an insider researcher.

2.0 LITERATURE REVIEW

2.1 Introduction

This section focuses on research in the field of motherhood and the experience of what it is like to become a mother. My search for relevant literature found very few studies that relate directly to my research topic and accordingly I looked at contemporary research which incorporates literature on the ethos of Asian women relying on family support but nothing about how they might be without it. Key words used in searches include; motherhood and the absence of maternal support, Asian women, Asian parents, history and culture of Asian Indian and Asian Pakistani parenting, motherhood, absence of maternal support during motherhood. Asian Indian parenting styles and other cultural ritual parenting styles. These searches led to an exploration of how the maternal family play a part in motherhood, the Asian culture, motherhood in maternal care, the experiences of a new mother and her availability to her new born infant. I draw this section to a close by underpinning my rationale for an interpretative qualitative research proposal which allows us to develop an understanding of a women's journey into motherhood.

2.2 Contemporary Research

Research by Raman et al (2014) investigated the way in which new mothers accessed support and examined where this support came from. In particular support during the perinatal period was elicited from their maternal sister, mother and friends. Highlighting the significance of creating and supporting the mother-infant dyad, an interesting point made by the researcher is that this perinatal

support builds the foundation for the after birth recovery process and aids maternal wellbeing. Using an ethnographic approach, in-depth qualitative interviews with participants aged 17-40 who were during their first trimester were analysed with semi purposeful sampling to ensure a mix of participants. Interviews were held in a location of the participants choice, socio cultural factors and healthcare utilisation patterns were observed including maternal, child antenatal and post-natal healthcare visits. Interviews were conducted in five different languages until they reached a saturation of themes.

One particular theme emerged which was the reliance upon the participants own mother known as Amma. Women appeared to rely heavily on the presence and support of their Amma for guidance on everyday occurrences and advice unless their Amma was unavailable due to geographical locations. Women who had access to their Amma felt 'particularly lucky' but where Amma was unavailable the women were sad and verbalised missing this support. Women with maternal support relied upon their Amma during the postnatal period as she seen as wise and knowledgeable. Parental availability came with cultural acceptance enabling the woman to spend a prolonged period of time in her maternal home soaking up care and empowering her to connect with her childhood home and surroundings. This proved to be positive, however, for those women unable to gain this care they experienced a sense of sadness and they relied on female friendships as a source of support. Further demonstrating that something was missing for them, this part of the research could have been taken further as this realisation alone is not enough. It is important for us to understand the impact of this sadness on both the new mother and her baby and to further share this knowledge and

insight with professionals in the area of maternal care and beyond so we as a profession and society can support these families.

All participants interviewed had husbands and there were a number of findings mainly relating to intimate networks of support and less or almost no reliance on healthcare professionals. For those able to access maternal support they expressed this was a major source of emotional and practical support with social class and education having some weight on how much these women relied on their husbands for support. Whilst the women who were unable to access family support relied on female networks or went without supportive resources were still less likely to access healthcare professionals for support. The researchers deviated from these interesting findings and detracted from the understanding that women were sad due to the lack of access they had to their maternal families and did not further their research to find out if this had an effect on their after birth recovery and ability to bond with their new born.

My research focuses on women who have become mothers for the first time and explores what current service provision are available for these women. This research falls short of using the data from the women without support to formulate clinical needs based on their experiences. I am seeking to understand the experiences of women without maternal support by asking new mothers about their experiences.

A comparative study was carried out by Holly et al (2008) on mothers who did have support versus those that did not have support, concluding that despite a lack of companionship and support for new mothers it was their cultural background which made a difference as to whether or not they accessed support. In particular, mothers who were of a black, Pakistani or poor background were more likely to miss antenatal classes and give birth without companionship versus white mothers. These mothers were also more likely to have a preterm birth or emergency cesarean section, lower satisfaction with life, shorter birth times and spinal pain relief in comparison to white mothers.

This study highlights important considerations about women who did not have a companion during childbirth and how modern NHS constraints have left midwives in a position in which they do not have the time or resources to offer such individualised care. Midwives also voiced their view that the idea of caring rather than being there to provide treatment devalued their role as professionals. This research further explored the reasons mothers gave birth unaccompanied and hypothesised that these infants were at risk of social and economic disadvantages. Other findings were that new mothers might not have known they could have bought someone other than the baby's father to support them during the birth. Researchers drew attention to the limitations of their study by highlighting that the participants may have misinterpreted the question and furthermore concluded that being alone during the birthing process might have led to high risk mothers requiring additional support however, the researchers did not extend this to specify what this support might entail. Given such important findings the researchers did not investigate why mothers from different

cultural backgrounds did not know they could bring someone with them. The researchers did not ask their participants what they would have liked to have experienced and were therefore unable to make a direct impact on maternal service provisions by taking their research questions further. As this study attempted to draw comparisons and did not focus on one group in terms of women being accompanied versus unaccompanied and further complicated the research by grouping multicultural women, black, Pakistani and white women in the same comparative sample. It was therefore no surprise that these women misunderstood the question when we think about their different cultural and historical backgrounds which in themselves are complex. My own research sets out to focus on women from one ethnic group and seeks to understand what their experience are by examining their lived life experience.

Recent research by Boram et al (2018) explored the relationship between parenting practices and perceptions amongst Korean immigrant parents in New Zealand. Emphasising that an increase in migration led to the Korean community becoming the fastest growing ethnic group in New Zealand. The research examined the perception that Korean parents thought they display warmth and moderate control. They felt this did not capture Korean parental values as Korean parents attempted to display more western ideals. It was interesting to note that 'maternal devotion' was set out to be a maternal Korean parental concept in which fathers were seen as the stern authoritarian 'disciplinarians and breadwinners'. A multiple regression analysis was performed on both parental responses and findings suggested that an authoritative parental style compromised warmth. This research included the views of both parents and

drew on the differences between maternal and paternal experiences, it was interesting to see that fathers veered more towards shaming/love withdrawal, modesty and encouragement whilst maternal directedness created fewer internalising problems given mothers were not highlighted as authoritarian. Children's ability to internalise problems were affected by their mothers' perception of being authoritative however, the study was unable to conclude how a direct parenting style could predict their child's behaviour. Other variables such as the self-reported bias in the way the parents rated themselves may have also affected the outcome and results.

As such this research raises questions about the way in which parents might self-report their parenting style. I do believe this research could have been extended to include the views of the children and their perceptions and experiences of growing up in New Zealand. In addition, interviews could have been conducted with the parents rather than relying on self-reports. Although the researchers were transparent about how the research benefitted from a diverse sample of Korean participants the shortage of participant numbers may have restricted the outcome. Despite these reservations the research has gone some way to opening up conversations about Korean parenting styles and enabling communities to compare and reflect on their parenting in western countries.

As my research is not set out to focus on parental styles it will be thought-provoking to see if the participants interweave their life histories and parental styles as part of their own journeys into becoming a mother at a time when they did not have maternal contact. This research also seeks as a contrast to my literature search as it helps us to understand different cultures and parenting

styles. The study was useful insofar as parents predict their child's behaviour based upon their perceptions of how they parent in a western country. It will be interesting to see how the participants in my research are able to think about themselves as parents and how they might think about parenting in a western community.

One study which extends the idea of parenting and the mother child relationship is research by Iqbal (2012) on parenting styles in multi ethnic Britain. Interviews were conducted during which the mother child observation scale was scored and coded using the parent child interaction. This research utilised a mixed sample of 12 British Indian, 12 British Pakistani and 12 White mothers, interviews were carried out and a thematic analysis was administered. The study sought to explore two aspects; parenting and child adjustment and cultural and contextual factors in family life and the findings upheld the hypothesis that positive parenting styles were associated with positive outcomes for children.

There were some differences detected across ethnic groups in the nature of the parent child relationships when it came to supervision, child centeredness and overt discipline. Further findings demonstrated that culture was acquired as part of the child's development and traditional Indian and Pakistani cultures provided a narrow realm of socialisation whereas white families promoted more opportunities to socialise widely. Prejudice amongst communities, stressful environments and ethnic inequalities were all contributors to the outcomes. All mothers recruited to the study were British born and spoke English as their first language however the mixed method of participant recruitment left the

researcher with various possible outcomes. Such mixed research groups tends to make it difficult to form a concrete analysis of the data and further fall into making comparisons opposed to devising results which can progress into service provisions.

The sample size grouped various women from different cultural backgrounds which could add to why there were different possible outcomes. My research seeks to concentrate on one group of mothers from an Asian background and centers on less variables enabling my research to concentrate on the research question about the lived life experiences of women who have given birth to their first new born baby without maternal support enabling me to attend to this event.

2.3 The role of family in motherhood

In my opinion emphasis on the role of the family is a significant part in supporting an Asian woman prior to, during and after the birth of her new born baby. This was studied by Grewal et al (2005) who discussed the influence of the family on immigrant South Asian women's health to understand the family members influence on health seeking behavior. Asian women were unable to access support from their extended family due to immigrating to another country. Individual face to face open ended interviews were conducted, audiotaped and transcribed. The findings suggested the importance of family was at the center of the lives of these women and this had an important influence on their health. Proposals were made for healthcare staff to take into account the women's relationship with their family and their involvement in healthcare decisions. This raised some important points

about Asian women using their family of origin as a first port of call when making important decisions about their own healthcare provisions.

Highlighting the importance of the family in making personal healthcare decisions is explored by Mahat (1998) Eastern Indians' childbearing practices and nursing implications and researches the importance of cultural awareness because a lack of understanding from healthcare professionals can affect the patient – professional interaction. Findings suggested that Indians were exposed to increased conflict and confusion due to their differing cultural backgrounds whilst in a new country. The advice and guidance of family members was highly regarded and sought in an eastern culture. The opinion of the mother-in-law is considered to be important in the experts' opinion for pregnant women who turn to them for advice and guidance.

A number of cultural differences between eastern practices and the western healthcare service was investigated by Mahat (1998) who concluded the need for “cultural awareness among nurses” (p.161). By increasing their awareness they would be better equipped to provide a much more thorough assessment and be able to impart their understanding of the cultural needs in terms of lifestyle, health beliefs and health practices of this population. This would increase the likelihood that nurses could provide a culturally sensitive approach and see a decline in the negative experiences that stem from a misunderstanding or ignorance about other cultural practices. This supports the need for professionals to understand Asian women are likely to turn to their own families for maternal support because this

need is not fulfilled by the current way in which maternity services provide care for their patients.

The psychological well-being experiences of Bangladeshi women was explored by Gausia et al (2012) which focused on the emotional wellbeing of Bangladeshi mothers during the postnatal period. Research demonstrated that the emotional wellbeing and health of mothers following the birth of their baby determined whether postnatal depression was recognised, how it was interpreted, the effect it had on the well-being of the mother and on the wider community. A qualitative focus group explored the views of ten mothers and findings suggested mothers tended to lean on family. Friends, religious leaders, and healthcare services were not their first point of contact. Further indications suggested healthcare staff could educate women about their role as it was important for health visitors to understand the significant cultural diversity of their patient group when assessing the scores of the postnatal depression scale to enable professionals to understand why mothers may choose to seek alternative methods to manage their health during the postpartum period.

2.4 Cultural experiences of women treated in Healthcare

I was interested in researching cultural diversity in healthcare and illness providing an insight into the nursing interventions following the birth of a new born baby. Research carried out by Spector (2010) focused on the initial hours after birth in particular guiding the mother and baby through these early moments highlighting the birth rituals, importance of cultural, religious beliefs and recognising how evil

spirits and good spirits have a part to play in rituals performed upon the birth of a new baby. The disadvantage of the healthcare system is one in which the provider who comes from one cultural background is unable to meet the patient's needs because they might well come from another cultural background and the importance of their needs is not taken into account. This can develop a barrier or as the writers describe a "wall" in which misunderstandings develop. This may leave the patient feeling unable to ask for care and the provider unable to meet the demands placed upon them. This could end in a breakdown of communication and dissatisfaction between the provider and recipient of the service. In this case the needs of the new mothers go unmet and the service falls short of recognising what those needs are ultimately ending in a disadvantaged position for both parties.

This also highlights that in treating American Indians there are a number of factors which need to be taken into account including the importance of non-verbal communication, using a lower tone of voice. Interacting in a way that allows one to remember what is being said rather than jotting down notes which can appear to be impersonal. This concludes that it is the health professionals' diversity that will lead to improved public services particularly demonstrating the need for ethnic minority patients to be seen by practitioners with whom they share the same or a common race. This also increases the likelihood that patients are in receipt of the appropriate care and empowers them to accept this care because they feel understood or respected.

Bharj et al (2008) researched ethnic inequalities in maternity service experiences and outcomes which highlight inequalities in UK maternity services still exist in

minority ethnic groups. Service provisions contribute to adverse outcomes for minority women and there are a number of barriers that block high quality care for minority women. Healthcare professionals need to be knowledgeable about their local population and involve service users to iron out inequalities. There is no room for practices that are discriminatory or oppressive further emphasising that it is unlawful to refuse or deliberately fail to provide services. This concludes that there is no room for providing poorer services and treating people differently or setting different terms and conditions for service users depending on their ethnic background.

This study demonstrates that inequalities need to be monitored, measured and effectively addressed as they occur and enabling services to be accountable for their staff and their provisions. This should include a request that healthcare staff should be adequately prepared to deal with a diverse population. More needs to be done to “bridge the gap between policy and practice” (page 6). Women from diverse, different or BME communities may continue to experience care in which they cannot communicate their needs or be understood. Such an experience is likely to leave them suffering a level of dissatisfaction and perhaps even being critical about the service provided. This will in turn contribute to an adverse experience for them in comparison to White British women who tend to know what services are available, are knowledgeable about the system and are able to ask for their needs to be met. This further widens the gap in service provisions and service user expectations.

Shaffer (2002) researched factors influencing the access to prenatal care by Hispanic pregnant women. Forty Six Hispanic pregnant women over a 12-month period were interviewed over the phone using 5 semi open ended questions. Results indicated Hispanic women were more likely to attend prenatal care when a healthcare professional demonstrated cultural sensitivity especially when the healthcare provider was bilingual. Such findings elaborate that not only was Spanish speaking important in communicating but also the healthcare providers knowledge of customs, cultures, traditions, expectations and norms were important factors for the patient when accessing prenatal care. Factors influencing their access was the availability to the clinics and having a healthcare provider with whom they could converse. An inability to have this experience could become a barrier to women accessing services concluding the importance of women having someone to translate their healthcare information. In addition they should have someone they could talk to about their feelings who had knowledge about their culture as an important reason as to why they might access services.

Kawaga-Singer (1997) also supported the notion that practitioners should have the ability to base their care on the needs of the culturally diverse community. Data captured demonstrated that having a service which was culturally attentive enables practitioners to increase their“ability to think critically both in the community and with individual assessments, develop relevant programs and ultimately increase positive outcomes” (p.95). Shaffer (2002) suggested a healthcare professional’s knowledge of the culture they work with increases the patient’s confidence and their engagement with the service provider.

Diversity in healthcare: Time to get real by Armada, et al (2002) was undertaken to understand the value differences between immigrant patients and western medical providers. This included racial disparities, cross cultural value differences and providing language access. Findings suggested that focusing on employing a diverse group of staff, especially in higher leadership positions, enables services to focus on the quality of care provided and address the changing cultural need of those that access the NHS. By employing a diverse population we would have much more access to ideas and the needs of a culturally diverse population. This should include an emphasis on the process of care, interpreting services, providing healthcare staff with educational and training strategies particularly focusing on a patients' healthcare beliefs, values and behaviors ultimately giving "the provider tools and skills to effectively address clinical issues" (Armada et al, 2002: p.13) and the needs and requirements of the diverse population coming through the doors. This indicates the importance of training healthcare staff to understand the cultural background of their patients to provide a focused intervention meeting the needs of a culturally diverse population.

Data on ethnicity, race and language would give the provider insight into what their patients needed from them which would ultimately lead to patient satisfaction. This is also reflected by the World Health Organisation (WHO) in an article on how health systems can address health inequities suggested linking this to migration and ethnicity stating that "babies of mothers who themselves had immigrated to England and Wales from the Caribbean or Pakistan had higher infant mortality rates" (2010: p.10). There were a number of contributory factors to this including individual lifestyle, social and community, socio economic and environmental

conditions. Measures were introduced to promote health services including research, education and the need for migration and ethnicity as part of a comprehensive health equity agenda.

2.5 The transition to motherhood

I have widely researched the literature in the field of maternal health in order to explore the experiences of women in their journey of motherhood. There is an established study (Rubin 1967) which explored the criteria of role-taking by conducting a comparative interview of women who were in the process of becoming first time mothers in comparison to existing mothers who had at least one child and were having another child to ascertain how they adjusted to their maternal role.

A variety of techniques were used to conduct the interviews in both the last trimester and a number of times in the period following birth to gather a pattern of role attainment. Analysis was coded, including the phenomenological processes on becoming a mother, into separate sections. The first was a self-system consisting of the ideal, self and body image. The second was operations which involved letting go of their previous role and taking on this new role as a mother which had more to do with identity and achievement. The third was mimicry concerned with behavioral manifestations specific to bearing, giving birth and rearing a child. Similarly the fourth was role play or trying out different behaviors to accommodate their own mother. The fifth was fantasy of the gender of the baby, seeing the baby as an extension of the self and shifting between the wished for or

dreaded self. The sixth was Introjection-projection-rejection to do with the logic of a mirrored image in becoming or being a mother. The seventh was identity and this combined where they were currently in their role and where they were heading which gave a score of role achievement. The final and eighth was grief work on the loss of their independent womanhood to taking up or building in their new role of becoming a mother. The results indicated that “mimicry was a beginning operation and introjection-projection-rejection a more advanced operation in role taking” (16; 3; 245).

In the second part of this study new mothers used their own image of their mother to formulate their aspirations as ‘mother as a model’. The second ‘peer models’ in which friendships or relatives were used as a template of experience for a relatively short space of time. The third ‘referents’ included the advice and views of doctors, nurses and social media whilst the fourth ‘identification of the partner’ in which newborns were compared by the mother for traits that resembled those of their father. One distinct finding from this research was that new mothers tended to use previous generations less so and look towards their own offspring to assess the extent to which they role take. Further research concerning the factors involved that influence Maternal role attainment by (Koniak-Griffin 1983) concluded that studies evaluating the relationship between maternal identity, confidence and behavior could provide valuable information to clinicians working in this field.

The way in which a woman adjusts to motherhood and how she manages her role as a new mother including “feelings about baby, gratification in role, maternal behavior and ways to handle child behavior, infant growth and maternal

attainment” was explored (Mercer, 1986; 19). These findings suggested women who were fairly confident or able to trust their own ability were able to trust others in their environment and adjust to the demands of their baby appropriately. Whilst there were some general cultural biases in the findings the study concluded with suggestions about mothers accessing support to help them embed changes that need to be made to cope with the demands placed upon them as they develop in the role of motherhood. This research demonstrates that not everyone naturally adjusts to the demands of a new baby easily or in the same way further giving rise to my research question about the impact the process of motherhood has on an individual women and her unique experience of this journey.

Further contributions to this discussion (George, 2005) on the practical and emotional preparation women experience before the arrival of their first born child and what expectations they might have of themselves and of others is reviewed in ‘The lack of preparedness’ (Rubin, 1984 and Mercer, 1995). Following the experiences of first time mothers these researchers make an interesting observation and suggest that women who transition into motherhood underwent a fourth trimester in addition to the first three. This included the period immediately after giving birth and was defined as a significant period of transition and recovery and concluded that period of adjustment was an additional trimester. This research demonstrated a pertinent view that once a woman had given birth the focus and priority became the new born baby and the mother was often left to cope with the shifting, changing and growing demands of her new born. In the field of maternal health there is a lack of detail in the literature on how fatigue and tiredness might impact the postnatal period (McQueen and Mander 2003). Furthermore there is

little recognition about the physical and emotional experience of giving birth and caring for a newborn and how this might impact a new mother's emotional wellbeing.

Research on the responsibility having a newborn places on a mother in the early postpartum stage found that women were not prepared (George, 2003) indicating that new mothers felt overwhelmed by the demands placed upon them by the needs of their new born baby. This was described as an experience layered with a diversion of priorities, responsibility beyond their ability, no clarity of role coupled with a sense of unknown expectations and a lack of knowledge. "Mothers were frustrated with themselves and others and propelled into information seeking behavior complicated by confusion over information resources, conflicting advice, feeling unwell and isolated" (2003: p. 253). This was described as a lack of preparedness which indicated women were vulnerable, perhaps due to fluctuating hormones, with new experiences or demands like changing, feeding and attending to the new born baby. This highlighted that women who felt unprepared also felt a need to seek advice which left them feeling confused, at odds and filled them with further uncertainty.

Research further concluded these women not only experienced a lack of preparedness but increased responsibility, vulnerability, being overwhelmed, exhaustion, feeling unwell and isolated leading to a struggle to adapt to motherhood. This highlights the primary feelings of women in the hours following the birth of a new born and gives an overall general sense of what it is like for a new mother. The transition to motherhood evolves over time as do the needs of a

new mother after discharge and programs to meet these experiences should be developed. George (2003) alongside Rubin (1984) and Mercer (1995) concluded that the primary source of information for these women was their own family and friends.

The postpartum period also termed as the “fourth stage of labour” is the period after birth and has three stages (Mattea R et al, 2010). The initial period which occurs in the 6-12 hours immediately after giving birth, the second phase which lasts 2-6 weeks and the third phase can last up to six months. During this entire period the body goes through major changes in metabolism and recovery. The emotional changes were further researched by Nelson (2003) who found that there were two processes in the postpartum phase of emotional maternal transition 'emerged engagement and transformation'. In 'Transition to motherhood' this description of 'Engagement' is described as committing to motherhood and engaging in the care of the child.“does a mother open herself to the opportunity to grow and be transformed” (p.467). This research involved nine qualitative studies featuring the transition to motherhood consisting of metaphors, themes, concepts and phrases. Further findings demonstrated five thematic categories signifying areas of disruption in maternal transition which were present in both the antenatal and postpartum periods. Research found there was a temporary phase which was not unusual or felt by all mothers in the same way, this lasted between three and six months in which a new mother felt overwhelmed, uncertain, mentally and physically exhausted. This concluded “that both maternal engagement and experience were necessary to increase maternal self-confidence” (p.476). A valid point was made that giving a new mother permission to feel

mentally and physically overwhelmed and exhausted by their newborn may indeed empower her to feel validated by her experience rather than unable to engage with the experience.

Given the postpartum phase is a time in which a woman's body undergoes many emotional and physical changes (Henderson et al, 2016) I was interested in how a mother develops her maternal capacity to regulate and parent her newborn (Stern, 1998) and develop an awareness of her baby's emotional needs. Stern discusses the "positive holding environment" termed by Winnicott encompassing the idea that a child's ability to be or adjust from one state of mind to another is contained by positive, grounded nurturance which enables the child to feel safe to explore their environment and able to react or respond without any threat. This embellishes questions about becoming a mother. Initially these questions are pertinent and then they move into the background as the mother evolves. However they can be easily activated when something is wrong with her child. Stern moves on to discuss how new mothers become preoccupied with 'keeping their baby safe' and normal fears which can consume a mother and leave her feeling exhausted and overwhelmed unless she is able to activate her own sense of a good holding environment on this theme of a mothers' ability to believe she is indeed competent and able to know what she does do well and where her shortfalls might be. My research follows the findings of Stern who concluded the necessity of a 'Maternal Matrix' in which a mother has access to an experienced mother or successful parent. "The relationship a mother has with her own mother is extremely important in creating the new mother's psychological context" (102; 1251). This highlighted not only how much a new mother might lean on her own maternal figure or select

someone she can trust for support but also how much emphasis a new mother might place on her own experience of being mothered.

Similarly my research into maternal adjustment was also explored by Brazleton (1963) who confirmed the idea that a “young mother’s reaction to becoming a mother is probably founded in her own infancy and childhood” (The early infant mother adjustment: p931). This suggests that motherhood was a time of physiological as well as emotional adjustment and the neonatal period was a chance to assess how the mother and baby adapt to their environments. The period after birth is split off into three sections in which the infant begins to adjust to their new environment outside of the womb. Initially alert and responsive, to a period of being settled in which the infant is unable to rouse. A final period in which the infant displays a level of alertness alongside the mothers’ ability to display a level of adjustment as they reorganise their capacity to regulate to one another.

Brazleton (1963) compared two case studies, one in which the mother took time to know and increase her availability to understand and bond with her baby versus one in which a mother’s tense responses initiate a hesitation of her ability to move from one state to another. These studies reflect different parenting styles which in turn result in different responses from babies. This presents an important observation of how a mother interacts with her baby and how this reflects the baby’s ability to settle into their environment in the period after birth.

I studied the literature on the confidence a mother has in parenting her newborn and how this has an impact on her ability as a parent. This was followed by Douglas et al (1991) looking at the role of child development and assessing how mothers' perceptions of their ability affected their parenting skills. The interactions of 48 clinically depressed versus 38 non-depressed mothers were observed. Findings suggest there is a direct link with maternal self-belief which affects behavioral competence. The research concludes the way in which a new mother adapts to motherhood is directly influenced by modelling influences like significant people in her life.

Crnic et al (1983) studied the effects of stress and social support on mothers of premature and full term infants and this research indicated mothers who were more prone to stress were less positive and mothers with a higher level of support were much more positive. Such social support for the mother also had several benefits on the development of the newborn baby. In particular, intimate support from someone the new mother was close to was beneficial. In essence "social support seems to be a meaningful, ecological variable influencing parenting attitudes, mother-infant interaction and infant development" (1983; 54; 216). There were no astounding differences between the infants that were premature or full term.

2.6 The emotional development in the newborn infant

I was interested in how a mother is able to attune to the needs of her newborn in the postnatal stage and explored how the emotional needs of a new born baby are met at a time when a woman's body is going through physical and emotional

changes from the initial after birth recovery process. Conway et al (2006) explored whether there was a relationship between emotional resilience and children's behaviour adaptation, researching if maternal sensitivity and infant negative affect longitudinally predict emotional resilience during preschool. One hundred and eighty-one children and their mothers took part in the study. The behaviour of mothers and infants were coded globally using a scale and children aged 33 months were invited to take part in four tasks to induce joy or anger: popping bubbles, locked toy in a container, draw a perfect circle and tickle the bunny.

Children were videotaped and these were subsequently coded and results indicated that "emotional resilience was not associated with children's aggressive behavior but negatively associated with low levels of parent reported child anxiety and depression" (p.275). Evidence shows that preschool children are able to recover quickly and generate positive emotions displaying resilience. Emotional resilience in early childhood might protect children from the development of affective disorders in later years.

I was interested in researching attachment styles. This was explored by Fonagy et al (1991) using the Adult Attachment Interview (AAI) which was administered to 100 women at two stages, once at pregnancy and then again at a 1-year follow up. Results demonstrated that mothers of avoidantly attached children reported stressful life events had contributed to their experience. However mothers of insecurely attached children reported major life events contributed over the course of the year. This concluded that distinct differences in attachment styles could predict the experiences of the child and the parental assessments of their own

childhood as fundamental in contributing to their ability to securely attach to their newborn child.

The predictive nature of this research does not lie in the quality of the past recollection of the experience but instead it relies on the organisation of this memory. In particular, a “mothers organisation of thought concerning relationships assessed prior to the birth of her child is associated to her child’s security of attachment at 1 year” (p.896). This demonstrates the influence of the mothers’ overall thoughts in a mentalizing form in which thought is organised during her pregnancy and particularly how she feels about her baby after the birth and the correlation between this and the security of attachment.

This is further researched and explained by Bowlby (1982) in his definition of social transmission of attachment across the generations that are internalised in early life and in the infants’ expectation. This provides a template from which the growing child forms new relationships. Both researchers suggest the new born infant internalises a memory of the mother baby relationship. This experience is influenced by the mothers’ ability to recall her own maternal relationship which plays a part in influencing this newly formed relationship. These studies provide us with some understanding about the childhood research and attachment in the field of maternal attachment and childhood development.

I researched the issues concerning the complexity of a secure attachment versus just the presence of the mother. Bowlby (1988) and Ainsworth et al (1978)

developed early attachment theories in which an infant responds to different shifts in emotions when under threat depending on their attachment style. Securely attached infants when under threat turn to their caregiver for comfort, safety and security and receive this support. From this continued experience children develop internal working models (Bowlby 1998) which become inherent beliefs. Children with a secure attachment use that caregiver as a foundation or secure base for exploration. However children with an insecure attachment demonstrate anxiety in that relationship and avoid their caregiver. These researchers illuminate a backdrop to enable us to understand the importance of the mother child dyad as well as the development of the child and the important role the mothers' history has in bringing up her own child. Furthermore how this in turn influences her decisions on childrearing is important and as such this research demonstrates that this critical early caregiver attachment relationship goes onto impact critical and important relationships and the child's social and emotional stability later on in life (Feeney and Noller 1996; Rothbard and Shaver 1994).

Further research by Cicirelli (1991) demonstrates attachment in adulthood, a secure attachment and the presence of the mother continues to shape our style of relating well into our adult years (West et al 1994). The early relationship provides a template upon which other significant interactions are based. A present mother who continues to represent a secure attachment can be experienced as supportive. However an adult who has an insecure attachment with a mother who is present does not necessarily experience this presence as supportive. Crispi, et al, (1997) indicated children who required less caregiving had a secure attachment style. However Pruchno et al (1994) indicated attachments were less intense when

parents were not available to the child or attend to the child's emotional needs due to being mentally unwell. Crose (1994) concluded that despite what circumstances may bring later on in life once an attachment pattern is forged, children go on to display this style of attachment throughout their development and lifespan.

Cicirelli (1993) explored the adult relationship of daughters with their mothers and the amount of caregiving provided by the daughter. Depending on the relationship securely attached daughters gave much more burdened free care without hesitation. Insecurely attached or less attached daughters were less involved and did not provide practical care (Carpenter, D 1997). Therefore the relationship a woman has with her mother or her style of attachment is likely to affect how much support she feels she can provide. The complexity regarding support accessed by women just because they have a mother present does not mean they will necessarily feel supported. The presence of a securely supportive relationship enables women to feel supported by their mother.

I was interested in exploring the experiences of the maternity service providers working with ethnic minority women. Lyons et al (2008) used a grounded theory approach to research a maternity service in Dublin. He found that despite a number of professional interpretation services available healthcare staff continued to rely on family and friends to interpret. This raised issues about confidentiality and the quality of what was actually being translated highlighting that one of the most common difficulties was the domain of communication when working with ethnic minorities.

I was aware that different cultures and religions have their own traditions during pregnancy and birth. James (2003) found that there was a lack of understanding of these which further exacerbated communication difficulties for healthcare staff. This is an area further researched by Henley-Einion (2003) adding that cultural traditions can be at odds with the medical model. A lack of understanding and viewing all ethnic minority women as the same regardless of their country of origin, language and cultural beliefs “is not only detrimental, but also racist, as women’s individual needs are not being considered” (p.271). This further indicates a notion of covert and overt racism which created a ‘them and us’ barrier to the quality of service received by ethnic minority women. Women who cannot speak the language cannot ask the right questions. Hence communication difficulties and language barriers have a profound effect on the women’s access to maternal care.

One of the most pertinent conclusions of this study was that ethnic minority women were expected to adapt to the services they were provided with whilst not being able to make any demands from it. This meant that they had to take what was offered and were not able to ask for their needs as new mothers to be met. The study was used to inform policy papers for improved interpretation services and introduce link workers. This highlighted the gap in why ethnic minority women do not access services and if they cannot communicate they are unlikely to know what the service offers them. This also contributes to why ethnic minority women tend to rely on family members for advice and guidance because such services do not take into account the cultural traditions of women from different backgrounds.

2.7 Specific research questions

I was interested in understanding the life experience of a woman who embarks on motherhood in the absence of maternal support. My literature search has highlighted that women experience differing emotions and physiological changes in different circumstances. My research into the area of motherhood covers the notion that motherhood is a complex time when women tend to rely on family members for support, feel isolated, are less likely to seek support from professionals they do not know personally and is a time that could result in postnatal depression.

Chowdry (1997) considered cultural dimensions of pregnancy, birth and post-natal care on Indian women giving birth in Australia. Health related beliefs, pregnancy, birth and infant aftercare were discussed as traditions that were carried out in Australia by new mothers. Cultural differences would have been carried out if these women had given birth in their own country of origin. However despite these women being in a foreign country they continue the tradition of the baby being a part of a community or a family member rather than an individual that is a separate self. Continuing cultural traditions enables them to focus on community in a ritualistic sense. Women do not see the baby as an individual separate from this despite the baby being born in a western culture as they continue to uphold their practices and beliefs. In a western community the new mother seeks to individualise the baby and research by Kitzinger (2008) indicated what we can take from non-western cultures and impart into western practices to achieve an ambience in childbirth practices de-humanising the western birth process in which a woman submits her body to have birthing done to her rather than non-western

practices in which a dula or woman to woman practices reduce the need for external interventions.

Childbirth in India, Pakistan and Asian countries involves a greater focus on family involvement in a community setting and less of an internalized separate self. Choudhry (1997) describes the cultural differences of maternal and child bearing practices amongst women in India and how these continue to influence migrant women. It is interesting to compare how such maternal practices are either unknown or unacceptable to western services where there is a more independent autonomous sense of woman independently accessing a maternity service.

My specific question is about how women experience motherhood in the absence of maternal support especially at a time when immigration is heightened and many more women will be in a position of giving birth without direct access to their maternal families. For the purposes of my research question I will be focusing on Asian women from India and Pakistan as this is a culture I am familiar with. I therefore conclude my research has a lot to offer the field of maternal health and wellbeing. Such research would add insight into the life experience of a woman giving birth in the NHS at a time when she does not have access to her maternal family. It would give rise to service provisions and valuable information to healthcare professionals on the experiences of these women.

3.0 RESEARCH DESIGN

Research on motherhood and the absence of maternal support with Asian women is about giving Asian mothers a voice so their experiences could be understood on their own terms. I evaluated a range of research designs when thinking about the overall structure of my research question and refer the reader onto my research methodology section below in which I explain my rationale for selecting Interpretive Phenomenological Analysis (IPA) as my chosen research methodology. This is followed by an explanation of the procedures used to think about the sample size, inclusion criteria, collection of data and analysis of the themes. I end this section with a carefully considered framework for trustworthiness, ethical and risk areas.

3.1 Design

Qualitative research involves the collection and analysis of psychological data and it was important to review and consider other approaches and evaluate which method would enable me to gain an understanding of the life experience of motherhood and the absence of maternal support.

I considered various different research methodologies for a suitable method to analyse the lived life experiences of Asian women. I considered grounded theory, a technique which involves closely examining the data collected from interviews to test out a theory or hypothesis. Grounded theory provides us with knowledge on how to identify categories and then make links with how they form a relationship to one another and in essence this creates a theory (Bryant et al 2007). I took into

account that in grounded theory, Strauss & Corbin state the philosophy is to expand upon an explanation of an experience or phenomena.

Grounded theory offers a complex methodology and in particular the early theories highlight a more positivist base identifying and integrating categories from the data categories generating both a product and meaning. This involves analytical concepts such as categorising data, or applying descriptive labels. This also involves analysing and coding, moving back and forth by constant comparative analysis of the coding, identifying similarities and differences in emerging subcategories. Negative case analysis enables the researcher to qualify data adding depth to the emerging data with theoretical sensitivity, sampling and saturation, memo writing and a research process and question, followed by data analysis and a report.

However not every researcher uses these principles and techniques of grounded theory in the same way. In fact each researcher uses their own approach tailored to their research purpose generating their own version of grounded theory as described by Moore (2009).

My research sought to explore a specific lived life experience exactly as it was for a participant at that time. Therefore this methodology would not have been suitable for the purpose of my research as I was not looking to co-construct meaning. Grounded theory in its earlier form highlights a more positivism base from the work of Glasser and Strauss (1967) using a hypothesis centered on conceptual ideas to

make sense of and understand behaviour. Grounded theory seeks to make and understand links. It falls short of being a technique that can explain why the links have a relationships with one another.

As such this method would not fit with my research idea because I was not looking at developing a theory. I was looking for an approach that enabled me to engage in understanding the life experience. Philosophical developments in grounded theory are advanced by Charmaz (2008) who discusses social constructivists in which meaning is created as individuals interact affirming the researcher and participant create and interpret meaning as they interact.

Charmaz (2006) strikes a balance between positivism and postmodernism taking into account the data and how meanings are constructed defining philosophical developments in the constructivist grounded theory which assumes relativism by taking into account the researcher's knowledge. Grounded theory identifies, maps and builds a process and therefore shares some features of phenomenological research which is more focused on the thoughts and feeling and phenomenological process of enquiry rather than the context.

Further methods explored were discourse analysis by Gee (2005) used to understand the personal, practical and political implications of how language is used to communicate. Discourse analysis focuses on the construction of language by using an interpretation of the texts. It "examines how people use language to construct versions of their worlds and what is gained from these constructions"

(Lyons et al: 2007, P:100). This method would not have been suitable as my research aim was to understand the experience rather than the type of language constructed.

However narrative analysis could have been a consideration for my research as it concentrates on the organisation of knowledge which is valuable and takes the story as the investigative focus Bruner (1991). Narrative approach takes into account the story told in a person's account of their life, exploring this account of their life and how it is narrated "collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus" (Clandinin & Connelly, 2000, p. 20). Hence narrative enquiry takes into account the researchers' subjectivity when trying to understand an experience or viewpoint Wang et al (2015).

To make sense of the approach a three dimensional space within the narrative structure enabling experience in a personal and social context was explored by Dewey (1938). Interaction, continuity and situation understanding made by the person telling the story and making sense or meaning out of their situation in the past, present and future is equally important in this approach.

Whilst my research intended to take the participant's story into account it was specifically geared towards a life experience of this story and not just an account of it. Therefore narrative analysis fell short of the correct method needed to analyse my participant's experience. I wanted them to re-tell their encounter in a way that

enabled them to engage with this experience and not in a way that allowed them to give me an account. "Narrative is someone telling somebody else, on some occasion and for some purpose, that something happened to someone or something" (Phelan, J et al, 2012, p. 3), a form of communication from one person to another making sense.

Phenomenology theorists such as Husserl (1931) regarded the individual experience as the source of knowledge as described by Dowling (2007), conceptualising phenomenology as a way to understand meaning in experiences whilst Heidegger's hermeneutic phenomenology emphasised interpretation and the participant researcher as the process for this. Heidegger's approach had more to do with being, understanding and personal engagement as expressed by Wilding and Whiteford, (2005). Husserl is further explained as descriptive based on what we know as people and Heidegger as interpretative, as being and seeking meaning. My research was about seeking meaning and I therefore believed that Heidegger presented a pre-requisite for Interpretative Phenomenological Analysis (IPA). Therefore this methodology would give me the opportunity to gain a deeper understanding of the participant's experience of this phenomena.

Van Manen (1990) defined hermeneutical as the participants' phenomenological experience and their interpretation as their lived experience of a phenomenon explained by Alase (2017) whilst Moustakas (1994) advocated for bracketing of the researchers experience whilst gathering the phenomenological enquiry and focused on the lived experience of the participant. Smith, Flowers and Larkin (2009) transformed phenomenology capturing the experiential and qualitative

aspects of research into Interpretative Phenomenological Analysis (IPA) as termed by Smith (1996). Having considered other research methodologies I explored IPA further (Smith et al, 2009). I decided that I was looking to understand an account in the way something has been experienced from my participants' perspective and explore this recollection.

3.2 Methodology - Choosing an IPA Approach

My research question originated from my own life experience and IPA “invites the researcher simultaneously to put aside their own experiences so they can enter the world of the participant and actively use their background knowledge, values and beliefs to interpret the experiences participants express” (Lyons et al: 2007, p. 163). This allowed me as the researcher to reflect on my dual lens in which I combined my life experience as a patient and my role in the NHS as an AHP and use these in the essence of research. This allowed a co-created intersubjective process to develop as described by Gadamer (1975) as a “fusion of horizons” in which the participant and researcher bring together their experience of the phenomenological shared understanding they hold. Transparency and my relationship to this area of research was taken into account and the mother tongue of my participants was also taken into account in case they decided to conduct the interviews in Urdu or Hindi.

My research was designed to capture the participant's life experience of mothering without maternal support. I was interested in their individual experience and wanted to learn about this and IPA takes this method of acquiring this knowledge

into account. "IPA is an inductive approach concerned with understanding an individual's personal account of a particular experience" (Clarke, 2009; p 93). Husserl developed the idea of phenomena as a philosophy, extended by Heidegger and Gadamer. Given my insider research relationship to this area of research it was important to acknowledge my own experience. Husserl's phenomenology was designed to understand the individual experience by bracketing the researchers' values or beliefs. Heidegger's perspective was that the researcher did not bracket their interest with the research question as he saw these as necessary to understand and make sense of the participants' experience (Shaw, 2001). My research sought to understand rather than elicit a description of the event facilitating me to understand the participant's experience of a major life event like 'becoming a mother' at a time when they did not have maternal support.

IPA assumes multiple connections, one in which a participant retells their experience whilst also holding in mind that how they retell their story may have an impact on them. At this moment it is down to the researcher to use their skill to interpret meaning and give a voice to what the participant might be thinking or feeling in that moment. There is also a process of making sense of what has been said with a theoretical meaning making sense of that meaning process that takes place (Eatough and Smith, 2006) and focusing on the depth of analysis.

I decided that I needed to ask participants to describe their personal life experience in detail. Furthermore IPA as illustrated by Smith (2007) uses a combination of psychological, interpretative and idiographic components. My research question fitted well within the framework of IPA as this particular

approach takes into account the individuals personal and subjective experience, which contains their experiences as unique, authentic and genuine.

I also planned to find a critical colleague and fellow researcher to read through the transcripts once transcribed and to ensure the transcripts were an accurate reflection of the spoken content. I also planned and asked this colleague to check the reliability and trustworthiness of the codes.

3.3 Sample Size

The purpose of my data gathering was to extract meaningful qualitative phenomenological data essentially to explore the life experience of ten participants. The literature by Reid et al, 2005; Hefferon & Gil-Rodriguez, 2011 suggests the sample size should be small and the focus should be on the quality of the data produced. The focus should be on the depth and description hence the quality of the data rather than on the amount. The British Psychological Society website recommends Smith (2009) suggestion of four to ten participants for doctoral studies.

Participants are selected because they have something to say about their experience of this phenomena, the richness of the data, lived life experience and account given. My research set out to understand the experience and I based my sample size on the interest of the data as the focus of IPA is on “detailed case by case analysis of individual transcripts” (Smith et al: 1997, p. 55). A further

“distinctive feature of IPA is its commitment to a detailed interpretative account of the cases” (Smith et al, 1997, p. 56). This can only be done when the focus of the research is on examining the content and description of the experience rather than focusing on the amount of data collected. I concluded that my sample size of ten participants was adequate to gain a full understanding of the life experience of Asian women and their experience of motherhood in the absence of maternal support.

3.4 Recruitment and inclusion criteria:

Only women who satisfied the following criteria were selected to take part in my research:

- Aged 18 or over.
- An Asian woman who had given birth to her first child;
- Who was in her first year of motherhood; and
- Had been screened for Postnatal Depression (PND) or had surpassed the first three months of motherhood. My reason for this was that postnatal depression is picked up in the first eight to ten-week post birth checkup following the Edinburgh postnatal depression score (EPDS). Given this is a sensitive topic I wanted to eliminate the risk of exploring this area with women who might be vulnerable. Therefore Health Visitors had screened all women prior to considering them as suitable candidates for my research. Whilst I hold in mind that the questions were framed from a western perspective and therefore this questionnaire may not have been a true reflection for the women I was selecting, I also had to bear in mind the ethics of safeguarding women who might already be sensitive and vulnerable to PND.

Ensuring participants were offered an opportunity to reflect

In phase two of the research I asked each participant to read the transcript and to ensure the transcript was an accurate reflection of their experience. I kept a research journal to ensure I reflected on the process and my experiences. I also asked my research supervisor to check the first transcript to ensure I was imparting the participant's true experience of what they said. IPA supposes that a researcher will use their interest of the topic being researched to enquire using their own lens.

My reflexive understanding enables me to think more deeply about my area of interest, my values, beliefs and all that made me the person I was during the process of this research. IPA does take into account that you cannot have direct access to like accurate life experiences exactly as they were at the time of the phenomena as described by Wilson (2002). These experiences will have been influenced by the person gathering the information and ultimately influenced by their own life experiences. It is the researchers understanding that is required to make sense of the participants' experience. Smith and Osborn (2008 p. 53) call this the 'dual process' in which the participant is trying to make sense of their experience and the researcher is trying to make sense of the participant trying to make sense of their experience.

Part of the process was how I understood and interpreted my participants' experience. One way of staying true to this technique was through the use of

research supervision. I ensured that I processed each transcript by taking my experience of this to supervision to allow space to reflect on this process. Using the research journal gave me the opportunity to immediately make a note of my thoughts and ideas so that I could reflect on the experience. I also found it useful to revisit a therapy space of my own to add clarity, reflection and to ensure I did not over identify with the research participants experience as I was an insider researcher and was mindful of this.

Finally, I asked a colleague who could speak and understand Urdu, Hindi, and English and was entirely independent of my research and the Metanoia Institute to check the credibility of the coding in ordinate and superordinate themes to confirm I had accurately coded and merged connecting themes.

3.5 Coding and identifying themes

According to Johnson (1997) there are three types of validity that can be applied to qualitative research; descriptive which refers to the factual accuracy of the description of the participants' experience; interpretive validity which refers to the extent to which the viewpoints are accurately understood and reported by the researcher; and theoretical validity as to how well the theoretical explanation fits the data derived from the participants' experience. Given validity is a positivist term I researched credibility by Yardley (2000) to ensure all aspects of the approach I used to collect the data, analysing this data and reflecting on the codes was discussed at each stage.

Before the codes could be checked, I wanted to gain an external view about the factual accuracy of my transcripts. I therefore asked a research friend (S. K) who holds a BSc (Hons) in Psychology, an MSc in Occupational Psychology and works as a data analyst for NHS England and who is completely independent of the Metanoia Institute to select sections of the transcripts and listen to the segments of these recordings thus ensuring that each transcript was an exact transcription of the recorded interview with each participant. Where Participants spoke in Urdu or Hindi she was able to listen and understand the words well enough to ensure my translation was an accurate representation of the interview.

I met with my research supervisor and went through the first four transcripts to ensure my questions were exploratory and not leading participants to answer in any particular way. I continued this process until I had administered all 10 transcripts to ensure I followed the same process for all the participants. This was important to me as it was paramount that I represented each participant's view as they said it, ensuring that the participants' viewpoints were accurately understood and reported.

Once the transcripts were checked I had arranged to meet with (Y.R) a fellow colleague at the Metanoia Institute as a critical research colleague. We met on a weekly basis to go through our transcripts together teaching one another how to code the transcripts line by line first into themes; first level, second level and third level. This joint process allowed us to bounce ideas off one another about our thoughts to gather a mutual understanding of the process and allowing us to work to the same standard using the same research methodology and furthermore to

ensure the coding and subsequent theoretical explanations were derived from the data and were truthful ensuring reliability and trustworthiness.

This process of jointly working through our transcripts allowed us to feel supported as colleagues undergoing immense pressure to complete our doctorates at a very high standard. We kept in regular telephone contact to talk over our coding categories and what theoretical interpretation of the data could be derived. Thus arriving at a theme was done systematically through a number of analyses of a piece and eventually by categorising this into themes. Going over each theme, looking at the wording and thinking about the message that these words were trying to convey allowed reflective and reflexive space through this timely process.

The topic of insider research has become a reflective piece and at times it has sparked my passion to want to voice this area of research and at other times it has become a hindrance and an obstacle to completing the write up of this dissertation. Recognising, admitting and keeping the focus of reflexivity as an insider researcher alive in research supervision, peer supervision discussions and in personal therapy has been a key part of my drive to complete this research.

3.6 Insider Researcher and the middle ground

For the purposes of this dissertation I focused on the effect that the absence of maternal support had on me as a new mother. With hindsight I could see that I had a child at a time when I really wanted and needed to be supported. Without the support of my birth family I felt very sad, alone and isolated regardless of the

situation through which I had lost contact with them. Whilst I am about to embark on research that I have a life experience of I am also aware of the position that this places me in some way as an insider researcher, however I am also in touch with my own experience and therefore this places me somewhere in the middle of this experience (Adam, 2013). In this position I am aware of my thoughts and feelings as a researcher, my role as a researcher, my own life experience and the notion of an insider researcher which enabled me to apply a reflexive approach to this research when considering the complexities and implications conducting this research could have upon me.

Much is written about insider/outsider research by Bradbury et al (2007) and their book gathers a number of studies established by researchers who have used their phenomenological experiences to conduct and establish their chosen research. The philosophy 'participatory' coins a term in which the researcher involves themselves, their knowledge and their experience of their area of interest in their research. Action research has two elements; the first is the idea of using your own experience to generate a research idea; whilst the second is using oneself to actively take a part in the research methodology to generate data.

From a philosophical position Richardson (1990) writes about insider research. I have thought carefully about using myself and my own life experience as a research topic. Being in touch with other people who have a similar life experience enables you to have shared experience and this can help to overcome separation and division of modern life. "It provides a sociological community, the linking of separate individuals into a shared consciousness. Once linked the possibility for

social action on behalf of the collective is present, and, therewith, the possibility of social transformation” (Richardson, L: 1990 p.26). I had both a desire to understand my chosen research from the perspective of other Asian women and a passion to share this research by writing this dissertation and giving these women the opportunity to voice their experiences.

I recollect attending to the everyday needs of my first-born child without anyone with whom I felt comfortable enough to seek advice, guidance or support. The early part of my journey into motherhood was overshadowed by loneliness and a huge sense of disconnection because I really needed practical support on how to parent my newborn child. I viewed myself as an insider researcher as described by Reason et al (2007) “Insider action research offers a unique perspective on systems precisely because it is from the inside” (p.644). From an ethical stance I felt being transparent about my own relationship to my research topic would engender participants to share their encounters. I informed participants from the outset that my interest in this area came from my own personal life experience and this disclosure formed part of my information sheet.

I used my research journal to note changes as they occurred and research supervision to ensure I explored my experience of conducting the research. I used a reflexive process which allowed the space for my participants experience and ensured I had a space to talk about how I approached this.

Following countless hours of my own therapy space I recalled feeling trapped, stuck and unable to move forward and either ask a professional for guidance or reach out to a friend for support. My feelings of leaving home which were left hidden came to the surface. I felt a huge sense of resentment which over time has turned into a sense of loss that my mother was not able to share that experience with me. As explained by Langdrige (2007) there are two dimensions to qualitative research. On the one hand the researcher is trying to get close to the participant experience whilst at the same time attempting to make sense of the participant's experience. This indicates participatory enquiry techniques which I have mentioned in the insider outsider literature on page 57.

3.7 Trustworthiness and planning

The data assembled came from the depth of my analysis and from my confidence that the quality of data I collected was a true and accurate reflection of the participants account. I kept a research journal in which I maintained pre and post interview notes, my thoughts and feelings about the research and meetings I had in connection with setting up the research. I also used this as a place to reflect on research supervision and the process of interviewing candidates.

Reliability in qualitative research is described as “..... dependable, trustworthy, unflinching, sure, authentic, genuine, reputable. Consistency is the main measure of reliability” (Perce et al, 2007, p. 83) further described by Lewis et al (1987) as an accurate word for word account of what is being described. Howitt (2010) encourages thoughts about the quality of the data by using qualitative methodologies to determine reliability, validity and trustworthiness and to think about the active role of the researcher and their reflexivity.

Within IPA there is a recognition that the methodology in an interview as defined by Yardley (2011) between a researcher and participant the interpretation produced is referred to as “inter-rater reliability” (Smith. J, 1999, p.216-217). Yardley (2000, 2011) further highlights the importance of judging validity in IPA by looking at the questions asked, methodology used and interpretation applied. My analysis involved what was said and what was going on for the participant. I kept a research journal to retain notes of the participants’ engagement and interaction.

I lean towards the description offered of ‘trustworthiness’ repetition offered by Lincoln & Guba (1985, p. 290) which draws my attention to four issues. I was aware as a researcher that credibility applied to whether the interpretation of the experience researched was drawn from the data. Transferability is a process in which the conclusions of research can be transferred if the interviews were to be repeated using my method, questions and style of research. Dependability and Confirmability confirmed the extent to which the transcripts and subsequent coding were a dependable and accurate paper trail of the experience the participant had described in the interview.

According to Smith and Osborn (2007) the interviewer decides which questions they will ask and constructs questions to extract the data. This is further broken down into the structured and semi structured interview in which the interviewer develops a rapport with the respondent and the ordering of questions is less

important. The interviewer is free to explore what was said by the respondent and follow their area of interest.

I conducted ten semi-structured interviews using the same format and questions for each interview. I used the same questions to start the interview and branched off to explore the answers given. I considered my participant to be the expert of their experience. My interest in their lived life experience of this phenomenon focused on facilitation and guidance. I was effectively asking one question and branching off to explore the answers given to the fullest and monitoring the affect and emotional regulation in the tone and pitch of my participants' voice when responding.

Kvale et al (2009) suggests the interviewer needs to be open to new and unexpected phenomena. During the interview process I explored the experience the participant described to me and this elicited something for them which was unique to us. Kvale and Brinkmann (2009) examine the ability to shift in the presence between the subject and the relationship to the participant retelling their story. Furthermore I viewed the interview process as an intersubjective process as described by Kvale et al (2009).

The interview was a combination of objectivity and subjectivity aspiring to a combination of both making it an intersubjective experience. Similarly when a client retells their story in therapy they will have a different experience of being heard or listened to. This combination is what makes the process intersubjective as defined

by Orange et al (1997). I thought carefully about my role as a researcher and the impact retelling an experience might have on the participant and I was therefore mindful of services I could signpost them to should they want to talk to someone in more depth.

In the event my research was repeated using the inclusion criteria and my question and subtopics and I would add that I am an Asian woman who researched a topic which focused on Asian women as the participants. My research question was borne out of my life experience and therefore this dynamic will have had a bearing on my results. It struck me that my findings raised issues with culture and how we understand culture has to be present in the workplace and amongst us as professionals in the workforce. I was able to lend myself as an Asian woman in the process of research by applying context to the culture when researching Asian women. As a British borne Asian woman who has grown up in a multicultural society I understand a code of conduct in how Asian women engage in a public setting. I therefore hold cultural knowledge and understanding of the Asian etiquettes and hold the capacity and ability to engage in a dialogue with women from different cultural settings.

My data is transferable only in as far as the issues that women spoke about in terms of their cultural expectations and their experiences in the early days of motherhood. I viewed my role in collecting data as active and participatory and as such I was aware of “the way in which the relationship between researcher and participant, including the balance of power, affected the collection of data and meaning” (Langdrige, 2007: Page 156) and how this may have affected the way

in which I explored the participants experience. My research demonstrates the implications for culturally focused researchers in which participants are culturally matched to the researchers cultural background.

I refer to validity as 'credibility' offered by Lincoln and Guba (1985) when explaining how the data was understood and interpreted. This helped me to reflect on my research methodology and lay out systematically in phase one how I gathered the data. With ongoing use of my research journal to write down my immediate thoughts I was able to explore the content of this practice in personal therapy and research supervision. What unfolded was that my own experience had become an area of interest opposed to an obstruction and this enabled me to develop the skill of compassion and understanding when concentrating on the unique experiences of each and every participant.

3.8 Potential Contribution to the Field of Maternal Well Being

My research seeks to contribute to the field of maternal health by informing clinicians in the field about the experience women face when they enter motherhood at a time when they were not in contact with their own maternal family.

Giving Women who have had this experience a Voice

From my review of the literature I have found there is research written about the experiences of women and their journey of becoming a mother and in particular the complexities during the first few days after the baby is born. My research

focuses on women's experience of motherhood specifically in the 'absence of maternal support'. What is their experience of giving birth to their first-born child at a time when they are not in contact with their birth family? Whilst there is some material available about the cultural complexities of motherhood and the experiences of Asian women giving birth in a western society I have found research that recognises Asian women tend to rely on their own families for support during this time. There remains nothing that focuses exclusively on the absence of maternal support hence my research seeks to understand and voice this experience.

Meeting Policy guidelines

In an Asian culture the mother's role is central, dominant and instrumental in the upbringing of her children. Asian women are at risk of developing mental health problems because ethnic minority groups experience greater rates of mental health problems. My research meets both the Department of Health (DOH) and National Institute of Clinical Excellence (NICE) Guidelines by conducting research into the needs of a growing diverse community and the National Service Framework (NSF) on 'Maternity matters' (2008) which contains relevant guidance for the trust on the provision of maternity services because they are obliged to follow government guidance. This document talks about meeting the physical and social needs of mothers (including mental health needs). It provides consultation on attending to vulnerable and excluded groups in which Asian women meet the criteria for a vulnerable and hard to reach group.

This has been highlighted in an NHS mandate aimed at improving the patient experience in maternity services “A long standing problem with maternity services has been concerns about coercive and disrespectful behavior experienced by women and families in particular by ethnic minorities” (Sandall. J, 2014:4). Hence the introduction of personalised midwife led care during the postnatal period has been incorporated into the NICE guidelines.

My research meets these targets because I am carrying out research on Asian women that seeks to evaluate women’s experiences by informing healthcare professionals about their current practices and future clinical and policy strategies. My research included the parent child interaction and the role of the father as well as making clinical and policy suggestions.

Raising Awareness

By asking Asian women about their experience my research seeks to understand and inform professionals in the field of maternal health by targeting G.P’s, Health Visitors, Counselling/Clinical Psychologist, Psychotherapist and Counsellors who may be involved in offering psychological support to the issues a woman from this background might face. Motherhood is a significant life event for any woman and a time that raises the chances of emotional or mental health difficulties such as postnatal depression. Whilst I have chosen not to research this area in detail, I remain mindful that the experience of my research topic on becoming a mother at a time where there is a lack of maternal support could contribute towards emotional difficulties. This ties in with the above focusing on ‘meeting policy

guidelines' as Asian women are a vulnerable group and seen as less likely to seek external services for support.

Highlight Risk Areas

My research seeks to inform health professionals about the vulnerability these women might pose to themselves and to their newborn child. Asian women may lack family support and this places a mother at a greater risk of developing mental health problems such as depression. There may be a link between women who are more likely to give up breastfeeding when they do not have support.

In a study about Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor Bryan (2003) concluded Asian women were less likely to use formal support services. This theory supports Brown et al (1978) that a 'vulnerability factor for depression is motherhood' and motherhood is a time when women are at an increased vulnerability to mental health problems such as depression, anxiety and psychosis.

There is a risk that the needs of Asian women fall outside the realm of what can be offered to them in terms of service delivery. When health professionals are not aware of or do not understand the experiences of Asian women who have their first child in the absence of maternal support this could lead to dissatisfaction in the care Asian women receive. My research seeks to highlight the multicultural issues

these women face. Further risk areas that pose a risk to the physical or emotional health of the mother or the newborn baby in any way have been removed. Only women who are not deemed as a risk have been identified as possible participants by health visitors and as being given the choice to opt in for my research.

4.0 PLANNED RESEARCH IN THE NHS

The aim and nature of my research was to explore and understand the experiences of Asian Women who have given birth to their first child at a time when they did not have support from their own maternal family. The most appropriate research method was “phenomenology – understanding the essence of experience about a phenomenon” (Creswell, J, 1998:65).

4.1 Berkshire Research Ethics Committee (REC) Approval

Following a rigorous process, the Berkshire Research Ethics Committee (REC) approved the research which took place in Berkshire Health Foundation Trust (BHFT). As an employee of the National Health Service (NHS) I can see how we deliver care and how this care is experienced varies. There is a wealth of experiences that can be researched by asking women who have used NHS maternity services about their experiences. There are a lot of medical and non-medical random clinical trials (RCT) conducted in the NHS which is quantitative. There is a growing awareness of qualitative research and the methods applied. However at the time of conducting my research I had to negotiate a number of tensions to locate my research in the NHS.

Before any research could be conducted I had to apply and undergo a series of formal Research Ethics Committee (REC) panel interviews, which consisted of a panel of fifteen senior consultants with a specialist interest in research. I therefore had to think quite carefully about my research proposal and my research technique and the paperwork I was going to use to recruit my participants. I had to think

rigorously about the wider context of the NHS and adjust my own thinking in terms of how I recruited participants so this process would comply with the rules and regulations set out by the REC.

Given that Berkshire Health Foundation Trust (BHFT) employed me and postnatal services fell under the remit of the Primary Care Trust (PCT) I had to seek the approval of two Clinical Governance Managers from each of these sections of the Trust before I could begin the research. I had to ask BHFT to draw up a contract with the Metanoia Institute to outline my responsibilities in conducting this research to satisfy the conditions set out by the REC. This contract was approved by Middlesex University.

It was quite a difficult task to gain ethical approval on a research idea based on phenomenological inquiry because the data collated is subjective and I had to negotiate tensions about how I would minimise subjectivity. One specific requirement of the Ethics committee was that I asked the same set of questions to each participant to ensure my research was not biased but fair and consistent. I designed a list of themes/questions I would ask all ten participants which complied with the ethics committee. The crux of tensions was that my application was not designed to conduct research on an NHS structure. Instead my research was an enquiry about the process. At times this process felt like an impossible task but with perseverance and support from my Metanoia research supervisor and the BHFT Clinical Governance Manager I attained REC clearance to begin my research.

4.2 Clinical Governance

The Clinical Governance sector had a further set of conditions to permit my research and I had to qualify for a 'research passport', which is a tick list to safeguard and protect the patients in the NHS. This document signified that I was a safe employee and qualified to carry out research on patients in the NHS. This gave me formal written permission to conduct the research. I therefore had to undergo a series of meetings with the allocated Clinical Governance Manager for BHFT through whom we devised a contract which would enable me to carry out research for the PCT whilst allocating the responsibility for me as an employee to BHFT and the Metanoia Institute. This was a lengthy and at times an incredibly challenging process. All of this continued to be subject to the conditions of my REC approval. Given that BHFT was a registered stakeholder for a number of NICE guidelines my entire research also needed to take into account the clinical governance agenda framework and NICE guidelines for postnatal mental health.

My final sign off meant I had to have an enhanced Criminal Records Bureau (CRB) disclosure check and a final interview with BHFT Human Resources Department to achieve the sign off for my research passport which formed my written permission to conduct the research. At times this process left me so far from the topic I was interested in researching I almost lost sight of my research. I knew I had a valuable research idea but just getting started seemed like it was a million miles away. I had so many formalities to achieve. In hindsight these formalities are designed to protect patients of the NHS by ensuring I am safe, capable and qualified to conduct the research. Fortunately the topic was a personal area of interest for me and therefore even on days when I felt I had so much to get through I managed to

remain faithful to my goal of conducting my research in the NHS. After what seemed to be an endless process I finally achieved clearances from the REC and obtained my research passport and a contract set out jointly by BHFT and the Metanoia Institute.

4.3 Sampling Issues

Because the research topic was intertwined with my own life experience I found myself feeling quite apprehensive that participants might not be willing to disclose such intimate life experiences with me as a researcher as I stepped out into the Health Visitors Clinics set up in the Berkshire Area and introduced my research topic. Health Visitors, doctors, nurses and other professionals involved in the overall care and well-being of women were actually very interested to learn. They were keen to understand and gain insight into the experiences of women who give birth to children at a time when they do not have maternal support from their own birth family. I began to speak to Health Visitors running clinics in community settings where women who had experienced my research area might be available to take part in my research.

4.4 Description of Proposed Sample

The team of Health Visitors seemed quite confident they would know of women who attended their clinics who would fit my criteria. Recruiting candidates by talking to someone who knows someone is a 'purposeful sampling strategy' and is described as "snowballing – identifying cases of interest from people who know people who know what cases are information-rich" (Creswell, J, 1998:119). This technique meant I could locate candidates who had experienced the issues I was addressing in my research and having read my participant information sheet they

would then participate in my research because they were interested in sharing their experience.

Snowballing is a method used for collecting qualitative data and has been explained by Noy, C as data “can generate a unique type of social knowledge that is emergent, political and interactional” (2008). The suggestion here is that professional relationships are used to build Social networks and recruit people who are interested in taking part in my research topic because they have had this life experience.

Snowballing is described by Hendricks et al (1992) as an informal method used to reach a target population and furthermore described by Snijders (1992) as a method to get a deeper understanding of a group of people. Both of which my research aims to do by asking health visitors to identify participants that they know might have experienced my research topic.

The table below sets out the range of clinics in the East of Berkshire.

4.5 Table 1 - Health Visiting Clinics in East Berkshire

Geographical Area Of East Berkshire	Location	Day & Time
EAST	M.A Children's Centre	Tuesday 9:30am– 11:00am
CENTRAL	J.E Children's Centre	Tuesday 9:30am– 11:00am
CENTRAL	M.C Children's Centre	Tuesday 9:30am– 11:00am
CENTRAL	S.M Children's Centre	Tuesday 9:30am– 11:00am
CENTRAL	I.Q Children's Centre	Wednesday 9:30am – 11:00am
SOUTHWEST	S.S Children's Centre	Wednesday 10:00am – 12:00am
NORTH	B.W Clinic	Wednesday 2:00pm – 4:00pm
EAST	O.R Surgery	1 st Wednesday of each month Wednesday 10:00am – 11:30am
EAST	L.H Centre	Thursday 9:30am – 11:30am
NORTH	P.W Children's Centre	Thursday 10:30am – 12:00am
SOUTHWEST	C. M Centre	Thursday 1:00pm – 3:00pm

4.6 Locating the Participants

In order to liaise with the Health Visitors, I went out to each of the Health Visiting Clinics to familiarise myself with the process of how the clinics were run. I felt my physical presence would help both the Health Visitors to introduce my research

and potential candidates to feel welcomed and encouraged to participate in my research.

To familiarise myself with the Health Visiting team and their senior team leaders/managers I arranged to meet the strategic lead and introduce myself and my area of research. I was invited along to the Health Visitors team meeting so I could meet the Health Visitors who were running the clinics listed in Table 1. This gave me the opportunity to introduce both myself and my research topic and to ask the Health Visitors for their support in assisting me to recruit candidates. What was apparent was that there were certain clinics where Asian Women would mostly attend and these clinics were mainly located in the EAST and CENTRAL locations. There were certain clinics where Asian women tended to locate themselves and this was purely due to where they lived and what was locally available for them within walking distance because a number of these women were not able to read or write in English and could not drive a car.

The Health Visiting team were particularly supportive of my research and welcomed me gaining a better understanding of the setup of their clinics. In doing so I was able to gauge which clinics would be the ones where my sample population would attend. The only struggle I encountered was that all the clinics relevant to my sample population began at the same time and on the same day. I therefore attempted to attend as many of the EAST and CENTRAL clinics as I could.

I began to develop a rapport and a link and I felt encouraged by the Health Visitors because I started to feel they were my colleagues. When the clinics were rushed and incredibly busy I too was encouraged to participate in setting up the materials. This involved laying out literature on maternal matters, setting up the weighing scales and mats to make access easier for the mothers to undress and lay their baby on the scales. Also ensuring there were plenty of cleaning rolls and wipes to adhere to infection control procedures. At times there were so many mothers waiting to enter the weight and plot the chart in their babies red book I would often step in and write these up for the Health Visitors which freed them up to deal with queries from the mothers. This built a working alliance between me and the Health Visitors and gave them the reassurance my research was to support their existing work with Asian mothers as well as potentially providing what additional support these mothers might access. Soon they became enthusiastic about my research and were incredibly supportive in recruiting candidates for my research. They ensured only candidates who met my research criteria were selected and they contacted me with the candidate's permission to pass her details to me.

4.7 Data Collection

As the Health Visitors recruited candidates, I then contacted each candidate and invited them to meet me at a clinic location at a time suitable for them. At this point I checked if they wanted to bring their baby with them and informed them of the facilities available. As the majority of centres were children's centres within schools or G. P's surgeries they were well catered and set up to accommodate buggies, babies and hygienic nappy disposal as well as manage infection control by use of alcohol gel and sinks to wash hands and provide drinking water.

By attending the Health Visitor's clinics, I became familiar with the staff and set up at each location and I had a working knowledge of how the clinics ran and familiarised myself with the process and my responsibilities as both an NHS member of staff as well as a researcher. I was at times mindful of my dual role held in the course of my research and remained incredibly aware of both my role as a researcher balanced with my area of research interest together with my ethics as both a researcher and an employee of the BHFT. I was humbled by the support I received from the Health Visitor's team and the time they took and the care they gave to me and my research. I was often present at the clinics and observed them recruit candidates for my research. I often experienced a powerful feeling of compassion for the Health Visitors and the work they did and felt very appreciative I had the opportunity to work alongside them to conduct my research.

By working collaboratively with the Health Visitors I ensured only candidates who met my criteria were selected. By being present at the Clinics I confirmed that only candidates who were interested in sharing their experiences were recruited. I believe my physical presence was to some extent a declaration of my commitment and passion for my research topic. This process eliminated any uninterested candidates.

4.8 Table 2 - Candidates selected by Health Visitors and invited for an interview

Clinics	Sample Size	Number of Research Participants
Candidates Recruited from the EAST Clinics	N = 6	4
Candidates Recruited from the SOUTH WEST Clinics	N = 1	0
Candidates Recruited from the NORTH Clinics	N = 0	0
Candidates Recruited from the CENTRAL Clinics	N = 8	6

Total population size of 15.

Explanation of the above table: Once I received 10 completed participant screening forms and found that some of the participants were not available to take part in the research I continued to recruit until I had 10 available participants. This meant that I received 15 (N=15) completed participant screening forms from the health visiting team.

At no point were any of the participants turned away or refused an interview but out of the 15 possible participants 5 declined to take part for the following reasons; 1 declined stating that she had changed her mind, 2 participants stated that they were returning to work and could not commit to an interview date or time and

therefore it was not convenient for them. The remaining 2 participants were returning to their native homes in India and Pakistan to be with their maternal families and therefore they could not commit to an interview in the foreseeable future. In meeting with the five participants who declined to partake in the research I reassured each one of them that they were free to change their mind at any point in the research selection during and after and that their withdrawal had no bearing on the service provision provided to them by the NHS. This was offered to all participants who took part ensuring that all participants were treated fairly and in accordance the requirements set out by the REC.

I was mindful of the REC guidelines and reassured each candidate who did not want to take part that the care they received as a patient of the NHS would not in any way be affected by their decision. I also reiterated to each candidate who did want to take part they were free to withdraw from my research at any point without giving me a reason. Again the care they received as an NHS patient would remain unaffected. As a result five candidates declined to be interviewed and ten candidates proceeded to then give their informed consent to become research participants in my research on motherhood and the absence of maternal support.

4.9 Interview Structure

The focus of the research was narrowed down to one question:

Please tell me about your experience of giving birth to your first child without the support of your maternal family?

This question highlights the mothers' interaction with her family.

I had six possible prompts that I aimed to feed into the narrative of their experience as appropriate;

1. Quality of the participants' relationship with her own maternal family?
2. Meaning of support?
3. Impact of the lack of maternal support?
4. Cultural importance of women and their role as a mother?
5. Quality of their partnership, relationship with the baby's father?
6. Is there anything you feel is important about your experience that you would like other health care professionals in the field of maternal health to know about your experience?

4.10 Subjectivity

Inevitably there are variables that could be taken into account as my own subjectivity or my view of the class or culture a client comes from could affect the data gathered. Nonetheless the document National Service Framework (NSF) on Maternity Matters seeks to highlight encouragement to conduct research on vulnerable and excluded women. Asian women tend to fall under this category because they do not access services. I was keen to ensure my research remained

open to such variables to include women who might not usually step forward to impart their life experiences due to language or social exclusion barriers.

Although I appreciated the need to consider my own subjectivity when analysing the data I also agreed with the conditions set out by the REC that women should not be selected for my research by class or status or any other inclusion criteria. I wanted to encourage Asian women to come forward with their experiences and including them in my research because they wanted to take part and share their experiences. This was an inclusion criterion as long as they met the initial recruitment criteria. At this point only those candidates who agreed to be interviewed became participants for my research project. I acknowledged the ethical significance of taking what these women might say and writing it down with integrity, care and compassion for their lived life experience.

4.11 Analysis of the Interviews

My questions were unstructured and open ended as Kvale et al (2009) suggest, the interview was collaboratively produced and this gave me the flexibility to explore individual participant experiences. I designed one question and used this as my focus. Once I had branched off with answers to my initial question, I used the subtopics quite naturally because my initial question was broad enough to inquire. IPA emphasises individual experience and this way of branching off ensured I remained consistent with my line of subsections and also allowed me to freely enquire about my participant's experience to the full.

I was aware of the power imbalance. My research was borne out of my own life experience “When we talk about the world we live in, we engage in the activity of giving it a particular character. Inevitably, we assign features and phenomena to it and make it out to work in a particular way. When we talk with someone else about the world, we take into account who the other is, what the other person could be presumed to know ‘where’ that other is in relation to our self in the world we talk about” (Baker, C, 1992: 9). I thought carefully about my interview style and agree with research conducted by Kvale et al (2009) that a combination of techniques could be deployed during the interview process. The technique I used was to take the answers my participant gave me and use these as further investigative areas.

I see the ultimate goal of the interview as an opportunity to understand my participants’ experience and this technique of branching off allowed me to track my client’s experience. I transcribed and analysed each transcript before I conducted the next interview. This process allowed me to confirm that my questions had allowed participants to express their view. I did this by returning the transcribed transcript to them to check and using my research journal to make notes about my experiences. I reviewed my reflective notes in my research journal and noted my experience as a researcher. I took this experience to my research supervision sessions and used supervision to reflect on the interview process. This allowed me to check I was asking about an experience and branching off to enquire further. This guaranteed the data gathered was a true reflection of the interview question.

Each transcript was posted out to the relevant participant approximately 3 weeks after our first interview (phase one) and at least seven days before our second interview (phase two).

4.12 Reflexivity

Whilst each participant brought forward a wealth of individual life experience I remained aware of the limitations of the interviews. The majority of research on interviewing styles is written from a white western philosophy. Having been born and brought up in the UK I could see the barriers to the cultural differences because I was born to Asian migrant parents and was influenced by my upbringing.

I soon became conscious of the unsaid or unspoken elements. I was acutely aware of the unspoken presence of the participant as she walked into the room including the colour of her skin, the smell of incense and perfume that came from her clothes together with the bright colour of her shalwar kamiz (Indian suit) and the matching bangles and jewelry. I became mindful of the cultural heritage and identity they brought into the room with them being an Asian woman living in the UK not necessarily having been born or brought up in the UK. "Good interviewing skills require practice and reflection by getting people to describe their own experience in their own terms" (Rubin & Rubin, 1995: p.2). I was aware of my own countertransference and I was mindful of how this experience brought me in touch with my own cultural heritage. I believe this experience sharpened my senses and enabled me to regulate my emotions and engage in a way that was sensitive to the culture of the participant sat in front of me.

What was not said in the interview was often also rich in cultural beliefs present in the way the woman carried herself into the room. This was often a statement about her class or educational background. I was acutely aware of these differences potentially becoming variables for consideration and attentive to how my subjectivity could interpret or become a barrier to women who access services.

4.13 Review of the Transcripts

An important part of the interview process was that of ensuring the accuracy and the quality of the participants' transcripts by including them in the process of verifying what they had said in the interview was transcribed accurately. I made a date for the second interview with each of the ten participants which was a follow up review in 4-6 weeks' time. This gave me the chance to consider the reflective space of the participants during the period of motherhood. After I typed up the transcript I posted a copy of this to the participant approximately seven days/1 week before our second meeting. This formed part of my validity check and gave us both the opportunity to consider the content of the transcript to check for accuracy and ensure the transcript was a true representation of the participant's experience. This held an element of ethics as this gave the women an opportunity to read the transcript in its exact state and word for word exactly how they reported their experience. This also satisfied the REC's requirements that participants were aware of the contribution they were making to my research.

The reflective space gave me a chance to explore if any therapeutic resources or further support services were available to the participants post interview and to assess whether these services were culturally sensitive and appropriate for the needs of Asian women. The second meeting was an ethical check and a reflective space to see what effect if any the interview had left on the participant and to form a closing session as we ended.

4.14 Cultural Issue on Interviewing

Although I had left a six-week gap between interview one and interview two. I continued to attend the mother and baby clinics to gather more participants for my research. The participants I had interviewed continued to approach me and there was ongoing contact with the participant outside of the interview. These participants were often interested in asking me how my research was progressing, showing me their baby's progression and how they were coping with the demands of motherhood. In Smith (2007) the interview process is described as one structured meeting designed to understand the participant's experiences and does not take into account the interaction outside of the structured interview. I had to carefully manage the delicate nature in which they had shared their personal life experiences with me and maintain confidentiality as I saw them in an open clinic. By inviting them to take part in an interview and asking them about their experience I had become someone they trusted and appeared to be at ease with. Culturally from my own upbringing in an Asian society my experience is that once you liaise professionally Asian women tend to become familiar with you and engage in a trusted relationship. With this in mind I managed the dynamics in a way that enabled me to stay in touch with them in the moment and ensured that

we did not become over familiar with one another, ensuring compliance and confidentiality was maintained between us.

This way of thinking ensured I remained mindful of the possibility of meeting a participant before the second interview and yet prepared me to contain the space for the second interview. Somehow this space in between gave me a sense of closeness to the participants experience I had not already taken into account as I was holding them in mind not just as a participant whose voice I had transcribed but also as a woman with whom I potentially could have an ongoing interaction in the physical clinic space. I found myself moving into the first interview as a researcher, out of this space as a recruiter and then back into another space as an interviewer who had established a rapport with the participant for the second interview. Finally I knew I would continue to engage with these participants in the clinics so we continued to have an ongoing dialogue because they had become familiar with me.

It was unavoidable for me not to be affected and impacted by the warmth and ultimate sharing these women had taken the time and trust to share with me which I valued. The space gave me an unexpected sense of closeness, intimacy and connectedness. I was mindful and respectful of containing and protecting the space in between giving the participants who wanted continued interaction to approach me. All ten participants continued to engage in this way with me. I was mindful of how this continued contact could enhance how I interpreted the analysis of the data. I was acutely aware also how I might misinterpret the data because I

had become too familiar with the participant. Hence the second validation/member check became a more important feature of the validation of my findings.

4.15 Phase Two – Validating the transcripts

After the first interview I made a date for the second interview. Once I had transcribed each interview seven days before our second meeting I posted a hard copy of the transcript to each participant and interestingly enough the space helped to enhance the second interview.

This meeting gave me an opportunity to appreciate the depth of the participants experience and the impact of seeing how they reacted when they saw the level of detail and the time I had taken to transcribe their experience in writing. All ten participants were equally amazed by the level of detail that emerged from each transcript. Participants were equally pleased with the quality of the transcripts and made only a few minor adjustments. The initial purpose of the second interview was to validate the data, check the quality of the data collated and to ensure I had accurately interpreted exactly what the participants had said.

This was an open opportunity for participants to consider the content of their transcript and to have equal control over their stories of motherhood and the absence of maternal support. None of the participants ticked a box requesting a copy of the analysis on the intake form and therefore no further data was sent to them. This also formed a closure to our first meeting which had in essence opened up their experience and provided a reflective space to validate their experience as genuine and real.

4.16 Thames Valley Mental Health Conference

The Thames Valley Mental Health Conference took place on 16 December 2009 at Reading University at which a poster session was run by Berkshire Healthcare Foundation Trust (BHFT) to complement the speaker's presentations. It was an opportunity to display the research carried out within the trust and strengthen our research links. Expressions of interest were called for and I was one of the successful candidates who was asked to design a poster board for my research (please see Appendix for a copy of my presentation). The posters were available for view during the coffee and lunch sessions and we were asked to provide information sheets for delegates wanting to contact us to get further information if they were interested. I attended the conference and this gave me an opportunity to raise the profile of my research on motherhood and the absence of maternal support and a significant opportunity to network with other researchers within the trust.

This was also an opportunity to highlight a qualitative study amongst many Quantitative Randomised Clinical Trials (RCT) studies as my poster board stood out as one of the very few qualitative studies. This generated a huge amount of interest and a number of delegates expressed an interest in my research area. The majority of these delegates were from healthcare professionals in the field of children's wellbeing.

5.0 RESULTS

5.1 Interview Data

The interviews were designed to explore participants' experiences of giving birth to their first child without maternal support from their own birth family. "The primary issue is to generate data which gives an authentic insight into people's experiences" (Silverman, D, 2006: 198). The research set out to explore participants' experiences in words. However the data was also set out to capture their emotional experiences and where possible to be able to put words to these not necessarily in English but at times in their mother tongue (please see Demographics table for further clarity on this).

All ten interviews were transcribed and the results were analysed into first, second and third level codes. From an IPA technique my data focused on the meanings derived from the ordinate and super ordinate codes. Each transcript was then member checked and the data was validated as described in the previous section.

At the end of each interview each participant was given an information sheet about services they could contact if they felt upset or distressed about the intimate material they discussed during the interview. For each of the participants their main form of support was their husband although on very rare occasions a few of the participants lived in an extended family context and had some support from their in-laws; no other forms of support were mentioned.

5.2 Demographics

The demographic form captured data about the participants.

Participant Code and Name	Age Range	Cultural Identity	Age of baby	1 st or 2 nd Generation	Language of Interview
(001) Taran	31-35	Indian	6 months	1 st Generation	English
(002) Savarshi	26-30	Indian	8 months	1 st Generation	Urdu
(003) Zaynub	26-30	Pakistani	5 months	1 st Generation	Hindi
(004) Amber	21-25	Pakistani	5 months	1 st Generation	English
(005) Mala	31-35	Indian	4 months	1 st Generation	English
(006) Aliya	21-25	Pakistani	3 months	2 nd Generation	English
(007) Simi	31-35	Indian	6 months	2 nd Generation	English
(008)	25-30	Indian	3 months	1 st	English

Ayesha				Generation	
(009) Nakita	31-35	Indian	3 months	1 st Generation	English
(010) Jacqueline	31-35	Indian	8 months	1 st Generation	Hindi

All ten participants were married and had some form of an arranged marriage which meant their birth parents had been involved in arranging the marriage. Nine participants had been introduced to their husband through their parents. Only one participant had met her husband through work and had chosen to marry her husband. Nonetheless all ten participants had parental support in the arrangements and lead up to their wedding. Each participant was married to a man of exactly the same culture and class they were from so there was an equality of language, cultural identity, religious beliefs and economical status.

Each participant was asked at the beginning of the interview which language they felt most comfortable to use in the interview. As such seven participants chose to speak in English using Hindi or Urdu words occasionally. Two participants spoke in Hindi fluently and one participant spoke in Urdu fluently. I was able to speak those languages and was able to translate each transcript into the English written language. Each of the transcripts was then member checked as per details in my methodology section.

All ten participants had no support from their birth parents because they were living in the UK through marriage to their husband. Eight participants had migrated to the UK following marriage to their husband in India or Pakistan hence 1st Generation Asian and two participants were born and brought up in the UK had married their husband but did not have support from their birth parents because they lived in another country hence 2nd generation Asian.

5.3 Identifying Themes based on participants experiences

Level of Theme	No of categories	Description
1 st Level Themes (Preliminary Themes)	4	<p>First level themes emerged naturally from the research as I grouped together 20 meaningful categories four themes took shape:</p> <p>Cultural expectation of support (5.6)</p> <p>Newness of being supported by their husband (5.7)</p> <p>The Emotional and physical impact of having a baby (5.8) and</p> <p>Pre and postnatal experience of having a baby in the NHS (5.9)</p>
2 nd Level themes (Subordinate Themes)	20	<p>I grouped together the third level codes into meaningful chunks and summarised what each participant was saying about their experience. This led to a further grouping of 20 themes. These subsections were then used to formulate the results section and became the sub headings for the relevant data</p>

		captured.
3 rd Level themes (Superordinate Themes)	70	These themes consisted of sentences and the immediate thought or feeling that each participant used to describe and express their experience in words. There were 70 third Level themes.

The data was split into three levels of themes (please see table 5.5 for details).

5.4 Grouping the data into Themes

As a reminder this is a summary of how I analysed the data. I went through each interview transcription manually as I wanted to derive the themes by personally going through the data line by line and immersing myself in the data. I made a note of the key issues and grouped them. This is how I derived the first level (preliminary) themes which resulted in 70 themes I reflected on these emerging themes during research supervision and began to look for commonalities for example where there were feelings I grouped these into emotions. I further reflected on this process and continued to merge themes, kept a reflective journal, discussed the themes during peer supervision and then grouped them into second level (subordinate) themes like the expectation of support. Once all the interviews had been transcribed these were further grouped into the third level (superordinate) themes as the cultural expectation of support. Initially I was looking for repetitive patterns and single words, then common sentences that were similar in language and meaning as listed in table 5.5. I was able to group these into similar themes, the process of transcribing the interviews served as a

reminder of my felt experience as a researcher and enabled me to group these collective experiences and narratives into meaningful third level themes.

5.5 Detailed table of participant themes derived from the data

1 st Theme (preliminary)	2 nd Theme (subordinate)	3 rd Theme (superordinate)	Participant Name	Line Number	Extract from Quote
Cultural Expectation of Support	Support from mother	Difficult Nightmare	Sarvashi	L/110, L/234, L223.	I had asked my husband if my mother could come over.
		Hard	Taran	L/294.	
		Stressed	Amber	L/270, L/292.	
		PND	Ayesha	L/34, L/37, L/58	
		Breastfeeding	Ayesha	L/62.	
			Mala	L/90, L/111.	
			Nakita	L/6, L/139, L/214, L/219.	
			Zaynub Jacqueline	L/17, L/27. L/68, L/157.	
	Traditions	Important Want Parents Words Courage	Mala	L/120, L/125, L/126.	They performed those rituals on the birth of the baby, so they performed afterwards when they came here.
			Aliya	L/174.	
			Jacqueline	L/145.	
	Chila	Chila	Amber	L/461, L/456, L/497, L/502.	I think mentally physically and emotionally you need somebody with you.
Herbal remedies	Upset Respectful Culture Generation	Amber	L/605.	Because in Pakistan when she constipated my mum told me a little bit of fennel	

Peri and postnatal experiences in the NHS	At the time of giving birth	Suffered Little Things Share Everything Uncomfortable Feel Bad Pressure Need someone	Nakita	L105, L/318. L/30, L/36, L/44, L/108, L/116, L/145.	But I am glad I was totally natural and gas and air I had about an hour.
			Zaynub	L/57.	
			Jacqueline		
			Taran	L/58, L/321. L/11, L/99, L/232. L/268, L/278.	
	Experience of being on the maternity ward	Strange Thing Can't leave Baby Difference Cannot Trust	Aliya	L/48	
			Zaynub	L/421, L/430.	
			Sarvashi	L/14.	
			Ayesha	L/41, L/46, L/51, L/55.	
			Simi	L/54.	
			Aliya Jacqueline	L/93, L/104, L/109, L/121. L/235, L/270, L/343, L/131.	
Process of labor	Neglect Self Feel Ugly, Fat, and Big Delivery System Lack of advice on how to care for baby	Mala	L/33, L/306.		
		Zaynub	L/258, L/405.		
		Aliya	L/7, L/15.		
Information participants	Needed Knowledge Miserable	Amber	L/193, L/519, L/532.		
		Nakita	L/349, L/366.		

	wanted future NHS services to take into account	Something Special Big Problem No Experience	Taran	L/454, L/461, L/466, L/483, L/501, L/517, L/558, L/531.	
	Postnatal care	Afraid	Amber	L/544.	
	Lack of breastfeeding support	Always Gives Teaches	Nakita Taran	L/178, L/188, L/199, L/235. L/17.	

5.6 Cultural expectation of support

Each participant had preset ideas about what support they wanted to have and for each of these women support from their own mother was paramount and not having support was difficult to come to terms with. It is also a very big part of the Asian way of life to expect your parents will support you emotionally, financially and physically throughout your lifetime and then when they are old and less capable you then support them in an extended family type role. This section explored the meaning of support and participants experience of giving birth in the absence of maternal support.

One participant explained how she knew ahead of the birth that she wanted her mother to support her *“I had asked my husband if my mother could come over rather than my sister-in-law. If my mother was here she would genuinely love my child because he is her own grandchild” (P/Sarvashi – L.110)*. From the tone of this participant’s voice I could hear the sadness in her voice as if she was telling me

that she felt she had missed out on something as she explained that the type of care she would have received for her son and towards her recovery would have been different if her mother had been present at the time of her son's birth. In an Indian culture maternal support is expected and paramount towards the recovery and healing process for an Indian woman.

Participants spoke about the idea they had a specific mother daughter relationship, which was unique to them, a relationship they did not have with anyone else, an intimate mother-daughter dyad in which they could ask their mother for anything. *"I even asked my husband to call my mother over here. I even said to him that it would be better if my mother came here to support me. You see with my own mother I can speak to her with comfort I can tell her exactly what it is that I want with authority and ease"* (P/Sarvashi – Line 223). It was clear this participant felt close and comfortable with her mother and felt able to ask her for support in a way she could not ask anyone else. Indian women tend to traditionally be the homemakers and as such girls tend to be close to their mothers and learn to cook, sew and maintain a household by mirroring their mother. This gives Indian women the unique closeness in which they can ask their mother for support with ease.

She elaborated on her relationship with her mother as a close tie which enabled her to ask her mother without hesitation and with freedom. *"Because you only build this relationship from your childhood. You see my mother-in-law will have this sort of a relationship with her own daughter. They have a right to speak to each other in this way. They can say absolutely anything to each other and they do say anything to one another"* (P/Sarvashi – Line 234). She described how she could rely upon

her mother implicitly, freely and without hesitation. It was then understandable that she was not able to feel free to ask anyone else for support in the same way. Asking for support would have to come from someone they felt close enough to rely on and for these women this person was their mother.

This experience was shared by other participants *“... you can't expect anything from your paternal side, in laws, even if you want, I can tell my mum, ok I want to eat this today, please make me this, I can't tell that to my mum-in-law”* (P/Taran – Line 294). Echoing this sense of ease when asking her own mother for help, again explaining the relationship she had built up with her mother from childhood. This unique close bond gave her the sense of freedom to ask for what she wanted. As she spoke of eating I could sense an almost unspoken understanding of intimacy and respect that she shared with her mother born out of her Asian culture and close mother daughter bond.

This experience continued to be shared among other participants at the center of this participant's experience of motherhood; she believed that not having someone with her led to her feeling insecure. *“Like, if my mother is with me and she is living with me it would make a lot of difference, in the way maybe I am more attached with my own mother, I can tell whatever. If it's useless or you know maybe I am feeling low, whatever, I can't tell anyone else, my mother I have a good relationship with her”* (P/Amber – Line 270). The support from a mother with whom she had learnt from, felt close to and expected to be able to rely on at a time when she needed her most like the birth of her new born baby. Culturally not having her mother's support was not something she would have been prepared for. This was

an emotion she had not prepared herself for as culturally she would have watched her family all rally around at the birth of other babies within the family and therefore to be left without maternal support would require a cognitive and emotional shift.

She made no distinction in her respect for her mother-in-law as she explained that she was also a grandmother to her child however she still longed for support from her own mother. Further explaining *"I can tell her to leave those work, whatever you're doing at home and take care of her, you know, I can say anything you know, if she is cleaning her own room, I will say, oh don't worry clean afterwards take her first, but with my mother-in-law I can't say to her"* (P/Amber – Line 292). Again traditionally the expectation would be for your mother to drop everything and prioritise the new born and her daughter as the Asian culture nurtures an intimate relationship that women have with their own mothers and the new or early in most cases developing relationship they appeared to have with their mothers in law.

Another participant spoke in great depth about the support she would like to have had if her mother was in the UK *"Yeah, (huge sigh). Yeah, they would help me with the baby"* (P/Ayesha – Line 34). She described the sort of practical help she would like to have had *"You know they would bath, I do not know how to explain. But they would bath the baby, now days I am doing the bath"* (P/Ayesha – Line 37). I felt really empathic towards this participant as she released a huge sigh as she went on to speak about the support her family would have given her if they were in this country. *"Mum will do this. Mum can do everything. Mum would cook for me and bath the baby. Lots of work, mum can do"* (P/Ayesha – Line 58) and *"she would have supported me"* (P/Ayesha – Line 62). The traditional expectation of support

that this participant spoke about was released in her sigh as she sighed at each pause I could hear the emotional connection and sense of loss as she described the support to hold her baby, bath her baby and take part in the chores which she could only have asked her mother for.

In contrast to having their baby in the UK one participant described her expectation of what support she would have expected from her family if she had her baby in India *“because in India each and everybody in your family very supportive to you and they give you any kind of help, because you have all the members they can take care of you and your baby too”* (P/Mala – Line 90). She described having a similar degree of support from her in-laws and felt she had been supported despite being in the UK.

However, she still felt that she missed her parents during the birthing process *“Parents give you support, courage, you need these things, if you, not only financially you need their support of words only, you become, you are ready to face any kind of problem so that is why I was missing for only this nothing else”* (P/Mala – Line 111). She described the importance of hearing her parents speak to her and felt their words would have provided her with encouragement that she needed to get through the difficulty of labour.

Another participant explained *“It was a very strange experience indeed. Mainly because I come from a country where you have a very good support network of uncle’s, auntie’s, neighbours you live in a community. You are not on your own,*

alone in a house where you don't know anybody where um you are completely relying on the healthcare service" (P/Nakita – Line 6). I sensed she felt alone and lonely and did not feel she had anyone to turn to for support. She explained her experience as strange, one in which she was relying on the medical profession for support and imagined her experience in India would have been one in which she relied on family members who had a vested interest in her well-being to extend their care by way of support. The absence of maternal support sounded like a cultural shift for this participant.

Explaining that she expected maternal support *"Um people come and go from your house to help you. So your aunties will cook something and bring it to you because they know you are a new mum. Your cousins will come around give you a hand, washing up, cleaning up because they know you have got your hands full"* (P/Nakita – Line 139) as she spoke of her expectations I could hear how the reality of becoming a mother in a western country in which she did not have maternal support left her feeling quite alone and lonely. As she emphasised her expectations I could hear the sense of sadness in the tone of her voice, which perhaps justified her experience of difference when she only had the healthcare system for support and no family to reach out to. I hypothesise her cultural expectation had an impact and prolonged her sadness about not having support in the same way.

The impact that the lack of maternal support had on another participant with breastfeeding her baby." *I suppose I would have had more support, more encouragement from my mother and also I would love to have asked her did she*

have that experience with me? Was she or was I an easy baby to breastfeed or a difficult baby I know, um, in India the formal method of feeding is breast milk” (P/Nakita – 214). Culturally the expectation for Asian women would be to breastfeed as it is the safest method of feeding. Sterilisation equipment is costly and imported and not even an option and here in the UK women were faced with a choice which further validated the absence of maternal support.

One participant described the sad and sudden loss of her father just before her baby was born *“My mum and dad they lived in Pakistan. They planned to come over here for the birth of my son. They arrived and a few days before his birth and my father died. He died one week before my son was born so my mum went back to Pakistan with the body”* (P/Zaynub – Line 17). She spoke of the special journey her parents made to the UK to be present for the birth of her forthcoming baby and their wish to help, support and to be there for her *“they actually came here to support me but they had to go back because I have other brothers and sisters there”* (P/Zaynub – Line 27). I could hear the devastation in her voice as she spoke of the trauma and such a huge loss, the combination of their expectation, excitement and anticipation alongside the loss of a loved and supportive father was very much alive in how she described the loss. Her illusion of support and expectations were shattered and she described how she no longer allowed herself to want support from her maternal family because she had brothers and sisters in Pakistan who now needed her mother more than ever. I was struck by how she went on to accept that same support from her mother-in-law in such a free manner allowing herself to integrate into her husband’s family in a much more enabling and free way.

Another participant explained that *“if my own mother were here she would be able to tell me what I should be doing and how I should be doing it. She would also help me to believe in myself and gain confidence as a mother. She would say this is your daughter do things the way you want to do them”* (P/Jacqueline – Line 68). In an Asian culture you expect to rely on maternal support and ask for guidance and this would have helped her confidence as her mother’s reassurance would have given her the support and confidence to believe in herself and validate her ability as a mother.

She went on to describe *“Over there in India, you do not do anything for forty days, in these days someone is always coming or going with clothes, toys and gifts for the baby and perhaps food for you like rice and pulses or special panjhiri (a sweet blend of pistachios and nuts). Someone else will bring you another dish everyone is there to help you; someone is always ready to help you in some sort of way”*. (P/Jacqueline – Line 157). This expectation of what support she would like to have had enabled her elaborate on how alone she felt here in the UK, no one knocks on your door and there is no family support to hand.

Expectations of motherhood were described *“it’s quite difficult to describe in one word or a few sentences initially, even when he was born and you know, when I was pregnant. I didn’t expect how it would be after the baby was born. You know, you always expect, all mothers expect, they have to feed the baby, change the nappy and put him to sleep, but it is not that easy”* (P/Taran – Line 4). This

participant went onto described the lack of practical and emotional support which is not something she had considered during her pregnancy. Coming from an Asian culture where everyone rallies around you she described a sense of being left to cope alone.

Traditions

In an Asian culture there is innate expectation that cultural traditions would be performed regardless of your religious background. Participants shared their experience when rituals and traditions were performed explaining that it is traditional to give the baby gifts and perform some sort of ritual according to religious beliefs, in an attempt to ward off the evil eye and to keep the baby safe from harm and illness. *“Traditions or ritual which are performed for you on the birth of your baby I was realizing that if I was in India, my parent like all their children of my sisters they also performed for my child also”* (P/Mala – Line 120). I could hear the sense of anticipation as a ritual to ward off evil spirits should take place at the time of the baby’s birth and this participant had to wait for her parents to come to the UK.

She further explained *“they performed those rituals on the birth of the baby so they performed afterwards when they came here, so I was happy for this because I know that my parents would come so I had this hope”* (P/Mala – 125). I was touched by her patience and the way in which she held on to the glimmer of hope that her parents would eventually come to the UK and perform the rituals. She appeared to feel able to be reassured in the knowledge and hope that they would

come and carry out this tradition. *“They brought anklers and some bangles for her. Gold different things they brought for her and clothes also and many things, still not in my mind so I mean whatever rituals are performed in India they did in the UK also for my baby”* (P/Mala – 166). I could hear she had some faith and belief that her baby was safe and a strong bond with her parents as she knew they would come to the UK. She sounded relieved and validated and somehow complete by the important value she placed upon this tradition.

One participant spoke about using Halva (an Indian semolina dessert) to ward off evil spirits *“when we came they did this halva thing where you eat it, I do not know it’s supposed to protect the baby and obviously because you come into the family and stuff. Just to keep them close together as a family, it’s some kind of tradition where you do a little prayer that brings you closer to the family”* (P/Aliya – Line 174). She placed great importance upon this ritual believing and enjoying the process and emphasising that the prayer would keep them close and safe as a family.

Another participant described worshipping the new mother *“These are all things that we do when the baby is first born; we firstly worship the new mother and take care of her, we do not left her do anything for herself and we take care of the new born baby ourselves. We put the black thread on their wrist to prevent the evil eye, we worship our gods to promote the health of our newborn baby and to signify our wish for the baby to have a long healthy life. Then we go to our house of worship the mandhir (Indian Hindu Temple) and we give out Indian sweets and share this out amongst the houses of our friends and families. Then for the new mother we*

have a special diet for her consisting of pulses and rice to encourage the flow of milk to help her breastfeed” (P/Jacqueline – Line 145). This participant described something important for the baby, their religion and also the mother. I was quite intrigued by her belief system that was so rich in culture and I was drawn into understanding its significance which was mirrored in the tone of her voice and how much she believed that god would protect her new born baby. This belief was described as Chila which she explained was a period of time after the birth in which the mother and baby are taken care of.

Chila

Chila was described by one participant as something she missed as the absence of family support meant that Chila could not take place *“I think mentally, emotionally and physically you need somebody with you. I think for 6 weeks. In Pakistan they call it Chila”* (P/Amber – Line 461). She further elaborated on this *“40 days, that is really important and it usually, they say oh take your baby and but I think you shouldn’t take anywhere”* (P/Amber – Line 465). She explained the difference in the UK where she was being told to take her baby out and in Pakistan the mother and baby are asked to stay at home for the first 40 days to keep the baby safe and give the baby a chance to build up their immunity from environmental illnesses like the common cold, flu and general bugs.

Chila was described by another participant as a time when a woman’s physical needs are taken care of, a time for the body to repair itself from the strain of carrying a baby for 9 months and careful consideration is given to her diet, this allows her time and space to bond with her new born, *“you have to think only about your baby and nothing else, even guests are coming around you don’t need to worry about any single thing”* (P/Amber – Line 497). I could hear the sadness in the tone of her voice as she described having missed out on a very important part of the becoming a new mother.

It sounded as though she had not been able to attend to her own needs and consequently had to prioritise the needs of her new born baby. Something that perhaps was at odds with the way it should have been for her given the concept of

Chila. *“I didn’t did my eyebrows and anything, I used to feel like, more ugly and you know and fat and ugly you know, you don’t feel like to look and wear you know”* (P/Amber – Line 502). I could hear such a sense of loss as this participant felt overwhelmed with prioritising the needs of her baby. So much so that she did not have any time to take care of herself and consequently felt unhappy with how she looked. She explained feeling as though her body weight had tripled in size and that she felt at odds with how she looked. This left her feeling uncomfortable and as she described spending most of her time attending to her baby I could hear how she had felt overwhelmed with the responsibility, this meant that she had very little or no time for herself and she described feeling very unhappy with her physical appearance. It sounded as though her appearance was tied into how she felt as a new mother and not having the time to attend to her own needs left her feeling disempowered as a new mother.

Medicinal Traditional Herbal remedies

One participant described the use of herbal remedies to relieve constipation. *“Because in Pakistan when she constipation, my mum told me a little bit of fennel seed for few days and that was really helpful. Because you can’t give any medicine and that makes a difference for her and there is another seed, you know like garam-masala (mixed spices) and cinnamon is really good”* (P/Amber – Line 605). She sounded genuinely concerned about the physical effect of medicine on her new born baby and preferred to rely on a telephone conversation with her mother in Pakistan to decide how best to alleviate her baby’s symptoms.

Such an important part of my research topic was centered on giving women a voice and it was equally important to hear their voices and understand how their expectations had been formed. Given that Asian women come from a culture where the setup is to expect support to be in a position where support from your maternal family is not available was a real challenge for these women a challenge that evoked emotions that at times impacted their ability to be present for their new born baby. This section gave me insight into the life experience and a real understanding of how these participants felt without maternal support. Participants recalled their expectations specifically focusing on the impact of the absence of maternal support in the early stages of motherhood and how this affected them personally.

5.7 Newness of being supported by their husbands

All ten participants were married so the baby's father in these cases was their husband. The Asian culture is one in which men are traditionally expected to go out and earn a living and the woman's parents would have been expected to support her through the pregnancy, especially during the afterbirth process and the early days whilst she adjusts to her new born baby's needs. The focus in this section was on the participant's perception of the fathers' role and their cultural expectations about the support they received from their husband which gave me an unexpected insight into the quality of their relationship with each other.

One participant described the difficulty of being upset in her relationship and she felt as though her husband was not able to support her and lacked emotional warmth. *"We were arguing all the time. I felt so alone and unhappy and lonely all the time just helpless"* (P/Sarvashi – Line 72). She sounded isolated in the marriage with no one else to turn to. She elaborated on this by explaining that he would manage the practical things *"If I asked him for things he would buy them for me. But he did not have the time or maybe he just did not think about it that maybe I should spend some time with my wife"* (P/Sarvashi – Line 136). She explained she felt under immense pressure with no emotional support from her husband. I suspected she found the early days of mothering an emotionally demanding time and perhaps struggled to reach out for emotional support as she felt he was able to provide practical support but not his time. *"It was very difficult for me. I had the caesarean and this made it difficult for me to do household chores. When I used to feel so upset and miserable it was quite difficult for me to be sweet towards my*

husband or to approach him and ask him for support. I feel like my whole life has changed (pause, participant cries)” (P/Sarvashi – Line 141). This participant was echoing desperation in her voice and her words as she described just wanting someone to reach out to her and meet her emotional needs.

Participants who had immigrated to the UK through marriage often found their husband to be the only form of support they had *“only my husband is helpful to me” (P/Ayesha – Line 20)* and *“My husband is also helping me. He is also going to work” (P/Ayesha – Line 65).* This participant described how her husband was the only person she had to support her and how he was juggling work commitments with helping her to take care of their new born baby.

One participant described how supportive her husband had been at the birth of their daughter. *“... when it came to the first time he was totally there with me all the way... and he was totally there for me, all the way, he was there for me. He was just spot on; my husband I cannot knock him for that at all” (P/Simi – Line 45).* She recalled his presence at the birth as the beginning of his support for her and she explained feeling validated by his support.

Another participant described feeling very supported and understood by her husband *“...my husband is very helpful, he understands my problems, my happiness what kind of help I need, my husband is ready so I am, I can say I am very lucky because I have a very good cooperating husband” (P/Mala – Line 70).* This participant explained how she felt a joined up sense of unity in which her

husband adequately met her needs. *“I am very happy because I have a husband who has all the qualities of a good heart so he is very sincere, honest, loving he loves me too much”* (P/Mala – Line 284). She described feeling supported and in harmony with her husband as her emotional and practical needs as a new mother were being met.

This participant further explained *“he always thinks positive and if I got some kind of problem in my life he never let me loose heart or let me down and he gives me courage”* (P/Mala – Line 294). She spoke of the closeness she felt with her husband and I believe this closeness would have an impact on how secure she felt in mothering her baby.

Another participant also described feeling supported in her marital relationship *“really good, we are very close, we are like best friends”* (P/Aliya – Line 246). She further described feeling *“I have a really good life”* (P/Aliya – Line 282) and *“because my husband has given me that support and he is not, so it is good, I cannot complain with him”* (P/Aliya – Line 286). Even the tone of her voice was quite upbeat and enhanced as she echoed feeling like she was in a good place as her husband was demonstrating his support.

Another participant described having *“A very good relationship yeah, understanding yeah, when she born, obviously he can't be with me 24/7. He has to work you know to put food on table, he has to work, I don't blame him”* (P/Amber –

Line 432). This participant was able to understand and was accepting of the practical nature of the way of life but felt emotionally supported and validated.

One participant felt that although her husband was supportive he also worked full time. *“My husband is quite supportive so I did not think it would matter too much”* (P/Nakita – Line 34). However, she went on to say, *“I also feel a little bit resentful towards my husband because he got to go out of the house. He did not get stuck inside the house looking after a new born baby and I think the choice of word stuck in the house is wrong because I would not have it any other way. But there were times that I felt completely resentful because I did want to have somebody that I could leave my baby with and just go outside for a few minutes without a child”* (P/Nakita – Line 151). She described feeling ‘stuck’ because she did not have her parents to support her and the resentment felt much more like a word she used to mask the sadness, *“So in a way I feel my husband has the best part of being a parent or a first time parent”* (P/Nakita – Line 259). The feeling of unfairness or aloneness that she felt was apparent as she remarked that she might not have felt so alone if she had given birth in India as she would have been surrounded by the presence of her family.

Another participant described her marital relationship and husband as *“it is very good he is very nice”* (P/Zaynub – Line 168). She elaborated on this *“he supports me a lot, especially when it comes to the English language. You know I cannot speak it properly”* (P/Zaynub – Line 171). She described feeling secure and supported by her husband. *“Everywhere I go he comes with me and does many practical things for me”* (P/Zaynub – Line 177) she spoke about the importance of

understanding each other's ways as a couple and gave examples of clinic appointments as he translated her concerns which enabled her to feel at ease and supported by him. I could sense that she felt the communication between them was integral to their skill as a couple.

Another participant described how little paternity leave her husband had. *"It was not easy and my husband had already taken up his paternity leave and his, obviously his work is important as well, he is earning money for the family so he would not get any leave....."* (P/Taran – Line 30). She described the loss of practical support in order to balance the practical need to earn an income.

She further described how difficult she found it when her husband was out working *"everything has its rewards but for me for the first 4½ months being very difficult, very difficult. In this period there was a time when my husband was working morning to late night. He used to leave at eight and he used to come by eight and between this time and also in the last 4½ months there is no night where I have slept more than 4 hours. So you imagine for 4 months if you just sleep 4 hours in the night, no sleep, forget sleep, no rest during the day and constant crying and doing running here and there in the house with the baby getting one thing or the other, so it is quite distressing"* (P/Taran – Line 155). Underneath this very practical description I sensed a feeling of disempowerment, a sense of needing to make do without the support of her husband and sense of getting on with the task.

She further described how they understood each other “you know when you get married, you start interchanging each other’s properties and good thing, not good thing” (P/Taran – Line 418). Whilst also allowing each other some space “and there are many things I would say that we don’t agree upon, but we like to give space to each other, but at the same time we love doing things together” (P/Taran – Line 425). As she felt he was supporting her with their baby “I think he is doing more than he can and he is not well and but still he does things that I really appreciate” (P/Taran – Line 439). I could sense a real divide here in her feelings as if she no longer knew how to feel, a combination of practical he needs to work verses a yearning for wanting his time and support and a feeling of residing and making do.

One of the most interesting parts of this section was learning that nine of the participants were newly married and had become pregnant within a few years of marriage. Eight of the participants were first generation Asian women, which meant that they had immigrated to the UK following their marriage. Therefore, these women in particular were dealing with their transition to the UK, the western culture, married life, not being able to speak English fluently and the arrival of a new baby without any support from their own birth family.

The focus in this section shifted from understanding the role the father played in the transition to motherhood for the participant to learning that each participant saw the fathers’ role as the provider for their family and their husband as the carrier of the financial and practical burden of providing for the family. They saw their role as the mother and one in which they were learning to take care of their

newborn baby and one in which at times they were getting to know their husband, developing a new relationship with him, for some participants recognising that they actually wanted more support than their husband was able to give them provided them with a recognition of missing maternal support.

5.8 The emotional and physical impact of having a baby

The third theme focused on the emotional and physical effects of motherhood particularly coming from an Asian perspective. I explored what women's expectations were at a time when they had become a mother without maternal support. I was intrigued about how they thought and experienced the time of the birth, during and after giving birth at a time when they did not have maternal support.

Having left the hospital this participant spoke about her experiences when she brought her newborn baby home. *"When I came home they were giving me food and that was it. They were giving me food and I was feeling so alone. I needed help with baby he was crying and then, a lot of thing because I could not move, when I was moving it was really hard to move when I had the C-section (P/Sarvashi – Line 26).* It sounded as though her basic need to be fed was met but what she yearned for was emotional support as she described feeling alone.

It was interesting that when asked a question about the emotional impact of giving birth this participant embarked on a similar theme to the previous two section of feeling left without support and feeling unable to verbalise this and describing the experience as feeling alone. *"I was really upset with this and fed up and I cried a lot. I could not talk to my mother or anybody from my husband's side there was nobody to who I could talk"* P/Sarvashi – Line no 45). They felt unable to communicate with each one another *"He then rang my mother-in-law in Indian. At this moment, it felt like having my son, and giving birth to this baby was the*

greatest regret of my life. I cried a lot and at that time, all I wanted was support, encouragement and love. Some days all I wanted was someone to sit with me and just talk to me and there was no one around to give me this. No one, these are the things that only your mother can do for you (pause, participant cries)” (P/Sarvashi – Line 54). It felt like the phone call to her mother-in-law brought down her wall of silence and her emotions raised to the surface as she described a much deeper sense of aloneness which came from her cultural expectations and a lack of support that did not match her expectation as she described feeling helpless.

I asked her what helpless meant to her *“Like I could not do anything for myself. I could not do anything for anyone else. I found it a complete struggle to take care of my child, to bath him, to feed him”* (P/Sarvashi – Line 76). She continued to describe how there was only time for the baby and not herself. *“There was not time for me. Taking care of the baby was becoming such a difficulty for me, with every new born everybody needs just one person beside them to help them”* (P/Sarvashi – Line 83). I could hear the compounding sense of aloneness and isolation.

“That’s why I was crying a lot and thinking a lot at that time.... I struggled even more. I could hardly cope with my child let alone cook a meal for my husband” (P/Sarvashi – Line 115). It felt as though her tears were about the loss of being understood and her voice was suffocating as she could not verbalise these emotions.

"I had some moments where I just needed to pick him up for a minute. You know a mother can get quite fed up being with her child all day long. She can become quite angry. I just had moments where I wanted someone to share this experience and cope with me, just pick him up or do a few household chores" (P/Sarvashi – Line 124). I had a huge sense something was missing for this participant and I asked her if there is any help, she would have liked or if anything in the experience was missing for her, she said, *"For me what was missing was that I did not feel loved. I was missing the support and companionship of my husband on this journey"* (P/Sarvashi – Line 132). Although she described the lack of support triggered by her husbands' absence, I sensed she was talking about a deeper sense of cultural aloneness which stemmed from the absence of maternal family.

"Because, it looks like, it feels like, (crying) like I have not laughed for years (long pause) I have forgotten how to laugh. I have become some, a miserable upset person I have forgotten what it is like to have a laugh and a conversation with anyone. I have lost my patience and become an angry person too; someone only needs to say a word to me and I become very angry, very quickly to the point that I even forget what I say. I was not like this before. This is why people just need to be supported by someone" (P/Sarvashi – Line 148). It sounded as though the loving side of her had shut down and the lack of maternal support has shadowed her experience of motherhood with sadness, aloneness and loneliness resulting in isolation and a feeling of pressure to meet the growing demands of her newborn baby.

Another participant spoke about her experience of having her baby *“he was three weeks early. His delivery date was 15 February and he was born on 26 January”* (P/Ayesha – Line 86). She described how she felt with her baby *“I am very happy even when he cries I am very happy”* (P/Ayesha – Line 90). She also talked about the importance of taking care of herself *“I do take care of myself. I look after myself; I started to feel dizzy so I take iron tablets. I have been to see the doctor, the doctor told me to take iron tablets. Now days I am o.k. now I am eating my food so it is o.k.”* (P/Ayesha – Line 97).

One participant spoke of the kind of support she expected to have from her extended family. *“Basically I would have liked it the most for her to get downstairs, pull out things from the draw for me, you know if I could not reach them like get nappies and little things like that would be such a major help really”* (P/Simi – Line 92). She echoed what other participants spoke of wanting for someone to hold their baby, yearning for practical support. I wondered if this was about her expectations as an Asian woman living in a western society with perhaps a first generation extended family culture where support actually has different meanings.

She went on to describe missing her own mother *“You know you just want that love from your own mother that little hug from your mother, because my mother-in-law does not feel like that.....I miss, um, that love, I felt like I miss that when they say my daughter we are here for you, I miss that”* (P/Simi – Line 500). It was as though becoming a mother elicited the affirmation that she too was loved by her own mother.

One participant described the moment of joy when she had her baby *“Because you have a gift of god in the form of daughter, so when I saw my daughter I get very happy then I have no problem”* (P/Mala – Line 38). This participant described how seeing her daughter helped her to forget everything else. *“It was a mixture of good and bad. Because this is the first baby of mine so, when I came from the hospital I had the feeling that it was a big problem for me because I don’t have any experience. Because I haven’t seen so small child so that’s why I was afraid in the beginning”* (P/Mala – Line 53). She expressed her fear and concern about adapting and learning to become a mother. *“Because I was on the bed because of stitches, for some day, each and every kind of help they gave me. They help me for the child and giving me food and everything they did for me”* (P/Mala – Line 62). She described how her in-laws helped her to take care of the day-to-day practical chores so that she could spend time with her baby. I could hear from the elevation of her voice she was content with the support from her in-laws.

This participant also described the moment of giving birth as an emotional experience in which she missed her parents *“I was actually weeping that we are only my husband and me, only two so during the delivery. I was weeping for this because this is the first time so; I was recalling my parents that they could be with me”* (P/Mala – Line 97). She described visualising their words to soothe her discomfort during labour *“I was missing them for that they can pacify me they can help me they can say some words of this type of things, they can share my misery of delivery”* (P/Mala – Line 104). It felt as though this participant felt comforted by

visualising her parents to ease her discomfort, an incredibly powerful metaphor which enabled her to give birth with ease.

Another participant described wanting the support of her own mother whilst also wanting to look after herself *“I was thinking that my mum would like to be there but to be honest, I was not thinking about anybody, just myself”* (P/Aliya – Line 33). She explained her thoughts at the time of the birth as confusion *“I don’t know it was just really hard, obviously my first time. I didn’t know what to expect but it was good and a lot of labours are really bad so I think mine was good, it was a good labour”* (P/Aliya – Line 43). She took an interestingly positive view of having had a good labour describing the changing routine of her baby *“even in the nights when he wakes up, he wakes up about every 2 - 3 hours. First it was every 4 hours, I had him in a routine, but now obviously he’s grown he wants a feed every hour to two hours.... but he’s a good baby, he’s a very good baby”* (P/Aliya – Line 243). She continued to describe a positive view of her baby having established a routine.

One participant described feeling panicked. *“Even she was alright but I still get panic very quickly, if she is not feeding, she was constipated as well, so every little thing makes you worried, even I used to cry a lot in the beginning, you get emotional. If somebody asked you any reason, you don’t know what’s the reason”* (P/Amber – Line 64). It felt as though she could feel emotions that she could not express in words.

She continued to describe how motherhood was a difficult experience *“taking care of baby is more hard I think, because that time period you know take 24 hours for two days, up to two days you will be alright, you know continuous you know....”* (P/Amber – Line 84). She believed the root of her distress lay in not having maternal support *“I think that no support, that’s why. I feel lonely you know most of the time, my husband when he came back from work and my brother, that was alright for me but even the day time was hard, you know I feel lonely I don’t know”* (P/Amber – Line 92). She described feeling a state of panic for the first six weeks and I wondered if this was to do with her feeling confident and how the effect of having support would have helped her feel much more secure as a new mother.

I had a deeper sense that the loneliness had compounded her early maternal experience and asked her if she felt lonely she responded by saying *“Lonely yes. I think definitely, because I think at that time period I want someone with me all the time, but you know nobody can manage. Because my mother-in-law she has her own family, her house and she can’t live with me and at that time I used to felt I want somebody with me all the time and that was impossible, my problem was you know loneliness”* (P/Amber – Line 105).

She further described the first few days of nursing her newborn baby *“when you need help that kind of help you know. You need someone with you, if you’re just telling me oh feed your baby go to sleep, that’s easy to say, but when you’re doing it on your own, it’s not easy. If your tired and restless, sleepless and at the same time you can’t leave your baby as well, because I was really insecure at that time you know, it was like I am taking care of her as well, my mid-wife was telling me,*

no you're doing good, you're doing good but I wasn't feeling good" (P/Amber – Line 318). It felt as though her loss of confidence was tied into the lack of support and this left her questioning her newly developed skill as a parent. It also sounded as though she kept busy focusing on the practical lack of support so that she did not free up her mind to think about the emotional lack of support.

This experience was shared by another participant who spoke about her experience *"I have no family here. No in-laws and no maternal parents here so it was just basically my husband and I and it was at the beginning exciting"* (P/Nakita – Line 30). From a cultural perspective her support network was in India and led to a mixture of feelings *"So as you can imagine first child very, very excited, very scared, um, until the baby is born you do not really know what you are letting yourself in for"* (P/Nakita – Line 36). She talked about lacking insight and information about what it was going to be like to have her first baby *"I had absolutely no idea what I was getting myself into."* (P/Nakita – Line 44). She talked about the element of surprise in hindsight the excitement and newness.

She also acknowledged she just wanted some support, I asked what sort of support she would have liked? *"Advice, sometimes you just need to cry. Someone who will let you sit there and just cry and then bring you a cup of tea afterwards. Um, somebody who you could trust with your child"* (P/Nakita – Line 108). She yearned for support from someone she could off load her emotions to and a similar element to the previous participant. *"But being near someone you can trust is actually being able to close your eyes and have a nap and know your child is in safe hands"* (P/Nakita – Line 116) this was echoed by the previous participant

wanting someone she could trust to hold and oversee her baby while she had a nap.

Having expected maternal support *"I remember seeing a lot of support for my aunts when they had, had babies. My mother cooking food taking it over we did not have any of that because my husband works, I was left with the baby. I was left to do the housework; I was left to do the cooking I was left to ensure there was food for us to eat as well as whatever needs doing for my baby. So I felt the nights and days just merged into one. I felt you did not know whether you were coming or going. You did not know whether it was morning, afternoon or night"* (P/Nakita – Line 145). She described being placed into a situation in which she managed to make everything happen on a practical note. It also sounded as though she felt so overwhelmed by the experience that she had no time to be present in this experience.

One participant described her upset of having lost her father a week before her baby was born *"I missed their presence not just mum but dad's presence too. Not so much for support but their presence so that they could have seen my son. I regret that they were not here to see him. Even for just one day, but it could not happen"* (P/Zaynub – Line 57). She described sadness and a regret, as her parents were not able to meet or see her baby I could hear the grief in her voice and I wondered if the grief was about processing the loss of her father amid the joy of the birth of her son.

She described the impact of missing her parents as she had immigrated to the UK following her marriage to her husband. *“I missed them too much; terribly in fact, I cannot find words to describe how much I remember them, think of them and miss them and how sad I feel when I think of missing them”* (P/Jacqueline – Line 58). This signified a huge sense of loss that she could not verbalise, missing her parents and starting a new part of her life in which she they were not present reminded her of this loss.

She was able to verbalise the context of her sadness *“a lot one you have the sadness of a newborn worrying if you are doing everything right, you want to sit with your child and spend some time with them but the household chores build up and make this impossible. The other thing is that I think of my mother and father a lot”* (P/Jacqueline – Line 321). It felt as though moments of sadness were present when she relaxed with her baby.

Another participant described the complexities of becoming a new mum whilst juggling all her other household chores *“whether you have maternal support or not, a mother has to support a lot, yeah, so the bottom line is, mother always supports and with husband’s support, it is easy. It’s difficult but you can sail through, but when you don’t have any support and you are on your own, you don’t have any relatives, friends and it’s like it’s your own flesh and blood, you can’t leave him crying ok? At the same time, you are so tired, the breast-feeding and you having to cook your own meals at the same time making sure the baby is happy”* (P/Taran – Line 11). It was evident from this participant that needing support from a relative stemmed from a cultural expectation. She described the immense struggle

between juggling the practical chores and attending to the emotional needs of her baby.

She further described not feeling prepared for the baby *“I personally thought, to be honest about it I was not prepared for it. He was born after 6 years. We really wanted to have this baby, I looked forward to it but we thought everything would be smooth and you know. Yeah, he does smile and some giggles and plays but like but he has peak times in the day, like 4 times a day, then he would not feed, he would not sleep he would just cry, not play, irritated no matter what you do so at that time. You feel so fed-up and frustrated you know, like sometimes you want to, I want to quit you know, and that the point you know, and it stays only for ½ hour that state of mind. Yeah, that feeling of where ever we find we are right, but for that ½ hour if you had somebody around you, who can just hold the baby, you know, you could just take a break, you know, so but that person is not there when you need them”* (P/Taran – Line 99). I could feel this participant allowing herself to sink into the emotions of what the early part of being a mother without maternal support has been like. I could hear the sadness in not having had maternal support and the struggle becoming a mother had been for her.

She continued to sink deeper into her emotions *“I wish I had somebody to come to my house, but that somebody cannot be anybody because I would not trust that somebody. Like my mum, ok, that’s, she’s the first person I would trust after myself with my baby. I mean, my husband is different because he is a man, you know the baby doesn’t feel the comfort like you know, it’s the warmth of the woman to be honest..... If my baby is crying, I do everything in the world to calm him down, but*

if I give to some person, they will not bother, because they will not see the pain that I would feel when the baby is crying” (P/Taran – Line 232). I could sense the genuine emotions of a mother who had her baby’s best interest at heart and how she felt that the only other person besides herself who could come close to this would have been her mother.

She further compared the support of paternal grandma’s “I mean, I have spoken to some ladies and they have their mother-in-law’s and I met a few at GP and they had chest pain or something and they also said, I said why don’t you give your baby for some time give to your mum as mum-in-law. Of course she is grand ma and she will take care of your baby but nobody does it for you, only your mum can do it for you. So she said (in hindi, Khaun kharta hai kissi ke leyeah?) who does anything for anyone? I was so touched by that I know how it feels (long pause crying)” (P/Taran – Line 268). For a very brief second this participant touched on an emotion that elicited tears, no one had shown her the kindness that she yearned for which was her mother’s support. I could feel a huge sense of loss as if the moment had passed and could not be recaptured.

It felt as though she had embarked on verbalising a repressed emotion I invited her to express her tears in words “So no matter how much, how much somebody is but when it comes to doing things for your family, it’s only your mum and dad (participant continues to cry), excuse me” (P/Taran – Line 278). I could sense this was a very raw emotion and she perhaps felt embarrassed and unexpectedly caught in emotions that were eliciting sad feelings which she did not expect to talk about. I could sense she felt uncomfortable, however it was evident was that she

had expressed some deeply buried feelings about her experience of having a baby at a time when she did not have maternal support.

5.9 Peri and postnatal experiences in the NHS

Women were asked about their experience of having their first baby without maternal support and a number of women told me about their experience of NHS healthcare staff and their experiences are paramount to understanding how maternity services deliver maternal care and ultimately influence service delivery and future policy provisions.

At the time of giving birth

One participant described her experience of being offered an Epidural *“but I am glad that I was totally natural and gas and air I had about an hour. I didn’t really like that but it was good, I didn’t have an epidural, no pethadene, no caesareans so I am really happy about that it was totally natural”* (P/Aliya – Line 48). She gave me the impression that she was not entirely confident about the side effects of an epidural and opted for a natural birth as it may have been a safe option.

Although each participant had the opportunity to write their birth plan for those who could not read, write or speak in English this would have been an impossible task. One participant spoke of giving birth without pain relief *“I felt the delivery was tough because I did not take the epidural for pain relief and gave birth without pain relief”* (P/Zaynub – Line 421). She further elaborated on what she felt to be safe alternatives *“the gas used to make me feel sleepy and I began to feel disorientated, so I stopped taking it. This is when they offered me the epidural and I was afraid to accept it so I delivered without pain relief”* (P/Zaynub – 430). She

elaborated on this by saying she did not know what the side effects of an epidural were and felt safer rejecting this option.

Experience of being on the maternity ward

One participant felt her inability to converse fluently in English prejudiced the care she received. *“They would speak to the ladies who could speak English but did not ask the rest of us who could not speak English fluently..... It was very hard for me to look after the baby, I was breast-feeding as well, and they were not supportive. You know starting with his birth like that I wanted to complain but I could not get their names because I was so depressed and I should have taken their names. I was so fed up by the third day I wanted to come home”* (P/Sarvashi, line no - 14). She knew the care she received felt different and she expressed this as segregated, separated, excluded and felt left out as if the care she received was prejudiced.

One participant told me about learning to bath her baby from a relative *“my aunty came to see me in the hospital and they told her how to bath the baby. That is why I know now how to bath the baby”* (P/Ayesha – Line 41). I was struck by this participant’s response and I asked if she had been taught to bath the baby whilst she was on the maternity ward *“No when there were bath days in the hospital, I did not go. I do not know why. I did not know about them so I missed that chance”* (P/Ayesha – Line 46). I wondered if there was a communication barrier *“I cannot speak quickly a little bit slowly”* (P/Ayesha – Line 51). Her inability to speak English fluently meant that she was not able to ask the staff on the ward how to bath the

baby and relied on her aunty who visited her once to translate for her *“my aunty took me to the health visitor”* (P/Ayesha – Line 55). I was very surprised a woman who could not speak English did not have any family or friends to support her and clearly was unable to interpret her needs on how she could bath her baby was left to leave the maternity ward without knowing how to bath her baby. This ultimately affects the quality of care she can give to her baby.

One participant described being left for the whole day *“No one had come to see me all day. I mean the nurses and health visitors they all are just so short staffed then I was thinking that I am just better off going home really which is what it was and then my husband came in the afternoon and then um, because my um, pulse was quite high they said that um. Because I had not been to the toilet all day, they said that we will not allow you to go home. It was my health risk at the same time you know so luckily everything had gone according to plan, I ate and everything.....I came home that evening”* (P/Simi – Line 54). I could sense her disappointment that there had been a staff shortage and she felt as if there was no point in her being on the ward. Her expectation of the ward staff was that they would provide her with guidance however a lack of staff left her feeling unattended.

Another participant described feeling dissatisfied *“Well basically at the hospital I wasn't too happy the first two days”* (P/Aliya – Line 93). She elaborated on asking for support *“I wanted him to bath the baby and one of the midwives said you can help yourself with the bath stuff, and I said ok can you just check the temperature for me because it was my first time. I didn't know, and she goes, it's alright, just normal temperature, she said that to me which wasn't very nice because I don't*

know what normal temperature is. So then one of the Asian women, I do not know her name, when she came, she said to me, she should not have done that because they do not really like to help out but she should not have done that. She should have said to you, I'll bath the baby while you watch and show you what to do, and then after that you can do it yourself" (P/Aliya – Line 104). She described having reached out for help and asked for guidance because she was unsure however her request was not met with guidance and I could hear sadness in the tone of her voice.

She also felt in immense pain and when she asked for help she was told off *"when I needed a bit of help because I couldn't move and stuff, so what I did I pressed the buzzer for the midwife and I asked can I get some tablets because I am in a bit of pain. She goes, you shouldn't have pressed the buzzer unless it is an emergency or something, I goes yeah but I can't get up, I can just about pick him up because my after birth was really bad, I couldn't move, I could move but it used to hurt a lot. So I was not too happy about the midwives at the birthing, they were not very nice"* (P/Aliya – Line 109). She described having a higher expectation *"it was not very good no; I was expecting more"* (P/Aliya – Line 121). She described not feeling cared for the by the professionals that were there to care for her.

One participant found her inability to speak English fluently a barrier to asking questions about her baby's health *"I do not always get the opportunity to go to the clinics regularly. Sometimes it can be up to once in two months that I get to go to the baby clinic because my English is just not very good and so I do not find it easy*

to ask questions so I tend to rely on what my mother-in-law tells me” (P/Jacqueline – Line 235). She explained relying on her mother-in-law as a source of information.

Her experience of being on the labour ward was similar *“I recall they used to ask me if I was ok and if my daughter was ok and if I had any questions but I could not ask them questions because I did not know how to ask them. So all the questions I had I asked my mother-in-law and either she would answer them herself or she would ask one of the staff and get an answer to my questions” (P/Jacqueline – Line 270). I had a sense that her mother-in-law had become the vessel through which she communicated with the NHS healthcare staff on the ward.*

She also described the sorts of questions she would like to have asked. *“You know questions like is my daughters weight o.k. or not, when can I start feeding her solids, how many times a week should I bath her should I do it every day or not every day. If I could have asked these questions directly myself I would have been so, so happy but I was not able to ask these questions to anyone all I had to go on was what my mother-in-law was showing me and I had to copy from her examples” (P/Jacqueline – Line 343).*

Process of Labour

One participant described the pain of undergoing labour *“it was very painful for me in the beginning, I was thinking that was happening just to me only, but the doctors or nurses tell me that it is happening in world because every woman after marriage gets pregnant and give birth to children” (P/Mala – Line 33). I could sense she was*

describing the immense pain of labour, this participant had previously spoken about yearning for the presence of her parents and their soothing words and I wondered if the lack of maternal support left her feeling unprepared for the physical pain.

She described her experience on the ward as a positive one *“They were taking each and every kind of care and they all coming after 5 minutes or whenever you need them. I saw whenever you need them they are giving you proper help and they are taking full care of your baby I was really happy to see that. If I was in an Indian hospital maybe that not happen so I really appreciate these doctors, health visitors’ people”* (P/Mala – Line 131). She spoke of the reality about the kind of care she would have expected to receive in India versus the care she received in the UK and I could sense the genuine gratitude she felt towards the healthcare professionals.

I asked this participant if she felt there was anything missing for her in the care she received *“I think whatever I needed at that time they almost give me all kind of knowledge and help. So I don’t think that I need to know more from them because if I had some difficulty or question regarding this, I asked them otherwise they already gave me all these knowledges. How to bring up your baby, how to take care of your babyso I am happy here”* (P/Mala – Line 306). She described feeling quite empowered to ask the questions she had and felt quite content with knowledge she had gained.

Similarly, another participant also echoed having the full support of the Health Visitors. *“They always say do what you think is best for your child they will sometimes suggest and say feed your child this or that and this might be good for your child but they never impose or tell me how to bring him up”* (P/Zaynub – Line 258). She felt content that although professionals had an opinion, the choice of how to feed her baby was still within her own control.

She further reiterated how supportive she found the Health Visitors *“they attended to me immediately, in fact the health visitor; she used to come to my house twice a week in the first week Then another nurse came once a month to see the progress of my child. Then at three months, they kept all his checks and immunisations up to date for both the child and me. When they felt reassured that this child is ok and well then they discharged him from their care and they offered me plenty of support. When they discharged my child, they said if I want any help or advice or if I am unsure of anything at all or even want to ask any questions then I can ring them and talk to them at any time”* (P/Zaynub – Line 405). I could hear she felt that the community staff were genuinely there for her and had her baby’s best interests at heart.

One participant described receiving traditional herbal remedies during the onset of labour *“Then I came back home, had a hot bath, my pains were getting really bad they were getting worse and becoming really frequent and then I started drink milk with butter and haldhi because that is considered good, so I started drinking that”* (P/Aliya – Line 7). She described drinking Haldhi and milk (Tamarind powder

mixed in milk and real animal fat) a herbal aid to help stimulate the labour and ease the process of giving birth.

Information participants wanted future NHS services to take into account

One participant felt they she was not well informed enough to know how to take care of her newborn *“I was thinking to tell my mid-wife as well, they just, during pregnancy, they just concentrate on you know about the pregnancy, about the delivery, they don’t talk about after baby. I used to watch a lot of programs I used to watch labour, delivery you know all sort of pregnancy programs, but I didn’t watch after baby programs you know, bring baby home, and that’s most important thing. You know mother should know a little bit about hic-cups you know something like that, they give you books but you don’t have the time after having baby to read that, yeah, they should give knowledge about after baby. I missed those little things you know, the child gets constipated, you need to give two three days, they tell you afterwards but at that time you are suffered you know.”* (P/Amber – Line 193). I could hear a sense of urgency in her voice that knowing about how to take care of a baby should be knowledge that every mother has access to before the baby is born and her wise words about how unpractical it is to have a book to guide you when her time after the birth was very pressurised in attending to the baby’s needs.

She commented on the birth centre *“Concept is really different and actual birth center is really different. Somebody told me our birth centre there is nothing left, there’s nothing there actually, but you know, during the labour, they took me to that*

center. I said to them I don't want to go birth center, but it was really good, but after 2 hours they had to take me to labor ward because I had high blood pressure but I felt really good. Midwife was really nice and they were really good, but I told them as well, they should change the concept you know, because when they show you picture before labor or delivery it is really horrible, they don't tell you there will be midwife there and you will have all sort of help" (P/Amber – Line 519). It was really interesting for this participant to express her lack of knowledge and how this could be better marketed.

She shared her experience with NHS staff *"yes I told them it was quite nice, it was really good and the room was cozy and you feel like it was really nice. The midwife was really nice, it was like they were friends and like having my mother, but after having her, they shifted me into ward, they were so horrible they were not helpful or I was lying down in blood for more than three hours. They didn't take care of anything, you feel like they are not paying attention to me, maybe they are busy or something like that. I said to them I want to go home because they are not paying any attention, what's the point you know staying there, they are not taking care of anything because she was puking, that was normal but I didn't know. I said she's not drinking and they said oh that normal, that's normal and they were gone. At that time, I had stitches"* (P/Amber – Line 532). She expressed the contrast between the birthing unit and the post-delivery labour ward.

One participant wanted to make suggestions *"I think there should be some kinds of support network maybe even um like a, you have mother and toddler group's maybe, it would be, it would be very helpful to have something like that.*

Specifically, for woman who are first time mother's and who have no support here because we do not know who we are turning to for advice we do not know if what we are doing is right" (P/Nakita – Line 349). She suggested a group who could target this group of vulnerable women and give them advice and guidance.

She further described accessing the baby clinics *"it's like a cattle field you know there's a whole list of women there could be 20 mother's with 20 children waiting to have their baby's weighed. So really what time do you have to speak to the nurses other than a few minutes because your very conscious that there still 20 other woman's sitting out there"* (P/Nakita – Line 366). She expressed feeling under pressure at the baby clinics and uncomfortable using the space to ask questions about her baby's health. This signified she did not really understand the purpose of these clinics which was to answer questions and queries regardless of how many women were waiting.

One participant suggested Health Visitors did not understand why she missed her mother's support *"So that's why they don't understand, because they themselves hadn't seen too much help around so that's why they see all babies cry, all mums have problems with breast feeding"* (P/Taran – Line 454). I wondered if she meant having maternal support was not a western way of life and she further reiterated that *"they would not expect it"* (P/Taran – Line 461). She described how she came to expect maternal support *"Because when I was born and my siblings were born, my mum had good support from her mum. You know, that's why, that's why she had that experience she knew how much difference she makes"* (P/Taran – Line

466). It felt as though her mother had maternal support and this was indeed a cultural expectation.

She also felt there was a cultural clash in putting the baby to bed “because here people say, *“put the baby in the cot, put the baby in the cot, cot, cot, cot”* he doesn’t feel secure and safe in the cot. So he, I mean, it’s like a big thing for them to let the baby sleep in your bed but if you see in Eastern Cultures it is not a big thing” (P/Taran – Line 483). I could hear a difference of opinion based on cultural ideas and that this participant felt comfortable and having the baby in her bed was a practical solution.

She suggested a Health visitor could see where the baby sleeps when they visit “I didn’t ask for this but when the health visitors do visit, you know I would have like. You know at that time I didn’t realise they should see where the baby sleeps, how it sleeps, you know, rather than explain of ok, do like this, just feed the baby by lying down, keeping pillow” (P/Taran – Line 501). She further suggested a “or maybe a demonstration by the mum that this is what I am doing please explain if it is right or wrong” (P/Taran – Line 517). She further felt “so it’s, very useful when you go to somebody’s place and you can assess by looking at the surroundings and then you can make suggestions according to that” (P/Taran – Line 558). It felt as though she had stepped into a practical solution giving mode which was based on her life experience.

There appears to be no understanding of cultural traditions *“I mean and some people are vegetarian so somebody said ok of you can give a drum-stick to the baby but my husband would not like that (laughing). My baby has not had his hair cutting ceremony, he cannot be given a drum stick, so it’s more like, we don’t want him to eat, we are quite open, like we are not like, he’s vegetarian but its fine for the baby to eat non-veg, but not right now. You know, it’s like all the ceremonies should happen and then afterwards. So more of the things are of the faith as well”* (P/Taran – Line 531). She made a valid point that Health visitors could do more to understand people’s faiths and cultures.

Postnatal care

She felt her care on the ward was not satisfactory and decided to go home rather than stay the night on the ward *“I had forceps baby but stitches you know, so I couldn’t move properly and they gave me an epidural as well. So my body was a little bit numb as well but they send me home after 12 hours, at that time I had complete help there because I went to my mother-in-law at that time I didn’t feel like traveling. My head was like hearing bells because I feel they should keep me for one day, but they didn’t pay any sort of attention, so in the ward that was no good, but in the delivery room the mid wife was really nice, really helpful, really good”* (P/Amber – Line 544). Again a difference in contrast as to the type of care received in the labour unit verses ward and aftercare.

Lack of Breastfeeding Support

One participant described feeling dissatisfied *“I found they were, personally I was not satisfied with the help I got. Because the issue of breastfeeding did raise its head and I was told that, I was not trying hard enough. I should persevere I should try different things. But if you have not slept for three or four nights, have a crying baby and the baby is not latching on you feel completely crap about yourself and you feel completely crap as a mother you do not need to hear that from a health professional.”* (P/Nakita – Line 178). She talked about feeling upset that she could not breast feed her baby and I asked her she felt the Health Visitor was implying *“I felt at that time that she was implying that as a mother I should do more and I should be breastfeeding my child and um. It was a failure on my behalf that I was not able to get the baby to latch on”* (P/Nakita – Line 188). It was apparent that she felt judged and criticised by the professional and in addition she felt let down.

This participant described what led up to her decision of giving up breastfeeding *“I think three days of your baby being hungry and crying, you yourself not getting any sleep is extremely, extremely stressful. You are quite zombified and at the end I thought that I am doing no good for our baby by not feeding him even formula milk. Yes, I wanted to breastfeed him and yes I understand breastfed children are much healthier but he was not latching on and I needed a piece of mind I needed to move on with this”* (P/Nakita – Line 199). She felt torn between feeling unable to breastfeed and understanding the benefits verses bottle feeding for peace of mind and fulfilling her baby’s hunger. She described physical deprivation and lack of sleep which led to extreme stress and the decision to bottle feed allowed her to move on.

Given this participant did not have maternal support from her own birth family I asked her if she linked her action of giving up breastfeeding to not having support. *“Probably I was so exhausted and so tired and like you said I did not have the support here to help me catch up on a little bit of sleep. To re-energize myself to um, so yeah I would say, and yeah also I was a new mum so it is a new experience to me”* (P/Nakita – Line 235). She described a combination of exhaustion and defeat which led to her giving up breastfeeding.

Another participant described the difficulty she had trying to get her son to latch on to her breast *“Because what happened with me, when I used to feed him, with him the problem was, he used to take his feed very slowly, you know, when you talk to health visitors, they will tell you the positions to feed him, everything. You know, but my baby would not open his mouth for food, you know, so his mouth is open quite, you know, small, not wide enough, so he was suck only to the front part of the breast, yeah”* (P/Taran – Line 17). It sounded as though she lacked further knowledge and support about how breast fed babies are fed on demand.

A number of participants described their expectation of the NHS Healthcare staff exceeded the amount of support they actually received and this left them feeling dissatisfied. A number of factors added to this and for some of the women not being able to converse in English left them feeling isolated and cut off. Two participants felt supported by the staff and felt their needs were suitably accommodated.

5.10 Mother and child interaction

At a non-verbal level I wanted to capture the interaction between the mother and the baby in the room during the interview. These sounds were picked up during the recordings of the interview.

Participant Code	Child Present in Room	Age of Child	Did Baby Interact
Taran	No	6 months	N/A
Sarvashi	Yes	8 months	Yes
Zaynub	Yes	5 months	Yes
Amber	Yes	5 months	Yes
Mala	No	4 months	N/A
Aliya	Yes	3 months	Yes
Simi	No	6 months	N/A
Ayesha	Yes	3 months	Yes
Nakita	Yes	3 months	Yes
Jacqueline	No	8 months	N/A

The interesting part about the interviews was the non-verbal cues, which were captured as slight gurgles on the tape recordings of the interviews. It was interesting to hear when participants spoke calmly the child remained quite calm and as the participant's voice rose and the child too seemed to gurgle quite loudly.

This is explored in further detail in section 5 and linked with the intergenerational literature under the heading importance of maternal relationship and Neonatal behavior.

5.11 Forms of support

Given the basis of my research is about the absence of maternal support specifically from the participant's birth family it was interesting to know whether they had any other forms of support from friends or their husband's family i.e. from their In-Laws.

Other forms of Support

No Support at All	Support from In-Laws but did not feel it helped	Support from In-Laws which did feel it helped
Participant - Taran	Participant - Sarvashi	Participant - Zaynub
Participant - Ayesha	Participant - Amber	Participant - Mala
Participant - Nakita	Participant - Simi	Participant - Aliya
	Participant - Jacqueline	

All ten participants did not have any other form of support like friends, aunts or uncles that were not related to them. Out of the ten participants three participants did not have any form of support, four participants did have some form of support that they did not feel they benefited from this and only three participants felt the support they had from their in-laws really made a difference for them.

In summary seven out of the ten participants felt the support they wanted was from their birth family and nothing else could replace this. The three participants who did have support in the form of their in laws and appreciated this help because they felt it did make a difference for them also stipulated they would have liked to have had maternal support from their birth parents.

5.12 Researcher Reflexivity

During the interviews I was in touch with my experience as a new mother and the parallels of my participants' experience of entering into their journey as a new mother. I managed this by revisiting my own space in supervision as a place of receiving support for this intricate process. This enabled me to voice what I saw to be the same issues or similarities in the experiences of my participants and enabled me to separate my experiences from those of the participants ensuring that I was giving their experience a voice.

6.0 DISCUSSION

My research set out to understand the individual experiences of ten Asian women who had given birth to their first child at a time when they were not in contact with their birth family. The results suggest four areas for which I give a brief overview below and then discuss in more detail in this section.

6.1 Findings from My Research:

- Asian women have a cultural expectation of support and what this support looks like. This cultural expectation is set into their psyche from birth, it is fostered in their cultural upbringing and includes Chila the confinement, care and support after giving birth, the baby receiving rituals after birth and advice sought from their maternal family highlighting the importance of maternal relationships.
- The second finding was that Asian women are not culturally brought up to expect care from their husbands as traditionally this care comes from their maternal family. These women are adjusting to the newness of their marriage as well as the newness of their husband's role as a father which ultimately changes the family structure.
- The third finding was the unexpected and being unprepared for the emotional and physical impact of having a newborn baby which these women suddenly found themselves experiencing in the early hours after giving birth. This sudden change in their hormones coupled with the reality of the responsibility of a newborn baby left these women excited and yet saddened as the reality of no maternal support kicked in. With feelings of

sadness there was also the potential for postpartum depression and the impact of this on their newborn baby.

- Finally these women have been able to voice their peri and postnatal experiences of giving birth in the UK. The methodological tensions faced in the NHS and the breast-feeding campaign. This gives us key findings for how future policy and strategic decisions around the care of women from ethnic minorities could be managed.

6.2 Cultural Expectations

From my research, it was clear that a number of participants felt the Health Visitor did not understand the cultural differences they faced. One participant remarked on her Health Visitor advising her to give her baby a drumstick and the participant felt misunderstood as her baby could not eat meat until he had his hair cutting ceremony. Another participant remarked on the importance of rituals and the confinement known as Chila.

Participants linked rituals as an important process in validating the birth of their baby. In a study by Mahat (1998) designed to inform nurses about the difficulties Indian women face between their traditional practices and the practices of another country when they enter the United States suggested “They experience increased conflict and confusion when they are exposed to health facilities and health professionals with different cultural practices and background” (p.155). This is consistent with my finding as a number of the participants in my research also commented on pain relief during labour. The participants had very little knowledge

or understanding what they were being offered at the time of labour and how such pain relief could potentially help them with the pain of childbirth.

Women reported confusion about the side effects of the epidural which limited their choices for effective pain relief and my research findings suggest health care professionals lack an awareness of cultural differences and this difference may affect their interaction with patients. If health professionals understood the woman who is being offered pain relief does not know what choices she has, lacks an awareness of what the pain relief can do and the ultimate side effects of the pain relief, perhaps they would prioritise the time to explain what an epidural is.

In the document prepared by Department of Health, called National Service Framework (NSF) Asian women are categorised as a vulnerable and excluded group. The results from my research suggest that Asian women did not really understand what the epidural was and when offered the epidural at the time of labour they refused it because they did not know enough about it. I anticipate their refusal was due to fear and a lack of knowledge.

Mahat (1998) raises the importance of the ritual of Chila (a point raised by my participants that this would have been a time for the mother to rest and recuperate) so she could be available to bond with her baby adequately. "The way people perceive and cope with health and illness is influenced by their beliefs and values" (p.155). It is important for health care professionals to recognise the important significance that Chila has for Asian women and to understand that women without

maternal support do not have a Chila because they do not have sufficient support in place. This leaves them unprepared and perhaps vulnerable to cope with an expectation that is not practically possible due to the absence of maternal support. Participants all touched on this subject with a sense of sadness and a focus of having to get on with practical tasks without the support a period of Chila would have provided them with.

6.3 Importance of Maternal Relationships

My first question was about the participant's relationship with her own maternal family. A number of participants were able to recall their own relationship with their parents and how this in turn influenced them to want to have the same or a similar relationship with their own child. Fonagy et al (1993) investigated the security of the child's relationship with their parents at the age of 12 and 18 months using the Adult Attachment Interview (AAI). This takes into account the parents' childhood prior to the birth of their child emphasising the psychoanalytical model presented by Freud (1940) "That history repeats itself and there exists an intergenerational concordance in relationship patterns" (p. 958).

I did not set out to make a direct link between how a mother recalls her own childhood and subsequently how this upbringing might affect her desire to parent her child as researched by Fonagy et al (1991). During my interview most mothers had left their babies at home, four participants brought their babies to the interview and two slept right through. Two babies were particularly vocal during the interviews. I noticed how these babies were initially quiet and still but as the interview progressed these babies became very vocal and at times when their

mothers talked about their distress the babies became particularly vocal. When their mothers relaxed into their experience the babies were so quiet I had forgotten about their presence in the room. "Attachment research demonstrates there are marked continuities in children's security of attachment maintained probably by the stable quality of the parent child relationship (Fonagy et al 1993; p. 961).

This led onto my second and third question about support. It was evident from my research findings this area raises further questions about the quality of the mother child attachment a mother without maternal support is able to have with her child. It also raises three very important questions about how Health Care professionals recognise when a mother is struggling to bond with her baby, how staff support these women and what support these staff have in place to skillfully recognise and where appropriate refer these women on. This highlights the absence of maternal support might leave a woman coming from an Asian culture feeling vulnerable as her usual expectation of support will not be accessible for her.

John Bowlby's attachment theory (1973) discussed the reasoning for the social transmission of relationship as a pattern that emerges across generations in which the child and caregiver interact in patterns that then become ingrained and adopted to the extent to which they lead and influence the infants' relational experiences. These continue to affect the predisposition of how relationships are experienced throughout the lifecycle. My research findings demonstrate that mothers describe depressive symptoms that have gone unrecognised. I question the quality of the mother child relationship that could then potentially become a

template for the child in future relationships which continues to keep these intergenerational patterns of attachment alive.

6.4 The role of the father

Another interesting finding was the role of fathers in section 4.4 and how each participant viewed the role of her husband. What was particularly interesting was that all the participants except Taran, Mala and Aliya did not expect practical support from their husband but Taran, Mala and Aliya appeared to have a western approach to the role of their baby's father and wanted the experience to be a shared experience.

For all the participants they appeared to be a nuclear family conforming to the western ideal. This is a concept in which two parents are the primary caregivers but this was an approach they were not at ease with. They all expressed the importance of the notion of the extended family in India or Pakistan in which multiple family members come together to take part in the practical everyday role such as attending to the needs of the newborn baby and the baby's mother and this includes various generations.

6.5 Change of a family structure

From a western perspective support means something different to an Asian woman. In a clash of cultures it is interesting from the findings that the type of support the participants were talking about was not just about having an extra pair of hands at their disposal but of a trusted person they could share both joy and worries with. For a woman motherhood is a personal life experience as Griffith

(2010) focused on connecting themes and how “health and motherhood because they are important points where personal experience, social institutions and notions of culture all intersect” (p. 289). Similarly an Asian woman comes into the maternity services with all her life experiences and cultural expectations with her regardless of the western environment she is going to give birth in as these will become a part of her newly formed experiences.

6.6 Feeling Excited and Apprehensive

A number of participants spoke about their joy of having a newborn versus their anticipation and worries about the health and feeding habits of their newborn child and how they would have sought maternal support from their own parents and in doing so their anxieties and insecurities about their child’s wellbeing would have diminished. A qualitative study drafted by Grewal et al (2005) examined the influence of family members on health seeking behaviour in South Asian women and found “daughters consulted with mothers and mothers turned to daughters for advice on health matters” (p.248). This outcome was consistent with my research findings in which participants’ spoke of the importance of seeking advice from their birth mother.

Further findings established “Daughters respected the knowledge and advice they received from their mothers as women who could draw on their own personal health experiences” (p.249) particularly around pregnancy advice. This was consistent with the findings from my research in which participants saw their own mother as a reliable resource and a woman with whom they felt comfortable to

relate to and from whom they could seek advice from because she had sufficient life experience.

Grewal et al (2005) highlighted the importance of family members and their role in providing transportation to and from appointments. This remained consistent with my research findings especially for Asian women whose mother tongue was not English. They relied heavily on support from their husbands to provide this role of transporting them to and from appointments and for translating between themselves and health care professionals. Consistent with my research findings the research concludes the important influence families have on maternal health and the subsequent well-being of Asian women.

6.7 Potential onset of Postpartum Depression

Five out of the ten participants reported feeling upset, tearful, sad and alone and these symptoms are related to the onset of depression. Interestingly enough only one participant was able to verbalise she felt depressed. Consistent with my findings research carried out by Bostock et al (1996), which concentrated on identifying women at risk of developing postpartum depression (PPD), also concluded that for women in “Asian Indian communities’ maternal depression tends to go unrecognised and can leave women feeling alone and isolated” (P. 34). Similarly my findings suggest a number of participants described depressive symptoms which had gone unnoticed by health care professionals and research carried out by Hearne et al (1998) concludes “Asian Indian women were more likely to be depressed than white women and they were at high risk of being non assessed for PPD” (p.1066).

In maternity services the Edinburgh Post Natal Depression Questionnaire (EPNDQ) has been viewed as a long out of date tool which may need care and sensitivity at the time of administering it. In my opinion it is not a culturally sensitive tool and professionals may well miss opportunities to detect women who are not able to access support. This questionnaire was used to screen out any women who might be vulnerable to symptoms of postnatal depression. However given my concerns about its cultural sensitivity I wonder if the scoring was an accurate measure of a woman's emotional wellbeing.

My research indicates participants had left the maternity ward feeling low in mood and this together with the lack of maternal support may have contributed to the likelihood of them feeling depressed. A study by Goyal, D et al recommended using the Postpartum Depression Screening Scale (PPDS) (Beck & Gamble, 2000,2001a, 2002) "based on the conceptual definition of PPD as a mood disorder that can begin at any time during the first year after delivery" (p.100). In addition, research by Morrow et al (2008) concluded women are predisposed to the likelihood of depressive like symptoms because they are often overtired. I believe Asian women who lack maternal support are particularly at risk of postpartum depression because they do not have anyone to lean on for support and are therefore more likely to feel over tired and equally more at risk of developing postpartum depression.

6.8 Neonatal Behavior

Throughout my research I questioned what the long term impact would be on the baby of the mothers who did not have maternal support. Studies dictate a number of factors can contribute to maternal depression including the quality of the mothers' current relationship and infant factors like the neonatal behaviour of a child can also lead to a mother becoming depressed, especially a mother who might be genetically predisposed to depression. A number of participants in my research talked about adverse experiences on the ward immediately following the birth of their child. "Because infant functioning in the days immediately following the birth is influenced by the nature of the labour and delivery and particularly the medication administered to the mother" (Lester et al, 1982; p. 27) suggests there may be a direct link between the mothers' experience and the subsequent function of their child.

Further research by Murray et al (1966) concluded, ".....the presence of behavioural difficulties in late infancy was found to be strongly associated with maternal mental state in the postpartum period" (p.130). It appears a number of factors can contribute towards postnatal depression, the maternal mood of the mother and the child's capacity to function. My research seeks to identify and make recommendations for strategic implementations that consider my findings.

6.9 Reflection on methodological tensions in the NHS

The current climate in the NHS has left many services depleted of resources and underfunding has resulted in the loss of many such services. At such a time of austerity service provisions have been more carefully thought through with cost analysis and financial business case propositions. As a result of my research I have gone back over recently submitted research conducted in the NHS and some resemble elements of mine. However my research gives a voice to the childhood experience and cultural bond Asian women have an expectation of when they give birth to their first child. As such this research is unique and gives an in-depth insight and life experience account of where the NHS falls short of service provisions for women of ethnic minorities.

6.10 Breast-Feeding and the Breast is best campaign

My research found that all participants attempted to breast feed their baby but struggled to maintain this when there was no maternal support. My research raises a number of suggestions and recommendations which need to be brought to the attention of the strategic lead for the health visiting team. A number of participants in my research commented on giving up breastfeeding because they were too exhausted dealing with practical chores to take care of themselves and therefore breast feeding is only really a practical option when women have support in place.

Each of the mothers in my research described the demands a newborn baby places on a mother and this is detailed in section 4.5 and in some cases resulted in them neglecting their own self-care. This in turn led to mothers feeling low about their appearance which perpetuated to their cycle of feeling alone and isolated. In

a study conducted by Noor et al (2007) “Breast feeding may have direct or indirect effects on maternal health or conversely the mood state of the mother may influence the choice of feeding method” (p.491). Participants from my research commented on how difficult it was to continue to breast feed when they could hardly meet the demands of their baby.

Participants Taran and Nakita both found that although they wanted to breastfeed their newborn they lacked emotional and practical support and were thoroughly exhausted. Research led by Carr et al (2009) indicated childhood feeding difficulties can be experienced as stressful situations for parents. The lack of maternal support could also be an indicative factor as to why women decide to give up breastfeeding as it can be demanding and exhausting for the mother and ultimately impact the mother child bond.

My findings suggest there are a number of experiences Asian women have in the absence of maternal support which can directly affect their emotional wellbeing at a critical time when they are beginning to parent their newborn baby. In section 6.1, I discuss how my findings can be taken back into the training of midwifery and support groups for new mothers.

6.11 Chila – A Period of Confinement

Most of the women spoke about what it might have been like if they had given birth to their newborn baby with support of their maternal family. Some spoke of this period of confinement which is a cultural ritual, a period that starts after the birth of the baby which involves postnatal recuperation. A time in which the family members rally round and attend to the physical needs of the mother and baby and provide resources to attend to these. The mother is instructed to rest and bond with her baby, taking away the practical stresses and strains so that she can regulate her emotions and attend to the needs of her new born baby enabling a bonding process to emerge.

In particular participants Taran and Nikita spoke about their desire to have had this support and their expectations of not needing to give up breastfeeding had they had more support to hand. This process of Chila is also known widely in many different countries; “The custom is well-documented in China, where it is known as "Sitting the month". Japanese women know it as "Sango no hidachi" and Korean women as "Samchilil". In Latin American countries it is called la cuarentena, which means "forty days" (the source of the English word "quarantine"). In India it is called jaappa (also transliterated japa)” (Wong et al, 2009). This process is one of formal support and was designed to guard women against postnatal depression, involves a special diet to increase hemoglobin levels to stimulate breast milk and refraining from sexual intercourse and housework to allow the body to recover from pregnancy and childbirth.

6.12 Important Contributions from my Research

It was interesting to learn from the table in 4.9 that participant Zaynub did not have maternal support. I was surprised to learn she had such a good rapport with her mother-in-law and felt this relationship gave her strength. In contrast Participant Sarvashi spoke of having her sister-in-law by her side and yet feeling so lonely and particularly felt impacted by the absence of maternal support that she reported how she struggled on numerous levels emotionally, missing her husband's support. This has helped me to understand that not having maternal support is not such a huge difficulty but rather the difficulty is not having support from someone you value.

This indicates the term support is a much more deeply ingrained idea borne out of culture and support has a much deeper meaning. It is not a matter of anyone providing these participants with support and in fact the important factor for these women was having support from someone they had a good relationship with and only then was that support well received, relied upon and trusted. Without this almost intimate understanding from the person supporting them there did not appear to be any basis upon which the support felt 'worth it'. It was natural for the majority of Asian women to want support from their birth family during the time they were entering the realm of motherhood. Ultimately this was due the cultural closeness Asian women will have experienced which many of them spoke about when they elaborated on having a good relationship with their parents and in particular their own mother as described in section 4.7.

Participant Mala was described in section 4.3 and she felt practically and emotionally supported by her in-laws and her husband. She felt the absence of her birth family when it came to the traditions she believed should have been carried out by her birth family at the time of her daughter's birth. She did not feel at peace until her parents came to the UK as traditionally only her birth parents would carry out these rituals. The surprise here was that support has many different interpretations and in this case support meant carrying out traditional ceremonies for her newborn.

In understanding these women's experience it was clear it did not matter as much whether the participants received support, it matters much more who they received the support from. In most cases participants wanted to receive support from their own mother because their mother was the person they valued the most. The other interesting finding here was that the word support moves beyond the dictionary meaning of "having someone to lean on" it takes on a much more holistic meaning. It shifts into having someone to talk to, depend on, ask for guidance and information, asking that person to accompany you to appointments, ask that someone to translate what you are saying in a way shared with each other.

The most recent research conducted in maternal health by McLeish et al (2015) concluded the need for peer support during the pregnancy and postnatal period. This research trialed volunteer supporters in a number of roles, listening and information giving through to providing practical support. Using thematic analysis

the study concluded that although the women receiving peer support felt some benefits the role of this support became quite blurred.

Another interesting finding here is that in a western medicalised formal environment the NHS is always concerned about confidentiality and thus having interpretation services to call upon so women can freely express themselves without being concerned what they are asking for is a true reflection of what they are questioning. Such a service is impersonal and I do not think professionals have thought about this. Having a baby is both a physical and emotional matter, one in which the woman should be given the choice about whether or not she wants to speak through an interpreter.

An interpreter service provided to a woman having a baby might cause a woman some concerns as she may need to talk about matters connected to her body and mind and such an impersonal service might impact and hinder the freedom with which she would speak. Women in this position could be held back from speaking freely through someone they have never met before, or are about to speak with for an appointment and who then walks out of the door with so much intimate information and personal details about the mother to be. As such research written by Shaffer (2002) highlights the importance of having a member of healthcare staff in the antenatal maternity clinic who can speak to Hispanic women in their mother tongue and how this impacts the amount of times Hispanic women access the antenatal services for advice and the relief they feel when they are able to talk about their feelings in their mother tongue.

6.13 Policy and Strategy Implications

By setting expectations in the NHS women would be better equipped to manage the care of their baby afterbirth and a need for support in the early weeks has been highlighted in the most recent research by Henderson et al “Almost a quarter in 2014 indicated that they would like to have seen a health professional more after hospital discharge and that they needed more help and support” (2017:39). Hence this remains an important area.

Further studies by McLeish (2014) indicated “mothers and babies from BME groups have been found to have poorer physical and mental health outcomes and they are less likely to access maternity and child healthcare services” (p. 2). This further signifies that women who are disadvantaged remain disadvantaged. My research lends itself to understanding why this group of women remain disadvantaged given their limited understanding of a western culture coupled with their early expectations and perhaps also not knowing what questions to ask, where to go and how to ask those questions to get the answers they require and this might also play a part in their limited language skills.

What is clear is that my research does give women who are disadvantaged a voice and that my research, if shared with professionals, has the opportunity to be seen and heard. As I reflect on the research carried out in the area of maternal well-being I notice that researchers have taken forward research gaps that can be explored. However throughout the research the same results keep on coming back and Asian women continue to feel excluded, not a part of the decision making

process, are more likely to feel misunderstood and ultimately leave the maternity ward feeling as though their needs were not met.

6.14 Taking My Research Findings Forward

Further to my results and findings above I reflected on my journal notes and the current position in the NHS at a time of austerity, budget cuts, and a huge influx into services with not enough resources to deliver these services hence the demand far outweighs what it is practically able to offer. It is also very clear the NHS is dedicated and continues to seek and support women who are at a disadvantage and constantly researches with a view to understanding how they can provide an increase in patient satisfaction with the setup of research by NHS England. As evidenced by Henderson et al (2017) "Government policy now favours choice for all women in the manner of their maternity care and there is an ever-increasing focus on continuity of care and carer, satisfaction, and quality of care as perceived by the women using the maternity services" (p. 36).

In taking my research forward I have had a telephone discussion on 11th February 2017 with two influential researchers in Oxford in the area of maternal health and wellbeing Maggie Redshaw and Jane Hederson. During my discussion I was encouraged to contact the lead researcher in the NCT with a view to discussing the findings from my research and putting together a presentation to healthcare professionals and people interested in this field. I was also encouraged to consider preparing a journal article for the Journal of Reproductive and Infant Psychology (JRIP), placing a copy of this on the health experiences group and giving talks about my research methodology and results to a number of local community

groups and organizations like the Health Visitors Association. I am currently in the process of making contact with the NCT to progress my research findings.

In comparison to similar researches carried out in maternal health studies my research sets itself apart giving women a voice about the unique lived life experience an Asian woman has. This indicates an opportunity to inform healthcare professionals about these women's cultural expectations when they walk into NHS services. In providing this insight to Health Care professionals involved in the care of women in maternity services we can empower professionals at the heart of these services to empower the women who are receiving this service. In doing so we can inform and educate women on what the NHS can provide, providing a unique understanding of what they may be expecting and how they might think about managing these expectations. By doing this we empower both healthcare staff to influence and empower the patient, person and woman receiving care to make decisions about how she will fulfil her expectations of support after the birth of her baby.

I believe my research adds an answer through the phenomenological process of enquiry. I have found that these women come in the NHS with inbuilt expectations, limited insight into what the NHS will offer them as a maternity service and perhaps limited or often no understanding of what they are about to experience. Such disempowerment keeps these disadvantaged women from breaking through the perception of them being disadvantaged just because of their minority status.

My research gives us clear answers on what that experience is like for Asian women. If we took these experiences into the training field and taught healthcare professionals about these women's cultural expectations they would be empowered to support these women to understand what the NHS provides and support these women to make a plan for the expectations they might have and where these expectations could be met. By doing this preventative work we would be empowering Health Care professionals, guiding service user expectations and empowering these women to find resources for themselves. This I do believe structures healthcare expectations and in turn could improve maternity outcomes.

6.15 Potential scope and impact of my research outside of the NHS

My research has the potential scope to be beneficial for schools and teachers and to reach the realms outside of the NHS. The reach of this research could support teachers to understand how Asian parents experience the word support and how this early dynamic might go influence how they interact in nursery and schools settings. In the field of Counselling Psychology my research seeks to inform clinicians and practitioners about the expectations that Asian women might have early on in their pregnancy and how not being able to fulfil these expectations might leave them feeling emotionally.

7.0 MOVING FORWARD

My research has highlighted a number of areas which can be addressed to ensure all women from a variety of backgrounds are provided with maternity services that consider their diverse needs. My contribution to the field of maternal health is not just one of strategic planning but one of educating healthcare professionals and potential volunteers about the difficulties Asian women face in the absence of maternal support.

7.1 Suggestions

My research highlights that Asian women come into maternity services with an expectation of what giving birth is going to be like for them. This expectation is set by their maternal upbringing and it would be useful to share this expectation with Health Care professionals. By using the birth plan as a tool to record what the NHS will provide in terms of physical and emotional support this would empower and enable them to structure an Asian woman's expectations from the outset and minimise the potential for dissatisfaction of maternal health provisions.

By incorporating psychoeducation or postnatal advice as part of the birth plan women could be shown videos and receive postnatal advice on how to care for their baby at antenatal classes. This would give women the time to think about caring for their newborn and avoid them feeling the need to lean on their family who might not be practically accessible for advice and might encourage them to contact health services for future advice on how to care for their newborn. It would

also build a relationship between healthcare providers and the service user and aid their knowledge of what services are available and how to access them.

With the introduction of perinatal and parent infant services across the NHS this incorporates talking therapies to help women with mental health difficulties bond and attach to their baby and support the process of early motherhood. My research interviews could inform these professionals about the expectations of first time Asian mothers and what might affect their mental wellbeing. These services are designed to identify women in their last trimester who might have be experiencing mental health difficulties and may need support which continues until the baby is at least 12 months old. Offering therapy and liaison with health visitors extends to an inpatient service to conduct antenatal and postnatal assessments.

Asian women tend to lean towards their family for advice. I suggest we encourage women to plan the birth by using the birth plan and incorporate whom they might lean on for support during the pregnancy and in the postnatal stage. This would encourage them to build a rapport and discourage isolation. Women could be invited in for a tour of the labour/delivery room so they are empowered to make a choice about where they want to give birth.

One opportunity to overcome the barrier about the epidural is to prepare these women so they are better able to make choices about what treatment they want at the time of the birth of their baby. In particular Asian women tend not to ask for an epidural, therefore my recommendation is to educate women about the epidural

and possible side effects. Giving them the research on it and to incorporate the idea that alternatives to pain relief could be introduced at antenatal classes and documented in the birth plan.

H.V could be offered more one to one Psychotherapy support, consultancy and advice from the CAMHS team for difficult cases. This already takes place in the Slough CAMHS team and the advice and guidance is provided to the Family Nurse Partnership specifically for nurses and staff working with young mothers. With the merger ahead of BHFT with Primary Healthcare Trusts we could look at equipping H.V to deal with the complexity of their job by giving them shared resources across the whole of Berkshire.

Clearly, the EPNDQ needs to be culturally sensitive to pick up the needs of depressed mothers. I suggest Health Visitors consider administering the Postpartum Depression Screening Scale (PPDS) (Beck and Gamble, 2000, 2001a, 2002).

Midwives could use the birth plan to encourage women to think about who will support them at the time of birth and after the birth. I also recommend midwives and nurses on the ward are trained to detect women who might suffer from Postnatal depression whilst on the ward. The women who lack support could be flagged up to Health Visitors as vulnerable to PND prior to them leaving the ward. Advise GP's and other health care professionals about the difficulties Asian women face and that these women are more sensitive to criticism and therefore

they should be treated with sensitivity as this might also trigger PND. If a group of volunteers was established referrals for women identified as vulnerable could be referred for more cohesive support.

My research steps out beyond the realms of maternity services and the NHS and adds value when we think about how the impact of the lack of maternal support may have influenced the maternal mother baby dyad. My research seeks to inform researchers and professionals that Asian women are a distinct group who do not readily seek support outside of their close knit family circles. As such the intimacy of pregnancy further pushes them into the realm of isolation making them vulnerable and unable to voice their needs.

My research found that some participants had left the ward without knowing how to take care of their baby's basic needs. I recommend all new mothers are asked to complete a questionnaire at least one day before their planned discharge to ensure all new mothers leave the ward knowing how to meet the basic needs of their new born including, breastfeeding, bathing, bottle feeding etc. This would also serve as an audit for the ward and for CQC and Ofsted compliance. It would further aid service delivery outcomes as well as act as a checklist ensuring women do not leave without this basic knowledge.

7.2 Multicultural Deficits

My research has highlighted the multicultural deficit that still exists when we treat patients from another culture to our own. There are language barriers that isolate patients from expressing their needs and communication barriers that deter non-white communities from accessing services. This is mainly because diverse communities do not know services are available and how they can help them. Asian women are experiencing a clash of cultures in the healthcare system and the absence of maternal support is a larger issue.

This research has highlighted preventative strategies if these women were flagged up as vulnerable before leaving the maternity ward. Health Visitors in the community would know what community resources were available for these women to access. This could eradicate and prevent women suffering which would in turn have less of a detrimental impact on their child. By incorporating the above strategies, the impact on the children of our future is less likely to be detrimental and their needs are less likely to be neglected by a mother who is perhaps feeling the impact of not having any maternal support.

7.3 Limitations of the Study

My study lent itself to the experiences of Asian women because this was a cultural group I was familiar with. In hindsight I could have had one further question and asked my participants what was missing in this experience for them. This would

have given them the opportunity to express what they placed more emphasis on. Perhaps a follow up research could incorporate a multiple choice questionnaire in which women are asked what their experience was like and then be asked what else could have been provided offering them multiple choice questions for which provisions could realistically be made.

My study only focused on the absence of maternal support it could have been compared to case studies of women who did have maternal support to measure if the satisfaction of maternity service provisions varied with these groups of women depending on what support they had in place. My research recruited first time mothers and it would be interesting to compare and contrast the experiences of first, second and third time mothers and to see how their expectations vary across their experience in maternity services.

My research highlights the experiences of Asian women that come to the UK as immigrants and do not have support from their maternal family. In particular my research highlights the unique way in which Asian women are set up from their early teens to become mothers. The interviews give a story about how maternal support aids recovery from the afterbirth, rituals take place to reassure the mother and how the mothers well-being continues to aid the harmony of the newborn. This unique story gives us insight into why Asian women are a vulnerable group and how they fall short of maternity services in the UK.

In considering transferability and the limitations of research I am aware that my own Asian heritage and the rapport that I built up with my participants may mean the research is unique to that of research conducted with Asian women by an Asian woman. As the researcher Asian women developed a connection with my presence as a fellow female Asian woman and engaged with me in a manner unique to Asian women where we respect one another as sisters regardless of our cultural hierarchy. Therefore it is important to note that it is possible that these women spoke to me in more depth than if I were not an Asian woman and may have been influenced by cultural presence.

My research was also only carried out in Berkshire where there is a diverse community and I wonder what the responses would have been if the same research was carried out in an area where there are more Asian families or in an area where there are less diverse communities.

Whilst my research gives us some idea about the reasons why Asian women do not access pre and post maternal an in-depth study giving specific reasons could be completed. Given that the quality of parenting is often a predictor of maternal well-being this is a disadvantaged group of women who do not appear to readily reach out for support it would be advantageous to do a qualitative study to understand why these women do not reach out for support. This would inform Health Care professionals and give an indication of how better to target information for these women.

There is a lot of research on the impact of the parental relationship on the infant's brain although my study did not take the baby's wellbeing into account there is a place for including the baby into this area of research. In particular once the baby was in the room as was the case during some of my interviews the mother baby interaction could have been recorded in some way and incorporated into the results. More in my research could have been included about the baby's response when the mother was recalling her experiences.

Finally most of the studies including mine continue to reiterate that women are struggling in the first few hours, days and weeks after giving birth to adjust to physical and emotional changes and try to meet the demands that a new baby places upon them. Given we now know this future research could include a study on what more could be done to highlight this need and how could resources be set up which meet this need. If this need remains unaddressed it puts weight on the NHS's future provisions and again research could be done on this to see how many women then seek advice, guidance and support from their GP' surgery to meet this need.

7.4 Conclusion

My own personal growth - I currently work in an NHS forensic setting and have found the process of undergoing a doctoral research dissertation informs my knowledge and has enhanced my understanding of research methodologies. My research informs the depth of my work within my private practice setting in which I can use my therapeutic relationship as a therapist to understand the experience of my client. I am able to gather a well-informed knowledge of their experience as a

child on the receiving end of being parented. As such my research gives me an understanding of how the clients I work with might form attachments, how they might attach or distance themselves from me and my clinical thinking to interpret their attachment styles. This facilitates my understanding and the connection of their phenomenological experience. In doing so I can glean some of what their early life experiences were like, how they attached to their mother and elicit an idea on the quality of this relationship.

I am also in touch with what it has been like for me to undertake a research topic that has been so closely intertwined with my own life experience. At times hearing the experiences of my participants has left me feeling re-traumatised and revisited my own therapy space. The write up has been a tough process, working full time, managing a family, progressing in my NHS roles, changing jobs and locations are all issues that have at times become barriers to completing this.

However the personal gain in completing this doctoral research has been empowering and enabled me to go on and confidently conduct research in my current working environment. I presented a 20 minute talk as a part of a symposium on the 22nd March 2018 at the British and Irish Group for The Study of Personality Disorder where I delivered a presentation on Defining a Supervision Process for Operational Staff Working in a Trauma Informed Service. I presented a poster presentation at the Male Psychology Conference in June 2018 on this topic and I had a poster presentation accepted by the Counselling Psychology Conference in July 2018 on The Usefulness of the ADOS II for Offenders with Personality Disorder in a Forensic Trauma Informed Service. Having undertaken

the process of completing this doctorate I feel inspired to undertake further research and I feel able to grapple with different research methodologies and ideas.

My research has signaled to doctors, nurses and other health professionals involved in the ongoing care of women there are particular difficulties a woman who does not have maternal support could face.

What I set out to do was to give my research participants a voice. As a result I have achieved a significant amount of support from the community health visiting team which has enabled me to incorporate much more. I have highlighted a number of ideas that can be incorporated in the transition for patients transferring from the maternity ward ready for discharge into community services to ensure open communication so that any women with difficulties can be easily highlighted and offered the appropriate services.

The clinical strategic suggestions I have made take into account the need for professionals to be skilled up to recognise vulnerable women and to be culturally sensitive to the situations they face. My suggestions also take into account some of the liaison elements and flagging up vulnerable women before they leave the ward and following them up in the first new birth visit in the community. We should be looking at perinatal pathways and support systems in place for staff to skill them up as well as for new mothers to ensure we can sign post them to services that can treat them.

By understanding the cultural expectations of Asian women, which could be incorporated in CPD training days provided by the trust, it would help to shape their expectations from the outset and this in turn would minimise their dissatisfaction when they leave maternity services. It also provides us with a framework for women coming from different cultures and enables the woman to take some responsibility for her own needs. If she were to incorporate what she expects into the birth plan she could be empowered to fill those expectations by planning ahead. This minimises the sense of loss after the birth that these women tend to experience.

My strategic suggestions look at perinatal pathways and support in terms of highlighting cultural issues so these can raise awareness of what some of the issues a woman coming from this background might face and how these can be addressed outside of routine quality and diversity training. There was an element of action research focus in the way I became involved in recruiting participants for my research by actively attending the mother and baby clinics.

My research offers professionals' an awareness, a number of nurses, health visitors, strategic leads, officials and other health care professionals suspected the absence of maternal support would have an impact on women and knew this experience would have some sort of effect on a new mother. Therefore they actively held this knowledge in the back of their mind. My research has brought

this topic to the front of their mind and opened up their awareness by asking them to be involved in selecting candidates they felt would be suitable for my research.

From the ten participants selected by Health Visitors to take part in my research it shows they knew their patients well enough and were spot on as each participant had so much valuable information about their experience to offer. The Health Visitors contribution was a key factor and crucial to the data collated and this links to the document NSF and fulfils the criteria of how vulnerable groups of women are being targeted and research is being conducted to ensure their perspectives on the services they receive are being taken into account.

The most fascinating part of my research journey was that I had struggled in the early stages of motherhood and I believed my struggle was because I did not have maternal support. My research passion became a place in which I could put my theory to the test. Am I the only woman who is struggling directly because of the absence of maternal support? I looked around me and for quite some time and believed my journey was unique. I could only understand my journey as a British Born Asian woman but in conducting my research I now understand the effect of the absence of maternal support is felt throughout the generations. Above all this research has taught me the word support means so much more in a cultural context than just having someone to lean on. Support in the context of my research has a very different cultural context and is all about having someone you can trust and feel free to ask for support. This cannot just be a request of support from anyone but someone whom the participant respected.

In conducting my research with both a mixture of first and second-generation Asian woman who had experienced giving birth to their first child without maternal support I can now understand my experience was not unique at all but a shared experience. Most importantly an experience my own mother may well have come to experience as she too arrived in the UK as a first-generation Asian woman who gave birth to me without maternal support. I have gained so much more from this research and I have realised like our patterns of attachment our experiences too can be intergenerational.

8.0 REFERENCES

Adam, Amina. (2013) Managing insider issues through reflexive techniques: An insider-researcher's journey. <https://www.researchgate.net/publication/275336987>.

Antonia, M. N. (2003) Transition to Motherhood. *Journal of Obstetric, Gynaecologic & Neonatal Nursing*. Volume 32, Number 4: 465-477.

Armada, A, A & Hubbard, M. F. (2003) Diversity in Healthcare: Time to Get Real! *Frontiers of Health Services Management*. Volume 16, Issue 26.3, 3-17.

Barn, R. Ladino, C. Rogers, B. (2006) Parenting in multi-racial Britain. London: National Children's Bureau, bibliog.

Baker, C. (1992) Description and Analysis in Classroom Talk and Interaction, *Journal of Classroom Interaction*, 27: 2, 9-14.

Barker, C. & Pistrang, N. (2002) *Research Methods in Clinical Psychology. An Introduction for Students and Practitioners*. Second Edition. John Wiley & Sons, LTD.

Bartlett, S. (2003) Beyond the looking glass: The Qualitative Research Process as a Development of Self. *Counselling Psychology Review*, Vol 18, No 2, Page 26 – 29).

Beebe, B. & Lachman, F.M. (1998) Co-constructing Inner and Relational Processes: Self and Mutual Regulation in Infant Research and Adult Treatment. *Psychoanalytical Psychology*, 15 (4), 480-516.

Beck, C. T (1995) The effects of postpartum depression on maternal-infant interaction: A meta-analysis. *Nursing Research*, 44, 298-304.

Beck, C. & Gamble, R. (2000). Postpartum depression screening scale: Development and psychometric testing. *Nursing Research*, 49, 272-282.

Bharj, K. K & Salway, S. M (2008) Addressing ethnic inequalities in maternity service experiences and outcomes: responding to women's needs and preferences. *Better Health Briefing 11*. Race Equality Foundation.

Blunt, L (2014) Improving service User Experience in Maternity Services. A report prepared by the patient experience network for NHS England.

Bond, T. (2004) Ethical guidelines for researching counselling and psychotherapy. Rugby: British Association for Counselling and Psychotherapy (BACP).

Boram, L., Louise J. Keown, and Gavin T. L. (2018) Relationships between parenting practices and perceptions of child behaviour among Korean immigrant mothers and fathers. Brown Faculty of Education and Social Work, The University of Auckland, Auckland, New Zealand. *International Journal of Psychology*, 2018 Vol. 53, No. 5, 402–410, DOI: 10.1002/ijop.12398

Bostock, J., Marsen, M., Sarwar, Z., & Stoltz, S. (1996). Postnatal depression in Asian women. *Community Nurse*, 10. 34-36.

Bowlby, J. (1988) *A Secure Base*. London: Routledge.

Brown, G.W. & Harris, T. (1978) *Social Origins of depression: A study of psychiatric Disorder in women*. London: Tavistock.

Bruner (1991) The narrative construction of reality, *Critical Inquiry*, 18 (1), 1-21.

Bryan, S. K & Omizo, M. (2003) Asian Cultural Values, Attitudes toward seeking professional Psychological Help, and Willingness to See a Counsellor. *The counselling Psychologist*. Volume 31, No 3: 343 – 361.

Carr, M. S & Scholten, I. (2009) Not Feeding, not coming home: parental experiences of infant feeding difficulties and family relationships in a neonatal unit. *Journal of Clinical Nursing*. Blackwell Publishing Ltd. 19, 249-258

Central and North West London NHS Foundation Trust. (2016)
<http://www.cnwl.nhs.uk/services/mental-health-services/child-and-adolescent-mental-health-services/perinatal-services>.

Clarke, C (2009) An Introduction to Interpretative Phenomenological Analysis: A useful approach for occupational therapy research, *British Journal of Occupational Therapy*, 72 (1), 37-39.

Chamaz, K (2008) Constructionism and the Grounded Theory. In J.A Holstein & J.F Gubrium (eds.), *Handbook of Constructionist Research* (pp. 397-412). New York: The Guildford Press.

Charmaz, C. (2006) *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage. Dey, I. (1999)

Cresswell, J. (1998) *Qualitative Inquiry and Research Design, Choosing among five traditions*. Thousand Oaks: Sage.

Crnic, K. A. Greenberg, M. T. Robinson, N. M. Ragozin, A. S. (1984) Maternal Stress and Social Support: Effects on the mother infant relationship from birth to eighteen months, *American journal of Orthopsychiatry*. 54: 224-235.

Davies, L. Edwards, H. & Mohay, H. (2003) Mother-infant interaction in premature infants at three months after nursery discharge. *International Journal of Nursing Practice* 2003; 9: 374 – 381.

Department of Health (2008) National Service Framework for children, young people and Maternity Services.

Dowling, L (2007) From Husserl to Van Manen: A Review of Different Phenomenological Approaches. *International journal of Nursing Studies*, 44, 131-142.

Eatough, V. and Smith J.A. (2006) (in press) 'Interpretative phenomenological analysis', in C. Willig and W. Stainton Rogers (eds) *Handbook of Qualitative Psychology*. London: Sage.

Edward, J. Ruskin, N & Turrini, P. (1991) *Separation/individuation. Theory and application*, (2nd Edn.). New York: Gardner Press.

Essex, H, Pickett, K (2008) Mothers without Companionship During Childbirth: An Analysis within the Millennium Cohort Study. *BIRTH* 35:4

Etherington, K. (2004) *Becoming a Reflexive Researcher: Using Ourselves in Research*. Jessica Kingsley Publishers.

Fei-Wan, N, Wai-Chi, C. S and Holroyd, E (2011) Maternal Coping during Early Motherhood among First-time Chinese Mothers. *Journal of Health Psychology* 17(2) 189 –196 © Reprints and permission: sagepub.co.uk/journalsPermissions.nav DOI: 10.1177/1359105311415728 hpq.sagepub.com

Fonagy, P, Steele, H, Steele, M, Moran, G. S & Higgitt, A. C (1991)

The Capacity for Understanding Mental States: The reflective Self in Parent and child and its significance for Security and Attachment. *Infant Mental Health Journal*, Volume 12, (3) Page 201 – 218.

Fonagy et al (1993) Measuring the Ghost in the Nursery. An Empirical Study between Parents Mental Representation of Childhood. Experiences and their Infants Security of Attachment. *Journal of The American Psychoanalytical Association*, Vol 41, part 4, Page 957 – 989.

Fonagy, P., Steele, H., & Steele, M. (1991b). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development*, 62, 891-905.

Gadamer, H.G. (1975). *Truth and Method*. London: Sheed and Ward.

Gee, J. P (2005) *An Introduction to Discourse Analysis. Second Edition*. Routledge.

George, L (2005) Lack of Preparedness: Experiences of first time mother. *Volume 30, Number 4: 251 – 255*.

Glasser, B. & Strauss, A. (1967) *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing Company.

Grewal S.K., Bhagat R. & Balneaves LG. (2008) Perinatal beliefs and practices of immigrant Punjabi women living in Canada. *Journal of Obstetric, Gynaecologic, & amp; Neonatal Nursing*, 01 May 2008, vol./is. 37/3(290-300), 08842175.

Grewal S., Bottorff J.L & Hilton B.A. (2005) The influence of family on immigrant South Asian women's health. *Journal of Family Nursing*, August 2005, vol./is. 11/3(242-63), 1074-8407, Sage Publications.

Griffith, L (2010) Motherhood, ethnicity and experience: a narrative analysis of the debates concerning culture in the provision of health services for Bangladeshi mothers in East London. *Anthropology and medicine*. Volume 17, No 3. 289 - 299.

Goyal. D., Murphy. S and Cohen, J. (2005) Immigrant Asian Indian women and postpartum depression. *JOGNN*, January 2006, vol./is. 35/1(98-104), 0884-2175.

Henley-Einion, A. (2003) The medicalisation of childbirth. In: C Squire,ed. *The social context of birth*. Abingdon, UK, Radcliffe Medical Press, 173-186.

Vida Henderson, Katrina Stumbras, Rachel Caskey, Sadia Haider, Kristin Rankin, and Arden Handler (2016). Understanding Factors Associated with Postpartum Visit Attendance and Contraception Choices: Listening to Low-Income Postpartum Women and Health Care Providers. *Maternal Child Health J*. 2016; 20(Suppl 1): 132–143. Published online 2016 Jun 24. doi: 10.1007/s10995-016-2044-7

Hearn, G., Liff, A., Jones, I., Kirby, A., Ormiston, P., Parr, P., et al. (1998). Postnatal depression in the community. *British Journal of General Practice*, 48, 1064-1066.

Heidegger, M. (1927/1962). *Being and Time*. [1962 text trans. J. Macquarrie & E. Robinson]. Oxford, UK: Blackwell.

Henderson. J, Gao. H & Redshaw. M. 2013. Experiencing maternity care: the care received and perceptions of women from different ethnic groups. *BMC Pregnancy and Childbirth* 2013, 13:196

Henderson, J Redshaw, M. (2017) Change over time in women's views and experiences of maternity care in England, 1995–2014: A comparison using survey data. *Midwifery* 44: 35–40.

Hendricks, V. M. Blanken, P and Adriaans, N. (1992) *Snowball Sampling: A pilot study on Cocaine Use*, Rotterdam: IVO.

Hirst, J, Hewison, J (2002) Hospital postnatal care: obtaining the views of Pakistani and indigenous 'white' women. *Clinical Effectiveness in Nursing*, March 2002, vol./is. 6/1(10-8), 1361-9004.

Howitt, D. (2010). *Introduction to qualitative methods in psychology*. Harlow: Pearson.

Hung, C. H (2005) *Measuring postpartum stress*. *Methodological Issues in nursing research*. Blackwell Publishing Ltd. (417 – 423).

Hung, C. H (2006) Correlates of First-Time Mothers Postpartum Stress. Kaohsiung J Med Sci, October, Vol 22, No 10, 500 – 506.

Husserl, E. (1952) Ideas: General Introduction to Pure Phenomenology.

(1st English edition 1931, 1st German edition 1913). New York, The Macmillan Company.

Iqbal, H (2018) Parenting and Child Development in Multi-Ethnic Britain: A study of British Indian, British Pakistani and non-immigrant White families living in the UK. St Edmund's College, University of Cambridge.

James, J. (2003) Refugee women. In: C.Squire,ed. The social context of birth. Abingdon, UK: Radcliffe Medical Press, 93-106.

Johnson, C-O. & Clinton, D. (2006) What do Mothers Attune to During Interactions With Their Infants? Infant and Child Development. John Wiley & Sons, Ltd. 15: 387 - 402.

Kagawa-Singer, M. (1997) Addressing issues for early detection and screening in ethnic populations. Oncology Nursing Forum, 24(10), 1705-1711.

Kareem, J and Littlewood, R (1992) *Intercultural Therapy – Themes Interpretations and Practice* , Oxford Press.

Kim-Godwin YS (2003) Postpartum beliefs & practices among non-Western cultures. *MCN: The American Journal of Maternal Child Nursing*, 01 March 2003, vol./is. 28/2(74-80), 0361929X.

Kvale, S. (1996) *An Introduction to Qualitative Research Interviewing*. Sage Publications, Thousand Oaks California.

Kvale, S. & Brinkmann, S. (2009) *Interviews: Learning the craft of qualitative research interviewing*, Second Edition. SAGE Publications Ltd.

Lago, C (2005) *Race, Culture and Counselling: The ongoing Challenge*. Second Edition. Open University Press.

Laungani, P. (2002) *Understanding Mental Illness across Cultures* in Palmer, S. (2002) *Multicultural Counselling*. Sage Publications Ltd.

Langdrige, D. (2007) *Phenomenological Psychology: Theory Research and Method*. Pearson education Limited.

Lester, B.M., H., & Brazleton, B. (1982). Regional obstetric anaesthesia and newborn behaviour. A reanalysis towards synergistic effects. *Child Development*, 56, 15-27.

Lewis, J & Ritchie, J. (1987) *Generalising from Qualitative Research*. 263-286.

Lincoln, Y. & Guba, Egon, G. (1989) *Ethics: The Failure of Positivist Science*. *Review of Higher Education*, 12 (3), 221-241.

Lyons, E. & Coyle, A. (2007) *Analysing Qualitative Data in Psychology*. SAGE Publications Ltd.

Lyons, S. M. & Frances, M. O'Keeffe, Clarke, T. & Staines, A. S. (2008) Cultural Diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. *Ethnicity and Health*. Volume 13, No 3, 261-276.

Macleod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*. London: Sage.

Mahat G. (1998) Eastern Indians' Childbearing practices and Nursing Implications. *Journal of Community Health Nursing*. 01 September 1998, vol./is. 15/3(155-161).

Mahler, M. S. Pine, F. & Bergman, A. (1975). *The psychological birth of the human infant*. London: Hutchinson.

Mattea Romano, Alessandra Cacciatore, Rosalba Giordano, and Beatrice La Rosa. (2010) Postpartum period: three distinct but continuous phases. *Journal of prenatal Medicine (J Prenat Med)*. 2010 Apr-Jun; 4(2): 22–25.

Mazharul Islam and Mohammad Shahed Masud, (2018) Healthcare seeking behavior during pregnancy, delivery and the postnatal period in Bangladesh: Assessing the compliance with WHO recommendations, Oman Institute of Statistical Research and Training (ISRT), University of Dhaka, Dhaka, 1000, Bangladesh. *Midwifery* 63, 8-16.

Melia, K.M. (1996) *Rediscovering Glaser. Grounding Grounded Theory: Guidelines for Qualitative Inquiry*. London: Academic Press. Glaser, B.G. (1992) *Emergence vs Forcing: Basics of Grounded Theory Analysis*. Mill Valley, CA: The Sociology Press.

McLeish, J & Redshaw, M (2015). Mothers' accounts of the impact on emotional wellbeing of organized peer support in pregnancy and early parenthood: a...
Journal of Reproductive and Infant Psychology, 71(7):1587–99

McLeish, J & Redshaw, M (2015). Peer support during pregnancy and early parenthood: a qualitative study of models and perceptions. *Pregnancy and Childbirth* 15:257

Merleau-Ponty, M. (1945/1962). *Phenomenology of Perception*. Trans. C. Smith. London, UK: Routledge.

Mercer, R. T (1995). *Becoming a mother*. New York: Springer.

Morrow, M. Smith, J. E. Lai, Y. Jaswal, S. (2008) *Shifting Landscapes: Immigrant Women and Postpartum Depression*. *Healthcare for women international*, Taylor and Francis Group, LLC. 29:593-617.

Moustakas, L. (1990) *Heuristic Research, Design, Methodology and Applications*. London: Sage.

Murray, L., & Cooper, P. J. (1997). The role of infant and maternal factors in postpartum depression, mother-infant interactions and infant outcome. In L. Murray & P. J. Cooper (Eds.), *Postpartum Depression and Child Development* (pp. 111-135). New York: Guilford Press.

Noor, S and Rousham, E. (2007) Breast-feeding and maternal mental well-being among Bangladeshi and Pakistani women in the north-east England. *Public Health Nutrition*: 11(5), 486-492.

Noy, C. (2008) Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research. *International Journal of Social Research Methodology*. Volume 11, Issue 4.

Pedersen, P., Draguns, J., Lonner, W. and Trimble, J. E. (2002) *Psychotherapy Across Cultures (Fifth Edition)*, Sage Publications.

Pilgrim, D. and Rogers, A. (2010) *A Sociology of Mental Health and Illness*. Open University Press. Fourth Edition.

Pilgrim, D. (2005) *Key Concepts in Mental Health*. Sage Publications LTD. Second Edition.

Ponterotto, J.G., Casas, J.M., Susuki, L.A., Alexander, C.M. (1995) *Handbook of Multicultural Counselling*. Sage Publications Inc.

Raman. S, Srinivasan. K, Kurpad. A, Dwarkanath. P, Ritchie. J and Worth. H (2014). My mothers, my sisters, my friends: Sources of maternal support in the perinatal period in urban India, *Mdwifery Journal*, 30, 130-137.

Reason, P. (1994) *Participation in Human Inquiry*. London : Sage.

Reason, P. and Bradbury, H. (2007) *The Sage Handbook of Action Research. Participative Inquiry and Practice*. Second Edition. Sage Publications Ltd.

Redshaw, M and McLeish, J. (2015) Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC Pregnancy and childbirth* 2015, **15**:257 doi:10.1186/s12884-015-0685-y

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring the lived experience. *The Psychologist*, 18, 20–23

Richardson, L. (1990) *Writing Strategies: Reaching Diverse Audiences*. London: SAGE.

Richens, Y. (2003) Building bridges: involving Pakistani women. *Practising Midwife*, September 2003, vol./is. 6/8(16-7), 0963-276X.

Rubin, R. (1984) *Maternal identity and maternal experience*. New York: Springer.

Rubin, Herbert & Rubin, I. (1995) *Qualitative Interview: The art of hearing data*. Thousand Oaks, C.A Sage.

Rutledge, E. O. (2001) *The Struggle for Equality in Healthcare Continues*. *Journal of Healthcare Management*. 46:5

Ryde, J. (2009) *Being White in the Helping Professions*. Jessica Kinsley Publishers.

Sandall, J. (2014) *The Contribution of Continuity of Midwifery Care to High Quality Maternity Care*. The Royal College of Midwives.

Saldana, J. (2009) *The coding Manual for qualitative researchers*. SAGE Publications Ltd.

Samuels, A. (1993) *The Political Psyche*. Routledge.

Sartre, J.-P. (1943/2003). *Being and Nothingness. An Essay on Phenomenological Ontology*. [Trans. H. Barnes.] London, UK: Routledge.

Schore, A. (1983) *Affect Dysregulation and disorders of the self*. W.W.Norton & Company, Inc.

Shaffer, C.F (2002) Factors Influencing the Access to Prenatal Care by Hispanic Pregnant Women. *Journal of the American Academy of Nurse Practitioners*. Volume 14, Issue 2, 93-96.

Shaw, R (2001) Why Use Interpretative Phenomenological Analysis in Health. *Psychology update*, 10 (4), 48-52..

Silverman, D. (2000) *Doing Qualitative Research, Second Edition : A Practical Handbook*, Sage Publications Ltd.

Silverman, D. (2006) *Interpreting Qualitative Data, Third Edition*. SAGE Publications Ltd.

Smith, J.A. (2003) *Qualitative Psychology: A Practical Guide to Research Methods*. Sage Publications.

Smith , J. A and Osborn, M (2008) Interpretative Phenomenological Analysis. In: J, A Smith, ed. *Qualitative Psychology: A practical guide to research methods*. London SAGE, 53-80.

Snijders, T. (1992) Estimation on the basis of snowball samples: how to weigh, *Bulletin Methodologies Sociologique*, Volume 36, 34-58.

Spector, R. E. (2010) *Cultural Diversity in Health and Illness*, Seventh Edition. Pearson Education, Inc.

Strauss, C. A & Corbin, J. M (2008) *Basics of Qualitative research: Grounded Theory Procedures and Techniques*. Sage Publications Ltd.

Sroufe, L. A. (1996) *Emotional Development: The organisation of emotional life in the early years*. New York: Cambridge University Press.

Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers, and their infants: Evidence for a relationship-specific perspective. *Child Development*, 67, 541-555.

Stern, D. (1985) *The interpersonal World of the Infant*. New York: Basic.

Strauss, A.L. and Corbin, J. (1998) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, 2nd edn *Qualitative Health Research* (Special Issue: *Advances in Grounded Theory*), 6(3): 368–78. London: Sage.

Thomas, L. (1992) *Racism and Psychotherapy*: in J. Kareem and R, Littlewood

Lawrence Erlbaum Associates.

Uwe. F. (2006) *An Introduction to qualitative Research*. SAGE Publications Ltd.

West, W. (1998) *Passionate Research: Heuristics and The Use of Self In Counselling Research*. *From Changes*, Vol 16, No 1, Page 60-66.

Wilding, C and Whiteford, G (2008) *Phenomenological Research: An exploration of conceptual theoretical and practical issues*. *OTJR: Occupation, Participation and Health*, 25 (3), 98-104.

Wilson, T. D (2002) *Alfred Schutz, Phenomenology and research methodology for Information behaviour research*. *Fourth International Conference for Information Seeking in Context*, Sept 11-13.

Wong, Josephine; Fisher, Jane (August 2009). "The role of traditional confinement practices in determining postpartum depression in women in Chinese cultures: A systematic review of the English language evidence". *Journal of Affective Disorders*. 116 (3): 161–169. doi:10.1016/j.jad.2008.11.00.

World Health Organisation. (2010) How Healthcare systems can address health inequities linked to migration and ethnicity. Briefing on policy issues produced through the WHO/European Commission equity project. 1-35.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Yardley, L. (2011). Demonstrating validity in qualitative research. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 234-251). London: SAGE.

9.0 Appendices

Welcome to the Integrated Research Application System**IRAS Project Filter**

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Motherhood and the absence of maternal support: Asian women

1. Is your project an audit or service evaluation?

Yes No

2. Select one category from the list below:

- Clinical trial of an investigational medicinal product
 Clinical investigation or other study of a medical device
 Combined trial of an investigational medicinal product and an investigational medical device
 Other clinical trial or clinical investigation
 Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
 Study involving qualitative methods only
 Study limited to working with human tissue samples, other human biological samples and/or data (*specific project only*)
 Research tissue bank
 Research database

If your work does not fit any of these categories, select the option below:

Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? Yes No
b) Will you be taking new human tissue samples (or other human biological samples)? Yes No
c) Will you be using existing human tissue samples (or other human biological samples)? Yes No

3. In which countries of the UK will the research sites be located? (Tick all that apply)

- England
 Scotland
 Wales
 Northern Ireland

3a. In which country of the UK will the lead R&D office be located?

- England
 Scotland
 Wales
 Northern Ireland

4. Which review bodies are you applying to?

- NHS/HSC Research and Development offices
 Research Ethics Committee
 Patient Information Advisory Group (PIAG)
 Ministry of Justice (MoJ)

5. Will any research sites in this study be NHS organisations?

- Yes No

5a. Do you want your application to be processed through the NIHR Coordinated System for gaining NHS Permission?

- Yes No

If yes, you must complete and submit the Portfolio Adoption Form immediately after completing this project filter, before proceeding with completing and submitting other applications.

6. Do you plan to include any participants who are children?

- Yes No

7. Do you plan to include any participants who are adults unable to consent for themselves through physical or mental incapacity? *The guidance notes explain how an adult is defined for this purpose.*

- Yes No

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service in England or Wales?

- Yes No

9. Is the study, or any part of the study, being undertaken as an educational project?

- Yes No

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

- Yes No

10. Is this project financially supported by the United States Department for Health and Human Services?

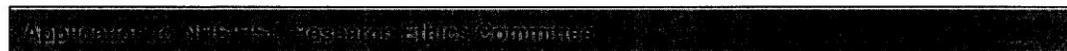
Yes No

11. Will identifiable patient data be accessed outside the clinical care team without prior consent at any stage of the project (including identification of potential participants)?

Yes No

Integrated Research Application System
Application Form for Research involving qualitative methods only

NHS
National Patient Safety Agency
National Research Ethics Service



The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Short title and version number: (maximum 70 characters – this will be inserted as header on all forms)
 Motherhood and the absence of maternal support: Asian women

Please complete these details after you have booked the REC application for review.

REC Name:
 Berkshire Research Ethics Committees

REC Reference Number:
 08/H0505/209

Submission date:
 20/11/2008

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Motherhood and the absence of maternal support: An exploration amongst second generation Asian Women

A2-1. Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
 Doctorate in Counselling Psychology and Psychotherapy (DCPSYCH)

Name of educational establishment:
 Metanoia Institute

Name and contact details of academic supervisor:

	Title	Forename/Initials	Surname
	Professor	Vanja	Orlans
Address	Metanoia Institute		
	13 North Common Road		
	Ealing, London		

Post Code W5 2QB
 E-mail vanjaorlans@metanoia.ac.uk
 Telephone 02085792505
 Fax 02088323070

Name and contact details of student:

Title Forename/Initials Surname
 Mrs Anita Sattar-Jenkins
 Address BDASS, Oak House, Upton Hospital
 Albert Street
 Slough, Berkshire
 Post Code SL1 2BJ
 E-mail anita.sattar-jenkins@berkshire.nhs.uk
 Telephone 01753821789
 Fax 01753635145

A copy of a current CV for the student (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- Student
 Academic supervisor
 Other

A3. Chief Investigator:

Title Forename/Initials Surname
 Mrs Anita Sattar-Jenkins
 Post Specialist Substance Misuse Counsellor
 Qualifications BSc(HONS) in Psychology, P.G.DIP in Counselling, M.A In Counselling. Currently completing a DCPSYCH in Counselling Psychology & Psychotherapy
 Employer Berkshire NHS Foundation Trust
 Work Address BDASS, Oak House, Upton Hospital
 Albert Street
 Slough, Berkshire
 Post Code SL1 2BJ
 Work E-mail anita.sattar-jenkins@berkshire.nhs.uk
 * Personal E-mail nutty_cat@hotmail.com
 Work Telephone 01753821789
 * Personal Telephone/Mobile 07947274545
 Fax 01753635145

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*

A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Is there a central study co-ordinator for this research?

Yes No

A5-1. Research reference numbers. Please give any relevant references for your study:

Applicant's/organisation's own reference number, e.g. R & D (if available): N/A

Sponsor's/protocol number:

Protocol Version:

Protocol Date:

Funder's reference number:

International Standard Randomised Controlled Trial Number (ISRCTN):

ClinicalTrials.gov Identifier (NCT number):

European Clinical Trials Database (EudraCT) number:

Project website:

Ref.Number	Description
------------	-------------

Reference Number

A5-2. Is this application linked to a previous study or another current application?

Yes No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. This summary will be published on the website of the National Research Ethics Service following the ethical review.

My research focuses on the life experience of a second generation Asian woman who has gone through the process of giving birth to her first child without the support of her own birth family.

Background – This research is formed out of my own life experience and very little is written on this topic.

A6-2. Summary of main issues. Please summarise the main ethical and design issues arising from the study and say how you have addressed them.

My research design is IPA (Interpretive Phenomenological Analysis). Ethical issues which might arise are listed below.

Informed Consent, negotiating a clear participant contract through which the participant is aware of the process and time commitment required from them.

My responsibility as a researcher – which may require a referral on pathway.

My research needs to take into account how women coming from this background may not have support structures in place to deal with this area of their life and I will check to see how my research might impact their life.

Representing the participants views as they see them.

Examine how my power as an Asian woman who is the researcher might affect the participant.

Awareness of my silent power about my own interest and lived experience of this area of research. Use research supervision to consider ways of managing this appropriately.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. Please tick all that apply.

- Case series/ case note review
- Case control
- Cohort observation
- Controlled trial without randomisation
- Cross-sectional study
- Database analysis
- Epidemiology
- Feasibility/ pilot study
- Laboratory study
- Metanalysis
- Qualitative research
- Questionnaire, interview or observation study
- Randomised controlled trial
- Other (please specify)

A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.

My question holds a broad focus to consider "What is the life experience of a second generation Asian women who has gone through the experience of becoming a mother without the support of her own birth family?" I want to understand this process with a view to thinking of service provisions and generating an exploration of this area.

My first question is "please tell me about your experience of giving birth to your first child without the support of your maternal family?"

A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.

I will ask the question set out in A10 and carry a list of five sub topics I would like to cover which are listed below:

- 1) Quality of the woman's relationship with her own maternal family.
- 2) Meaning of support.
- 3) Impact of the lack of maternal support.
- 4) Cultural importance of women and their role as a mother.
- 5) Quality of their partnership, relationship with the baby's father.

A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.

I believe there are four areas that my research seeks to inform.

- 1) Raise Awareness – By informing Psychologist and psychotherapists what issues a woman coming from this background might face.
- 2) Give this area a voice – Very little is written on the cultural complexities of motherhood and the experience of Asian Women in a western society.
- 3) Meet DOH/Clinical Governance Guidelines – By making a case for strategic implementation of services that can support

the needs of a growing diverse community.

4) Highlight risk issues – This vulnerable group of women might encounter.

A13. Please give a full summary of your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

As I am interested in the life experience a woman has had about this topic I have chosen a Qualitative IPA methodology.

I have approached a team of Health Visitors based in community settings who know of women fitting my criteria and who may be interested in taking part in my research, which would fit with my snowballing technique. I will interview ten women who have experienced giving birth to their first child in the U.K without the support of their family of origin or maternal family.

My main reason for this is that postnatal depression is picked up in the first eight to ten week post birth check up following the Edinburgh postnatal depression score (EPDS). Given my topic area is sensitive I want to eliminate the risk of exploring this topic with women who might be vulnerable. Therefore, Health Visitors will have screened all women prior to considering them as suitable candidates at which point the health visitor will give the candidate details about my research, which will include the rationale for my research. If the candidate indicates she is interested in taking part, the Health Visitor will refer her to me and I will contact her directly to arrange the first interview. At this point, the candidate will become a participant.

Physical Environment of the interview

All the Health visitor clinics are located within a listed Dr's surgery. Therefore, the most appropriate context and venue for my interview will be the Dr's surgery. Once a participant is identified, I will liaise with the practice manager to book a clinic room for the interview. I will also notify the participant of the limited resources available so she can prepare the adequate necessary equipment for her baby.

Phase One

My research will be qualitative so that I can extract meaningful data and essentially a phenomenological method of inquiry through the first interview that will last for one hour and fifteen minutes. I will ask one question and carry a list of five sub topics I would like to cover. I will record the interview and will be using IPA as my method of analysis. IPA "is basically a systematic and practical approach to analyzing phenomenological data" (Barker, C et al, 2003: Page 81). This is further elaborated by Smith, A as "a suitable approach when one is trying to find out how individuals are perceiving the particular situation they are facing, how they are making sense of their personal and social world" (2003: Page 53). At the end of this interview, I will make a date for Phase Two which will be a follow up review in 4-6 weeks time. This will give me the chance to consider the reflective space of participants during the period of motherhood.

Phase Two

Having typed up the transcript I will post a copy of this to the participant approx seven days/1 week before our second meeting. This will form part of my validity check and give us both the opportunity to consider the content of the transcript and check for accuracy and that the transcript is a true representation of the participant's experience.

The reflective space will also give me a chance to explore if any therapeutic resources or political support services were available to the participants post interview and to assess whether these services were culturally sensitive and appropriate for the needs of Asian women.

The second meeting will also be a member check and allow the participants to verify and see the typed transcript to ensure it is an accurate representation of what they have said. This will also be a reflective space to see what effect if any the interview will have left on the participant and also form a closing session as we end.

Research milestones – Interviews stage one and two = 3 months, Data analysis = 1 month and write up period = 3 months. Total time = 6 months.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, or members of the public?

- Design of the research
- Management of the research
- Undertaking the research
- Analysis of results
- Dissemination of findings
- None of the above

Give details of involvement, or if none please justify the absence of involvement.

In the first interview participants will be asked to share their experience of giving birth to their first child without any maternal support from their own family of origin.

In the second interview participants will be invited to read the transcript from the first interview and verify that the transcript is an accurate reflection of their experience.

Hence participants will be actively involved in the data collection phase and to verify what is documented in their transcript.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17. Please list the principal inclusion and exclusion criteria.

- Participants will be second-generation Asian women who were born to migrants from Pakistan, India or Bangladesh.
- Able to speak a basic level of English
- Aged 18 and over
- Given birth to their first child
- In their first year of motherhood and
- Specifically surpass the first three months.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Initial Information Sheet	1		20 minutes	Health Visitor in clinic.
First Interview	1		1 hr and 15 minutes	In a room at the designated G.P surgery by the chief investigator.
Copy of the transcript to review	1		1 hr and 15 minutes	To be posted to their home address so they can review the transcript process to be completed by participant.
	1		45 minutes	

Second Interview to confirm or amend the transcript			In a room at the designated G.P surgery by the chief investigator.
---	--	--	--

A19. Give details of any clinical intervention(s) or procedure(s) to be received by participants as part of the research protocol. *These include uses of medicinal products or devices, other medical treatments or assessments, mental health interventions, imaging investigations and taking samples of human biological material. Include procedures which might be received as routine clinical care outside of the research.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days).
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
---------------------------	---	---	---	---

A21. How long do you expect each participant to be in the study in total?

From completion of the intake form to the end of the second interview each participant will have been in my research for 3 months.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

The potential risk is that when a woman talks about her experience of giving birth to her first child without the support of her maternal family of origin she might feel emotional discomfort and may get upset or distressed. I will be able to speak to them directly and advise them on where they can obtain help or counselling. Any risks to their child are covered in the referral on pathway. Please see A23 as this may also be a potential risk that I have considered.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

Yes No

If Yes, please give details of procedures in place to deal with these issues:

I have been assured by the Health Visitor lead that all possible participants will be well known by them and any at risk cases will be followed up using the Berkshire NHS policy for Child Protection procedures 2006. Therefore, I will attend to this at a process level by generally asking the participant how she is getting on with her baby. If at any point of my interviews, I identify any issues that pose a risk to the participant or her baby I will discuss them with my research supervisor and refer the participant back to the Health Visitor who will then follow the allocated procedure.

A24. What is the potential for benefit to research participants?

To be able to tell me as a researcher about their own life experience of this topic which will help services to make provisions for this area.

A26. What are the potential risks for the researchers themselves? (if any)

As the research topic is closely tied to my own life experiences the quality of data needs protecting and there is the potential my interview style could bias the data. On the one hand, subjectivity/bias is inevitable as my chosen topic is one that is borne out of personal life experience. I have acknowledged this by being transparent in the participant information sheet. However, I am mindful of the validity of the data and I will ask my research supervisor to check the first transcript to ensure I am unpacking with a participant what they said and to check that I am bracketing off my own experience.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).

Potential participants will be identified by Health Visitors who will ask participants to complete my information sheet.

All data collected will be kept in a locked filing cabinet at my place of work which is an NHS Trust premises. Only I will have access to this data.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

Yes No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

Yes No

A29. How and by whom will potential participants first be approached?

Community Health Visitors will select a candidate matching my criteria.

A30-1. Will you obtain informed consent from or on behalf of research participants?

Yes No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Consent will be obtained on a written 'Participant Consent Sheet'.

If you are not obtaining consent, please explain why not.

N/A

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

Yes No

A31. How long will you allow potential participants to decide whether or not to take part?

From the point of first contact when the participant has been approached by the health visitor all participants will be given 2 days/48 hours to decide whether or not to take part.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters)

I will be approaching 2nd generation Asian women who will have some level of comprehension of the English language. I can also speak Urdu and Hindi fluently and therefore I will be able to converse in the languages required for this culture. However where I am unable to converse fluently I will arrange for a translator if required to ensure all participants understand the information provided.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.

- The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- The participant would continue to be included in the study.
- Not applicable – informed consent will not be sought from any participants in this research.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? (Tick as appropriate)**

- Access to medical records by those outside the direct healthcare team
- Electronic transfer by magnetic or optical media, email or computer networks
- Sharing of personal data with other organisations
- Export of personal data outside the EEA
- Use of personal addresses, postcodes, faxes, emails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:

- Manual files including X-rays
- NHS computers
- Home or other personal computers
- University computers
- Private company computers
- Laptop computers

Further details:

My dissertation is for a doctorate in Counselling Psychology and Psychotherapy and therefore a publishable document. Every participant will be made aware of this and asked for their written consent to participate in my research at the beginning of my research. A separate consent on the information sheet will be sought for any direct quotes.

A38. How will you ensure the confidentiality of personal data? Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.

The participants name, age, address and DOB will be removed from the transcript prior to storage. Data will be stored following the NHS codes of confidentiality.

A40. Who will have access to participants' personal data during the study? Where access is by individuals outside the direct healthcare team, please justify and say whether consent will be sought.

Personal data will only be accessible to myself as the Chief Investigator.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

- Less than 3 months
- 3 – 6 months
- 6 – 12 months
- 12 months – 3 years
- Over 3 years

If longer than 12 months, please justify:

The Metanoia Institute have advised me that data should be stored in line with clinical notes and following the guidelines set out by the British Psychological Association (BPS). Therefore the Metanoia Institute have suggested that I keep all data relating to this research for 6 years.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

- Yes
- No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

Yes No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

Yes No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health professional responsible for their care) that they are taking part in the study?

Yes No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

Yes No

*Please give details, or justify if not registering the research.
Yes my research will be recorded on the Metanoia Institute Website.*

A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:

- Peer reviewed scientific journals
- Internal report
- Conference presentation
- Publication on website
- Other publication
- Submission to regulatory authorities
- Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- No plans to report or disseminate the results
- Other (please specify)

Write up of a 35,000 word Dissertation

A53. Will you inform participants of the results?

Yes No

*Please give details of how you will inform participants or justify if not doing so.
After the first interview each participant will be invited to review their answers to my key question as such each participant will be informed of their responses and asked to check this for accuracy to ensure my account is a true representation of their response.*

Once the research is completed if the participant is interested in receiving a summary of the research I will compose a

newsletter format and post them a copy.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- Independent external review
- Review within a company
- Review within a multi-centre research group
- Review within the Chief Investigator's institution or host organisation
- Review within the research team
- Review by educational supervisor
- Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

My research proposal has been reviewed by the Metanoia Institute DCPSYCH board. A copy of their comments together with my proposal will be submitted with this document.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 10
 Total international sample size (including UK):
 Total in European Economic Area:

Further details:
 There are ten participants.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Evaluated the research into IPA states 6 –10 sample size.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Consistent with IPA I have chosen to use a systematic analysis of themes. I will manually cut, paste, extract themes and categories rich in information to give this research a voice. I will not be going through it randomly but generating the themes analysing them and then doing the next interview. I will be looking at the data and clustering the themes into ordinate and superordinate by looking at the relationship between them to build up a table of themes.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.

A64. Details of research sponsor(s)

A64-1. Lead sponsor (must be completed in all cases)

Name of organisation which will act as the lead sponsor for the research:

Sylvia Warwick – Research and Development Manager

Status:

NHS or HSC care organisation Academic Pharmaceutical industry Medical device industry Other

Address Fitzwilliam House
 Skimped Hill Lane
 Bracknell, Berkshire

Post Code RG12 1LD

Country U.K

Telephone 01344415825

Fax 01344415666

Mobile N.K

E-mail sylvia.warwick@berkshire.nhs.uk

A64-2. Sponsor's UK contact point for correspondence (must be completed in all cases)

	Title	Forename/Initials	Surname
	Ms	Sylvia	Warwick
Post	Research and Development Manager		
Work Address	Fitzwilliam House Skimped Hill Lane Bracknell, Berkshire		
Post Code	RG12 1LD		
Telephone	01344415825		
Fax	01344415666		
Mobile	N.K		
E-mail	sylvia.warwick@berkshire.nhs.uk		

A64-3. Are there any co-sponsors for this research?

Yes No

Give details of all co-sponsors:

Name of organisation:

Metanoia Institute(joint programme with Middlesex University)

Status:

NHS or HSC care organisation Academic Pharmaceutical industry Medical device industry Other

Address Kate Fromant – General
Manager
Metanoia Institute
13 North Common Road, Ealing
London

Post Code W5 2QB
Country U.K
Telephone 02088323078
Fax 02088323070
Mobile
Email katefromant@metanoia.ac.uk

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

Yes No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68. Give details of the lead NHS R&D contact for this research:

Title	Forename/Initials	Surname
Ms	Mary	Barwick
Organisation	Clinical Audit and Research Manager	
Address	Clinical Development Unit George Ward, St Marks Hospital St Marks Road, Maidenhead	
Post Code	SL6 6DU	
Work Email	mary.barwick@berkshire.nhs.uk	
Telephone	01753636805	
Fax	01753638753	
Mobile		

Details can be obtained from the NHS R&D Forum website: www.rdforum.nhs.uk

A69. How long do you expect the study to last?

Planned start date: 01/06/2009

Planned end date: 31/08/2009

Duration:

Years: 0

Months: 3

A71-1. Is this a single centre study? Yes No**A71-2. Where will the research take place? (Tick as appropriate)**

- England
 Scotland
 Wales
 Northern Ireland
 Other states in European Union
 Other countries in European Economic Area
 USA
 Other international (please specify)

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:

- | | |
|--|---|
| <input checked="" type="checkbox"/> NHS organisations in England | 1 |
| <input type="checkbox"/> NHS organisations in Wales | |
| <input type="checkbox"/> NHS organisations in Scotland | |
| <input type="checkbox"/> HSC organisations in Northern Ireland | |
| <input type="checkbox"/> GP practices in England | 0 |
| <input type="checkbox"/> GP practices in Wales | 0 |
| <input type="checkbox"/> GP practices in Scotland | 0 |
| <input type="checkbox"/> GP practices in Northern Ireland | 0 |
| <input type="checkbox"/> Social care organisations | 0 |
| <input type="checkbox"/> Phase 1 trial units | 0 |
| <input type="checkbox"/> Prison establishments | 0 |
| <input type="checkbox"/> Probation areas | 0 |
| <input type="checkbox"/> Independent hospitals | 0 |
| <input type="checkbox"/> Educational establishments | 0 |
| <input type="checkbox"/> Independent research units | 0 |
| <input type="checkbox"/> Other (give details) | 0 |

Total UK sites in study: 1

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (NHS sponsors only)
 Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)
 Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
 Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

PART C: Overview of research sites

Please enter details of the host organisations (NHS or other) in the UK that will be responsible for the research sites.

Research site	PI/ local collaborator
G.P Practices	

AL (page 20 of 24)

PART D: Declarations**D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
 - ◆ Will be held by the main REC or the GTAC (as applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
 - ◆ May be disclosed to the operational managers of review bodies, or the appointing authority for the main REC, in order to check that the application has been processed correctly or to investigate any complaint.
 - ◆ May be seen by auditors appointed to undertake accreditation of RECs.
 - ◆ Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

- Chief Investigator
- Sponsor's UK contact point
- Study co-ordinator
- Student
- Other – please give details
- None

Title:
Forename / Initials:
Surname:
Post:
Work address:
Work email:
Work telephone:

Access to application for training purposes

Optional – please tick as appropriate:

I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature:

Print Name: Anita Sattar-Jenkins

Date: 31/03/2009 (dd/mm/yyyy)

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature:

Print Name: Sylvia Warwick

Date: 08/04/2009 (dd/mm/yyyy)

D3. Declaration for student projects by academic supervisor

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the Chief Investigator and the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Signature:

Print Name: Professor Vanja Orland

Date: 03/04/2009 (dd/mm/yyyy)

Post: Academic Research Supervisor

Organisation: Metanoia Institute

Curriculum Vitae

Title:	Forename/Initials	Surname
Mrs	Anita	Sattar-Jenkins

Present appointment: *(Job title, department, and organisation.)*

Specialist Substance Misuse Counsellor
BDASS
Berkshire NHS Foundation Trust

Start date for present appointment:

May 2004

Address: *(Full work address.)*

BDASS, Oak House, Albert Street

Slough,

Berkshire

Postcode:

SL1 2BJ

Telephone number:

01753 821 789

Email address:

anita.sattar-jenkins@berkshire.nhs.uk

Qualifications:

BSC (Hons) Psychology
RSA In Counselling
Post Graduate Diploma In Counselling
Master of Arts in Counselling
Currently doing a DCPSYCH (Doctorate in Counselling Psychology and Psychotherapy)

Professional registration: *(Name of body, registration number and date of registration.)*

BACP (British Association of Counselling & Psychotherapy)
Registration Number :537603
Date of Registration: 12/2000

BPS (British Psychological Society)

Registration Number :194334

Date of Registration : 12/2004

Previous and other appointments: *(Include previous appointments in the last 5 years and other current appointments.)*

The general capacity within which I work is as a Counsellor and Supervisor for a specialist Tier 3 Substance Misuse Service at CASCADE. Alongside my role at CASCADE, I have been sponsored by the Trust to complete a DCPSYCH (Doctorate in Counselling Psychology & Psychotherapy). I have therefore been successful in acquiring a series of placements that have contributed towards my experience of providing specialist psychological assessments. Including a twenty-day placement in an acute psychiatric ward, a one-year placement in the department of psychotherapy specifically working with a team of Cognitive Analytical Therapists (CAT) (Ryle et al: 1992). More recently a one year placement at the department of psychology based in

the Community Mental Health Team (CMHT) working as a Counselling Psychology and Integrative Psychotherapy Trainee.

Research experience: *(Summary of research experience, including the extent of your involvement. Refer to any specific clinical or research experience relevant to the current application.)*

Research Dissertation for my Hons Degree in Psychology, my masters in counselling and I have completed practitioner research modules throughout the course my doctorate studies.

Research training: *(Details of any relevant training in the design or conduct of research, for example in the Clinical Trials Regulations, Good Clinical Practice or other training appropriate to non-clinical research. Give the date of the training.)*

From 2005 to September 2008 as part of my doctorate studies I have completed and successfully passed training modules on practitioner research.

I adhere to the NHS, BPS and BACP ethical framework research guidelines.

Relevant publications: *(Give references to all publications in the last two years plus other publications relevant to the current application.)*

None

Signature: _____

Date: _____

APPLICATION TO RESEARCH ETHICS COMMITTEE

All studies except clinical trials of investigational medicinal products

REC Ref: 08/H0505/209
Short Title of Study: Motherhood and the absence of maternal support: Asian women
CI Name: Mrs Anita Sattar-Jenkins
Sponsor: Sylvia Warwick – Research and Development Manager

Please complete this checklist and send it with your application

- Except where stated, send ONE hard copy of each document to the REC office by the agreed submission date.
- Check that the submission code appears on each page of the application form before sending. It is acceptable to send hard copies of signature pages only, as long as the submission code at the top of the page is the same as on the electronic version.
- All documents must bear version numbers and dates (except where indicated).
- Documents marked as mandatory must be submitted in all cases for the application to be valid. Other documents should be submitted if relevant to the application.
- When collating please do NOT staple documents as they will need to be photocopied.
- This button allows you to add extra documents of the same type. Include subtitles if appropriate, e.g. "Information sheet for relative".

Document Title	Subtitle	Enclosed?	Date	Version	OfficeUse
Covering letter on headed paper		<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009		
REC application (IRAS Parts A–D)		Mandatory	31/03/2009	V2.0	
Site-Specific Information Form (if main REC is also the SSA REC for a research site)		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Research protocol or project proposal (6 copies)		Mandatory			
Summary C.V. for Chief Investigator (CI)		Mandatory			
Summary C.V. for supervisor (student research)		<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009		
Research participant information sheet (PIS)		<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009	V2	
Letters of invitation to participants		<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009	V2	
GP/Consultant information sheets or letters		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Statement of indemnity arrangements		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Letter from sponsor		<input checked="" type="radio"/> Yes <input type="radio"/> No	08/04/2009		
Research participant consent form		<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009	V2	
Letter from statistician		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Letter from funder		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Referees' or other scientific critique report		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Summary, synopsis or diagram (flowchart) of protocol in non-technical language		<input type="radio"/> Yes <input checked="" type="radio"/> No			
Interview schedules or topic guides for participants		<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009	V2	

Validated questionnaire		<input type="radio"/> Yes <input checked="" type="radio"/> No				
Non-validated questionnaire		<input type="radio"/> Yes <input checked="" type="radio"/> No				
Copies of advertisement material for research participants, e.g. posters, newspaper adverts, website. For video or audio cassettes, please also provide the printed script.		<input type="radio"/> Yes <input checked="" type="radio"/> No				
Other (please specify)	Candidate Demographic Form	<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009	V2		
Other (please specify)	Participant Debriefing Information	<input checked="" type="radio"/> Yes <input type="radio"/> No	31/03/2009	V2		

Proposal

**Motherhood and the absence of maternal support: An
exploration amongst second generation Asian Women**

REC Application 09.12.2008 – V2

A4 (page 1 of 20)

Contents Page

Contents	Page No
Background	1
Aims of the Research	1 - 4
Literature Search	4 - 7
Broad Research Design	7 - 8
Description of Proposed Sample	8 - 12
Ethical Issues & Validity	12 - 14
My Contribution to the Field	14 - 15
Summary	15
Timetable	15
Attachments	16
References	17 - 18

Word Count - 4397

2 of 17

REC Application 09.12.2008 – V2

A4 (page 2 of 20)

Title

My question holds a broad focus to consider "What is the life experience of second generation Asian women who have gone through the experience of becoming a mother without the support of their own birth family?" I want to understand this process with a view to thinking of service provision and generating an exploration of this area because I am not currently aware of the issues involved.

Background

My relationship to this area of interest is borne out of my own life experience as an Asian woman who was born into a culture that imposed a certain type of mother daughter relationship that set the scene for specific life experiences. This is coupled with my work as a therapist in which I see many Asian women who come from traditional cultural homes like I did, struggling to cope with the complex demands of mothering in a multicultural society without the role model of their own mother.

In the world of therapy so much emphasis is given to early childhood experiences, yet little is written about the mother who needs to have had this background to enable her to pass the experience on to her own offspring. Little is written about the well-being of mothers and how a lack of traditional and cultural support from the parents can affect the mothers' well being at such a critical time in her life where the joy of her first-born could be shadowed by sadness if support systems are simply not available or communication barriers have broken down. My research is about giving a voice to this specific life experience.

Aims of the Research

I would like to capture the real life experiences of the lives of women who have experienced birth into and maturing up in an Asian family with traditional family values in a western society.".... We are more than a product of our language or our

individual psychology; we are also embodied beings and a product of history and culture" (Etherington, K 2004: Page 23). The focus of my research is on the phenomenological experience of Asian women who give birth to their first child at a time when they do not have any contact or support from their family of origin.

I have considered positivism and anti positivism of which my assumptions are not everything can be observed or researched objectively. I do think it is important to consider my role as a researcher coming from a positivist angle. However, I do not feel my research ideas fit into positivist ideas given my chosen topic of research is one that has arisen out of my own life experience.

The rationale for my research topic includes using myself as a researcher and this forms part of my phenomenological methodological research and I identify with critical subjectivity. It is hard not to be influenced in my role as a researcher by the many other roles in which I see myself, as a mother, a therapist, a client, a participant and researcher who may share similar cultural heritage to that of my participants. "Reason, P argues for what he calls "critical subjectivity" by which he means an acceptance of our involvement with those we research, but an involvement that is 'critical, self-aware, discriminating and informed" (1994: Page 11)". West, W 'further elaborates on how the theoretical tradition we follow will affect how we use ourselves as researchers' (1998). This has encouraged me to think about the influence my integrative model might have on the way I think about my participants. As a humanistic therapist, I might pay particular attention to using the core conditions to create an environment in which the participant can bring their full self. In essence therapists or "...counsellors are used to monitoring the way their clients affect them and using this data to inform their work" (West, W 1998: Page 61). My use of myself as a researcher can facilitate my inquiry because I am particularly interested in a

participant's life experience and the influence this has had on them in shaping them into the person they are now.

In thinking about the methodology and process of research, I will need to pay attention to my use of the skills I hold as a therapist. Whilst I can use these skills it is important to bare in mind the purpose of my research is not therapeutic openness and I intend to pay attention to this difference in my role as a researcher from that of a therapist.

That said my relationship to this area is both a personal one as well as a professional one. In relating Strawbridge and Woolfe's description of "reflexive activity" (2003) from my own research angle, I need to take into account 'how the subjective experience of the researcher and the participant may affect one another' (2003) and how my participants experience might reawaken some of the doors I thought I had closed. At these times, I might need to pay particular attention to some of my own unresolved material as a daughter and a mother who lacked support and contact from my own family of origin at various intervals of my life. To be aware that some of this material might intertwine in my role as a researcher is important. A series of narrative interviews as a research approach were used by Etherington, K which formed the most part of her research and she also explored the importance of reflexivity "By allowing ourselves to be known and seen by others, we open up the possibility of learning more about our topic and ourselves, and in greater depth" (2004: Page 25). Whilst there is a degree to which I can use my own life experience to facilitate my research I remain mindful this is an area that also needs to be explored under ethical issues and personal process issues can also be explored under the methodology section.

My area of interest has a personal element to it and I did wonder if this was just my interests or if this area would interest research participants. I carried out an experiential pilot study to test interest in this area. This also gave me a feel for methodology and sampling methods I could use. My literature search also left me feeling very curious about why there was so little written on this area.

Literature search

Motherhood is a significant life event for any woman and a time that raises the chances of emotional or mental health difficulties such as postnatal depression. Whilst I have chosen not to research this area in detail, I remain mindful the experience of my research topic on becoming a mother at a time where there is a lack of maternal support can also contribute towards emotional unwellness.

After carrying out a number of literature searches I was surprised to find very little written about the trauma of cultural integration in second-generation Asian women, which specifically covered my area of research. Whilst there were various articles on the experiences of mothering, there was nothing specifically written on experiences of Asian women giving birth to their first child without the support of their family of origin. I found one study by Bhopal, K (1998) who wrote about how intergenerational support in extended families influences the upbringing of a child. This study explored the power dynamics with the paternal influences on child rearing opposed to the maternal influences and excused these as not being present because the woman had to leave her hometown for an arranged marriage. This research highlights one of the many reasons why maternal support is not always a possibility and my research seeks to elaborate on this further and explore a woman's experience of this lack of support.

I further narrowed the search of my literature review down to issues of culture and the consequences of disconnection from cultural traditions or norms. There were a number of studies that focused on arranged marriages in particular autobiographical literature regarding Asian women's experiences and one study by Sanghera, J focused on the consequences of running away from the set up of an arranged marriage which enforced devastating consequences on the rest of her life. The title of her book "Shame" (2007) forms the central issue that arose as a direct result of her actions on both her family and herself. Here I refer to shame upon the cultural honour of commitment and shame that was seen as disrespect and dishonour. ***Similarly Wilson, A (2006) Who talks about both her own personal experience and that of others as she interviews Asian women's personal experiences. She talks about culture, shame and honour using the Hindi language and uses her own definitions to translate these words. Having been born and brought up in an Asian culture I can appreciate both these authors take on patriarchy and the demands these place on a woman and her role in the western society. I will continue to review personal life stories and autobiographical accounts and incorporate these in my literature review.***

Whilst these studies did not focus in sameness on my chosen area of research, they hold similarities. They both focused on research into the same culture of Asian women I am looking to use as participants in my research. Therefore, they both hold cultural perspectives mirroring the traditional values of my participants.

As an Asian woman how can I expect my fellow colleagues who come from various different cultures, often different from mine, to understand my topic area without resources? This has left me wondering why there are no studies in this area when there is so much interest and inquiry. I then wonder if the lack of research in this field

is due to the lack of willing participants who are willing to breathe life into their experiences and give this area of research a voice.

Particular agencies have been set up to specifically cater for Asian cultures like Mother tongue set up Beverley Costa and the Bridge Project set up by Dr Sue Holland. They have found ways to locate and encourage clients to attend therapy. These resources, ideas and best practices could be shared amongst services. I feel particularly saddened when my colleagues and peers working in a psychology department in an NHS setting ask me why I think there is a lack of Asian clients accessing psychological therapy because they feel they have such little opportunity to work with clients from an Asian background. This is not to say they do not exist but they do not access talking therapies. Bartlett, S found that "Much of her learning throughout the study has developed thoughts or views she already held, but to which she had not given sufficient thought or that lacked the underpinning of the literature" (2003: Page 27).

The position of interest in the wider field my research topic holds is one that influences practitioners offering psychological therapy on a number of levels to assess risk, health, integration of a culture into a western society and questions about the issues a woman coming from this background might face. I feel research into the experiences of Asian women giving birth to their first child without any parental support raises questions in the domain of service provisions, especially when it comes to providing services and offering cultural diversity. This also questions cultural access to therapy.

I have chosen to use Interpretative Phenomenological Analysis (IPA) where the "aim is to explore, flexibly and in detail, an area of concern" being an example of a research question addressed by IPA illustrated by Smith, A from this study. I

6 of 17

REC Application 09.12.2008 – V2

A 4 (page 8 of 20)

understand the aim of IPA is to draw an in-depth understanding of the participant's life experiences rather than to make general links. By purposeful sampling, I can find a group who will have been affected by my research question (2003: Page 53).

Insider Research Literature

From a philosophical position as an insider I have thought carefully about self-disclosure and deem this a necessary part of my recruitment phase as such I view myself as an insider researcher as described by Reason et al "Insider action research offers a unique perspective on systems, precisely because it is from the inside" (2007: Page 644). From an ethical stance, I feel that by being transparent prior to recruiting participants will empower them. I will be telling my participants from the out set that my interest in this area comes from my own personal life experience. This disclosure will be part of my information sheet.

Broad Research Design

My research supervisor suggested I pilot my idea experientially by talking to people about it and noticing their body language. I somewhat hesitantly took this idea into my supervision session with my placement supervisor and found it generated significant interest. In fact, the discussion resulted in my research supervisor giving me a very valuable lead from a recent article she had read. As I began to approach the pilot study, I found people were interested. This gave me some confidence to speak about my idea with another clinical supervisor who also expressed a keen interest in the topic. I then felt confident to continue talking through my ideas with a number of senior colleagues within my work setting and this resulted in finding a possible participant.

As I gradually gained confidence in my area of interest, I started to record short conversations with professionals in and around my working environment to get an idea of how they viewed my area of interest. This pilot study, which was started to find out if there was any interest in the area, left me feeling very charged, excited, full of ideas and eager to go.

In supervision, I was able to consider sampling methods, put a name to my method of inquiry and discuss possible ways of analysing the data. The nature of my research is one of exploring and understanding what fits well with "Phenomenology – understanding the essence of experience about phenomena" (Cresswell, J 1998: Page 65). I also began to make some tentative steps towards designing my research. Initially I did not think it would be possible to gather participants but by talking to someone with contacts, I started finding interested participants. This "Purposeful sampling strategy" is described as "Snowball - identifying cases of interest from people who know people who know what cases are information-rich" (Cresswell, J 1998: Page 119). This was a way in which I could locate participants who will have experienced my research area and would be interested in sharing their life experience.

Description of proposed sample

I have approached a team of midwives based in community settings who know of women fitting my criteria and who may be interested in taking part in my research, which would fit with my snowballing technique. I will be looking to interview up to ten women who have experienced giving birth to their first child in the U.K without the support of their family of origin or maternal family.

- Participants will be second-generation Asian women who were born to migrants from Pakistan, India or Bangladesh.

8 of 17

REC Application 09.12.2008 – V2

A A (page 10 of 20)

- **Able to speak a basic level of English**
- **Aged 18 and over**
- **Given birth to their first child**
- **In their first year of motherhood and**
- **Specifically surpass the first three months.**

My main reason for this is that postnatal depression is picked up in the first eight to ten week post birth check up following the Edinburgh postnatal depression score (EPDS) and given my topic area is sensitive I want to eliminate the risk of exploring this topic with women who might be vulnerable. Therefore, Health Visitors will have screened all women prior to considering them as suitable candidates at which point the midwife will give the candidate details about my research, which will include the rationale for my research. If the candidate indicates she is interested in taking part, the midwife will refer her to me and I will contact her directly to arrange the first interview. At this point, the candidate will become a participant.

Physical Environment of the interview

All the Health visitor clinics are located within a listed Dr's surgery. Therefore, the most appropriate context and venue for my interview will be the Dr's surgery. Once a participant is identified, I will liaise with the practice manager to book a clinic room for the interview. I will also notify the participant of the limited resources available so she can prepare the adequate necessary equipment for her baby.

Management of Child Protection

I have been assured by the Health Visitor lead that all possible participants will be well known by them and any at risk cases will be followed up using the

Berkshire NHS policy for Child Protection procedures 2006. Therefore, I will attend to this at a process level by generally asking the participant how she is getting on with her baby. If at any point of my interviews, I identify any issues that pose a risk to the participant or her baby I will discuss them with my research supervisor and refer the participant back to the Health Visitor who will then follow the allocated procedure.

Phase One

My research will be qualitative so that I can extract meaningful data and essentially a phenomenological method of inquiry through the first interview that will last for one hour and fifteen minutes. I will ask one question and carry a list of sub topics I would like to cover. I will record the interview and will be using IPA as my method of analysis. IPA "is basically a systematic and practical approach to analyzing phenomenological data" (Barker, C et al, 2003: Page 81). This is further elaborated by Smith, A as "a suitable approach when one is trying to find out how individuals are perceiving the particular situation they are facing, how they are making sense of their personal and social world" (2003: Page 53). At the end of this interview, I will make a date for Phase Two which will be a follow up review in 4-6 weeks time. This will give me the chance to consider the reflective space of participants during the period of motherhood.

Phase Two

Having typed up the transcript I will post a copy of this to the participant approx seven days/1 week before our second meeting. This will form part of my validity check and give us both the opportunity to consider the content of the transcript and check for accuracy and that the transcript is a true representation of the participant's experience.

10 of 17

REC Application 09.12.2008 – V2

A4 Page 12 of 20)

The reflective space will also give me a chance to explore if any therapeutic resources or political support services were available to the participants post interview and to assess whether these services were culturally sensitive and appropriate for the needs of Asian women.

The second meeting will also be an ethical check and a reflective space to see what effect if any the interview will have left on the participant and also form a closing session as we end.

Data Analysis Strategy

I understand there are various data analysis tools I could use to extract meaning from my qualitative enquiry. In reviewing two of these, I found XSIGHT was used to perform rapid analysis and NVIVO for deep analysis of data. Consistent with IPA I have chosen to use a systematic analysis of themes. I will manually cut and paste and extract themes and categories rich in information to give this research a voice. I will not be going through it randomly but generating the themes analysing them and then doing the next interview. I will be looking at the data and clustering the themes into ordinate and superordinate by looking at the relationship between them to build up a table of themes.

Methods of recording and storing the Data

I will keep a research journal and audio recording of the interview additionally keeping notes on the participant's body language and how they respond emotionally or react non-verbally. All tape recordings, transcripts, manual notes and any personal information relating to the participants will be stored in a locked filing cabinet.

Validity

As the research topic is closely tied to my own life experiences the quality of data needs protecting and there is the potential my interview style could bias the data. On the one hand, subjectivity/bias is inevitable as my chosen topic is one that is borne out of personal life experience. I have acknowledged this by being transparent in the participant information sheet. However, I am mindful of the validity of the data and I will ask my research supervisor to check the first transcript to ensure I am unpacking with a participant what they said and to check that I am bracketing off my own experience. Once transcribed, I have asked a colleague who is independent of my research to check the credibility of the coding in ordinate and super ordinate themes.

Ethical Research Principles

Transcriptions - Each of the tape-recorded interviews will be transcribed by a designated NHS (Trust) medical secretary. As I am conducting the research within the trust using participants from the trust I will be adhering to professional codes of conduct by ensuring the material will be transcribed by an employee of the trust who remains bound to the codes, principles and ethics of confidentiality.

I intend to develop ideas taken from Gabriel, (1999) on; 'providing clear guidelines on the detail of my research' before the participants commit to taking part in the research.

"Informed consent" will form an effective research alliance by negotiating a clear participant/researcher contract from which the participant is fully aware of the process and time commitment required of them.

I will inform clients there will be one recorded interview for up to two hours and a transcript to review.

My responsibility to my participants will include communicating the limits of our relationship and having a clear policy on confidentiality, which I hope to draw up as a part of our contract for the participant to sign. I will need to consider how I cultivate self-reflexivity and review the process of researcher/participant in order to reflect on my use of supervision.

In reviewing the ethical guidelines I also need to think about my responsibility as a researcher and this might also include a referral on pathway if any material comes up for the participant whom they feel could benefit from further work. My role will therefore be to offer information on services available to these women.

My research has implications of risk given that therapy is largely a western concept formed in a western society. There are struggles to encourage people from other cultures to understand how they might use therapy to inform them in their own life. The Ethical principles below have been taken from Bond, T (1993) in which I have made suggestions on how they might arise and how I might manage them.

Beneficence – “Doing good for others”.

I will use material from my interviews with participants to represent perspectives and ensure practitioners in the field are clinically informed about their struggles so future women coming from this perspective will have support and understanding. Informing clinical practice and highlighting risk issues that might come up for a woman utilising psychological therapy with a similar background is also necessary.

Non maleficence – “doing no harm”.

I must ensure my research takes into account how women coming from this background might not have the necessary support structures in place to open up this

area of their life and to check how this research hearing, reading and taking part might influence their life.

Autonomy – “respecting the rights of others to make decisions for themselves”. I will respect decisions although I might not agree with their perspective.

Fidelity – “being fair and just”. Representing the truth as it is said.

I will determine references and timelines for the development of the work and a list of timelines and references are included at the end of this draft proposal.

Power – I will examine how an Asian woman might experience me as a researcher (Starhawk, 1990) also protecting the anonymity of the participant. The ethics of researching this area and placing my research in the public domain concern me. Researching a very private area about the relationship between becoming a mother and coping without parental support is an extreme and culturally sensitive area. I need to remain aware and find suitable ways of managing the boundaries and privacy.

I also need to consider my silent power about my own interest and lived experience in this topic. I intend to use research supervision to consider ways of managing this carefully with participants and in preparing myself to consider sharing my genuine reasons for researching this topic.

My Contribution to the Field

Raise Awareness – By informing Psychologist and psychotherapists what issues a woman coming from this back might face.

Give this area a voice – Very little is written on the cultural complexities of motherhood and the experience of Asian Women in a western society.

Meet DOH/Clinical Governance Guidelines – By making a case for strategic implementation of services that can support the needs of a growing diverse community.

Highlight risk issues – This vulnerable group of women encounter.

Others – I imagine there will be more but these will develop from my analysis.

Summary

In compiling this proposal, I have had mixed reactions and at times “I cannot wait to get started on my research topic” and at other times I find myself backing off because “I am so scared to get in touch with some of my own very sore experiences”. However, balancing my enthusiasm with my reluctance is proving to be a challenge I am constantly reviewing in supervision. According to Moustakas 1990, “there are six stages to research” and at this moment I would say I have slowly moved on from the initial stage of “initial engagement” and am gently approaching the next phase “immersion” (Page 55).

Encls – Project Plan

Design letters to participants and forms to capture biographical details – July 2008

Contract/Confidentiality and arrange interview dates and venues – July 2008

Begin interviews – December 2008

End interviews – February 2009

Type transcripts – February 2009

Complete data analysis – March – April 2009

Complete write up of the Dissertation – April – May 2009

Submit Draft Proposal – May 2009

Submission of final draft – June 2009

Attachments

Pathway – Maternal Mood Assessment

Health Visitor Surgery's

Child Protection Procedures 2006

Application Form for Research Ethics Approval

Bibliography

Barker, C & Pistrang, N (2002) Research Methods in Clinical Psychology. An Introduction for Students and Practitioners. Second Edition. John Wiley & Sons, LTD.

Bartlett, S (2003) Beyond the looking glass: The Qualitative Research Process as a Development of Self. Counselling Psychology Review, Vol 18, No 2, Page 26 – 29).

Bhopal, K (1998) South Asian women in East London Motherhood and Social Support. Women's Studies International Forum. Volume 21, Issue 5, Pages 485 – 492.

Bond, T (2004) Ethical guidelines for researching counselling and psychotherapy. Rugby: British Association for Counselling and Psychotherapy (BACP).

Cresswell, J (1998) Qualitative Inquiry and Research Design, Choosing among five traditions. Thousand Oaks: Sage.

Etherington, K (2004) Becoming a Reflexive Researcher. Using ourselves in research. Jessica Kingsley Publishers.

Gabriel (1999)

Macleod, J (2000) Qualitative Research in Counselling and Psychotherapy.

Moustakas (1990) Heuristic Research, Design, Methodology and Applications. London: Sage.

Pedersen, P, Draguns, J, Lonner, W and Trimble, J E, 2002, *Psychotherapy Across Cultures (Fifth Edition)*, Sage Publications.

Reason, P (ed) (1994) *Participation in Human Inquiry*. London : Sage.

Reason, P and Bradbury, H (2007) *The Sage Handbook of Action Research. Participative Inquiry and Practice. Second Edition*. Sage Publications Ltd.

Sanghera, J (2007) *Shame*. Hodder & Stoughton.

Silverman, D (2000) *Doing Qualitative Research : A Practical Handbook*, Sage Publications Ltd.

Smith, J.A. (2003) *Qualitative Psychology : A Practical Guide to Research Methods*.

Thomas, L (1992) *Racism and Psychotherapy* : in J. Kareem and R, Littlewood
Lawrence Erlbaum Associates.

West, W (1998) *Passionate Research : Heuristics and The Use of Self In Counselling Research*. *From Changes*, Vol 16, No 1, Page 60-66.

Wilson, A (2006) *Dreams, Questions, Struggles: Asian Women In Britain*. Pluto Press.

Woolfe, R, Dryden, W and Strawbridge, S (2003) *Handbook of counselling psychology*, 2nd Edition, Sage publications.

10th April 2008

Anita Sattar-Jenkins



Dear Anita,

Below is the confirmed outcome of your Programme Approval Panel presentation on 28th March, 2008.

Anita Sattar Jenkins: Candidate No. M00158349

Project Title:

Motherhood and the absence of maternal support: An exploration amongst second generation Asian Women.

Panel Decision: Approved with seven conditions and two recommendations.

Conditions:

1. ✓ Increase the number of participants;
2. ✓ Examine the insider/outsider literature research;
3. ✓ Consider the implications of child protection issues within the interviews and the management of this;
4. ✓ To reconsider the therapeutic resources available post interview, and for the researcher to identify whether these are appropriate for the needs of Asian women; →
5. ✓ To consider quality of typed transcript and to share these with the participants for accuracy; ↓
6. ✓ Define more clearly the context in which this research is taking place;
7. ✓ Consider the reflective space of participants during this period of motherhood the research to undertake a follow-up interview 4-6 weeks after the initial interview.

Recommendations:

1. To consider autobiographic literature regarding Asian women's experiences and to incorporate in literature review;
2. To consider the physical environment of the interview setting and baby care arrangements.

The panel suggests that these conditions and recommendations should be implemented and submitted to the DCPsych Programme Leader and Research Supervisor for approval within three months.

Should you have any questions please do not hesitate to contact me.

Professor Vanja Orlans
Programme Leader, DCPsych
Metanoia Institute
Tel (direct): +44(0)20 8208 1235
email: VanjaOrlans@btinternet.com

Mi
METANOIA
INSTITUTE

13 North Common Road
Ealing, London W5 2QB
Telephone 020 8579 2505
Facsimile 020 8832 3070
www.metanoia.ac.uk

Registered in England at the
above address No. 2918520
Registered Charity No. 1050175

A4 (Approval 1 of 3)

Metanoia Institute Application Form for Research Ethics Approval

Purpose of this form

This form is reviewed by the Research Ethics Committee in order to assess the ethical implications of your research project and your response to these implications. The research cannot proceed until ethical approval has been obtained. Applicants may be asked to review and re-submit this form in the light of the Research Ethics Committee's decision regarding whether ethical issues have been adequately identified and addressed prior to starting the research work.

Guidance notes

To assist you in completing this form, candidates should read the relevant section of the course handbook that gives general guidance on ethical issues in psychological research.

All applicants should read the British Psychological Society's *Ethical Principles for Conducting Research with Human Participants* (2006) the *Code of Ethics and Conduct* (2006) (available to download at www.bps.org.uk), and the British Association for Counselling and Psychotherapy's *Ethical Framework for Good Practice in Counselling and Psychotherapy* (2002) (available to download at www.bacp.co.uk). Applicants should also familiarise themselves with the Data Protection Act (1998) - information and guidance on this is provided by the Information Commissioner's Office (available at: www.ico.gov.uk) - and also the Research Governance Framework for Health and Social Care (2005) (available to download at: www.dh.gov.uk/PolicyandGuidance/ResearchandDevelopment).

Consistent with BPS and BACP guidance, ethical conduct needs to be viewed as a process. Hence, ethical matters should be continually reviewed and addressed throughout the course of the project and in consultation with your research supervisor. If there are significant changes to your research design, you should consider the ethical implications of these changes and consider also, in consultation with your research supervisor, whether formal ethical approval needs to be obtained again.

Before completing this form you should discuss the ethical implications of your research with your research supervisor.

Once completed, two copies of this form should be submitted to the Research Ethics Committee, accompanied by:

- Two copies of your finalised research proposal
- Two copies of any research materials such as participant recruitment advertisements, letters/email communications to participants, information sheets and consent forms
- Two copies of research materials such as interview schedules, topic guides, questionnaires, or other research protocol materials.

PART 1: DETAILS OF APPLICANT AND RESEARCH SUPERVISOR

1.1. Applicant's name: Amita Sattar - Jenkins

1.2. Email address: amita.sattar-jenkins@berkshire.nhs.uk

1.3. Telephone number: 07947 274545

1.4. Research supervisor(s) name and institution/contact details (if applicable):

Professor - Vanja Orlans - Metanoia Institute.

1.5. Project title:

Motherhood and The Absence of Maternal Support: An exploration amongst second generation Asian Women

PART 2: ETHICAL CONSIDERATIONS

	YES	NO	N/A
1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? Please attach a copy of any recruitment letters and information sheet to be used.	✓		
2. Will you tell participants that their participation is voluntary?	✓		
3. Will you obtain written consent for participation?	✓		
4. If the research is observational, will you ask participants for their consent to being observed?			✓
5. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw?	✓		
6. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer?	✓		
7. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	✓		
8. Have you made provision for the safe-keeping of written data or video/audio recordings?	✓		
9. Will you debrief participants at the end of their participation?	✓		
10. Have you ensured that your research is culture/ belief/ social system sensitive and that every precaution has been taken to ensure the dignity and respect of the participants?	✓		

If you have answered 'NO' to any of the questions listed in 1 to 10 above, then please provide further details on a separate page and attach it to this application.

	YES	NO	N/A
11. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, what will you tell them to do if they should experience any problems (e.g. who they can contact for help.)	✓		
12. Is there an existing relationship between the researcher and any of the research participants? If YES, please describe the ethical implications and the safeguards in place to minimise risks.		✓	
13. Will the project involve working with children under 16 years of age? If YES, please describe parental consent and safeguarding procedures.		✓	
14. Will your project involve deliberately misleading participants in any way? If YES, please explain why this is necessary.		✓	
15. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval or else describe procedures being carried out to obtain it.	✓		
16. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? If YES, please describe on a separate sheet.		✓	

If you have answered 'YES' to any of the questions listed under 11 to 16 above, then please provide further details on a separate page and attach it to this application. I have attached to this throughout the proposal.

15) I am now going to submit my application for this.

PART 3: DECLARATION

I have read the BACP and the BPS guidelines for ethical practices in research and have discussed them with my research supervisor.

Signed: *Anita Sattar* Print name: ANITA SATTAR- Date: 17.7.08
(Applicant) JENKINS

Agreement of research supervisor

Signed: *V. Orleans* Print name: PROF. V. ORLANS Date: 15.8.08
(Research Supervisor)

PART 4: STATEMENT OF ETHICAL APPROVAL

This project has been considered by the Research Ethics Committee and is now approved.

Signed: *P. Moran* Print name: P. MORAN Date: 15.8.08
(On behalf of the Research Ethics Committee)

BDASS
Oak House
Upton Hospital
Albert Street
Slough
SL1 2BJ

Tel: 01753 821 789

Fax: 01753 635 145

Study Reference Number: 08/H0505/209

Participant Identification Number:

Candidate Information Sheet

Title of Project: Motherhood and the absence of maternal support: Asian Women

Name of Researcher: Anita Sattar-Jenkins

We would like to invite you to take part in a research study. Before you decide you need to understand, why the research is being done and what it would involve for you.

Please take time to read the following information carefully. Talk to the Health Visitor about the study if you wish.

What is the purpose of the study?

I am a Counselling Psychologist and Psychotherapist in training at the Metanoia Institute; I am also an employee of Berkshire NHS Foundation Trust. I am conducting a study, which focuses on exploring the absence of maternal support during motherhood, and we are interested in your experience of this area. My own interest in this area stems from my personal experience. I am a 2nd generation Asian woman and I have had the experience of giving birth to my first child at a time when I was not in contact with my maternal family.

This study is being completed as part of an educational qualification.

Why have I been invited?

If you are a second generation, Asian woman, in your first year of motherhood, have given birth to your first child and have been screened for Post Natal Depression (PND) then your Health Visitor will ask you if you are interested in taking part in this research. If you would like to take part in this study, we would be interested in your experience of this area and would appreciate it if you could complete the attached demographic form and hand it back to your Health Visitor who will pass it on to us.

Do I have to take part?

It is up to you to decide. We will describe the study and go through this information sheet, which we will give you. We will then ask you to sign a consent form to show you have agreed to take part. Your participation in this study is voluntary and you are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

Once we receive the attached demographic form, we will contact you to arrange a mutually convenient time for you to take part in an interview. This will last for one hour and fifteen minutes the interview will be recorded and transcribed. The interview will concentrate entirely on your experience of this area. I will then book a second interview date with you and send you the transcript approx seven days before our second meeting. The second interviews will last forty-five minutes the purpose of this will be to ensure that the transcript is a correct representation of your experience.

Will my data be confidential?

All information, which is collected, about you during the course of the research will be kept strictly confidential, and any information about you which leaves the surgery will have your name and address removed so that you cannot be recognised.

How will the data be stored?

All data collected will be kept in a locked filing cabinet on NHS Trust premises. We will keep your information in confidence. We will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Who has reviewed this study?

This study was given a favourable ethical opinion for conduct by the Berkshire Research Ethics Committee.

Whom should I contact if I have a complaint about the study?

If you have a concern about any aspect of this study, you can speak to us and we will do our best to answer your questions. Contact Anita Sattar-Jenkins: 01753 821-789.

If you remain unhappy and wish to complain formally, you can do this through contacting the research supervisor: Professor Vanja Orlans on 0208 579-2505.

Researchers contact details:

Anita Sattar-Jenkins
BDASS
Oak House
Upton Hospital
Albert Street
Berkshire SL1 2BJ
Telephone: 01753 821-789.

BDASS

Oak House
Upton Hospital
Albert Street
Slough
SL1 2BJ

Tel: 01753 821 789
Fax: 01753 635 145

Study Reference Number: 08/H0505/209

Participant Identification Number:

Candidate Demographic Form

Title of Project: Motherhood and the absence of maternal support: Asian Women

Name of Researcher: Anita Sattar-Jenkins

Thank you for participating in this research study. It would be useful if you could read and complete the following information about yourself. The information will not be used to identify you in any way but will help with the data analysis.

1. Age (Please circle)

- 21 – 25
- 26 – 30
- 31 – 35
- 36 – 40
- 40+

2. Please state the country your parents were born in?

Mother _____ Father _____

3. How would you describe your ethnicity? (Please circle)

- Asian/Bangladeshi
- Asian/Indian
- Asian/Pakistani

4. Your marital status

Single
Married
Other (please state) _____

5. Please state the month and year your first child was born

6. Gender of our child

7. When did you loose contact with your maternal family?

0 – 6 months
6 – 12 months
12 – 18 months
18 – 24 months
More than 24 months ago (please state) _____

8. Do you have any other form of support?

Paternal family
Friends
Mother and baby/toddler groups
Other (please state) _____

The return of this completed sheet will be taken as an indication of informed consent to participate in the research.

Thank you for taking the time to complete this.

BDASS
Oak House
Upton Hospital
Albert Street
Slough
SL1 2BJ

Tel: 01753 821 789
Fax: 01753 635 145

Study Reference Number: 08/H0505/209
Participant Identification Number:

Participant Consent Form

Title of Project: Motherhood and the absence of maternal support: Asian Women

Name of Researcher: Anita Sattar-Jenkins

Please initial
box

1. I agree to the location of the interview and have been informed of the limited facilities available to you. I have been given a copy of this consent form and a copy of the British Psychological Society (BPS) code of ethics and conduct for research.
2. I understand that I will be interviewed about my experience the interview will last for one hour and fifteen minutes. The interview will be taped and transcribed. I will be sent a copy of the transcript and invited back for a second interview to validate the content of the transcript. Our second meeting will also give me the chance to debrief where any issues or concern can be raised.
3. I understand that the tape and transcript will be kept in a secure place at all times and all identifiable details will be eliminated from the transcript. The research may also be submitted to a journal for publishing and in this case, their policy would be followed as to how long the raw data is kept.
4. I understand any information provided by you will be kept strictly confidential on a pass worded computer and will only be available to the researcher, research supervisor and the examination board. However, names or any identifying characteristics will not be included.

1 of 2

REC Application 31.03.2009 – V2

A7 (page 1 of 2)

- 5. I am aware that confidentiality can be broken as the researcher is obliged under the BPS code of ethics to take action if the researcher thought I was likely to harm someone or myself. However, in the unlikely event the researcher will inform me of this.
- 6. I understand there will be space at the end of the each interview to ask questions. The researcher has a duty of care towards participants and should any issues be raised where further support is deemed suitable the researcher will refer me back to my health visitor and consult the research supervisor about any further suggestions or recommendations that are made.
- 7. I confirm that I have read and understand the information sheet dated 31.03.2009 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 8. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason, without my medical care or legal rights being affected.
- 9. I agree to give my consent to be taped and to have this recording transcribed.
- 10. I agree to take part in the above study.

 Name of Participant Date Signature

 Name of Person taking consent Date Signature

If you would like feedback about this study, please tick this box.

When completed, 1 for participant; 1 for researcher file; 1 (original) to be kept in Health Visitor's Records.

A7 (page 2 of 2)

BDASS

Oak House
Upton Hospital
Albert Street
Slough
SL1 2BJ

Tel: 01753 821 789

Fax: 01753 635 145

Study Reference Number: 08/H0505/209

Participant Identification Number:

Participant Questions

Title of Project: Motherhood and the absence of maternal support: Asian Women

Name of Researcher: Anita Sattar-Jenkins

Research Question:

Please tell me about your experience of giving birth to your first child without the support of your maternal family?

There are five subtopics I would like to cover:

1. Quality of the participant's relationship with her own maternal family?
2. Meaning of support?
3. Impact of the lack of maternal support?
4. Cultural importance of women and their role as a mother?
5. Quality of their partnership, relationship with the baby's father?

BDASS
Oak House
Upton Hospital
Albert Street
Slough
SL1 2BJ

Tel: 01753 821 789
Fax: 01753 635 145

Study Reference Number: 08/H0505/209
Participant Identification Number:

Participant Debriefing Information

Title of Project: Motherhood and the absence of maternal support: Asian Women

Name of Researcher: Anita Sattar-Jenkins

Thank you for participating in my research project. Since I have asked you to talk about your experience of Motherhood "Motherhood and the absence of maternal support", I understand that this may have elicited difficult feelings and thoughts. If this is the case, I would be happy to talk through the options listed below. You may also wish to consult with your Health Visitor as she can refer you on to a confidential counselling organisation.

Alternatively, you can contact the following:

Your G.P – As there may be a facility for you to access counselling at your local G.P surgery.

SPACE – You can contact this organisation directly using the telephone number below.

SPACE
81 – 83 Windsor Road, Slough, Berkshire SL1 2JL
Tel – 01753 575 432

Samaritans – 0845 909090

**Co-Sponsorship of Research in Health and Social Care
under the
Department of Health Research Governance Framework**

This Co-sponsorship Agreement is made this

1st of July 2009 between

METANIOA INSTITUTE/MIDDLESEX UNIVERSITY (hereafter "the University")

And

Berkshire Healthcare NHS Foundation Trust, Fitzwilliam House, Skimped Hill,
Bracknell, RG12 1LD (hereafter "The Trust")

(individually a "Party" and together "the Parties").

WHEREAS

- A. Anita Sattar–Jenkins, an enrolled student on the Doctorate in Counselling Psychology and Psychotherapy (DCPsych) under the auspices of the Integrative Department of Metanoia Institute and the School of Health and Social Sciences at the University, is undertaking research entitled Motherhood and the absence of maternal support: An exploration amongst second generation Asian Women under the supervision of Professor Vanja Orlans at the University and Sylvia Warwick at the Trust.
- B. Metanoia Institute/The University and The Trust are willing to act as Co-Sponsors for the research project under the provisions of the Department of Health's Research Governance Framework for Health and Social Care (2nd Edition, April 2005), as amended from time to time.
- C. This co-sponsorship arrangement covers only the research project conducted by Anita Sattar–Jenkins.
- D. This Agreement starts on 13th July 2009 and ends on 31st December 2009 unless terminated by either Party with no less than 28 days written notice.

IT IS AGREED

- 1. The University and The Trust shall act as Co-Sponsors, taking on specific responsibility for different activities of the project.
- 2. The duties to be undertaken by each party are as shown in Schedule 1. The nominated parties shall have responsibility for the duty of Sponsor in each area and may only delegate such responsibilities in their area if agreed in writing by both Parties.

For and on behalf of
**Metanoia Institute/
Middlesex University**

Name: Kate Fromant

Title: Head of Central Services

Signature.....



For and on behalf of
**Berkshire Healthcare NHS
Foundation Trust**

Name: SYLVIA WARWICK

Title: RESEARCH & DEVELOPMENT
MANAGER

Signature.....



Schedule 1

Assignment of Sponsor duties between parties

Sponsor Duty	Assigned to
The research proposal is worthwhile and of a scientific quality that is appropriate for a student doctoral project	Metanoia Institute/The University
Ongoing management/supervision of the project	Metanoia Institute/The University
Intellectual property rights and their management are appropriately addressed	The Trust
Arrangements proposed for the work are consistent with the Department of Health Research Governance Framework	The Trust
Ongoing monitoring of the project	The Trust
The research project reflects the dignity, rights, safety and well-being of participants and the relationship with care professionals	Metanoia Institute/The University and The Trust
The research proposal has been approved by an appropriate research ethics committee and is subject to Middlesex University's audit system.	Metanoia Institute/The University and The Trust
All scientific judgements made by the sponsor in relation to responsibilities set out here are based on independent and expert advice	Metanoia Institute/The University (review panel)
Arrangements are proposed for disseminating the findings	Metanoia Institute/The University and The Trust

Research Passport

Please refer to the guidance notes before completing the form.

Section 1 - Details of Researcher <i>To be completed by Researcher</i>			
1.	Surname: SATTAR-JENKINS	Prof <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input checked="" type="checkbox"/>	
	Forename(s): ANITA	Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/>	
	Home Address: [REDACTED]		
	Work Address/Place of Study: BDASS EAST, UPTON HOSPITAL, ALBERT STREET SLOUGH, BERKS SL1 2BJ		
	Work Tel: 01753 821 789 Mobile: 07947274545 Email: Anita.Sattar-Jenkins@berkshire.nhs.uk		
2.	Date of birth: [REDACTED]	Gender: Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>	
	Ethnicity: [REDACTED]	National Insurance number: [REDACTED]	
3.	Professional registration details (if applicable):		N/A <input type="checkbox"/>
4.	Employer: BERKSHIRE HEALTHCARE FOUNDATION TRUST or place of study: METANIA INSTITUTE		
	Post or status held: SPECIALIST COUNSELOR		
Section 2 - Details of Research <i>To be completed by Researcher</i>			
5.	What type of Research Passport do you need? Project-specific <input checked="" type="checkbox"/> Three-year <input type="checkbox"/>		
	<i>If you will be conducting only one project please complete the details below. If you will be undertaking more than one project at any one time, please give details in the Appendix.</i>		
	Project Title: MOTHERHOOD AND THE ABSENCE OF MATERNAL SUPPORT: AN EXPLORATION AMONGST SECOND GENERATION ASIAN WOMEN		
	Project Timetable: Start Date: 01.07.09 End Date: 31.10.2009		
	NHS organisation(s):	Dept(s):	Proposed research activities:
	BERKSHIRE PRIMARY CARE TRUST	HEALTH VISITING DEPT	INTERVIEWS
			Manager in NHS organisation:
			CLARE O'RIORDAN
Section 3 - Declaration by Researcher <i>To be completed by Researcher</i>			
6.	Have you ever been refused an honorary research contract?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
	Have you ever had an honorary research contract revoked?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
	If yes to either question, please give details: N.A		
I consent to the information requested in this Research Passport (including attached documents) being processed and held by authorised staff of the NHS organisations where I will be conducting research.			
Signed: Anita		Date: 23.06.2009	
When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.			

All (page 1 of 5)

Section 4 - Suitability of Researcher

To be completed by researcher's substantive employer, e.g. line manager, or academic supervisor

7. I am satisfied that the above named individual is suitably trained and experienced to undertake the duties associated with the research activities outlined in this Research Passport form.

Signed: *Vanja Orlans* Date: *23.6.09*

Name: *PROF. VANJA ORLANS* Job Title: *HEAD OF DEPT.*

Organisation: *RETANONIA INSTITUTE / MIDDLESEX UNIV.* Department: *INTEGRATIVE DEPT*

Address: *13 NORTH CAMPION RD., EALING, LONDON W5 2GB*

Email: *VanjaOrlans@btinternet.com*

When Section 4 has been completed, the researcher should forward the form to the appropriate person to complete Section 5.

Section 5 - Pre-engagement checks

To be completed by the HR department of the researcher's substantive employer or registry at place of study

8. Can you confirm that a clear criminal record disclosure has been obtained for the above-named individual, with no subsequent reports from the individual of changes to this record? Yes No N/A

If yes, please provide details of the clear disclosure
 Date of disclosure: *4-AUGUST-2009*
 Type of disclosure: *ENHANCED*
 Organisation that requested disclosure: *BERKSHIRE SHARED SERVICES (on behalf of BHFT)*

9. Have the pre-engagement checks described below been carried out with regard to the above-named individual?

<ul style="list-style-type: none"> ▪ Employment/student screening: <ul style="list-style-type: none"> ○ ID with photograph ○ two references ○ verification of permission to work/study in the UK ○ exploration of any gaps in employment 	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
▪ Evidence of current professional registration	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
▪ Evidence of qualifications	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
▪ Occupational health screening	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> *

+ on starting with TRUST. Interview process.

Signed: *Louise Atkinson* Date: *14-AUG-2009*

Name: *LOUISE ATKINSON* Job Title: *HR OFFICER*

Organisation: *BHFT* Department: *HR*

Address: *2ND FLOOR FITZWILLIAM HOUSE, SKIMPED HILL LANE, BRACKWELL RG12 1CF*

Email: *louise.atkinson@berkshire.nhs.uk*

Please return the form to the researcher.

** on commencement of employment with the TRUST.*

Section 6 - Instructions to applicants	
<i>To be completed by Researcher</i>	
<i>Please indicate which of the following documents are attached to this Research Passport:</i>	
Current curriculum vitae, including details of qualifications, training and professional registration (please use the template C.V. at http://www.rdforum.nhs.uk/docs/template_cv.doc)	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Researcher's copy of criminal record disclosure (if question 8 is answered Yes)	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Evidence of occupational health screening	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Appendix	Appendix numbers: N/A <input type="checkbox"/>

Please send the completed form and original documents to the lead R&D office. The completed form and original documents will be returned to you. This package of documents will form your completed Research Passport. You may, where relevant, provide the Research Passport to other NHS organisations.

You must inform all NHS organisations that have received this Research Passport of any changes to the information supplied above. Failure to do so may result in withdrawal of your honorary research contract or letter of access. As part of the quality control procedures for the Research Passport, random checks on the accuracy of the information held on this Research Passport may be made.

Section 7			
This section should be completed by HR in the lead NHS organisation, only if additional checks are undertaken			
Having undertaken the necessary additional pre-engagement checks, I am satisfied that the above named researcher is suitable to carry out the duties associated with their research activity outlined in this Research Passport.			
Signed:	<i>Louise Atkinson</i>	Date:	<i>14-AUGUST-2009.</i>
Name:	<i>LOUISE ATKINSON</i>	Job Title:	<i>HR OFFICER.</i>
Organisation:	<i>BHFT.</i>	Department:	<i>HUMAN RESOURCES</i>
Email:	<i>louise.atkinson@berkshire.nhs.uk.</i>		
Section 8 - For Office Use Only			
<i>This section should be completed by the NHS R&D office that received the initial application. The NHS R&D office must countersign and date retained photocopies of the documents. The grey section must be completed before returning the form to the applicant.</i>			
CV reviewed?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Training?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Evidence of qualifications?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Appendix pages reviewed?	Numbers:
Registration details reviewed?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Occupational health evidence reviewed?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Criminal record disclosure reviewed?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Date of disclosure:	Certificate No:
Enter Electronic Staff Record Number (if issued):		<i>4th August 2009</i>	<i>00124590260.</i>
Valid Research Passport issued: Project specific <input checked="" type="checkbox"/> Three-year <input type="checkbox"/>			
Signed:	<i>Mary B. Bewick</i>	Date:	<i>9/09/09.</i>
Name:	<i>MARY B. BEWICK</i>		
Date Honorary Research Contract/letter of access issued (delete as appropriate)			

<i>This section should be completed by the NHS R&D office receiving the valid Research Passport. The NHS R&D office must countersign and date retained photocopies of the documents. The original Research Passport and documents should be returned to the applicant.</i>			
CV reviewed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Training?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Evidence of qualifications?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Appendix pages reviewed?	Numbers:
Registration details reviewed?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Occupational health evidence reviewed?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Criminal record disclosure reviewed?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Date of disclosure:	Certificate No:
Checked Electronic Staff Record: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			
Signed:		Date:	
Name:			
Date Honorary Research Contract/letter of access issued (delete as appropriate)			

Passport Appendix. List of projects and amendments

Appendix Number:

If you are applying for a three-year Research Passport, please use this section to enter details of projects and activities that will be covered by this Research Passport. Once you have a complete Research Passport, you may add details of subsequent projects during the three years that this Research Passport is valid.

If you are applying for a project-specific Research Passport, but need to subsequently add further sites to the project, please enter the details below.

Whenever you add further details, the full Research Passport and accompanying documents must be submitted to the relevant NHS organisations.

Title:		Start Date:	End Date:
NHS organisation(s):	Dept(s):	Proposed research activities:	Manager in NHS organisation:

Amendments to the Research Passport

Please state what these are, e.g. they might be a change in name or employment details, or a change in research activities.

Please check with the NHS organisation where you are undertaking your research if you are unsure whether you will need a new Research Passport.

Date	Old Details	New Details	Office use only NHS R&D signature

To add more projects please copy this page or download further blank pages. Each appendix page should be numbered.

For office use only:

A photocopy of the appendix should be retained whenever any amendments or additions to the appendix are made.



National Research Ethics Service

Berkshire Research Ethics Committee

Building L27
University of Reading
London Road
Reading
RG1 5AQ

23 June 2009

Telephone: 0118 918 0550 / 0551
Facsimile: 0118 918 0559

Mrs Anita Sattar-Jenkins
Specialist Substance Misuse Counsellor
Berkshire NHS Foundation Trust
CASCADE, Oak House
Upton Hospital
Albert Street, Slough
Berkshire, SL1 2BJ

Dear Mrs Sattar-Jenkins

Study Title: Motherhood and the absence of maternal support: An exploration amongst second generation Asian Women
REC reference number: 08/H0505/209
Protocol number: 2

Thank you for your letter of 10 June 2009, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

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

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

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

A12 (page 1 of 7)

Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		19 November 2008
Investigator CV		17 November 2008
Protocol	2	09 December 2008
Email re: Programme Approval		17 September 2008
Child Protection Procedures 2006		
Letter from MI re: Programme Approval Panel Presentation		10 April 2008
Application to MI for Research Ethics Approval		15 August 2008
Draft Proposal	1	09 December 2008
Presentation	1	09 December 2008
Application Checklist	1	20 November 2008
Response to Request for Further Information		16 April 2009
Application	2.0	31 March 2009
CV: V Orleans		31 March 2009
Participant Questions	2	31 March 2009
Participant Debriefing Information	2	31 March 2009
Canadidate Demographic Form	3	12 June 2009
Response to Request for Further Information		10 June 2009
Participant Consent Form	3	12 June 2009
Participant Information Sheet	3	12 June 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

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

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:
This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk

08/H0505/209

Please quote this number on all correspondence

Yours sincerely

pp Wellman

**Professor Nigel Wellman
Chair**

Email: scsha.berksrec@nhs.net

*Enclosures: List of names and professions of members who were present at the meeting
"After ethical review – guidance for researchers"*

*Copy to: Sponsor / R&D office for NHS care organisation at lead site
- Mrs Sylvia Warwick, Berkshire Healthcare NHS Trust*

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

*The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England*

A 12 (page 3 of 7)

Berkshire Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 20 June 2009

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mr Arden Bhattacharya	Barrister	Yes	Vice Chair
Mrs Vivienne Laurie	Barrister	Yes	Lay Member

N:\Letters\08 REC Numbers\08.H0505.201 - 210\08.H0505.209 - SL14 - 23.06.09.doc

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

*The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England*

All (page 4 of 4)

- 2.5 Should the research not commence within 24 months, the favourable opinion may be suspended and the application would need to be re-submitted for ethical review.

- 3. Duration of ethical approval

- 3.1 The favourable opinion for the research generally applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Committee should be notified.
- 3.2 Where the research involves the use of "relevant material" for the purposes of the Human Tissue Act 2004, authority to hold the material under the terms of the ethical approval applies until the end of the period declared in the application and approved by the Committee.

- 4. Progress reports

- 4.1 Research Ethics Committees are required to keep a favourable opinion under review in the light of progress reports and any developments in the study. The Chief Investigator should submit a progress report to the Committee 12 months after the date on which the favourable opinion was given. Annual progress reports should be submitted thereafter.
- 4.2 Progress reports should be in the format prescribed by NRES and published on the website (see www.nres.npsa.nhs.uk).
- 4.3 The Chief Investigator may be requested to attend a meeting of the Committee or Sub-Committee to discuss the progress of the research.

- 5. Amendments

- 5.1 If it is proposed to make a substantial amendment to the research, the Chief Investigator should submit a notice of amendment to the Committee.

In the case of any new NHS site, the Site-Specific Information (SSI) Form should be submitted to the R&D office for review as part of the R&D application.

Site-specific assessment (where required)

- 6.2 The following guidance applies only to studies requiring site-specific assessment (SSA) as part of ethical review.
- 6.3 In the case of NHS/HSC sites, SSA responsibilities are undertaken on behalf of the REC by the relevant R&D office as part of the research governance review. The Committee's favourable opinion for the study will apply to any new sites and other changes at sites provided that management permission is obtained. There is no need to notify the Committee (or any other REC) about new sites or other changes, or to provide a copy of the SSI Form.
- 6.4 Changes at non-NHS sites require review by the local REC responsible for site-specific assessment (SSA REC). Please submit the SSI Form (or revised SSI Form as appropriate) to the SSA REC together with relevant supporting documentation. The SSA REC will advise the main REC whether it has any objection to the new site/PI or other change. The main REC will notify the Chief Investigator and sponsor of its opinion within a maximum of 35 days from the date on which a valid SSA application has been received by the SSA REC.

Studies not requiring SSA

- 6.5 For studies designated by the Committee as not requiring SSA, there is no requirement to notify the Committee of the inclusion of new sites or other changes at sites, either for NHS or non-NHS sites. However, management permission should still be obtained from the responsible host organisation (see 6.1 above)..
7. Urgent safety measures
- 7.1 The sponsor or the Chief Investigator, or the local Principal Investigator at a trial site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

- 9.2 If the research is terminated early, the Chief Investigator should notify the Committee within 15 days of the date of termination. An explanation of the reasons for early termination should be given.
- 9.3 Reports of conclusion or early termination should be submitted in the form prescribed by NRES and published on the website.

- 10. Final report
 - 10.1 A summary of the final report on the research should be provided to the Committee within 12 months of the conclusion of the study. This should include information on whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research including any feedback to participants.

- 11. Review of ethical opinion
 - 11.1 The Committee may review its opinion at any time in the light of any relevant information it receives.
 - 11.2 The Chief Investigator may at any time request that the Committee reviews its opinion, or seek advice from the Committee on any ethical issue relating to the research.

[\(Back to Contents\)](#)

Motherhood and the absence of maternal support

An exploration amongst Asian Women

Objective

My question holds a broad focus to consider "What is the life experience of an Asian woman who has gone through the experience of becoming a mother without the support of her own birth family?"

I want to understand this process with a view to thinking of service provisions and generating an exploration of this area.

Motherhood is a significant life event for any woman and a time that raises the chances of emotional or mental health difficulties such as postnatal depression. I remain mindful of the experience of my research topic on becoming a mother at a time where there is a lack of maternal support which can also contribute towards emotional unwellness.

Who has reviewed this study?

This study was given a favourable ethical opinion for conduct by the Berkshire Research Ethics Committee in May 2009.

Methodology & Data Collection

This is Qualitative Research

I am using a method called Interpretative Phenomenological Analysis (IPA). This method utilises semi structured interviews. IPA "is basically a systematic and practical approach to analysing phenomenological data" (Barker, C. et al, 2003, Page 81). Elaborated by Smith, A. as "a suitable approach when one is trying to find out how individuals are perceiving the particular situation they are facing, how they are making sense of their personal and social world" (2003, Page 53).

Sampling

My interview sample are contacted via Community Health Visitors using the following criteria:

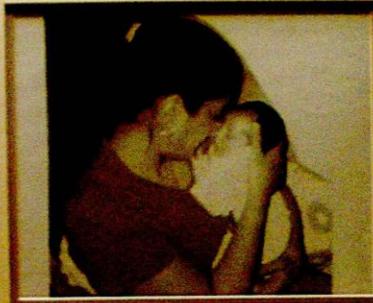
An Asian woman who has given birth to her first child.

In her first year of motherhood. Has been screened for PND (after the first three months of birth).

Health Visitors give interested candidates a copy of my information sheet.

If she decides she does not want to take part her details will be not passed on.

If she decides to take part in my research she becomes a participant. The Health Visitor refers her to me and I assist her to complete the demographic sheet. I arrange a suitable time to conduct the first interview and confirm the location of the interview which lasts for 1 hour and 15 minutes.



Why This Topic - So What?

Giving this area a voice

Very little is written about the cultural complexities of motherhood and experiences of Asian women that give birth in a western society.

Raise Awareness

By informing G.P's, Health Visitors, Counselling/Clinical Psychologist, Psychotherapist and counselors or any other professional involved in offering psychological support what issues a woman from this background might face.

Highlight Risk Areas

This vulnerable group of women encounter, there may be a link between women that are more likely to give up breastfeeding when they do not have support.

Meeting DOH & NICE Guidelines

Conducting research into the needs of a growing diverse community.

NSF on 'Maternity matters'

National Service Framework was produced in 2008. This contains relevant guidance for the trust on the provision of maternity services as they are obliged to follow government guidance. This document talks about meeting physical and social needs of mothers (including mental health needs) and also talks about attending to vulnerable and excluded groups. Hence my research meets these targets as I am carrying out research on Asian women.

Background

Motherhood In an Asian Culture

Motherhood is a time when women are at an increased vulnerability to mental health problems such as depression, anxiety and psychosis. (Browe & Harter, 1998) - a vulnerability factor for depression in motherhood.

In the Asian culture the mothers are central, dominant and instrumental in the upbringing of her children. Asian women are at risk developing mental health problems because:

- Ethnic minority groups experience greater rates of mental health problems.
- Some Asian women may lack family support, and a lack of support places a mother at a greater risk of developing mental health problems such as depression.
- They are less likely to use formal support services (Bryan - 2003 - Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counsellor).

Some of the Results

Asian women come from a background of support. Their mother was supported and their mothers mother was supported, they expect to have maternal support. They struggle when they don't have maternal support. Without maternal support these women are more likely to give up breastfeeding.

Asian women are more likely to neglect their own physical and emotional needs.

When a baby is born in the western world the baby becomes the priority and attention centres around the baby.

In an Asian culture the mother's physical needs become a central focus for 40 days.

Asian women are less likely to encourage their baby to become independent. They come from a culture of extended families and hold the belief that "we take care of our young children in the hope that one day they will care for their elders".

More

My results raise the issue of support when Asian women find themselves outside of their own culture.

What is emerging is that Asian women come from a culture that is embedded in community involvement and find themselves giving birth in one that pushes for independence and isolation within nuclear family.

Anita Sattar-Jenkins

UKCP REGISTERED PSYCHOTHERAPIST
Senior Candidate on the Doctorate in Counselling Psychology &
Psychotherapy by Professional Studies

Interview Number 004 - AMBER

Tuesday 26th January 2010 at Lea Children's Centre at Iqra School

1 Interviewer (1): Could you tell me about your experience of motherhood and the
2 absence of maternal support?
3 Participant (1): Ok, it was really difficult, in the beginning it was alright for me because
4 my mother in law was with me and up to when I came back home it was like nightmare.
5
6 Interviewer (2): Ok so tell me from the beginning, where are your parents.
7 Participant (2): They are in Pakistan.
8
9 Interviewer (3): Ok, So you are in this country on your own.
10 Participant (3): On my own yes.
11
12 Interviewer (4): You don't live with your husband.
13 Participant (4): No I live on my own.
14
15 Interviewer (5): So when you first had your daughter, how long was it before you came
16 here to your own place?
17 Participant (5): I think 10 days.
18
19 Interviewer (6): So you lived with your mother-in-law for 10 days.
20 Participant (6) Yes for ten day.
21
22 Interviewer (7): And how did you find that?
23 Participant (7): That was easy because you know at night time she was take care of her
24 and usually she take care of me as well, food and everything.
25
26 Interviewer (8): So she would cook for you and she would help your with the baby.
27 Participant (8): Yes completely, she was here helping me.
28
29 Interviewer (9): So she was very supportive.
30 Participant (9): Yes.
31
32 Interviewer (10): What happened after the 10 days.
33 Participant (10): Yeah when I came back, I was really hard because my husband he
34 had to go to work and my mother she can't come every day, you know, if she comes
35 around, she would stay for one hour or two, because she had to go, she has family as
36 well, so.. and I think that breast feeding was hard for me, because I was little bit stressed
37 and having post natal depression as well and when mixed together, it was you know
38 really difficult for me to cope with her.
39
40 Interviewer (11): Do you think you suffered from post natal depression?
41 Participant (11): Yes, it wasn't in the night time, in the day time you know clean the
42 house even cooking was really hard, you know you have to feed baby after every one
43 hour, breast feeding and it was really hard and she got ill, that was more difficult time.
44
45 Interviewer (12): What happened when you say she got ill?

Experience?
Difficult
nightmare
alone.
in laws for
10 days
chila
Ease with
support
Cooking
completely
here
hard
Other commitments
Stressed
PND
difficult to
cope.
Clean
feed
hard
ill

gave up
breast feeding
because she
lacked support
and felt
depressed
I asked if
she felt she
suffered PND
she said she
had it hard

hard coping
with her newborn
difficult

for 5/6
who she was
mixed better
than the other
bf

wanted
decided it on
her to adjust
and easily
switched
and cried a
lot and left
emotional
till week 6

had some
support from
mother-in-law
but doesn't
help

I asked her
what she found
difficult

46 **Participant (12):** After I came when she was three weeks when she was feeding she
 47 had chest infection and night time she usually has blocked nose and I had to go for one
 48 week I had to get her every day to hospital and night time I came late and you know it
 49 was really hard.
 50
 51 **Interviewer (13):** Yeah..
 52 **Participant (13):** And when I stopped breastfeeding it was easier for me.
 53
 54 **Interviewer (14):** How long was it before you stopped breastfeeding?
 55 **Participant (14):** For five weeks I think I fed her but in the end it was mixed and after
 56 that yeah and after 6 weeks I was getting a little bit better and I stopped breastfeeding
 57 and I started going out as well, it was better you know, if somebody came around I feel
 58 more easy. Sometimes my brother and my husband he pick up her and even at home I
 59 feel is really good and healthy and most I think is to feel good about yourself about you
 60 know everything is ok, you make sure to realize yourself that everything is ok.
 61
 62 **Interviewer (15):** Yes.
 63 **Participant (15):** That I think is a very important thing and that was missing in the
 64 beginning because I can feel every thing is ok. Even she was alright but I still get panic
 65 very quickly, if she is not feeding, she was constipated as well, so every little thing
 66 makes you worried, even I used to cry a lot in the beginning, you get emotional. If
 67 somebody asked you any reason, you don't know what's the reason.
 68
 69 **Interviewer (16):** Because you were crying.
 70 **Participant (16):** Yeah after 6 weeks to 8 weeks yeah, it start getting better.
 71
 72 **Interviewer (17):** So it was quite a difficult time for you then.
 73 **Participant (17):** Yeah very difficult yeah.
 74
 75 **Interviewer (18):** Given that you had some support from your mother-in-law at the
 76 beginning and then you had no support, so from the 10 days to the 8 week period it was
 77 very difficult for you.
 78 **Participant (18):** It was very very hard.
 79
 80 **Interviewer (19):** Very hard.
 81 **Participant (19):** Even I find the delivery wasn't that hard.
 82
 83 **Interviewer (20):** Yeah.
 84 **Participant (20):** Funny taking care of baby is more hard I think, because that time
 85 period you know take 24 hours for two days. up to two days you will be alright, you know
 86 continuous you know, work, you have to you know.
 87
 88 **Interviewer (21):** It is continuously giving to the baby.
 89 **Participant (21):** Yeah.
 90
 91 **Interviewer (22):** What is it you found hard about it.
 92 **Participant (22):** I think that no support, that's why. I feel lonely you know most of the
 93 time. my husband when he came back from work and my brother, that was alright for me
 94 but even the day time was hard, you know I feel lonely I don't know. If I go somewhere I
 95 feel more panic and something happen to her. Even you know but I think up to 6 weeks
 96 that came better, but in the beginning it was really hard.

Baby ill

Breastfeeding

mixed

6 weeks better

Started going out
to feel good
important

missing in
beginning

worried
emotional

Cry for no
reason.

6-8 weeks
better

difficult

Very very
hard

delivery not hard

taking care of
baby - continuous

no support
feel lonely
hard

97
 98 **Interviewer (23):** You describe it as being a hard experience for you.
 99 **Participant (23):** It was yeah.
 100
 101 **Interviewer (24):** Tough experience.
 102 **Participant (24):** Very tough yeah.
 103
 104 **Interviewer (25):** And quite lonely.
 105 **Participant (25):** Lonely yes. I think definitely because I think at that time period I want
 106 someone with me all the time, but you know nobody can manage because my mother-in-law
 107 she has her own family, her house and she can't live with me and at that time I used to
 108 felt I want somebody with me all the time and that was impossible, my problem was you
 109 know loneliness.
 110
 111 **Interviewer (26):** Yes, yes.
 112 **Participant (26):** Yes.
 113
 114 **Interviewer (27):** When you describe that loneliness do you think that was because you
 115 didn't have your own mother or your own family or was there someone else you wanted.
 116 **Participant (27):** I just want somebody with me like even my mother-in-law, even my
 117 sister-in-law, you know it is really hard for them to live with me you know for 24.
 118
 119 **Interviewer (28):** Yes.
 120 **Participant (28):** I would like, it is not easy for them as well but on my own, I used to
 121 think I need someone.
 122
 123 **Interviewer (29):** Do you think it made a difference that you didn't have any contact from
 124 your own mum and dad.
 125 **Participant (29):** Yes, they phone me every day but you know, talking with them or you
 126 know to have a chat with them, I want somebody personally with me. I don't need any
 127 that sort of expert but I want somebody with me, you know sit around, I can feel
 128 somebody is with me.
 129
 130 **Interviewer (30):** So somebody is present?
 131 **Participant (30):** Yeah, I used to feel like that.
 132
 133 **Interviewer (31):** What difference would that presence have made for you?
 134 **Participant (31):** Because I think I was emotional at that time, I need someone because
 135 if somebody came around, even my mother-in-law, I feel like secured, I used to feel in
 136 secured basically and when somebody is around me I feel secured. I don't know
 137 because it wasn't with my baby or with me I don't feel scared but insecure.
 138
 139 **Interviewer (32):** Insecure, ok.
 140 **Participant (32):** Yeah.
 141
 142 **Interviewer (33):** What's your relationship like with your own mum and dad?
 143 **Participant (33):** A really good relationship, they are very friendly to me. We don't have
 144 like mother daughter relationship, we have friend's relationship.
 145
 146 **Interviewer (34):** You have a very good relationship.
 147 **Participant (34):** Very good yeah.

*be hard
 and by mother-in-law
 in lonely journey*

*and just
 want
 someone
 with her.
 want to think
 I need
 someone*

*give me to
 sit with me*

*Be come
 with me to
 feel insecure*

*Emotional
 impact of
 having baby*

Very tough

*Lonely
 I want
 someone with
 me all the time.
 Loneliness*

*just someone
 on own*

need someone

*want
 somebody*

*Someone's
 presence.
 Security
 Scared*

Parents

*very good
 friendly*

She felt a gap if someone was not around

I would be left out from depression

She felt someone was missing her

as afraid of someone getting sick

Aspirin what she needed quality support

advice her midwife no advice during pregnancy

148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198

Interviewer (35): Would you call it a secure relationship with them?
Participant (35): Yeah very secure, even with my mother-in-law and sister-in-law I have very good relationship with them, they are very nice but you know I need to feel that gap. I don't know, if you think psychologically something was missing, and if somebody is around, you feel that gap in your mind basically, yeah and I think at that time you need someone with you, if you are not in depression maybe you will be alright, but if you are in depression, maybe you need because I used to get more annoyed if the house is dirty and nothing is happening. Yeah and you know those kind of things come altogether then if your baby is not happy with you and you're not sleeping with baby they are all things that come together and they give you depression and stress.

Interviewer (36): And it feels like you suffered from some depression?
Participant (36): Yes, I think so, yes.

Interviewer (37): You said that psychology wise, there was something missing for you, sounds like you thought about that quite a lot?
Participant (37): Yeah I think 3 -4 times yeah.

Interviewer (38): I was just wondering if you've worked out for yourself what that something missing was for you.
Participant (38): Because maybe I was tired that element is important you know, you want everything good for your baby as well but at the same time you're tired, you need to feed her. I was forever changing nappies and this and that but I think that was a difficult time, yeah.

Interviewer (39): It was a tough time.
Participant (39): Tough time, yes. I used to get insecure about her as well if somebody is sneezing, I would think, she will get flu, you know she might catch it and I used to wash my hand very much, and you know, every time I sterilize the bottle, that's normal, but I feel it's not clean.

Interviewer (40): You had a very good relationship with your mum and dad.
Participant (40): Yes.

Interviewer (41): What would you say the meaning of support if you say "if I had had some support for someone to sit, not do anything in my house, just some support?"
Participant (41): Yes well you know, I want somebody elder with me like, if kids come around I feel insecure with her and if somebody you know.

Interviewer (42): What sort of mother figure? Father figure? Or brother or sister?
Participant (42): Anyone, sort of like take them to your place, a person who has really a good knowledge, of what ever is going on, he can help me and deal with that.

Interviewer (43): And you need support with the baby, to advise you.
Participant (43): Yes to advise me/I was thinking to tell my mid-wife as well, they just during pregnancy, they just concentrate on you know about the pregnancy, about the delivery, they don't talk about after baby. I used to watch a lot of programmes I used to watch labor, delivery you know all sort of pregnancy programs, but I didn't watch after baby programs you know, bring baby home, and that's most important thing. You know mother should know a little bit about hic-cups you know something like that, they give

Very Secure
Something missing
Need someone
Annoyed
altogether gives depression + stress

Something missing

physically tired
meeting needs
difficult

tough time
Sterile
not clean

Somebody
elder
Insecure feeling

Anyone
taking care of baby

advise me, H.V
don't talk about after baby
most important bringing baby home.

miss able to
day after childbirth
the support
she needed

insistent on
having the classes
before the baby
is

little
more when
before baby
is born

Dr. J. showed
to be sensitive to
new mothers
feelings

199 you books but you don't have the time after having baby to read that, yeah, they should
200 give knowledge about after baby. I missed those little things you know, the child gets
201 constipated, you need to give two three days, they tell you afterwards but at that time
202 you are suffered you know. After when you go there they will tell you well I think these
203 little things you should know before, if you don't want to get worried, that's why I think I
204 want someone like that who can tell me this is normal, this is serious, something like
205 that, I think that was missing.

206
207 **Interviewer (44):** Do you think in our culture, when we live at home and we have our
208 parents and we have them close to us.

209 **Participant (44):** That's what I'm saying, they teach you everything, how to change a
210 nappy, how to hold her, what's normal and what's not normal, basically and with your
211 first baby you don't know anything, because baby is really small, those kind of things
212 there those kind of things are missing. They should teach new mums after baby during
213 pregnancy. Because after your having baby, that's useless because I can't go to take
214 classes when my baby is just two or three days or one week, they should before delivery
215 about only one or two classes give them books or whatever, so they are mentally
216 prepared you know. When I was pregnant I used to watch programs, read on the internet
217 anything that happens during pregnancy I was well informed, if anything happened I
218 know that's all right I need to pay attention if I am not eating or whatever you know, or if
219 you have iron deficiency you need, you know little things, information is most important
220 thing and after baby I wasn't aware of anything and that I think is what I was missing
221 because I was well informed in pregnancy after having baby I was like blank, so I think
222 maybe.

223
224 **Interviewer (45):** Do you think you would have retained any of that, remembered that
225 though, when you say after having baby you were blank?

226 **Participant (45):** Blank in a way that whatever happens to her, little things like hic-cups.
227 I worried why she has so many hic-cups, these kind of little things, after 6 or 8 weeks I
228 read books, well informed books but that was useless at that time. You know you're too
229 late, I think they should give lessons before delivery for new mums.

230
231 **Interviewer (46):** So what would you call that sort of information on?

232 **Participant (46):** I mean like taking care of baby, new born baby, especially I think 4
233 weeks are very important because at that time you can't give any medicine. You know
234 and after 5 weeks you can give any kind of medication, like baby gets temperature or
235 any kind of infection or whatever, but for 4 weeks you think as well if anything happens
236 you can't give medicine cause she had wheezing and cough and when I take to my
237 doctor. I don't like her she was crap as well because she don't pay much attention, oh
238 that's normal, it's new baby things like that.

239
240 **Interviewer (47):** So the doctor sends you away.

241 **Participant (47):** Because new mums they get worried, anything happens they get really
242 worried and your doctor you should tell in a nice way but not in not way. Maybe I was in
243 depression I feel like she just making fun of me or something like that.

244
245 **Interviewer (48):** So you started to feel she.

246 **Participant (48):** Yeah she attention to me or to my baby and maybe she was alright
247 but.

248
249 **Interviewer (48):** At the time you felt it.

Suffered
diarrhea

teaching
normal?

During pregnancy
useless
mentally

prepared
pay attention
iron deficiency
information

hic cups
little things
books
inform

4 weeks
important
no medicine
infection

new mums
get worried
depression

not paying
attention to me

Explained how support from her mother would have made a difference.

Also she would tell her mother in law but had a fight with her some.

Explained how she can talk to her mother he overheard her she is too much for her mother.

Explained how she is comfortable with her sister in law she can speak to her own mother.

250 **Participant (48):** Yeah and the way talking to the baby, maybe I had depression that's
 251 why I felt like that, a that time they should take more care in what they say, how they
 252 behave.
 253
 254 **Interviewer (49):** Ok, do you think it made a difference that you didn't have support from
 255 your own parents.
 256 **Participant (49):** Yeah maybe yeah
 257
 258 **Interviewer (50):** Ok in what way.
 259 **Participant (50):** Like, if my mother is with me and she is living with me it would make a
 260 lot of difference, in the way maybe I am more attached with my own mother, I can tell
 261 whatever. If it's useless or you know maybe I am feeling low, whatever, I can't tell
 262 anyone else, my mother I have a good relationship with her, but I can't share everything
 263 with (pause).
 264
 265 **Interviewer (51):** You were saying that you can't tell your mum everything but some
 266 things.
 267 **Participant (51):** No, my own mum I can tell her everything.
 268
 269 **Interviewer (52):** Ok.
 270 **Participant (52):** I can tell everything to my mother-in-law as well but something is
 271 happening with. I would think if I tell her she could say oh that's nothing you know, at
 272 that time I was like emotional. I want them to pay attention to every single thing every
 273 little thing, if I wrapped her, they would say oh you wrapped her too much and I will say, I
 274 wrapped her, but I can't say why I wrapped her, these kind of things you know.
 275
 276 **Interviewer (53):** So if that was your mum, you would have been able to say.
 277 **Participant (53):** Yes I can talk to her about everything you know, if I want something I
 278 will say yes I want this yes.
 279
 280 **Interviewer (54):** So you would leave her with your mum.
 281 **Participant (54):** Yes my mother-in-law always says leave your baby with me, but I used
 282 to think oh she is cleaning her house, or guests were coming. I used to think I should
 283 take her by myself, I can give to her but I was thinking it would be too much for her then
 284 but if it is my own mother, then I can leave with her.
 285
 286 **Interviewer (55):** Why.
 287 **Participant (55):** Because I don't know because usually my cousins have their own
 288 mother, if their mother is tired, they will leave their kids with their mother, but with
 289 mother-in-law you feel little bit like maybe she thinks, what shall I say, I don't know.
 290
 291 **Interviewer (56):** Uncomfortable?
 292 **Participant (56):** Yeah maybe yeah little bit uncomfortable, not that way. I know she will
 293 take care of her, anyway she is like mother to her, she is grandma and she is really nice
 294 to my other sister-in-laws kids, she is nice and she will take care, but at the same time I
 295 was thinking maybe she feel bad you know, giving her too much pressure, I was staying
 296 with her, she used to do everything for me like even cleaning my dirty clothes, but I used
 297 to think if I leave baby with her. She is cleaning house as well, it will be too much for her,
 298 but if it's my own mother. I can tell her to leave those work, whatever you're doing at
 299 home and take care of her, you know, I can say anything you know, if she is cleaning her

depression
 more care
 at that time
 yeah maybe
 living with me
 my mother makes
 a lot of difference
 share everything
 tell her everything
 not with
 mother in law
 pay attention
 wrapped her
 with mother in law
 leave baby
 too much
 for her
 Cousins can
 leave baby with
 own mother
 little bit
 uncomfortable
 nice grandma
 will take care
 feel bad
 pressure
 too much for her
 my own mother
 can say anything

Certain things
she can't say to
her mother-in-law

described
in impact
if having
baby not
ready
support.
wish I feel
good!
All depressed

Explained
having had
a good
relationship
with her
mother and
wishing this
will be my
baby.

300 own room, I will say, oh don't worry clean afterwards take her first, but with my mother-
 301 in-law I can't say to her.
 302
 303 Interviewer (57): And is that because you respect her.
 304 Participant (57): Yes.
 305
 306 Interviewer (58): So you don't feel like you can be straight with her.
 307 Participant (58): Straight with her yes.
 308
 309 Interviewer (59): So you have got a lot of respect for your mother-in-law.
 310 Participant (59): Yes she is really nice.
 311
 312 Interviewer (60): So it's made a difference to you if your parents were here then you
 313 would be able to leave baby with them, you may have felt more supportive by them.
 314 Participant (60): Yeah I think so.
 315
 316 Interviewer (61): And the fact that they are at the end of the telephone, didn't feel very
 317 supportive.
 318 Participant (61): Yes it's ok, but when you need help, that kind of help you know. You
 319 need someone with you, if your just telling me oh feed your baby go to sleep, that's easy
 320 to say, but when your doing it on your own, its not easy. If your tired and restless,
 321 sleepless and at the same time you can't leave your baby as well, because I was really
 322 in secured at that time you know, it was like I am taking care of her as well, my mid-wife
 323 was telling me, no your doing good, your doing good but I wasn't feeling good. I was
 324 insecure, if she didn't drink for two hours I will get worried, she didn't drink, why. You
 325 know, these kind of little things. I think when your in depression, you need someone, if
 326 you don't have, that will make you, you know, like psycho. I used to wash my hands so
 327 much, they were really bad.
 328
 329 Interviewer (62): Do you think it made you do strange things like?
 330 Participant (62): I used to wash hands yes.
 331
 332 Interviewer (63): Still doing that.
 333 Participant (63): No, its better now, I tell you after 6 weeks to 8 week yes, things are
 334 getting normal, maybe I was feeling normal, things started to get normal. Maybe it's the
 335 first one that why you feel more insecure about baby as well.
 336
 337 Interviewer (64): Ok. Tell me a bit, in your view what is the culture importance of women
 338 and their role as a mother? If you think of your own mum what is the important role of
 339 being a mother for you?
 340 Participant (64): Its like in the beginning you know when I was a baby we had a good
 341 relationship, we were 5 sisters but we had really good relationship, we can share
 342 everything with our mother, anything, good or bad what ever. If we made any mistake or
 343 something like that, I will tell her anyway, I will get punishment and something like that
 344 but I have to tell her. I will feel not satisfied inside if I don't tell her and even she used to
 345 share everything with us, her problems what ever, that makes a difference/I think
 346 parents should have really friendly relationship with their kids. I want same relationship
 347 with my own daughter what I had with my mother, and that's missing here I think. Most
 348 people if kids get older they don't have relationship, they don't share, parents don't share
 349 anything with their kids.
 350

mother in law
 can't say to her
 respect her
 can't be
 straight with her
 leave baby
 yeah
 help
 easy to say
 hard when your
 tired, coping
 can't leave baby
 feel insecure
 worried, need
 someone in depression
 made me psycho
 shame
 strange things
 wash hands
 maybe 1st one
 feeling more
 insecure.
 really good
 relationship o.k
 to make mistakes
 have to tell her
 share everything
 really friendly
 relationship.

351 **Interviewer (65):** Are you're talking about the western culture.
 352 **Participant (65):** Western culture yeah, even Asian people who living here, born here, I
 353 don't feel like they have that kind of relationship with their parents, that's missing here.
 354
 355 **Interviewer (66):** Ok.
 356 **Participant (66):** They live together but they are not together, they don't share
 357 everything, they don't chat in that way, they don't ask them what's their problem or why
 358 they sad or something like that, cause they don't have that kind of relationship, but we
 359 have in Asia, in Pakistan yeah. We live, we don't have this we live separately but we
 360 share everything with our parents.
 361
 362 **Interviewer (67):** Your immediate family.
 363 **Participant (67):** Yeah, when you're sad or when you're happy you want your own
 364 family your loved once with you, we want our parents, sister brothers but here they want
 365 their friends.
 366
 367 **Interviewer (68):** So there's a difference for you, you would only trust and confide in
 368 your mum, your brothers and sisters but here you think they haven't got that support so
 369 they go to friends.
 370 **Participant (68):** Yes they would share with their friends first then their parents maybe.
 371 Everybody is not the same.
 372
 373 **Interviewer (69):** But that's how you see it.
 374 **Participant (69):** Yes, some do have good relationship here but if you see you know at
 375 the community but all people together, even girls and boys, they not that friendly
 376 relationship with their parents. If they do something really wrong, then everything is
 377 finished then they will tell their parents. That I think is really bad, obviously parents will
 378 get worried or annoyed what ever they do, but I think that's missing here. They should
 379 have a good relationship with their parents.
 380
 381 **Interviewer (70):** You think there's a difference between the Asian culture and the
 382 western culture.
 383 **Participant (70):** Yes. There is a difference.
 384
 385 **Interviewer (71):** That's a very important point you made when you feel they would
 386 firstly go to friends and then go to their parents, whereas in the Asian culture you would
 387 only confide in your family.
 388 **Participant (71):** Because you know they would help you, with whatever happens.
 389
 390 **Interviewer (72):** Do you think that's because we're brought up as Asian people are
 391 brought up to believe in confiding in your family, don't take it outside.
 392 **Participant (72):** Yeah, yeah.
 393
 394 **Interviewer (73):** Do you think that made a difference in your experience?
 395 **Participant (73):** Yes I think it has because if I talk to my parents and my sister-in-laws
 396 relationship with her mother, I think there's a difference. She will share what she wants
 397 to share.
 398
 399 **Interviewer (74):** And was she born here.
 400 **Participant (74):** Yes, they have the relationship where I can't tell my mum or my dad
 401 you know, anything, like little things, but I think in Pakistan we share everything, like we

relationship
 missing here
 don't share
 everything Don't
 ask about
 problems
 sad, happy
 family love
 Confide in, got
 support
 share
 good relationship
 not friendly with
 parents
 missing here
 good relationship
 Yes different
 here
 Yes can ask
 mum for help
 yeah
 my parents
 there is a
 difference
 can tell mum
 everything.

afraid that in the
UK children are not close to
their parents

described
how it is
in Pakistan
respect
is important

is noted
friendship as
important
element to
motherhood

Relationship
with husband

402 used to like when we come back from school college we used to tell our mum, this
 403 happened today with our teacher or our school but here they don't have any kind of
 404 respect for the teachers and that I don't see any single person who respects their
 405 teachers. In Pakistan, in our religion in our culture, they teach us our teachers are like
 406 our parents you know, the same kind of respect you have to pay them, and that's why I
 407 think kids are not like respectful to anyone, and if I think parents are against their kids,
 408 the kids won't respect their parents and I think that's why, parents, whatever they do oh
 409 ok you can do this and that. I think that is very important issues, they should find some
 410 relationship with their teachers, we have a very different relationship with teachers, if a
 411 teacher strict or whatever we never say anything disrespectful.
 412
 413 **Interviewer (75):** Uum never questioned it.
 414 **Participant (75):** Never questioned it, anything we won't say. I will say oh that's too strict
 415 other than that we don't say anything but here.
 416
 417 **Interviewer (76):** And bearing in mind your experiences about teaches and how
 418 important it is to have respect, how do you see your role as a mother.
 419 **Participant (76):** I want the same relationship with her as my relationship with my
 420 parents, my mother. I used to share everything with my parents, that's why I didn't get
 421 any kind of trouble in my life and I want same relationship with my daughter. In any kind
 422 of relationship you need friendship, that's most important, as mother you should be
 423 friendly to your kids, if your kids are scared of you that's really bad, you should be
 424 friendly. Teach them but in a friendly way. I think here more people get angry quickly,
 425 when we were kids we never see anyone angry to anyone, maybe they are independent
 426 something like that.
 427
 428 **Interviewer (77):** It's a very different culture.
 429 **Participant (77):** Very different.
 430
 431 **Interviewer (78):** What's your relationship like with your husband?
 432 **Participant (78):** A very good relationship yeah, understanding yeah, when she born,
 433 obviously he can't be with me 24/7. He has to work you know to put food on table, he
 434 has to work, I don't blame him, but at that time, maybe I want my mother or mother-in-
 435 law with me, maybe because he man. I don't trust he can care for baby, my mother or
 436 my mother, maybe they are experienced maybe that's why, I want my mother or mother
 437 -in -law with me.
 438
 439 **Interviewer (79):** That makes sense, it is very important for you to have your mother in
 440 law.
 441 **Participant (79):** Anybody who is experienced who you can trust basically yeah, you
 442 can't trust anyone.
 443
 444 **Interviewer (80):** But you trust your mother-in-law, it doesn't feel like you could be open
 445 with her because?
 446 **Participant (80):** I can be open but I can't leave everything with her, I cant you know put
 447 everything on her, she has her own family. If my mother here or my sisters, maybe that
 448 will be different, if I want something I can appreciate them.
 449
 450 **Interviewer (81):** So really what you're saying when you had needs you couldn't express
 451 them to your mother in law, because she was your mother in law, but if that had been
 452 your mother you would have been able to say.

College tell
mum what
happened.
respect teachers
like our parents
important to
find relationship
with parents

teachers
too strict

Want the same
relationship...
Need a friend
friendly to child
Teach them in
a friendly way.

Very good
relationship
works to put
food on table
SHU want my
mother with me.

anyone experienced
can't trust
just anyone

mother in law
can trust but
can't leave
everything to her

with my mother
different

453 **Participant (81):** I can say to my mother-in-law, but I was thinking maybe she feel you
 454 know I'm just throwing everything in her. I know if I ask her she will help me to stay with
 455 me but I know she can't. She has her own family because her kids are not married they
 456 younger that's why. You ask somebody to take everything serious for you whether it's
 457 serious or not.
 458
 459 **Interviewer (82):** I wonder if you had to be everything to her and you needed someone
 460 to support you.
 461 **Participant (82):** Yeah, yeah, I think mentally and emotionally physically you need
 462 somebody with you. I think for 6 weeks. In Pakistan they call it chila.
 463
 464 **Interviewer (83):** Yeah 40 days.
 465 **Participant (83):** Yeas 40 days that is really important and it usually they say oh take
 466 your baby and but I think you shouldn't take anywhere because I took her when she was
 467 2 weeks to one of my aunties. They were serving cake and that day, her cold was
 468 starting basically and she got some germs from them and she started coughing and after
 469 3 weeks there was a birthday. I had to go there and I took her and things were getting
 470 more worse and after 6 weeks baby settled down as well, but I think that's important
 471 time, that's really important time for you and your baby, 6 weeks yeah.
 472
 473 **Interviewer (84):** The first 6 weeks.
 474 **Participant (84):** Yeah.
 475
 476 **Interviewer (85):** What would have happened in Pakistan during that time?
 477 **Participant (85):** If I'm there, if I don't want to take her any where I can say no, in
 478 Pakistan they will say to you, don't go out because.
 479
 480 **Interviewer (86):** They shave the hair in the first 40 days.
 481 **Participant (86):** Yes I shaved her hair after 3 days.
 482
 483 **Interviewer (87):** Oh did you.
 484 **Participant (87):** Yes because she was really marshallah healthy.
 485
 486 **Interviewer (88):** Is that her second set of hair.
 487 **Participant (88):** No I have to do that again now, because the family around here, your
 488 cousin, your aunties even your neighbors they are really supportive anyone you know
 489 come for one hour, two hours when they gone your any other aunty will come and help
 490 and especially.
 491
 492 **Interviewer (89):** Yes it's you doing the housework, looking after the baby and your
 493 husband.
 494 **Participant (89):** Yeah, you can't get any servants easily there and that why.
 495
 496 **Interviewer (90):** It makes a big difference.
 497 **Participant (90):** Yes big difference, you have to think only about your baby and nothing
 498 else, even guests are coming around you don't need to worry about any single thing but
 499 here you will be, your house is dirty, you didn't serve them, these kind of things.
 500
 501 **Interviewer (91):** And what about yourself, did you neglect yourself when she was born.
 502 **Participant (91):** Yes, I didn't did my eyebrows and anything, I used to feel like more
 503 ugly and you know and fat and ugly you know, you don't feel like to look and wear you

Maybe she
 feels, others
 have own family
 take it seriously

Chila for
 6 weeks
 need someone
 mentally, physically
 emotionally

40 days.
 shouldn't take
 baby out anywhere.
 germs, coughing
 after 6 weeks
 settled down

In Pakistan
 don't take her
 out

shave hair
 after 3 days

Supportive
 family, neighbors
 family.
 no housework

Servants

only have to
 think about baby
 nothing else

neglect self
 eyebrows, feel
 ugly, fat
 don't feel like
 it

difference
 in Pakistan

impact of
 baby

meant she neglected
 herself and felt
 ugly

and led to her
feeling
unwell

NH&D service
Cancer is
different from
really.

Shift in
service and
care after the
baby was
born
I protest and
didn't
leave until
I was
sent home.

helped by
maternal law

504 know. I was really skinny and then when I got pregnant. I was like triple size I think, I was
 505 so big, when I think about the baby that's alright, but when I look at my face. I used to
 506 feel so ugly and after I had baby, these kind of things you know makes you more
 507 worried, you get worried and you know.
 508
 509 **Interviewer (92):** If you were in Pakistan, you could have a beautician do your
 510 eyebrows.
 511 **Participant (92):** Yeah it was different I can leave baby, its easy.
 512
 513 **Interviewer (93):** It's a different life completely.
 514 **Participant (93):** Completely different.
 515
 516 **Interviewer (94):** What about your experience with the health visitor and their delivery
 517 system here. Did you find anything that could have been different that you have like to
 518 be different?
 519 **Participant (94):** I think that ok, but concept about baby birth centre. Concept is really
 520 different and actual birth centre is really different. Somebody told me our birth centre
 521 there is nothing left, there's nothing there actually, but you know, during the labour, they
 522 took me to that centre. I said to them I don't want to go birth centre, but it was really
 523 good, but after 2 hours they had to take me to labor ward because I had high blood
 524 pressure but I felt really good. Midwife was really nice and they were really good, but I
 525 told them as well, they should change the concept you know, because when they show
 526 you picture before labor or delivery it is really horrible, they don't tell you there will be
 527 midwife there and you will have all sort of help. Before I used to think oh there is nothing
 528 because somebody told me there is nothing in the room, no like sort of any equipment
 529 when you give birth.
 530
 531 **Interviewer (95):** It wasn't true.
 532 **Participant (95):** It wasn't true, yes I told them it was quite nice, it was really good and
 533 the room was cozy and you feel like it was really nice.
 534 The midwife was really nice, it was like they were friends and like having my mother, but
 535 after having her, they shifted me into ward, they were so horrible they were not helpful or
 536 I was lying down in blood for more than three hours. They didn't take care of anything.
 537 you feel like they are not paying attention to me, maybe they are busy or something like
 538 that. I said to them I want to go home because they are not paying any attention, what's
 539 the point you know staying there, they are not taking care of anything because she was
 540 puking, that was normal but I didn't know. I said she's not drinking and they said oh that
 541 normal, that's normal and they were gone. At that time I had stitches.
 542
 543 **Interviewer (96):** Did you have a caesarian?
 544 **Participant (96):** No I had forceps baby but stitches you know, so I couldn't move
 545 properly and they gave me an epidural as well. So my body was a little bit numb as well
 546 but they send me home after 12 hours, at that time I had complete help there because I
 547 went to my mother-in-law at that time I didn't feel like traveling. My head was like hearing
 548 bells because I feel they should keep me for one day, but they didn't pay any any sort of
 549 attention, so in the ward that was no good, but in the delivery room the mid wife was
 550 really nice, really helpful, really good. That was my good and bad experience. Yeah.
 551
 552 **Interviewer (97):** And is there anything else you would like to add about your experience
 553 in your maternal support and how that affected you.

triple size
 Baby's alright
 feel ugly, older
 feel worried
 different in
 Pakistan
 delivery system
 O.K. Baby birth
 centre - concept is
 different and is
 actually really
 good. Midwife
 really nice.
 don't tell you
 midwives are here.
 midwives really
 nice, like friends
 after birth shift
 into ward, horrible
 not helpful, left
 no attention not
 taking care of you
 gone. Stitches
 Stitches
 numb with
 epidural, went
 to mother in law
 for complete help
 ward was no good
 good bed
 experience

wanted more advice about taking care of baby before the birth

well informed ask birth

missed support

554 **Participant (97):** Yeah, first I think you should have information about having baby
 555 anything, everything, they should give you books or give you lessons or whatever.
 556
 557 **Interviewer (98):** Before?
 558 **Participant (98):** Yes, there is post natal classes but they will teach you about delivery,
 559 about labor they wont teach you about when the baby is how, how to cope with the little
 560 things that will happen, they should tell you, that will happen to your baby, that will
 561 happen to you. You need to be prepared, mentally prepared about everything, cause I
 562 was well prepared for the delivery, I know about forceps, caesarian whatever, everything
 563 but after baby I was like blank. I didn't know anything.
 564
 565 **Interviewer (99):** And you think that would have made a difference.
 566 **Participant (99):** Yeah big difference.
 567
 568 **Interviewer (100):** You should be better informed.
 569 **Participant (100):** Yeah better, you won't get worried quickly then, oh yeah that will
 570 happen, because when I was pregnant, because if baby is not moving, I know why its
 571 not moving, how I can make movement, little things you know. Because after 4 weeks
 572 you have to go to doctor.
 573
 574 **Interviewer (101):** Yes.
 575 **Participant (101):** I think, if it's cold, winter, they should come here!
 576
 577 **Interviewer (102):** More regularly?
 578 **Participant (102):** Yeah, they were nice, I won't blame them, they were helpful but at the
 579 same time, that was missing.
 580
 581 **Interviewer (103):** It was missing for you?
 582 **Participant (103):** Yes and after baby you need someone you know like your mother or
 583 anyone who can support you, mentally or physically, if somebody is with you after having
 584 baby, even more good.
 585
 586 **Interviewer (104):** It will make a difference.
 587 **Participant (104):** Big difference especially for mother because baby you know does not
 588 know anything but for you must have somebody or well informed because if somebody is
 589 in post natal depression, it can be bad they won't get better.
 590
 591 **Interviewer (105):** And you think your post natal depression was because you didn't
 592 have the support?
 593 **Participant (105):** Maybe, maybe yeah because I used to feel lonely or sad, cause she
 594 was wasn't that well.
 595
 596 **Interviewer (106):** And that upset you?
 597 **Participant (106):** Upset me yeah more.
 598
 599 **Interviewer (107):** And you already felt quite emotional?
 600 **Participant (107):** Yeah, yeah, I think any new mum, what you should do and what you
 601 shouldn't but there should be somebody who can tell you but the situation can different
 602 for everybody, but obviously baby not same but situation can be same for anyone, like
 603 feeding problems, nappies, these kind of little things. I had two three, they new mums as
 604 well, I usually tell them everything, they really trust me because you know, they know I

information about having baby
 only taught about delivery not how to cope with baby mentally prepared
 big difference
 better less worried
 health visitors do more home visits
 nice helpful
 mentally physically, includes confidence to have somebody
 B.S. difference
 feel lonely, sad wasn't well
 upset me more
 should be someone there who can tell you trust

Traditional
herbal
remedies

605 had my own little one so I am experienced. It really helpful for them when I should feed
606 baby, what to give her, if her stomach upset what I can give her. Because in Pakistan
607 when she constipation, my mum told me a little bit of fennel seed for few days and that
608 was really helpful and because you can't give any medicine and that makes a difference
609 for her and there is another seed, you know like garam masala and cinnamon is really
610 good.

611

612 **Interviewer (108):** To help with her constipation?

613 **Participant (108):** No she was chest infection, and I was really worried maybe she get
614 asthma and I give her cinnamon water and that was really good for her and these little
615 things you know make a difference, if your well informed you know, I can give her this.

616

617 **Interviewer (109):** Is there anything else you would like to add, because you have given
618 me fantastic interview about your experience?

619 **Participant (109):** No there isn't anything else I can tell you.

620

621 **Interviewer (110):** Thank you very much T..... thank you.

helpful

when I should

feed what I can

give her for

constipation it

make a difference

really worried

little things

well informed

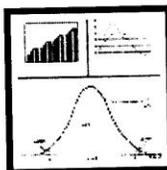
Level One Codes – Ordinate Codes

- 1) Difficult
- 2) Nightmare
- 3) Chila
- 4) Hard
- 4) Stressed
- 6) PND
- 7) Breastfeeding
- 8) Missing
- 9) Worried
- 10) Emotional
- 11) Very, Very Hard
- 12) No Support
- 13) Feel Lonely
- 14) Mixed
- 15) Very Tough
- 16) On my Own
- 17) Need Somebody
- 18) Need Someone
- 19) Want somebody's Presence
- 20) Security
- 21) Scared
- 22) Something Missing
- 23) Depression
- 24) Physically Tired
- 25) Insecure Feeling
- 26) Suffered
- 27) Little Things
- 28) Share Everything
- 29) Uncomfortable
- 30) Feel Bad
- 31) Pressure
- 32) Need Someone
- 33) Strange Thing
- 34) Can't leave Baby
- 35) Difference
- 36) Cannot Trust
- 37) Neglect Self
- 38) Feel Ugly, Fat, and Big
- 39) Delivery System
- 40) Lack of advice on how to care for baby
- 41) Upset
- 42) Respectful
- 43) Culture
- 44) Generation
- 45) Balance
- 46) Important
- 47) Want Parents
- 48) Words
- 49) Courage
- 50) Always Gives

- 51) Teaches
- 52) Positive
- 53) Want to Pass it on
- 54) Qualities
- 55) Stands by me
- 56) Needed
- 57) Knowledge
- 58) Miserable
- 59) Something Special
- 60) Big Problem
- 61) No Experience
- 62) Understands
- 63) Lucky
- 64) Learn
- 65) Afraid
- 66) Purpose
- 67) Family
- 68) Traditions
- 69) Weeping
- 70) Appreciate

Level Two – Super Ordinate Codes/First Level Themes

- 1) Support from Mother
- 2) Without Support
- 3) Mother-in-laws Role
- 4) Conflicting Advice from Health Visitors
- 5) On the Ward Experiences
- 6) Experience of Midwife
- 7) Staff Support
- 8) Depression
- 9) Physical Impact
- 10) Cultural Differences
- 11) Relationship with Husband
- 12) Alone/Loneliness
- 13) Experience of Becoming a Mother
- 14) Concerns After the Baby is born
- 15) Mother's Role is to teach you
- 16) Sense of ease with own Mother
- 17) Practical Support
- 18) Body Image
- 19) The heart of Motherhood
- 20) Importance of Friendship



Clinical Development Unit

STATUS OF RESEARCH PROJECT

Date: April 2010
 Project Title: Motherhood and the Absence of Material Support: An Exploration Amongst Second Generation Asian Women
 Chief Investigator: Mrs Anita Sattar-Jenkins
 MREC: 08/H0505/209

Please tick the box below that which best describes the stage this study is at:

- Planning
- Data Collection (Recruiting)
- Analysis
- Preparing Report
- Report Complete (Copy enclosed):

	BERKSHIRE EAST: Windsor Ascot & Maidenhead, Slough, Bracknell Forest	BERKSHIRE WEST: Reading, Newbury & Community, Wokingham
Number of Patients Recruited into Study:	I recruited and interviewed 10 women for my research. I am in the process of writing my dissertation, hence preparing the report.	
Number of Staff Recruited into Study:	None	

October 2009-March 2010