UNDERSTANDING MATERNAL DEPRESSION: ILLNESS NARRATIVES, IMPACTS AND TREATMENT SEEKING BEHAVIOUR IN ISLAMABAD

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CERTIFICATE

This is to certify that this thesis entitled: **"Understanding Maternal Depression: Illness Narratives, Impacts and Treatment Seeking Behaviour in Islamabad"** submitted by **Rabab Sakina** is accepted in its present form by the PIDE School of Social Sciences, Pakistan Institute of Development Economics (PIDE), Islamabad as satisfying the requirements for partial fulfillment of the degree in Master of Philosophy in Development Studies.

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Author's Declaration

I Rabab Sakina hereby state that my PhD thesis titled Understanding Maternal Depression: Illness Narratives, Impacts and Treatment Seeking Behaviour in Islamabad is my own work and has not been submitted previously by me for taking any degree from Pakistan Institute of Development Economics or anywhere else in the country/world.

At any time if my statement is found to be incorrect even after my Graduation the university has the right to withdraw my MPhil. degree.

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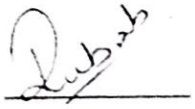

Rabab Sakina

Dedication

I dedicate this thesis to all those mothers who have suffered knowingly and unknowingly. This thesis is also dedicated to all those who have been struggling with distorted mental health, unable to express or seek help; they are the most courageous to face the world every single day.

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ABSTRACT

This study explores the perceptions and experiences of women regarding maternal depression, the response posited by these women and their families towards the label of being "maternally depressed," and the health seeking behaviours adopted by these women in order to cope with the illness. It documents the lay interpretations of the community women that have been diagnosed using Leventhal's Common Sense Model of Illness, and also argues that the sociocultural lens of patients plays a significant role in the perception and expression of their experiences regarding the illness as well as their health care seeking behaviour. This study was conducted in a primary and a secondary health facility of district Rawalpindi. The study sample comprises of women diagnosed with maternal depression (n=12) that have been registered in the respective health facilities, their potential family members (n=3), the LHVs that have taken a part in the registration of the women (n=3), and the physicians that have dealt with patients of maternal depression (n=3).

This study is the first of its kind in Pakistan with the application of Leventhal's Common Sense Model of Illness, and can be extended at a broader level in order to understand the lay interpretations and illness perspectives of the mothers struggling with maternal depression in order to address their needs by drafting tailor-made policies and mechanisms for prevention and treatment of maternal depression.

Key words: Depression, maternal depression, illness narratives, Common Sense Model of Illness, sociocultural perspectives

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LIST OF ABBREVIATIONS

CSM	Common Sense Model
EPDS	Edinburgh Postnatal Depression Scale
GAD-7	General Anxiety Disorder - 7
LHV	Lady Health Visitor
LHW	Lady Health Worker
MNCH	Mother, Neonatal and Child Health
PHQ-9	Patient Health Questionnaire - 9
RHC	Rural Health Centre
IRMNCH	Integrated Reproductive, Maternal, Newborn and Child Health
THQ	Tehsil Headquarter

CHAPTER 1

INTRODUCTION

Depression has the highest rate among all the psychological disorders out of the non-communicable diseases. It is considered being one of the prime causes of disease burden in high and middle-income states by 2030 (Rodda, Walker, & Carter, 2011). Millions of people along with their families face the devastating effects of depression (Hammen, 2009), but only 25% are able to receive the necessary and appropriate care. (AS, R, CD, & KB, 2001). It is usually associated with varying root causes such as unwanted pregnancies, difficulties during school life, abusive family relationships, sexual violence etc. Although depression varies with person to person, and has, somehow, heterogeneous manifestations, it commonly falls in the perspective of diathesis-stress, which means that the triggering point of depression is usually a stressful or a chronic situation (Hammen, 2009). Despite the fact that it is pervasive, its presence is not easily recognized. This can eventually lead to distressing, and at times, devastating effects on the patients (Miller, 1967). However, depression as a psychological disorder often co-morbid with other diseases of its kind, mainly anxiety disorders; it is rarely a standalone disease (Kessler, Chiu, Demler, & Walters, 2005).

Maternal Depression encompasses the wide range of disorders that mothers are prone to during their gestational period, and up to twelve months during the postpartum period. Postpartum depression is one of the conditions that come under maternal depression along with the other conditions including prenatal depression and postpartum psychosis. Postpartum depression is widely recognised as a global public health issue that has a significant impact on the lives of women, their children, and families. Its symptoms are similar to those of baby blues, but the period is minimum of two weeks and can last up to a year. Depression that goes undiagnosed during pregnancy might lead to postpartum depression. Changes in appetite, anxiety, sleeplessness or hyperinsomnia, and physical symptoms such as chest discomfort and headaches are all signs of this illness (NIHCM, 2010).

The prevalence rate of maternal depression in Asian countries ranges from 3.5% to 63.3% (Klainin & Arthur, 2009). Among the Asian countries, Pakistan holds the highest prevalence rate of postpartum depression i.e., 28%-63% (Gulamani, Shaikh, & Chagani, 2013). Relevant literature shows that prevalence of postpartum depression is one of the greatest burdens being faced by the developing states (Mayberry, Horowitz, & Declercq, 2007). Research also shows that the prevalence is comparatively double from being equal in the developing states as compared to the developed ones (Husain et al., 2006). However, the dilemma in the context of Pakistan is that above half of the cases of maternal depression remain unrecognized (Emmanuel, Mazhar, & Shahid, 2011). The consequences of maternal depression, especially postpartum depression, affect not only the mothers, but also their family and children, which in severe cases may lead to child infanticide, and also maternal death by committing suicide. Despite the availability of various treatment options, not all the women suffering from maternal depression are assessed and seek the recommended care (Almond, 2009). Henceforth, highlighting the existence of maternal depression, as well as its stigma and care seeking behaviour is very important.

The focus of analysis of the research will be the women residing in the research locales and sub-locales who have been diagnosed with maternal depression. The research tends to explore the experiences of women, their healthcare seeking behaviour, the barriers, and the role of family in it, as well as the role of socio-cultural system in the whole episode of maternal depression.

1.1. Statement of the problem

Mental health is an emerging global issue with significant impacts on health of people around the globe. Various mental disorders are in their preliminary phases of recognition. Maternal Depression encompasses an array of disorders that women are prone to during their gestational period, and up to twelve months during the postpartum period. Existing literature shows that a lot of work has been done on the diagnosis, assessment and treatment of maternal depression; different types of maternal depression are defined along with their risk factors; and a detailed study has been conducted on economic and social barriers to its treatment, and interventions have also been done. Unfortunately, the assumed hosts for the study have mostly been the developed states, and there are only a

few traces of research and interventions in low and middle-income countries, specifically Pakistan. A complete recognition of maternal depression as a health problem, that needs to be attended, is yet a milestone to be achieved in Pakistan, where the maternal mortality rate is 186 deaths per 100,000 live births as per 2020 (Pakistan, 2020).

This study is a socio-cultural perspective of maternal depression, how the patients and their families perceive it, how they accept the label if they do, and what are the different treatment seeking behaviours that they adopt and why. This will help the public health practitioners understand the lay perception of maternal depression and the limitations in adhering to the treatment

1.2. Research Problem

Based on the narrative, the problem has been narrowed down into the topic of this research, "Understanding Maternal Depression: Illness Narratives, Impacts, and Treatment Seeking Behaviour," and operationalized it into following research questions and objectives:

1.3. Research Objectives

The research questions stated and discussed below have generated the following research objectives:

- **To document the experiences of women during maternal depression**

This objective will help bringing to light, the experiences and perceptions of women going/have gone through maternal depression in local expressions. For this, interviews were conducted with the registered mothers in the selected mental health facilities.

- **To explore the perceptions and attitudes of the mother(s) and family(s) towards the label**

This objective is quite significant as it will focus on limelighting the stigma towards mental illness, specifically in rural communities (if it exists), and the impact of the stigma on the healthcare of women and if it results in social suffering. For this, interviews were conducted with the patients, their families and the respective LHVs/LHWs operational in the locale.

- **To document their health care seeking behaviour and the role of their family(s) in it**

This objective explores the health care seeking behaviour and the role of family in it as it is quite significant in case of the rural and semi-urban areas of a developing states like Pakistan, where extended family structure is deeply rooted within the cultural setting, and potential family members play an important role in the decision-making behaviour of the household.

1.4. Research Questions

This research responds to the following research questions:

- **How do the patients of maternal depression perceive and describe their illness and experiences?**

Many women in developing states are unable to recognise the symptoms of maternal depression due to lack of awareness. Therefore, this question assesses how these women perceive and describe their experience(s) of maternal depression in socio-cultural context. Incorporating these views in the primary and secondary health management system also improves the chances of diagnosis of maternal depression in these areas. The data in response to this question was extracted from the registered patients of maternal depression in the specified research locale(s), selected through random sampling.

- **How do the patient(s) and her family(s) respond to the label?**

Acceptance of the label after diagnosis is a challenge as mental health is not a mainstream concept, specifically in the society(s) and culture(s) of developing states due to the lack of awareness. Hence, people often find it hard to accept the fact that they are facing any sort of mental issue and need to seek psychiatric care for it due to the stigma attached to the concept. Therefore, exploring this aspect plays an integral part in reducing the stigma, promoting the awareness, and enhancing the treatment seeking behaviour and its follow-up. Data for this question was extracted through semi-structured interviews conducted from the registered patients and their potential family members (e.g., parents, parents-in-law, husband etc.).

- **What health care seeking behaviour(s) do they adopt, and what is the role of their family(s) in it?**

The culture and society of Pakistan holds the concept of extended family(s), especially in the rural and semi-urban areas, where mostly people residing belong to the low-middle income or low income economic strata, and require family support in various ways. Therefore, families, specifically the potential family members play a significant role in the decision-making process(s). Therefore, this research question explores the type of health care seeking behaviour that the women of these areas adopt, the socio-economic barriers they might face in seeking treatment or following-up, the alternative/parallel treatments and coping mechanisms they adopt, and what role does their family play in it. This can help in improving the medical treatment seeking behaviour and increased visits of patients of maternal depression to the respective health facility(s) in the future.

1.5. Explanation of the key concepts

The following concepts are the key concepts as the objectives of the study tend to revolve around these concepts. As the study is focused on explaining the perceptions and experiences of women while suffering from maternal depression, which is the type of depression experienced during and after the gestational period, 'depression,' 'maternal depression' and 'postpartum depression' are considered as the key concepts. Furthermore, the study also tends to explore the response towards the label and the healthcare seeking behaviour as well as the role of family in it. Hence, 'stigma towards mental illness' tends to be another key concept of the study as it paves way for the type of healthcare opted by the patient and her family.

Depression: According to American Psychological Association, depression is defined as a negative affective state that ranges from feeling discontent and unhappy to extremely sad, pessimist and despondent, which interferes with daily activities. Various cognitive, physical and social changes may also occur that may result in to altered sleeping and eating habits, difficulty in concentration and making decisions, lack of motivation or energy, and withdrawing or avoiding social activities (APA Dictionary of Psychology, n.d.). This definition is applicable on this study as it posits a holistic perspective of depression, and can help in explaining not only the physical, but also the cognitive and social changes.

Maternal Depression: The NIHCM Foundation describes Maternal Depression as an all-encompassing term for a range of depressive conditions that may be experienced by mothers during their gestational period as well as during the postpartum period. These conditions comprise of prenatal/prepartum depression, baby blues, postnatal/postpartum depression and postpartum psychosis (NIHCM, 2010). The researcher will be documenting the experiences of women in all the above-mentioned conditions, but an emphasis will be placed on the experiences of women with postpartum depression.

Postpartum Depression: The NIHCM Foundation defines Postpartum Depression as an affective mood disorder. It is marked by symptoms similar to those of baby blues; however, it differentiates on the basis of the duration as it extends a time period of two to three weeks (unlike baby blues that lasts two to three weeks postpartum). Postpartum depression comprises of a spectrum of symptoms including frequent crying, persistent sadness, indecisiveness or poor concentration, memory loss, feeling of inadequacy and worthlessness, irritability, loss of interest in taking care of one's self, not being able to do everyday tasks, fatigue, insomnia or hyperinsomnia, change in appetite, anxiety, obsessive thoughts e.g. harming the baby, somatic symptoms (chest pains, headaches, numbness, heart palpitations and hyperventilation), lack of interest in the surrounding (environment, baby, family etc.), poor bonding with the baby, loss of pleasure in various activities (including sex), recurrent thoughts of suicide or death. Patients of maternal depression must be marked with at least five of the abovementioned symptoms (NIHCM, 2010). This definition can be easily operationalized for this study as it is quite comprehensive and provides an in-depth explanation of the symptoms that might be experienced during postpartum depression.

Stigma towards mental illness: Patrick Corrigan (2004), a Professor of mental illness, describes public stigma towards mental illness to occur when the general population accepts and endorses stereotypes, and start discriminating against people who are mentally ill. This results in impacts on care seeking as people tend to avoid the label by not interacting with mental health providers or going to the clinics, as to escape the unfair treatment and loss of opportunity(s) that the stigmatized labels pave way to. This definition can be quite useful for the study in the context of this study as it tends to

investigate the care seeking behaviour of mothers with maternal depression, the role of their families in it, and the issues they face (social stigma, economic barriers etc.).

1.6. Units of data collection

Units of data collection are all the sources from which the data is collected in the research e.g., person, group, media, books, objects or any other entity from which the researcher intends to draw data for analysis.

Patients and their Families: Data was collected from the female patients registered in the health facilities that are a part of the research locale, and their relevant family members who were the stakeholders in their health decision making i.e., mothers-in-law through semi-structured interviews. They brought the relevant information in order to explore the whole episode of maternal depression, as well as the role of the family towards the label, as well as healthcare seeking behaviour.

Physicians/Psychiatrists/Therapists: Data was also extracted from the physicians who have worked and dealt with such patients as part of the relevant interventions carried out by non-governmental organizations. They were included in the UDCs as they were able to provide the information regarding the experiences and perceptions of the patients, the treatment seeking behaviour of the patients, and the role of the family members in the whole episode of maternal depression.

Lady Health Visitors: Lady Health Visitors (LHVs) who are working in accordance with the opted health facilities, and are in contact with the registered patients and their families were also included in the units of data collection as they are in a close contact with the patients and their families, and played a significant role in the Maternal and Neonatal Child Health (MNCH) Program. Therefore, they brought a valuable insight of the first-hand experiences of the women dealing with maternal depression, the response and decision-making behaviour in terms of treatment within the family structure of the patients, and the factors that act as barriers in seeking medical treatment or following-up.

Data Inventory: Data was also collected from the inventory(s) of the associated non-governmental organization that has operated the maternal mental health intervention in the research locale. From this, relevant women were selected that were registered as patients, and contacted to become the participants for the study.

1.7. Organization of the thesis:

The thesis has been divided into seven chapters. Chapter 1 provides an introduction to the topic, its key terms, research problem, objectives, research questions, and units of data collection. Chapter 2 consists of review of relevant literature and the proposed theoretical framework. In the light of the existing literature, it also sheds light on the research gap and significance of this research. Chapter 3 comprehensively describes the research methodology used for the research. Chapter 4 is based on the main findings as per the objectives of the research. Chapter 5 incorporates a comprehensive discussion of the findings in relation to similar findings in the existing literature while keeping in view the theoretical framework. Chapter 6 presents the implications of the research with respect to policy making, and Chapter 7 concludes the thesis.

CHAPTER 2
REVIEW OF LITERATURE

I have arranged my review of literature under different themes which have been extracted from the literature reviewed for the current research.

2.1. Women's Mental Health: Depression and Anxiety

Ratios of certain disorders like major depressive disorder, post-traumatic stress disorder, anxiety disorder, eating disorders and seasonal affective disorder are relatively greater in women as compared to men (Nakamura, 2005). Due to different biological profile of hormones, women are more prone to having depression, relapse, the course of disorders and their recovery (Schreiber, 1996; Mental health, 1999; Nakamura, 2005). Similarly, a relatively higher vulnerability to depression is posed by women in variant period of reproductive endocrine i.e., premenstrual, perimenopausal and postpartum periods (Nakamura, 2005). With the increasing age, the risk of depression and anxiety increases in women (Mental health, 1999). One of the major risk factors for a future depressive episode is having experienced it in the past. With increasing episodes, the risks of severity of disability, chronicity and suicide increase. Therefore, such women become progressively weaker (Alexander, 2007). However, if a comprehensive and a consistent plan of dietary and lifestyle changes is drafted and followed along with alternative and complementary treatments such as spiritual therapy and acupuncture may result into a more in-depth and a sustainable recovery (Kim & Bowers, 2007; Meyer & Taylor, 2008). It is found that the most frequently occurring mental disorders i.e., anxiety disorders, are diagnosed twice in women as compared to men, and is categorized in panic disorder, generalized anxiety disorder, social phobia, specific phobia, agoraphobia, acute-distress disorder, obsessive-compulsive disorder and post-traumatic stress disorder (Mental health, 1999). Its treatment is similar to that of depression, and comprises of the combination of psychotherapy and medications. The recovery process can be expedited and improved in this case as well, if the treatment is complemented with dietary and lifestyle changes (Zender & Olshansky, 2009). Literature also reveals that the behavioral and emotional disturbances arise in the lives of the youth and young women due to mood disorders, affecting their academic, social and interpersonal functioning. There are high rates of

future depressive symptoms in cases that remain undiagnosed. Boys and girls both have an equal tendency of developing depressive disorders during childhood; however, chances of girls are twice as compared to their counterparts to have experienced major depressive disorder by the age of 15 (Lack & Green, 2009).

2.2. Maternal Depression in Women:

Women are also prone to ante-, peri-, and postpartum depression, where 51% of the general population of pregnant women experience increased rates of depression during their last two trimesters (Bowen & Muhajarine, 2006). In their life cycle, women are most likely to show depressive symptoms during the postpartum period. Such women are highly likely to experience depression 4 years following the postpartum depression as compared to those who did not have postpartum depression. Therefore, postpartum depression is considered as one of the most common complications of childbirth after the delivery (Mann, et al., 2008). It may pose serious effects on the emotional and physical health of the mother, the offspring, and the family members (Tezel & Gözüm, 2006; Mann, et al., 2008). Inculcating awareness in people regarding the presence of anxiety and depression in women, their comorbidity with various other physical and psychological disorders, coping mechanisms of women in terms of self-management, and treatment seeking behaviour including medical assessment, medical treatment and alternative and complementary treatment, may produce favourable outcomes as it may result in education, timely detection, and intervention, as well as a reduction in stigma and suffering in women (Zender & Olshansky, 2009).

2.3. Women's Disempowerment during Maternal Depression

Various studies have been conducted, addressing the gender gap in mental health while the ratio of women experiencing mood disorders and anxiety is relatively higher worldwide (Pigott, 1999). However, no prior studies have addressed the role of women's disempowerment, particularly in South Asia (Yount, et al., 2014). A study was conducted in order to explore the anxiety and autonomy experienced by the pregnant women of Pakistan during that critical and vulnerable period. The results of the study showed that the women in the region faced multiple barriers for speaking up e.g., hesitance, upsetting one's mother-in-law, fear of developing an argument with the husband etc.; had a larger responsibility to take care of their husband's and family's diet rather their own; had to

face many restrictions barring them from availing prenatal care e.g., they were not allowed to go anywhere alone, neither could they visit any health facility more often as the husbands were not capable of or willing to bare such expenses; and felt hesitant in sharing their symptoms and experiences even with their peers, in fear of being judged or mocked. It also highlighted the relationship of the women with the doctor. While some had a good experience and viewed their healthcare providers as potential mitigators, the medical encounters of most of the women actually exacerbated their anxiety due to being treated rudely or insulted, or by being denied care arbitrarily by being made to rush or bounce between different areas of the healthcare facility. 'Gender norms' was found to be another source of anxiety for the pregnant women as there was a perceivable biasness and a preference towards male children, and women who bore their counterparts were not considered significant socially and culturally (Rowther, et al., 2020).

2.4. Identities and Experiences of Women during Maternal Depression

Literature also highlights the first-hand experiences of women experiencing postpartum depression (PPD) that include 1) practical life concerns; 2) crushed maternal role expectations; 3) going into hiding; 4) loss of sense of self; and 5) intense feelings of vulnerability (Mollard, 2014).

Many studies have been conducted on the existence of postnatal depression. However, less focus has been placed on its cross-cultural comparative prevalence, psychosocial origins and consequences. Therefore, a study was conducted to clearly identify whether postnatal depression is experienced universally with mutual expressions and attributions across cultures and nations, or is it only a Western concept. It tended to explore the understanding, beliefs and views of the respondents about the factors leading to happiness or unhappiness during the gestational period and after the childbirth; understanding and causes of maternal depression in their perception; ways through this issue can be addressed in their opinion, and suggestions for improving the healthcare. The data was analysed into themes depicting the findings of the study i.e., common themes to the contributors of happiness and unhappiness, relationship with the baby, morbid unhappiness (postnatal depression), and themes from health professionals (Oates, et al., 2004).

Research explores, how in the context of PPD and poverty symptoms, do women from low-income groups negotiate their symptoms of maternal identity. In this context, this qualitative study also focused on how these women deal with stigmatization and negotiate their alternate meanings of the maternal identity. While using the constructivist grounded theory, the researchers conducted focused group discussions besides individual interviews with community key informants, service providers and women with symptoms of PPD, in order to address the barriers faced by low-income women with PPD in help seeking. The analysis of the data resulted in three main findings: 1) "Threats to idealized mothering" that illustrated ways in which women described their mothering relation with respect to their depressive symptoms, the issue of economic insecurity and poverty, the dominant discourse in relation to intensive motherhood, and stigmatized themselves as "bad mothers" during their postpartum experience; 2) "Asserting positive maternal identities," that suggests that these women developed alternative discourse(s) of "good mothering" in order to counter the effect of stigmatization; and 3) "Negotiation strategies," where women verified their state of conflicting states of self (Abrams & Curran, 2011).

Another research was conducted in Melbourne, Victoria, Australia that focuses on exploring the missing voices, perceptions and experiences of women going through postnatal depression (Buultjens & Liamputtong, 2007). While women's experiences of childbirth and the postnatal period has been pathologised and medicalised by medical sciences (Littlewood & McHugh, 1997), it has certain limitations to its coverage, and fails to address the cultural and social constraints of motherhood (Buultjens & Liamputtong, 2007). Hence, the physical and emotional exhaustion experienced by the mothers during motherhood is not considered by the medical models (Rossiter, 1988). Mostly studies currently conducted relevant to postnatal depression are, therefore, quantitative (Small et al., 2003; Lumley et al., 2004; Dennis et al., 2004). However, quantitative studies are more focused on discovering the truth, rather digging out and lime lighting the actual experiences of the women. Therefore, this study focused on finding out and conveying women's accounts of expectations regarding childbirth, as well as the depression that followed it. As the social context of the women plays a significant role in determining the symptoms of depression and their experiences, this

study also identifies that the cultural and social factors have a potential contribution in postnatal depression and motherhood. The data was analysed later through thematic analysis which generated the following themes: 1) “Becoming a mother: what to expect?” that described the expectations of women regarding the childbirth. The data included positive, negative, and mixed responses; 2) “The birth of the baby: the experience of hospital stay.” It included happy and unhappy or dissatisfied experiences of women that also varied on the basis of the number of their individual experiences (e.g. first child, second child.…). There were many factors that determined these experiences e.g. health issues post-delivery, hospital and staff management etc; 3) “Perceptions of causes and experiences of postnatal depression,” comprised of many risk factors that, according to the women, were factors of causation of their depression. These risk factors included their disturbed relationship with their partner and mother, unsettled babies, lack of sleep, lack of self-esteem and confidence, unwanted pregnancy, and effortful simple day-to-day activities; and 4) “Women’s perceived social support” was a depiction of lack of social support (physical and emotional assistance) to some extent by the respective partners and family members (Buultjens & Liamputtong, 2007).

In another study, the researchers tend to understand and develop a theoretical model in order to understand the experiences of the women going through post-partum depression and their families. The study used Grounded Theory as a methodological approach, while Symbolic Interactionism was used as a theoretical referential. 10 women were selected as respondents who were medically and psychologically diagnosed and confirmed as patients of postpartum depression. Apart from them, 10 family members were also selected, one in the case of each patient, who accompanied them at the time of the onset of depression. These respondents were recruited from health care units and public hospitals in Cuiaba-MT, Brazil. Through this study, the understanding of the meanings and experiences of maternal postpartum depression for the women and their family members was developed as a psychosocial process. Support and control were the potential symbolic elements in determining the experience of women and their family members from the onset of the symptoms of postpartum depression to diagnosis and treatment seeking. The model generated three categories with further subcategories that are a depiction of the experiences of women and their family members, and their way of

adaptation to the family life while dealing with the consequences of postpartum depression. The first category, “Struggling with maternity,” sheds light on the initial stages of the model that comprises of the condition of the woman dealing with the experience of being a new mother, and showing feelings of fear and frustration in inability of performing simple tasks to address the needs of the neonatal. In such cases where simple management of the child gets out of control, the family intervenes, without knowing the reason behind this, and tries to support the mother and normalize her reactions while cooperating with her. It also involves the anxiety and emotional imbalance that develops in the mother when she has to struggle with the crying child, as well as struggling with breastfeeding. The second stage of the theoretical model is described in the second category, “Getting lost in the middle of feeling in the fight with the unknown,” in which the woman starts feeling depressive symptoms in the form of unfamiliar and strange feelings. Her functioning as a mother varies, and the situation is getting more severe and less controllable. In this phase, the family has an important role and responsibility of supporting her in keeping up with the child’s care. However, the woman feels a sense of loneliness due to the difficulty of expressing her fears and families towards her family. Such events lead her to lose her connection with the people around, and develop a feeling of loneliness. Later, the woman gets trapped in depression to the extent where she loses control of herself and abandons herself. The third category depicts the last stage of the model i.e. “Taking control.” This is identified by the woman’s struggles to take back the control of her life again. This stage is marked by the diagnosis of PPD and treatment seeking by the woman. The family is deeply integrated in this phase, protecting and supporting the woman and managing those situations for her that she is unable to manage. With such situations controlled, the woman develops a greater hope for being recovered. The family supports the treatment while perceiving it as a means of improving the quality of life of the woman and the family on a whole. After being enlightened about her psycho-emotional condition through media and other relevant sources, she gets motivated to seek expert’s advice and help to reliever her sufferings. She may also seek other possible alternatives e.g., spiritual help. Eventually, she tries to develop a good motherhood as she gets better and has thoughts about her condition and attitude towards the child during depression (Barbosa & Ângelo, 2016).

2.5. Research Gap

In light of the literature review, the researcher will tend to cover the areas in this study that have not been comprehensively discussed before. Although the role socio-cultural impacts of the environment on the women have been discussed, the researcher will explore this aspect specifically with respect to the women experiencing maternal depression in semi-urban areas. Similarly, the understanding of women about their condition, realization of help seeking, as well as the role of family and other social, cultural or economic issues in managing the treatment seeking behaviour has also been limitedly explored. This study tends to explain these domains comprehensively, with respect to women in the semi-urban context.

2.6. Theoretical/ Conceptual Framework:

The conceptual or theoretical framework for this study has been adopted from the contributions of Howard Leventhal who is an American psychologist and works in the fields of health psychology and clinical psychology. Leventhal's Common Sense Model (CSM) tells how people respond to their respective illnesses (French & Weinman, 2008). This model suggests that the perceptions of people regarding their illnesses directly influence their coping strategies/mechanisms, and eventually the outcomes (Brownlee, Leventhal, & Leventhal, 2000). Illness perceptions may be regarded as the lay interpretations of the patient(s) regarding their illness and its experience (Leventhal, Meyer, & Nerenz, 1980). 5 main cognitive domains are covered by this model; Identity (symptoms and labels), timeline, consequences, cause and perceived cure and controllability.

Identity (symptoms and labels): This domain has brought the first-hand experiences, symptoms and perceptions of the women regarding maternal depression, and also helps in explaining how they identify or label these experiences or condition. The data for this domain was collected through interviews that used an interview guide based on the Common Sense Model.

Cause: This domain intends to focus on the underlying reasons that might have resulted in the disease in the perception of the patient. This shed light on the reasons and risk factors of maternal depression in view of the patients, and the treatment that they seek in response.

Consequences: This domain of the model focuses on the impacts of maternal depression on the lives of the patients, and those around them. This also helped in operationalizing the first objective of the study that intends to document the experience of maternal depression for the women.

Timeline: This domain provides an insight regarding the perceptions of the patients regarding the timeline of the disease, if it's curable or lifelong. It also helps in explaining their treatment seeking behaviour.

Perceived Controllability: This domain of the model comprises of beliefs and perceptions regarding different efforts or measures that should be to gain control as well as the perceived ability in order to achieve control by adopting those measures. Hence, through this domain, data was collected as well as explained regarding the type of coping mechanisms or the treatment that the patients seek, as well as its impacts on their condition.

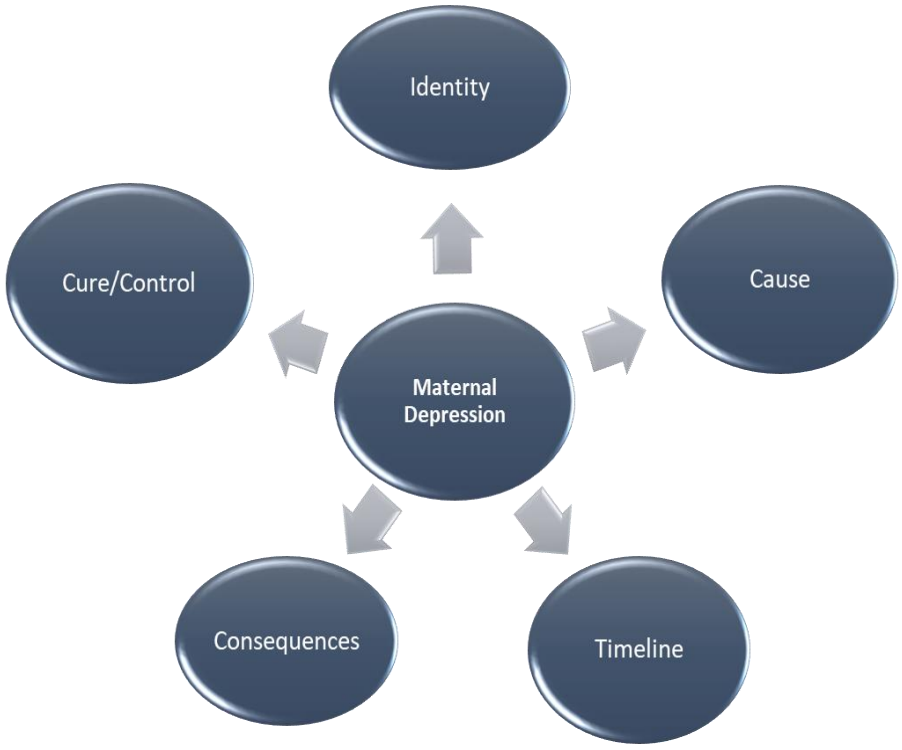

Fig 2.1. Common Sense Model of Maternal Depression

2.6. Conclusion/ Significance of Research

Although the government has taken an initiative to address the health and well-being issues of mothers and their children through Mother, Neonatal and Child Health Programme, mental health is one of the issues that remains unexplored, specifically in the mothers in rural and semi-urban areas, since there is a lack of research and awareness in this domain. This does not only have implications on the well-being of the mothers, but also their families and children since mothers play a significant role, and have a huge impact over the other members of the household in Pakistan. Therefore, this study will be a contribution to the government in revisiting and redesigning their initiatives in order to reform mother and child health, while incorporating the aspect of mental well-being in its socio-cultural context, so that it can be addressed on local and national level.

CHAPTER 3
RESEARCH METHODOLOGY

3.1. Introduction

Research methodology is a systematic way of carrying out the research. The procedures and the methods that the researcher use as a work plan for predicting, describing and explaining phenomena are called the methodology of the research. Typically, it comprises of concepts such as theoretical model, phases, paradigm, and quantitative or qualitative techniques.

3.2. Research Strategy

This study is qualitative as it focuses on the experiences and the journey of women through maternal depression in words, rather than quantifying the data while its collection and analysis. The researcher attempted to gain an interpretive understanding of the experiences and response of women and their family(s) towards maternal depression. The study was based on the inductive approach for generating new findings about the experiences of women during maternal depression and their perceptions about it, their response towards the label, their treatment seeking behaviour and the role of their family in it, and the impact of their condition on their children.

3.3. Research Design

Research design for any empirical research is its ‘blueprint’ that aims at testing specific hypotheses or answering specific research questions. The research design of this study was explanatory as it helped in further explaining the experiences and illness narratives of women with maternal depression in the developing areas, and the whole episode of their illness.

3.4. Methods of Data Collection

Data was collected through narrative and semi-structured interviews. Separate interview guides were constructed for the patients/families/therapists and the lady health workers/visitors in order to draft an outline regarding the essential data to be collected. However, it was kept open-ended to keep space for probing.

3.4.1. Rapport building:

Rapport building is a simple technique to get access to a community or an area that is being investigated as part of a study. Depression, particularly maternal depression, is a sensitive subject. Women who have gone through it or are still going through it may find it difficult to share their experiences with others. They are highly selective in who they confide in and open up to as they want to trust those individuals with the situation they are in, and expect them to understand. As a result, rapport building has shown to be a useful method in gaining the trust of such respondents. Support from the associated non-governmental organisation that has operated in the different health institutions in collaboration with the Punjab Government was gained to develop rapport in this study. Through manuals and activities, the associated non-governmental organisation trained health professionals in the respective study areas during a six weeks project, screened (translated version of PHQ-9[1] and GAD-7[2] attached as Appendix A), treated and referred mothers and their children as needed, and also raised awareness about mother and child health among service providers and care seekers. Since the LHVs from the respective health facilities had interacted with the implementing NGO, they granted the researcher access to information as per referral, and were employed as key informants at both the health facilities. They introduced the researcher to the respective functioning LHWs, who had been in contact with the mothers suffering from maternal depression and had acted as the medium for connecting them with the Rural Health Centre (RHC) and Tehsil Headquarter Hospital (THQ) to get them registered as patients and get them treated. As a result, these LHWs assisted in bringing the diagnosed mothers to the respective health facilities, and also introduced the researcher to them in order to melt the ice and a smooth start to the interview. These women were close to the LHW(s) and locally referred them as 'baaji.' Henceforth, I informed them that it was only a research in which I was attempting to explore and understand the cultural beliefs regarding Maternal Depression in the hope of assisting other women in the future in identifying and understanding their experiences and seeking appropriate care. With the support of the LHWs, I was able to persuade them to speak to me and participate in my study. The LHWs also helped the

[1] A questionnaire based on 9 questions used to screen patients for the presence and severity of depression
[2] A questionnaire based on 7 questions used to screen patients for the presence and severity of anxiety

mothers in communicating more easily and comprehensively by adding points about their condition while they explained it.

3.4.2. Ethical Consideration:

The intervention conducted by the associated NGO was registered with the National Bioethics Committee after ensuring minimal risks and the participants were recruited after gaining verbal consent. For this study, these women were not contacted directly, rather through a credible medium i.e., the LHWs. They were interviewed after explaining the study and having gained verbal consent. In order to avoid any risks, verbal consent was also obtained before reaching out to their family for the interviews.

3.4.3. Narrative Interviews

The researcher conducted narrative interviews from the patients that have been diagnosed with maternal depression as the aim was to make these women feel significant and not mere vessels of data and epistemologically passive in order to gain an in-depth insight of the perceptions and experiences of these women regarding maternal depression in their narrative. Each interview lasted from 30 minutes to 1 hour. The duration of these interviews varied as per each respondent. Verbal consent was taken before for commencing as well as recording the interview(s). Notes were also taken in parallel. The mode of communication (English or Urdu) varied as per the nature and the socio-cultural background of the respondent(s).

3.4.4. Semi-Structured Interviews

Semi-structured interviews were used to interview the LHVs/LHWs and the relevant family members of the patient's family, keeping in view the sensitivity of the topic. An interview guide was drafted to cover the important details; however, it was kept open to probes and additional information. Each interview lasted from 30 minutes to 1 hour. The duration of these interviews varied as per each respondent. Verbal consent was taken before for commencing as well as recording the interview(s). Notes were also taken in parallel. The mode of communication (English or Urdu) varied as per the nature and the socio-cultural background of the respondent(s).

3.5. Data collection tools

Following tools were used in order to collect the data under the above-mentioned methods:

3.5.1. Interview Guide

The research tends to document the whole episode of maternal depression, for which, an interview guide was designed keeping in consideration the general framework of Leventhal's Common Sense Model (CSM). Hence, the questions were drafted keeping in view the following themes:

Identity: The symptoms that the mothers associate with the illness

Cause: What caused the illness?

Timeline: Whether the illness is temporary or permanent in the perceptions of the mother(s). How long will it last?

Consequence: What consequences does maternal depression have on the life of the patient and those around with whom the patient interacts? What is the intensity of the seriousness of illness?

Cure-Control and Perceived Controllability: The treatment being seeked, and whether it will be effective in curing the illness. Is the illness in control? What mechanisms do the patient adopts in order to control the illness?

However, different interview guides were designed for the family members and physicians/ LHWs (Attached as Appendix B)

3.6. Data Analysis

Thematic Analysis is a process that involves searching for themes that are categories identified by the analyst from the collected data. Typically, these themes relate to the research questions, and develop a theoretical understanding of the data that may lead to theoretical contribution of the literature in the research area (Bryman, 2015)

After the transcription of the data, thematic analysis was used, and the data collected was incorporated in the already available themes drafted as per the interview guide. New

themes were also added as needed for the tabulation of the relevant data. This way, it was feasible to sort findings and patients' responses in the relevant themes.

3.7. Sampling

The study used the following sampling techniques against the respective UDCs:

Registered patients: The sample of the registered patients was drawn through random sampling as the patients were randomly selected from the available directory of women diagnosed with postpartum depression. The associated NGO provided a list of patients registered in their six-week programme, and the LHVs were utilised to contact these women. In order to be interviewed, 12 patients were selected from the respective health facilities.

Families of the patients: The respective family members who used to accompany the randomly selected patients during the hospital visits and were potential stakeholders in their health decision making were selected as respondents for the study. In this study, it was found that this role was played by their mother-in-law.

LHVs: The Lady Health Visitors were selected through purposive sampling as only those workers were made part of the study who are/have been in direct/indirect contact with the patients and their families in terms of the training/treatment for maternal depression.

Physicians: The physicians were selected through purposive sampling as only those physicians were selected for the interviews that were included in the intervention that was subjected to diagnose and counsel mothers with depression.

Table 3.1: Grid for interviews conducted

Categories	Number of participants interviewed	Codes (for identification)
Registered patients (mothers)	12	M1 – M12
Family members	3	F1, F2, F3
Lady Health Visitors	3	LHV1, LHV2, LHV3
Physicians	3	P1, P2, P3

3.8. Research Locale:

The study was conducted in the relevant health facilities that were subjected to the health interventions by relevant NGOs that aimed to provide psychiatric care to the patients of maternal depression. This includes Rural Health Centre Khayaban-e-Sir Syed (a primary healthcare facility) and Tehsil Headquarter Hospital Taxila (a secondary healthcare facility) that were a part of the Maternal and Child Health integrated intervention by Association for Social Development (ASD). This included visits of LHWs to mother's homes to bring them for routine care that included assessment of mothers for nutritional status; however, as part of the intervention, their mental health was also assessed by the LHVs. After assessing the mothers for depression, anxiety and psychosis, these mothers were counselled accordingly by the LHVs who explained them the concept of "Maa'on ki zehni sehat" and oriented them on behavioral activation through the use of a flipbook and brochure (that also included images along with text) and referred them to the physician who prescribed antidepressants/ anti-psychotic drugs. Along with this, physicians from Human Development Research Foundation within the Rawalpindi district were also interviewed that were a part of the Perinatal Depression Treatment and Child Development intervention.

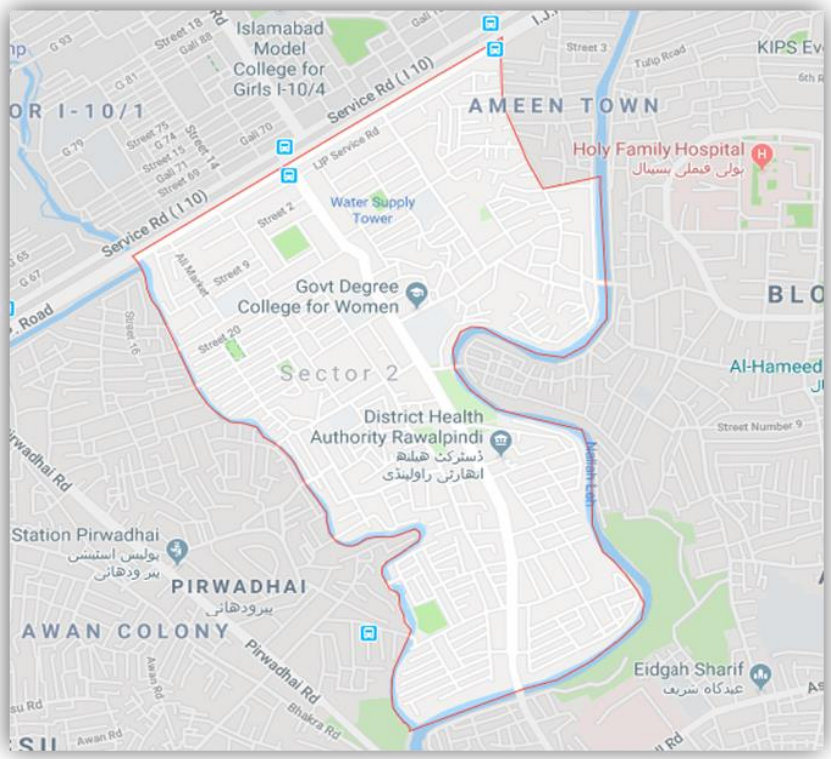

Fig. 3.1. The geographical map of Khayaban e Sir Syed, Rawalpindi

Source: Google Maps

Fig. 3.2. A visit to Rural Health Centre Khayaban e Sir Syed

Fig. 3.3. The geographical map of THQ Hospital Taxila, Rawalpindi

Source: Google Maps

Fig. 3.4. A visit to THQ Hospital, Taxila

3.9. Summary

Data was collected from the respondents and analysed as per the methodology planned. However, some respondents could not be reached as expected i.e., the families of the patients; as some of them were not willing to participate themselves, while in some cases, the mothers did not approve of involving their families in the research. Therefore, the potential family members of only three respondents were added in the study. The interviews were conducted from May 2021 to October 2021.

CHAPTER 4
FINDINGS

4.1. Introduction

This chapter comprises of the data that was collected through semi-structured in-depth interviews and narrative interviews. The data gathered was transcribed, followed by coding and extraction of themes from the collected data. Each theme is a collation of the responses provided by different responses i.e., women diagnosed with maternal depression, their family, physicians and LHVs. Significant statements from the interviews of these respondents were highlighted, and have been mentioned as verbatims in Urdu along with their translation quoted in English to add meaning to the respective themes. These verbatims can also act as means of verification for the credibility of the data collected. In order to keep the anonymity of the respondents intact as assured, pseudonyms have been used.

The findings are accompanied by summary tables with narratives against each subtheme, categorized and analyzed as micro, meso, and macro narratives. This explains how people create narratives and are shaped by them. In case of micro narratives, individual is the research focus. This focus scales up to policy players in the policy subsystem at the meso level (e.g., groups, coalitions, organizations). Similarly, the focus penetrate institutions, society, and cultural norms at the macro level (Shanahan et al., 2018).

Table 4.1: Themes and subthemes extracted from the findings

Themes	Subthemes
4.1. Perceptions regarding Maternal Depression	4.1.1. Meaning
	4.1.2. Factors associated with causation 4.1.2.1. Emotional factors 4.1.2.2. Physical factors 4.1.2.3. Social factors 4.1.2.4. Economic factors

	4.1.2.5. Cultural factors
4.2. Experiences regarding Maternal Depression	4.2.1. Physical Symptomatology
	4.2.2. Emotional Symptomatology 4.2.2.1. Effects on social and domestic activities 4.2.2.2. Perception of not being a good mother 4.2.2.3. Neglection of other children
	4.2.3. Onset of the symptoms
	4.2.4. Frequency of the symptoms
4.3. Labelling and Diagnosis	4.3.1. Screening and Diagnosis
	4.3.2. Reaction of the patient towards the label
	4.3.3. Reaction of the family towards the label
4.4. Health Seeking Behaviour and Role of Family	4.4.1. Cultural Coping Mechanisms 4.4.1.1. Religious/ Spiritual Healing 4.4.1.2. Hakeem/ Homeopathic Treatment 4.4.1.3. Other Coping Mechanisms

All of the above-mentioned themes and their sub-themes are an extract of the research objectives derived in the beginning which are as follows:

- To document the experiences of women during maternal depression
- To explore the perceptions and attitudes of the mother(s) and family(s) towards the label
- To document their health care seeking behaviour and the role of their family(s) in it

The following chapters comprise of a detailed view of the themes and their respective sub-themes.

4.2. Perceptions regarding Maternal Depression

The mothers diagnosed with maternal depression were interviewed regarding their perceptions about maternal depression, their beliefs about the illness, its causation and occurrence.

Table 4.2: Sample Characteristics of Mothers (*N* = 12)

	MOTHERS (*N* = 12)	%
Age		
Mean (SD)	**29 ± 4**	
Range	**24-37**	
Education		
Primary education	**10**	**83.2**
Secondary education	**1**	**8.4**
Tertiary education	**1**	**8.4**
Marital Status		
Single	**0**	**0**
Married	**12**	**100**
Divorced/ Separated	**0**	**0**
Family Structure		
Joint	**9**	**75**
Nuclear	**3**	**25**
No. of children		
Mean (SD)	**3 ± 1**	
Range	**2-7**	

4.2.1. Meaning of Illness (Maternal Depression):

When questioned about their understanding of maternal depression, most of the mothers could not initially define it, and could not respond. They lacked the words to express the illness specifically. Although the physicians used to counsel them following the diagnosis, some of them were still unclear about the notion of '*maa'on ki zehni sehat*;' however, they did realize that they were disturbed, and maternal depression had a

connection with it. One mother, when asked, what she understood by '*maa'on ki zehni sehat*' pointed towards her head and replied:

"Mujhe tou andaza nae tha iska. Jab doctor sahiba ne mujhe samjhaya k

mujhe ye bemari hai, mujhe us waqt bas yahi samajh aya k yahan masla hai"

Translation:

"I didn't know about this. When doctor *sahiba* said to me that

I have this, I just know that at that time I was not well in here" – M1

Few of the mothers had developed their own understanding and perspective about the notion. Although they still did not know the specific details of the condition, they were able to relate the concept of maternal depression with mind not being well due to the lack of care towards one's self, and the importance of addressing this in order to take control of the related situations. One such mother on being asked how she would define '*maa'on ki zehni sehat'* replied:

"Insan ko taaza bhala hona chahiye. Sab se zaroori

cheez hai k mind cool hona chahiye"

Translation:

"A person should stay healthy and fresh; he should definitely

have a cool mind, it's very important" – M2

Another respondent described maternal depression as the consequence of not taking care of herself. As stated by her:

"Bas apna kam he rakhti hun khayal"

Translation:

"I take less care of myself" – M5

4.2.2. Factors associated with causation

The women were inquired regarding the factors that, according to them, had caused their illness and resulted in the deterioration of their health condition. Interestingly, the mothers had developed personal narratives regarding their difficulties, and held various uncertain factors responsible for the causation of their illness. They did express the biomedical conditions that they had experienced that acted as physical evidence; however, their view towards these conditions was not clinical in most of the cases. While adopting the available discourses and explanations, they identified contextual based stressors that included emotional, physical, social, economic and cultural based factors. However, it is significant to be mentioned that besides the range of explanations that these women came up with regarding the causation of their illness, there still was a hint of uncertainty in the description of their expressions (e.g., "I think," "I assume" etc.). This uncertainty is an indication of the causal factors stemming out of their own perceptions.

4.2.2.1. Emotional factors

It was found that some mothers had experienced losing a child at least once during the past, and expressed their condition as a result of the trauma throughout their recent conception and delivery. According to them, the trauma had resulted in them a constant fear of losing another child, and this made them sad and anxious. At some point of their lives, these women had had a miscarriage or had to get a child aborted for some reason. While there is no evidence of maternal depression experienced by these mothers right after the loss of their child, it was, however, observed in the pregnancy afterwards (when they were screened and diagnosed). According to them, they had struggled for a child after losing one, and had matured with a fear of losing another one. One such mother who had previously experienced the death of three of her children stated:

"Mere teen bachay faut hogae thay tou pareshan
rehti thi k is dafa bhi aisa na ho"

Translation:

"Three of my babies had died earlier and

I was afraid that it might repeat this time" – M6

Similarly, another such mother with a history of miscarriage when inquired about having experienced depression back then replied:

"Uss time kuch arsa rahi thi aisi he halat, phir set hogae"

Translation:

"At that time, I experienced the same condition for some time, but then felt ok" – M11

One of the mothers who had a history of getting an 8 months old foetus aborted due to having certain abnormalities was also asked about her experience with this birth (after she was screened and diagnosed); she answered:

"Main bohat roti thi usko (the aborted child) yaad kr k,

par ab sabar kr liya hai; Allah ki nemat thi usne le li"

Translation:

"I used to cry a lot in his (the aborted child) memory, but I am

patient now; it was a blessing from Allah, and He took it back" M-10

4.2.2.2. Physical factors

It was inferred from the analysis of the data collected that in some cases, difficult pregnancy and delivery i.e., poor physical conditions during the gestational phase and after delivery were also associated with the biomedical factors that the mothers had been experiencing. The painful occurrences had made the overall experience of pregnancy and delivery unpleasant for them. These factors included tiredness and exhaustion, operated delivery/ history of operated delivery(s) and its consequences, back pain, sciatica pain, and other health issues. One such mother who had developed sciatica pain during her pregnancy and got bed-ridden for some time claimed that her overthinking and hopelessness originated then and there. She elaborated this by saying:

"Main bohat mayoos rehne lagi thi. Main hil bhi nae sakti thi aur life jaise khatam horahi thi. Samajh mein nae ata tha k main theek hun ge ya nae; aur bachay ki fikr lagi rehti thi k iske kaam bhi nae kar sakti"

Translation:

"I used to stay so hopeless. I couldn't move and it felt like my life was ending. I couldn't understand if I'll ever be fine; and I used to worry that I can't take care of my child" M-12

Similarly, another mother who had undergone a caesarean section reported:

"Beti ki paidaish operation say hue thi, uske baad meri sehat kharab rehne lag gae thi"

Translation:

"I went through an operation for my daughter's delivery. My health started getting poor after that" – M11

Difficult births were a mutual concern of many participants; however, other mothers did not associate it with the causal, rather claimed that it complemented the other stressors that were causing the illness and sorrow. These conditions were often evaluated and addressed during the antenatal visits of the mothers, during which the physician or the lady health visitor (LHV) in charge counselled the relevant family member to take care of the mother-to-be. However, the counselling had its limitations. One of the LHV stated:

"Mothers hamare paas bohat buri buri conditions mein ati hain apne antenatal visits mein; tou humen unki saas aur husband ko samjhana parhta hai k inka khayal rakhen"

Translation:

"The mothers are in a very bad state when they visit us during their antenatal visits; we have to counsel their mother-in-law or husband to take good care of them" – LHV1

4.2.2.3. Social factors

Most of the women were living in an extended family and were potentially affected by the social relations they had with others. Some women considered the issues in their

affinal kin responsible for causing them stress that they referred as *'Tension.*' As stated by one of the respondents:

"Bohat ziada tension ani jani. Kuj vi honda ae ty tension ho jani ae; Mian (husband) ghar der nu ponche tou vi tension ho jani ae"

Translation:

"I get a lot of stress. I get stressed on any adverse event;

even if my husband gets home late" – M1

This was found mostly in their relationship with the mother-in-law and the husband as they were the potential decision makers and influencers of the household. Social support from the family was an important aspect in the overall experience of giving birth. Whereas, some women responded positively when inquired about their relation with the other family members. As stated by one of the mothers:

"Main hil nae sakti thi tou mera aur bachay ka khayal tou meri saas he rakhti thin; unho ne bohat sahara diya hai"

Translation:

"I couldn't move so my mother-in-law used to look after

me and my child; she has supported me a lot" – M12

However, some women were complaining about their suboptimal relationship with their family members and this affecting their overall condition; this significantly included disturbed relationship with husband. Some women, when inquired, talked about their husbands not spending enough time with them, not listening to them, or not understanding them. On being probed, this was further associated with the type of marriage i.e., arranged or love marriage. One of the mothers stated:

"Meri pasand ki shadi thi, par ab mere mian meri baat nae suntay aur mere sath kahin nae jatay. Main is wajah say bohat tension mein rehti hun, udaas hojati hun"

Translation:

"I had a love marriage, but now my husband doesn't listen to me, he doesn't accompany me anywhere in family functions etc. I often stay tensed and sad due to this" – M10

4.2.2.4. Economic factors

Most of the women that were interviewed hailed from households financially not too well. This was inferred from the responses that they provided as they constantly stated lack of finances to be a major cause of their stress. This included not being able to or hardly being able to meet with the household needs, pay house bills, and pay school fees for the kids. Some of these women even claimed to contribute in the house economy by working (sewing clothes for people, sweeping etc.). As stated by one such woman:

"Tension bohat rehti hai, tabhi tabyat kharab hojati hai … ghar ki tension, bachon k school ki fees ki tension, beti ki shadi karni hai uski tension"

Translation:

"I remain stressed that's why I become unwell … house stress, stress regarding school fees of kids and daughter's marriage" – M3

4.2.2.5. Cultural factors

Keeping in view the cultural lens and world view of these women, some of them held certain cultural factors responsible for the causation of their illness. These cultural factors were inclusive of social evils like black magic. While living in an extended family, some women were doubtful that some family members like *nand, jethaani, dewarani* etc. might have taken support from social evils like *kaala jadoo* (black magic) to challenge their stability and make things worse for them. While some women conformed to such cultural views, most of the women denied believing in such factors playing a role in the causation of their illness. As stated by a woman:

"Nae aisa tou kuch nae hota"

Translation:

"No, nothing of the sort happens" – M2

However, one woman claimed that she had symptoms after the birth of her son, but they exacerbated when she lost her brother-in-law after some period. She associated this with his wife, her *jethaani,* claiming that she was jealous of her and using the evil source of black magic against her to cause her ill.

"Nazar lag gae shayad, ya kuch karwaya hai, bas tab

say he main bemaar rehne lage hun"

Translation:

"I don't know if it's evil eye or black magic, I am not well since" – M6

4.3. Experiences regarding Maternal Depression

As the research tends to explore the experiences of women during maternal depression, the women were asked about those. The responses were in the domain of the biomedical experiences; however, they were explained in local and cultural terms as per their setting and understanding. Such local expressions that were often used by women included terms such as *ziada rona, udaas rehna, chirchira pan, dil doobna, patthay khichna, bila waja ki pareshani* etc. As found, they often got triggered by a certain stress prompting episode that varied in different cases. It was inferred from the data collected that these women, that were subjected to the research, used to externalize their internally constructed experiences by referring them as 'it,' 'is,' or *'haalat'* i.e., 'state.' These experiences have been explained while categorizing them in various subthemes.

4.3.1. Physical Symptomatology

The physical symptoms experienced by the women were mostly the same, while there were some unusual findings as well. Most of the women expressed in local terms what they had encountered. While shedding light on her physical condition, one of the mothers during the interview said:

"Mera sar aise bhaari hojata tha jaise kisi ne eenthen rakh di houn"

Translation:

"My head used to get so heavy as if someone had placed bricks over it" – M3

A very common symptom of maternal depression that the respondents stated was 'crying' because they also used it as a temporary coping mechanism. Many women had reported that they did not use to be explicit and vocal about their condition in front of their family members as no one understood, and thus, claimed that they used to cry alone as it made them feel better. As stated by one such mother:

"Main bohat chirchiri hogae thi aur bohat rona ata tha,

pr uske baad mann halka hojata tha"

Translation:

"I got so irritated and used to cry a lot, but then I felt better" – M5

Heart sinking and palpitations were other experiences that were mostly perceived and expressed locally as "*dil doobna*" and "*ziada dil dharakna*" respectively. As stated by one of the respondents while explaining her physical symptoms:

"Baychaini si hoti rehti thi, dil jaise doob sa raha hota tha

aur dharkan bhi tez hojaya karti thi"

Translation:

"I felt very uneasy in those days; my heart used to sink

and heart started beating fast (palpitations)" – M5

As mentioned before, while most of the symptoms were repetitive during the interviews, there were some physical symptoms that varied. For instance, change in appetite was reported by many respondents during their depressive days; however, some of these respondents reported a drastic increase in appetite while others reported a drastic decrease. While referring to this, one of the respondents stated:

"Mera dil karta tha har waqt kuch na kuch khati rahun kyunke

bhook bohat ziada lagti thi"

Translation:

"I used to feel like eating all the time as I used

to get hungry unusually more often" – M10

While another respondent, while referring to change in her appetite said:

"Kamzori bhi hoti thi, pr kuch khanay ko dil bhi nae karta tha"

Translation:

"I used to feel weak, but still didn't used to feel like eating" – M11

4.3.2. Emotional Symptomatology

Emotional symptomatology refers to the emotional symptoms experienced by these women that led to certain behavioral changes as well. This change in the behaviour of

women reportedly affected them as well as their families. This can be explained as most of these women were found to be housewives and contributing in the house chores. Therefore, effect on their usual everyday activities during maternal depression affected the household holistically. The altered behaviors reported by women included avoidance of social contact, isolation, remaining lost, moroseness, agitation etc. According to some of the respondents, they used to have a constant thought that something worse might happen; therefore, they had this urge of keeping themselves mentally and physically prepared. While most of the respondents claimed to be isolated, there were a few that reported to have become more sensitive than usual, and had developed a fear of unknown. This was locally also expressed as "*bila waja ki pareshani.*" One of the respondents was found saying:

"Mujhe aik anhona sa khauf rehne lag gaya tha;
akele rehne say bohat dar lagta tha"

Translation:

"I had developed a very unusual fear which was always there;
I used to be so scared of being alone" – M3

4.3.2.1. Effect on Social and Domestic Activities

The emotional symptoms and behavioral changes majorly affected the social and domestic activities of the women. Women, either living in a nuclear or a joint family, had the responsibility of looking after the household, getting everyday chores done (cooking, cleaning etc.), looking after the kids etc. With physical and emotional symptoms, their social and domestic activities got hurdled as they reportedly became quiet, isolated, and slow. One of the respondents while referring to this stated:

"Mera dil karta tha kisi say baat na karun, bas akeli bethi rahun.
Kisi kaam mein bhi dil nahin lagta tha"

Translation:

"I did not feel like talking, I wanted to sit alone. I felt uninterested
in the works I used to do" – M3

The effect on their social and domestic activities, as they became dull and were not able to keep up with the everyday activities, was reciprocated by the families in many cases.

This included concern, scolding, accusing of being dramatic, and accusing of being crazy. As stated by one of the respondents:

"Meri aik he nand hai, wo mujhe tanay deti rehti thi"

Translation:

"I have just one sister-in-law; she used to rebuke me often during those days" – M6

Whereas social segregation was reported by most of the women, some claimed that they preferred being more social so they may get distracted and feel better. This included actions such as visiting a friend, calling their mother etc.

4.3.2.2. Effect on Children

Another finding inferred from the responses of the women was a shift in their behaviour towards their children while being in such a state. This was a symptom that almost all of the women had in common; however, it differed from mother to mother. This altered behaviour included developing an unusual attachment with children, getting irritated by them, rebuking them ignore them on the spur of the moment, and ignoring them. In reference to this, one of the mothers stated:

"Main bohat pareshan rehti thi. Mujhe fikr rehti thi bachon ki jab mujhse door jatay thay. Main chahti thi k bas aas paas he rahen"

Translation:

"I used to get really worried when my children were not in sight.
I wanted them to stay around me" – M12

Some women also reported getting agitated by their children during that phase, and scolding them every now and then. One mother stated:

"Bachay bardasht he nae hotay thay. Sara ghussa unpy nikal deti thi, phir bohat dukh hota tha"

Translation:

"I couldn't tolerate my own kids and used to make them a subject to my frustration, but after that I used to get sadder" – M5

It was also inferred from the data collected that some mothers experienced sadness and concern because the neonatal had high demands in terms of time and care provided by the mother, and not being able to manage the birth of a new child efficiently left other

children ignored; this affected their bonding with them. This was mostly found in women hailing from a nuclear family as there was a lack of support in this domain that was provided by other family members to the mothers living in a joint family. As per their perception, this was one of the factors that led them to postpartum depression.

"Mera aik he barha beta hai, bohat ladla hai. Jab beti hue aur usko ghar le kar ae tou sara dehaan uski taraf hota tha aur wo sath beth kar dekhta rehta tha. Mera dil bohat udaas hota tha k mera beta mujhse door horaha hai"

Translation:

"I had only one son when my daughter was born. When we brought her home, all my concentration went on her and my son got ignored. I used to get really upset that my son is getting at a distance from me" – M11

4.3.2.3. Perception of not being a good mother

As explained before, women in this cultural setting had to do multi-tasking. These women not only had in-door responsibilities that included cooking, cleaning, looking after children and parents-in-law etc., but out-door responsibilities as well that included doing grocery, job work (in case they were working) etc. Failure in any of these responsibilities led to judgements and perceived incompetency. Since the social and domestic activities were hurdled due to physical and emotional symptomatology, and this included not being able to look after their children (especially the neonatal) efficiently, one of the notions developed by these mothers in this phase was that of not being a good mother. They claimed that they used to strive to meet personal, social, and cultural ideals of being an optimally capable mother. One of the respondents stated:

"Kabhi kabhi aisa hojata tha k mujhe lagta tha k main theek say khayal nae rakh sakti tou…"

Translation:

"Sometimes or so it happened that I had a thought that

I am not able to take good care (of the child)" – M2

4.3.3. Onset of the symptoms

The women were asked regarding the onset of their symptoms i.e., when, in their perception, did they start experiencing the symptoms of maternal depression. The women linked this with events during prepartum or postpartum. Most of the responses indicated that although these women were able to identify the biomedical experiences, they were unaware of the fact that these symptoms were an indication of maternal depression, and associated them with conception and delivery. According to some, the symptoms had started because of operated deliveries and a new routine with the neonatal that was tough than usual. Some women with a history of conception claimed that this condition had been usual for them during each experience, while it was new for some of them. Therefore, the responses included association with the number of deliveries as well. Some of such responses included:

"Jab sab say chota beta paida hua tha tou tab tabyat kharab rehne lagi thi"

Translation:

"I started feeling the symptoms after the birth of my youngest son" – M5

Similarly, another woman stated:

"Aisi halat tou meri sab bachon ki paidaish par hue. Bas doctor k

paas baaji satway bachay ki bari le gaen"

Translation:

"I experienced these symptoms during and after all of my pregnancies. However, it was after the seventh one that baaji (LHW) brought me to the health facility" – M3

4.3.4. Frequency of the symptoms

The frequency of the symptoms was also discussed during the interviews that covered, how often the women experienced the symptoms while being maternally depressed. The responses to this question were dynamic and varied. Mostly, the women described it

generically as *"sometimes."* Those who specified it described it on the basis of weeks, days, and hours. For instance, one of the mothers replied as follows:

"Har time he tabyat ajeeb rehti thi, lekin haftay mein kuch

din ziada kharab hojaya karti thi"

Translation:

"Although my condition used to constantly remain poor during

that time, it used to get worse during few days a week" – M5

Some women also elaborated that their symptoms used to trigger and worsen after a certain incident that was stressful for them.

"Kisi khas wajah sy saans waghera phoolne lag jata hai, koe pareshani ki baat ho tou"

Translation:

"My breathing gets heavy when I encounter a stressful situation" – M2

4.4. Diagnosis and Labelling

This theme focuses on the second objective of the study, and documents the response of the women as well as their families towards the label "maternal depression" after getting diagnosed.

4.4.1. Screening and Diagnosis

As a part of the respective interventions, these women were reached out to by the help of community health workers (CHWs) that were usually LHVs and LHWs, who parallelly screened them for depression while conducting their duties assigned as per the Expanded Programme on Immunization (EPI) and other national level programmes. The respondents and their families have direct interaction with the LHWs. When the women were unable to communicate their concerns about their deteriorating health with their families, they functioned as a mediator. These women shared their health concerns with the LHWs who took the responsibility of persuading their families and have them join the mother and child health intervention with their child. One of the respondents said:

"Baaji (LHW) ko bataya tha apni tabyat ka tou unhon ne
ghar mein baat ki aur mujhe le kar gaen"

Translation:

"I told baaji about my health, so she talked to my family
and took me (to the health facility)" – M5

As women were recruited directly in one intervention, they were also recruited indirectly in the other intervention; as stated by one of the physicians who was an active participant in the intervention:

"Hum in auraton ko yahi batate thay k apka kurra-andazi mein naam ayah ai tou apka aur apke bachay ka muft check-up hoga"

Translation:

"We used to tell these women that you have been selected through a lucky draw for a free medical check up of you and your child" – P2

The tools used for screening the women included PHQ-9, GAD-7, Q-3 (Attached as Appendix 1) and EPDS[3] scale. The women that fell in the range of mild and moderate depression were made part of the interventions (counselling and treatment), while mothers with severe depression were referred to a specialized psychiatric care unit.

4.4.2. Reaction of the patient towards the label

Most of the patients, although did not completely understand the term 'maternal depression,' they did get some awareness regarding the notion of 'Maa'on ki zehni sehat' by the LHWs and the physicians. They accepted the fact that they were not well regardless of the causal factors. Most of the women stressed over the social factors while accepting and claiming that they were stressed. However, this was, in some cases, on an individual level or in front of the LHWs and the physicians only as some women were scared of being stigmatized due to the fear that no one in their family will understand. This was one of the reasons in the non-adherence of women with counselling sessions and lost to follow-ups. As stated by one of the physicians:

"Iski awareness nae hai aur auraton k liye mushkil hota hai. Kuch tou hamen batati thin k ap k janay k baad hamare ghar walay kehte hain k tum pagal ho tbhi pagalon k doctor aye thay tumhara ilaaj karne"

Translation:

"People are not aware of this and it gets tough for the women (diagnosed). Some of the mothers used to say that they are labelled as mental patients after we leave (after providing counselling session)" – P4

Whereas, some diagnosed women had not accepted the label. These women did not follow-up after their screening and diagnosis and preferred adopting other coping mechanisms. While referring to this, one of the LHVs said:

"Kuch auraten nahin bhi kartin understand"

Translation:

"Some women are unable to understand" - LHV 2

[3] A 10-item questionnaire used to identify women with postpartum depression

4.4.3. Reaction of the family towards the label

However, some women claimed that their family understood (although to some extent). According to them, they were provided financial and social support by their families as their husband or mother-in-law accompanied them to the health facility for the follow-up visits. On being asked the response of the family towards he label, one of the mothers stated:

"In (husband's) k ghar walay parhay likhay samajhdaar hain sab,
tou wo maan gae thay"

Translation:

"All his (husband's) family members are educated people;
hence, they accepted it" – M1

However, in most of the cases, either the family had ignored the label, had not accepted it, or the women had not disclosed it to their family. Some families had other possible explanations and reasons for the condition of the mothers. Although most of the associated family members/ care takers could not be accessed, one of the mothers-in law who got interviewed stated:

"Pata nae kya tha; bachay k baad kamzori gas shas hojati hai sar dard karti hai,
tbhi aisi chirchiri si hogae thi shyd"

Translation:

"I don't know what happened; usually women get gas and weakness after delivery,
maybe that's why she used to get irritated all the time" – FM1

Similarly, while referring to such families, the LHVs also talked about the difficulties they faced in performing their duties and not being able to bring women for the follow-ups. One of the LHVs stated:

"Inka apna contact number nae hota aur husbands hamara phone nae uthate thay ya
utha k keh dete thay k wo ghar par nahin hai"

Translation:

"The women don't have a mobile phone of their own; and the husbands used to not attend
our calls, or say that they (mothers) are not home" - LHV 1

It was also found that some families had accepted the label, but did not consider getting the mothers treated for it significant. They, rather suggested certain alternatives to get

better e.g., pray, and recite the Holy Quran[4] and different religious supplications. As stated by one of the mothers-in law interviewed:

"Beta cancer thori hai, ilaaj kya iska, bs banda duaen parhe, Quran Pak parhe, Allah k kalam mein bohat shifa hai"

Translation:

"It's not cancer, what to treat. A person should just recite Quran Pak and other supplications; these things are very effective" - FM3

[4] Religious book/scripture in Islam

4.5. Help Seeking Behaviour and Role of the Family

This chapter focuses on the help seeking behaviours adopted by the women and the role that their family played in it, keeping in view the family dynamics and some members from the family being potential decision makers in the household such as husbands, mothers-in-law etc. These health seeking mechanisms adopted by the mothers to cope with their condition were found to be integrated in the socio-cultural fabric of the society. Apart from the medical treatment (i.e., counselling and drugs), these women were reported to have adopted parallel treatment mechanisms as well that they or the family perceived will play a supportive role in terms of their health. These have been listed below:

4.5.1. Cultural Coping Mechanisms

The respondents perceived that certain cultural factors could help in withering away their symptoms for the time being; hence, they used these measures to cope with situation. Many of them held a strong belief in the indigenous wisdom, and reported that these mechanisms had helped them throughout, especially before getting diagnosed and commencement of the treatment.

4.5.1.1. Religious/ Spiritual Healing

Religion was found to have been a strong component that these women had adopted in order to cope with the situation. This was so as they also had beliefs regarding emotional, social and cultural causal factors e.g., *buri nazar, jadoo* etc. Therefore, seeked refuge in it as they thought that this will help them and heal them. They would recite Holy Quran and religious supplications to feel better. A respondent said:

"Logon k agay ronay say tou mazak banta hai. Main Allah k agay namaz parh k bohat roya karti thi jab tabyat aisi hojati thi"

Translation:

"Crying in front of people gives them a chance to make fun of you; I used to cry in front of Allah while offering prayers when I didn't use to feel well" – M2

Women were also found to recite additional supplications at times when they felt weak e.g., *panj soorah*, *durood shareef* etc. As mentioned earlier, one of the respondents said:

"*Quran Paki aur duaen parhti rehti thi; Ammi k kehne par Ehad Naama bhi parhti thi"*

Translation:

"I used to recite Quran Pak and other supplications; I also used to recite Ehad Naama on the guidance of my mother-in-law" – M10

Visiting shrines was also considered as an aspect of spiritual well being in the community. However, while referring to this, one of the respondents stated while opposing the concept:

"Mere susraal walay aik peer ko mantay hain aur darbaron par jatay hain, lekin main sirf Allah he say madad mangti hun"

Translation:

"My in-laws believe in a spiritual healer and visit shrines, but I only have faith in Allah" M-1

4.5.1.2. Hakeem/ Homeopathic Treatment

Hakeem and homeopathic treatment were another type of health seeking behavior found to have been adopted by the respondents. This was so, because this type of treatment included herbal therapy as well as spiritual therapy. This mechanism of health seeking was commonly found in the community. One of the respondents stated:

"Main apni nand k saath hakeem sahab k gae thi, unhon ne nabz dekh k dawai de di, aur Quran say duaen bhi parhne ko din"

Translation:

"I went to the hakeem with my sister-in-law. After checking my pulse, he gave me medicine and also advised me some supplications from the Holy Quran" – M8

Conditions that the respondents stated for having treated by the homeopathic included headaches, back pain, fatigue etc.

4.5.1.3. Other Coping Mechanisms

Many women identified coping mechanisms that were locally and culturally approachable for them. They used, what they referred as '*totkay'* to attain temporary

relief. This included eating or drinking something that they liked, paying a visit to their parent's house, talking to a dear friend etc. One of the respondents stated:

"Tabyat ko bahaal kane k liye main ya tou kuch kha pi leti thi jaise kehwa, ya apni Ammi say milne chali jaya karti thi, wo parhos mein he rehti hain"

Translation:

"In order to feel better, I used to have something (to eat or drink) that I like e.g., green tea; or I used to go meet my mother who lives around" M6

4.6. Case Study of Sheeba (Pseudonym)

Sheeba (pseudonym) was a 32 year old woman and a mother to three kids. She had bore her son three months before her diagnosis. This was the only delivery out of three of her deliveries that was operated. Her pregnancy had been difficult for her as she had developed sciatica nerve pain during her last trimester. This pain not only caused her physical trauma but also a mental trauma as she got bed ridden. After her delivery, it took a few weeks for her to get better. During this time period, Sheeba had lost all hope of getting better, being able to stand or walk, and being able to look after her child. She started staying sad for days and cried for hours. She became over protective of her kids and asked them to stay around her as she couldn't stay around them for herself. During this time, her mother-in-law would support her and look after her kids. She would also give her religious supplications and verses from the Holy Quran to recite and pray.

"Main hil nae sakti thi tou mera aur bachay ka khayal tou meri

saas he rakhti thin; unho ne bohat sahara diya hai"

Translation:

"I couldn't move so my mother-in-law used to look after

me and my child; she has supported me a lot"

After some time, Sheeba did get better physically, but stayed melancholic as she had developed a thought of missing out on the care during the earliest days of her third neonatal, and considered herself as not being a good mother. She started staying in her room with her child, and would talk to people around her very less often. She started staying lost and wouldn't work much either. Although her mother-in-law was supportive of her, she would still remain concerned for her behaviour despite her sciatica nerve pain getting better. One day, Masooma baaji (pseudonym), the LHW came to her house to vaccinate the child for polio. As she observed Sheeba, she inquired about her health. Sheeba shared about her feelings with Masooma baaji, and she told her about the ongoing Mother, Neonatal and Child Health programme in the nearby Rural Health Centre. She

gained permission from her mother-in-law and husband by telling them that it was an awareness session set up for new mothers and their babies, and brought Sheeba and her baby to the health facility along. There, Sheeba was screened through PHQ-9, GAD-7 and Q3, and diagnosed with mild depression. She was made aware and explained regarding the concept of "*Maa'on ki zehni sehat,*" and also provided with a pictorial brochure emphasizing the importance of self-care for new mothers.

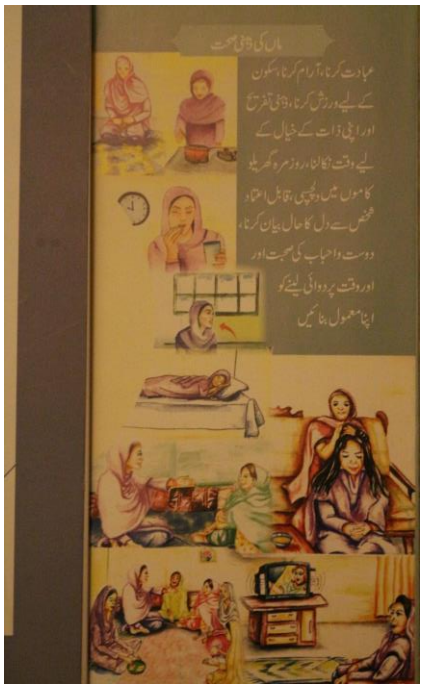

Fig. 4.1. A section from the pictorial brochure provided during the intervention

As for the treatment, Sheeba was prescribed antidepressants and counselling sessions via monthly follow ups. Although the concept of "*Maa'on ki zehni sehat*" was new to Sheeba, she wasn't completely oblivious to it. As Sheeba was an educated girl (had gained secondary education) she atleast understood that she was stressed and needed to relax after *doctor sahiba* had counselled her.

"Mujhe tou andaza nae tha iska. Jab doctor sahiba ne mujhe samjhaya k

mujhe ye bemari hai, mujhe us waqt bas yahi samajh aya k yahan masla hai"

Translation:

"I didn't know about this. When doctor sahiba said to me that

I have this, I just know that at that time I was not well in here" – M1

Later onwards, Sheeba, along with Masooma baji, talked to her husband and mother-in-law about it who understood and motivated her to get better. Nonetheless, her mother-in-law did not seem much interested in her medical treatment although she did not oppose it either, and would accompany her to her monthly follow-up visits. However, she believed that it was the religious supplications, recitation of Quranic verses and prayers that could actually make her better. She would recommend her different verses and religious supplications to recite all day long. Sheeba started feeling some better, mainly due to the counselling sessions. She thought that the major thing that brought her relief was talking her heart out. However, talking to doctor sahiba was just once a month. Therefore, she started talking to her "*sahelis*" over the phone and visiting her mother more often. According to Sheeba, these mechanisms would bring her relief, and she would do them more often.

4.7. Case Study of Amna (Pseudonym)

Amna is a 40 years old mother with seven children and lives with a joint family that includes her *saas* and *susar* (parents-in-law) and her *jethaani* (sister-in-law). She works as a cleaner at the local school and her husband is a security guard there. Her children are educated and tutor local children to contribute to the house economy as they have been experiencing financial crisis for some time now. Amna claims that she got really sick when her second child was born; this included fatigue, backache, headaches, exhaustion, and unusual and unexplained melancholy. She has experienced this since, after the birth of all her children.

"Aisi halat tou meri sab bachon ki paidaish par hue. Bas doctor k

paas baaji satway bachay ki bari le gaen"

Translation:

"I experienced these symptoms during and after all of my pregnancies. However, it was

after the seventh one that baaji (LHW) brought me to the health facility"

However, despite her history of similar experiences, Amna had a different set of beliefs after the birth of her seventh child. Shortly before Amna's baby was born, her brother-in-law passed away in an accident. Amna believes that it was a traumatizing incident for the

whole family; however, she could not get recovered from the consequences that it brought for a long time. According to Amna, the wife of her late brother-in-law, her *jethaani*, was jealous of Amna and her family as she had lost her husband. Therefore, it was her evil eye or black magic casted by her that had made her sick and also caused them financial issues.

"Jab say mere jeth ka inteqaal hua, meri tou halat he ajeeb rehne lagi. Mujhe pata tha k meri jethaani ne he kuch karwaya hai ya uski nazar lag gae hai kyunke hum dou he thin; mera shauhar tha aur uska nae tha"

Translation:

"Since my brother-in-law passed away, my state started worsening.
I knew that this was a mischief made by his wife; either black magic
or evil eye, as we were the only two daughters-in-law in the family,
and my husband was there while her's was not"

Amna used to experience fatigue, backache, headaches, exhaustion, sadness, and a fear of unknown. This kept on going for five months until one of her children fell ill and she had to take him to the nearby THQ hospital. Amna and her family always visited this hospital when someone got a fever, cough, diarrhea etc. In the same hospital had Amna delivered her children. There, Amna's condition was observed by *Gurhya* (pseudonym), the local LHV. Gurhya had been recently trained regarding *"Maa'on ki zehni sehat"* as per the ongoing intervention on mother and child health, and was able to recognize the symptoms in Amna, keeping in view that she was a new mother. Gurhya talked to Amna about her health and recommended her to participate in the intervention where she and her child, both would be able to get a free check-up. Regardless her beliefs regarding the causes of her illness, Amna decided to get a free checkup. Since Amna was a working elderly woman, she was not much dependent on the decisions made by her family, but she was subjected to the decisions made by her husband. Therefore, Amna confided in her husband regarding her health and asked to get the free checkup. Since it was free and the conveyance cost was also covered in terms of incentives, her husband did not mind and gave her the permission. When Amna got herself screened, she was got diagnosed with mild depression. However, now Amna also believed that the direct cause of her illness

was the financial stress, and the indirect cause was the evil eye or black magic that had caused financial issues.

"Tension bohat rehti hai, tabhi tabyat kharab hojati hai … ghar ki tension, bachon k school ki fees ki tension, beti ki shadi karni hai uski tension"

Translation:

"I remain stressed that's why I become unwell … house stress, stress regarding school fees of kids and daughter's marriage"

Amna was offered counselling sessions; however, she missed on its follow-ups as she believed that it was just a support while the actual help that she needed was supererogatory prayers and Quranic recitations that she recited for her recovery.

4.8. Summary:

It was found that the lay interpretations are defined by the meaning(s) gained by the term "maternal depression" by the women, and its perceived causal factors. It can be concluded from the findings that these factors were an amalgam of emotional, physical, social, economic and cultural views of the women based on their psychosocial and psychocultural world view. As the research tends to explore the experiences of women during maternal depression, the women were questioned regarding their encounter with the illness. The responses were in the domain of the biomedical experiences; however, they were expressed in local and cultural terms as per their setting and understanding. Such local expressions that were often used by women included terms such as ziada rona, udaas rehna, chirchira pan, dil doobna, patthay khichna, bila waja ki pareshani etc. As found, they often got triggered by a certain stress prompting episode that varied in different cases. It was inferred from the data collected that these women, that were subjected to the research, used to externalize their internally constructed experiences by referring them as 'it,' 'is,' or 'haalat' i.e., 'state.' Women were diagnosed using various globally recognized screening tools, and explained regarding the concept of maternal depression. However, both types of respondents were found; those who accepted the label as well as those who found it hard to accept that they were mentally not well. Similar was the case with the families; some accepted the label while others stigmatized. These health seeking mechanisms adopted by the mothers to cope with their condition were found to

be integrated in the socio-cultural fabric of the society. Apart from the medical treatment (i.e., counselling and drugs), these women were reported to have adopted parallel treatment mechanisms as well that they or the family perceived will play a supportive role in terms of their health. While some women were found to seek these coping mechanisms themselves, some women also reported the contribution of their families (e.g., mother-in-law) in them in terms of suggestions as well as decisions.

CHAPTER 5
DISCUSSION

5.1. Introduction

This study explores the illness beliefs and narratives of women in maternal depression; Participants were provided a chance to introspect and share their experiences with the help of qualitative methodology. The author in the study explores the illness narratives, impacts and treatment seeking behaviour regarding maternal depression, and tends to develop a conceptual understanding of these perceptions using the "Common Sense Model of Illness" described by Leventhal and colleagues (Leventhal, et al., 1980).

5.2. Discussion

This model tends to understand the relation of the responses of the individuals towards health threats with actions taken to cater them. This model suggests that the perceptions of people regarding their illnesses directly influence their coping strategies/mechanisms, and eventually the outcomes (Brownlee, Leventhal, & Leventhal, 2000). Illness perceptions may be regarded as the lay interpretations of the patient(s) regarding their illness and its experience (Leventhal, Meyer, & Nerenz, 1980). 5 main cognitive domains are covered by this model: *Identity* that brings the first-hand experiences, symptoms and perceptions and also helps explain how patients identify or label these experiences or condition; *causes* that tend to focus on the underlying reasons that might have resulted in the disease in the perception of the patient; *timeline* that provides an insight regarding the perceptions of the patients regarding the timeline of the disease, if it's curable or lifelong; *consequences* that focus on the impacts of the illness on the lives of the patients and those around them; and *perceived cure and controllability* that explains the beliefs and perceptions of patients regarding different efforts or measures that should be taken to gain control, as well as the perceived ability in order to achieve control by adopting those measures.

The mothers identified various physical and emotional symptoms during maternal depression. Commonly experienced symptoms included headaches, fatigue and exhaustion, sadness and the urge to be alone, irritation and aggression, loss of interest in

everyday activities, and fear of unknown. This has been also reported in various other studies (Baines, Wittkowski, & Wieck, 2013; Kathree, Selohilwe, Bhana, & Petersen, 2014). It was also found that they used local terms to describe and explain their symptoms and experiences as they were not aware of maternal depression as an illness or clinical expressions. This was also recorded by Adefolarin and Arulogun (2018) who found that local terms like “irewesi” for “depression” and “ironu” (severe worry) and “aidunnu” (chronic unhappiness) for postpartum and perinatal mood disorder in communities of Nigeria.

Different sets of causal factors were reported by the women that in their perspective were responsible for their illness that were psychosocial in nature. Other researches have also indicated that women with maternal depression use perceptive conceptual frameworks that support psychosocial stressors as compared to clinical models of illness (Buultjens, & Liamputtong, 2007; Chew-Graham, Sharp, Chamberlain, Folkes & Turner, 2009). Although the mothers reported biomedical experiences and symptoms, the causal factors and stressors that they associated were extracted from the context of their lives; this led them to the development of the aetiology that was predominantly socio-cultural in nature. This finding is in congruence with the findings of Tasneem and colleagues (2018). According to Everingham and colleagues (2006), there are certain sociocultural lenses that shape the understanding of mothers regarding maternal depression, and are organized by their backgrounds, biographies and past experiences. In this study, mothers were also found to have constructed their uncertain multiple perceptions regarding the causes as per their history, experiences and living conditions i.e., loss of a child in the past, relationship with partner, financial issues etc.

The patients discussed uncertainty and loss of hope in their recovery; however, they had a belief that they can wither away the symptoms temporarily through various coping mechanisms. Although the mothers in this study did not explicitly state any fear of permanent disability or repetitive episodes, this finding has been indicated in a previous study where it was found that regardless of the subjective improvement in their condition, mothers with postnatal depression remained doubtful with respect to their prognosis and long-term treatment, as well as reoccurrence of depressive episodes in the future (Patel et al., 2013).

Mothers identified and discussed the consequences of maternal depression for themselves as well as their families. This included hurdles in their social and domestic lives and disturbed relationship with those around them. These consequences of maternal depression have also been discussed previously in literature by Cheryl Tatano Beck i.e., loss of control (Beck, 1992) and loss of relationships (Beck, 2002). The mothers in this study also indicated the impact of their illness on their relationship with children and vice versa. This led them to developing an alternative identity of being "not a good mother." This finding of loss of former identity is in congruence with the findings of another study by Chung-Hey Chen and colleagues (Chen, Wang, Chung, Tseng & Chou, 2006).

It has been proved from the existing literature that there is a relation between the illness perspectives of a patient and his/her management of the state, adopted coping mechanisms (Diefenbach & Leventhal, 1996), and adherence to the treatment. In this study, it was found that the coping mechanism of the mothers were guided by their illness beliefs as well as practical consequences (i.e., family making decisions on their behalf). Therefore, regardless of the fact that mothers were seeking counselling as a part of the intervention, they were also utilizing non-clinical inputs e.g., spiritual healing, homeopathic treatment etc. This finding complements the findings of Akbari and colleagues (2020) who indicated a reduction in the effects of postpartum depression through high level of spiritual wellbeing and perceived social support.

5.3. Summary

Some studies have indicated that physical health models e.g., Leventhal's Common Sense Model of Illness, although are comprehensive, descriptive and quite helpful in understanding the illness beliefs of the patients, have a certain amount of limited applicability in the domain of mental health and need to be modified (Kinderman et al., 2006; Higbed & Fox, 2010). Mothers as well as the physicians indicated towards the stigma attached with maternal depression that caused issues in disclosure and acceptance. Furthermore, this also relates to the awareness regarding the illness and its meaning for the patient. In this study, it was inferred that the patients barely had any concept regarding maternal depression prior to their first encounter with the health facility during the interventions. All five domains of the CSM are deeply influenced by the awareness

and perceived meaning of the illness in patients' lives. Therefore, it can be carefully stated that CSM needs to be extended further and awareness and meaning regarding the illness should also be incorporated specifically in the cases of mental illnesses in order to address the stigma attached to them.

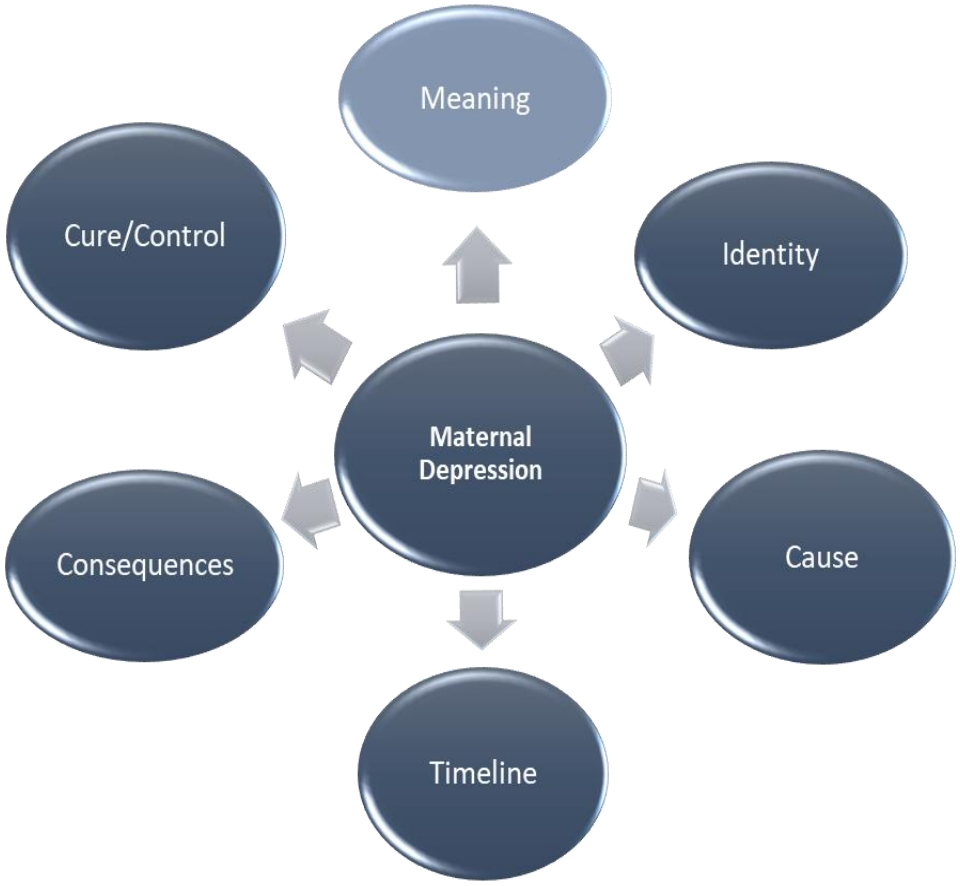

Fig 5.1. Contextual form of Leventhal's Common Sense Model of Maternal Depression

CHAPTER 6
Policy Implications

6.1. Introduction

The concept of mental health is still being recognized gradually in Pakistan; however, the impacts of disturbed mental health in individuals are relatively prevailing. Pakistan has a poor track record when it comes to mental health concerns, with an estimated 50 million individuals suffering from mental illnesses. Only 500 psychiatrists are available to address these issues, with a patient-to-psychiatrist ratio of 1:100,000 (Nisar et al., 2019). Among other mental health issues, maternal depression is becoming more widely recognised as a global health issue, with far-reaching consequences for an individual's career, family, and the baby's health and development (Shidhaye & Giri, 2016). Given the strong association of child mental health with maternal depression, strong intervention efforts with respect to maternal mental health have been recommended in the case of Pakistan (Maselko et al., 2015).

6.2. Policy Implications

Although the doctors and the allied staff were found to have been trained by the associated non-governmental institutions as a part of the interventions integrated in the MNCH program and necessary equipment were also provided, it was observed that the health facilities lacked these components regardless of the involvement of the third party (NGO); hence, there were no proper facilities to treat mothers with maternal depression after the completion of the intervention. The currently ongoing Integrated Reproductive, Maternal, Newborn and Child Health & Nutrition Program (IRMNCH) program include preventive measures such as counselling of the mothers as well as their families during the antenatal visits to avoid them from getting depressed; however, no facilities were found to have been currently available for awareness and treatment of such patients in the primary health sector subjected to the study.

The concept of maternal mental health has been addressed in Pakistan via certain non-governmental organisations through tailor-made interventions. However, these interventions are only affective until they are functioning. In order to scale up treatment

of maternal depression, it is indispensable that the government takes action. The respondents in this study had widely different understanding, experiences, narratives, and understandings with respect to maternal depression. However, a theoretical understanding of the beliefs and narratives regarding the illness was developed regardless of this variability. The findings of this study are intended to enlighten and impact how the government and healthcare providers (through the relevant ministry i.e., the Ministry of Health) can design and develop interventions, or integrate the notion of maternal mental health in the already running programmes in order to raise awareness, as well as approach and address the sufferings of mothers with maternal depression.

6.3. Recommendations

Some recommendations are as follows:

1. The notion of maternal mental health should be integrated in the current Integrated Reproductive, Maternal, Newborn and Child Health & Nutrition Program (IRMNCH) national level health program i.e., awareness, prevention and treatment at all (primary, secondary and tertiary) levels.
2. Through community health workers (CHWs) i.e., the LHVs and the LHWs, access of people has been observed to have enhanced to the health services. Therefore, they should be trained and equipped to understand the mental health of mothers (to be or newly) and take actions accordingly.
3. In primary care setting, guidelines should be drafted for the female doctor(s) who administers the antenatal visits of the women, and she should be trained for investigating and administering maternal mental health in the women who have conceived.
4. As there are progressive private institutes and non-governmental institutes that are working with patients of maternal depression at an individual level, public-private linkage should be established where their expertise can be optimally utilized in public sector e.g., through trainings and interventions.

CHAPTER 7
Conclusion

7.1. Introduction

This study explores the perceptions and experiences of women regarding maternal depression, the response posited by these women and their families towards the label of being "maternally depressed," and the health seeking behaviours adopted by these women in order to cope with the illness. It documents the lay interpretations of the community women that have been diagnosed using Leventhal's Common Sense Model of Illness, and also argues that the sociocultural lens of patients plays a significant role in the perception and expression of their experiences regarding the illness as well as their health care seeking behaviour.

7.2. Conclusion

The research locale for the study included a primary and a secondary health facility of district Rawalpindi. It is a qualitative study as it focuses on the experiences and the journey of women through maternal depression. The research design of this study was explanatory as it helped in further explaining the experiences and illness narratives of women with maternal depression Narrative and semi structured interviews were conducted with a sample of women diagnosed with maternal depression that have been registered in the respective health facilities, their potential family members, LHVs that took a part in the registration of these women, and physicians that have dealt with patients of maternal depression. The data was analyzed through thematic analysis. The model used i.e., Howard Leventhal's Common Sense Model of Illness tells how people respond to their respective illnesses, and suggests that the perceptions of people regarding their illnesses directly influence their coping strategies/mechanisms, and eventually the outcomes. Therefore, the findings revolve around the five aspects of the model i.e., identity, which explains the first-hand experiences, symptoms and perceptions of the women regarding maternal depression; cause, the underlying factors that might have resulted in the disease in the perception of the patient; consequences, that are the impacts of maternal depression on the lives of the patients, and those around them; timeline, which explains the perceptions of the patients regarding the timeline of the disease, if it's

curable or lifelong; and lastly perceived controllability, that explains the beliefs and perceptions regarding different efforts or measures that these women took to gain control of the disease.

It was found that women in Pakistan, especially the peri-urban and the rural communities are subject to multifactorial and multifaceted stressors during the pregnancy, as well as following the birth of the child, possibly making them more susceptible to developing maternal depression and influencing their subsequent healthcare seeking behaviour. The perception of these women regarding the symptoms experienced, the causal factors, as well as the ways to address the illness and various coping mechanisms originated from their socio-cultural context. Labelling of maternal depression was not universally accepted, and in many cases was found to be stigmatized either by the patient herself or her family as there was a perceived lack of awareness found in the mothers and their families regarding maternal depression. Since this finding was beyond the five domains of the CSM, it has been suggested that the "meaning" of illness should also be integrated in the model in order to further explain the lay interpretations of the patients regarding their illness.

The findings of this study are intended to enlighten and impact how the government and healthcare providers (through the relevant ministry i.e., the Ministry of Health) can design and develop interventions, or integrate the notion of maternal mental health in the already running programmes in order to raise awareness, as well as approach and address the sufferings of mothers with maternal depression. This study is the first of its kind in Pakistan with the application of Leventhal's Common Sense Model of Illness, and can be extended at a broader level in order to understand the lay interpretations and illness perspectives of the mothers struggling with maternal depression in order to address their needs by drafting tailor-made policies and mechanisms for prevention and treatment of maternal depression.

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Appendix A

Translated version of PHQ-9, GAD-7 and Q-3

ذہنی صحت کا معائنہ

(سیکشن 1: ذہنی صحت کی ہنگامی حالت کا معائنہ)

	کیا مریض کو فوری طور پر ماہر نفسیات کی طرف بھیجنے کی ضرورت ہے؟	نہیں	ہاں
1	ماضی میں خودکشی کی کوشش کی ہو یا ابھی ارادہ رکھتا ہو؟		
2	ماضی میں کسی کو نقصان پہچانے کی کوشش کی ہو یا ابھی ارادہ رکھتا ہو؟		
	کسی بھی سوال میں ہاں کی صورت میں فوری طور پر ماہر نفسیات کی طرف بھیجیں۔		

(سیکشن 2: معائنہ برائے ڈپریشن)

	گزشتہ 2 ہفتوں کے دوران آپ کو کتنی مرتبہ درج ذیل مسائل پیش آئے؟	بالکل نہیں	کئی دن	آدھے دن سے زیادہ	تقریباً روزانہ
1	کیا آپ کو کچھ بھی کرنے میں بہت کم دلچسپی یا خوشی محسوس ہوتی ہے؟	0	1	2	3
2	کیا آپ کو ناامیدی یا افسردگی محسوس ہوتی ہے؟	0	1	2	3
	اگر تین یا تین سے زیادہ سکور آئے تو اگلے سوالات پوچھیں				
3	کیا آپ کو سونے یا سوئے رہنے میں مشکل محسوس ہوتی ہے	0	1	2	3
4	کیا آپ کو توانائی میں کمی یا تھکان محسوس ہوتی ہے	0	1	2	3
5	کیا آپ کو بھوک میں کمی یا زیادتی محسوس ہوتی ہے	0	1	2	3
6	کیا آپ خود کو برا یا ناکارہ محسوس کرتے ہیں یا ایسا کہ آپ نے خود کو یا اپنے خاندان والوں کو مایوس کیا ہو؟	0	1	2	3
7	کیا آپ کو کسی بھی کام اچیز میں توجہ مرکوز کرنے میں مشکل ہوتی ہے جیسا کی ٹی وی دیکھتے ہوئے توجہ نہ رکھ پانا؟	0	1	2	3
8	کیا آپ کو بولنے یا حرکت کرنے میں ایسی سستی یا بے چینی ہوتی ہے جو دوسرے بھی محسوس کرتے ہوں؟	0	1	2	3
9	کیا آپ کو اس قسم کے خیالات آتے ہیں کہ آپ کا مرجانا ہی بہتر ہے یا آپ خود کو کسی طریقے سے نقصان پہنچائیں؟	0	1	2	3

Depression score key: Severe:≥20; Moderate: 10-19; Mild: 5-9

(سیکشن 3: معائنہ برائے اینزائٹی)

	گزشتہ 2 ہفتوں کے دوران آپ کو کتنی مرتبہ درج ذیل مسائل پیش آئے؟	بالکل نہیں	کئی دن	آدھے دن سے زیادہ	تقریباً روزانہ
1	کیا آپ کو گھبراہٹ، بے چینی یا شدید تناؤ محسوس ہوتا ہے؟	0	1	2	3
2	کیا آپ کو فکرمندی روکنے یا اس پر قابو پالینے میں مشکل ہوتی ہے؟	0	1	2	3
	اگر تین یا تین سے زیادہ سکور آئے تو اگلے سوالات پوچھیں				
3	کیا آپ کو مختلف چیزوں کو لے کر ضرورت سے زیادہ فکرمندی ہوتی ہے؟	0	1	2	3
4	کیا آپ کو پرسکون ہونے میں دشواری ہوتی ہے؟	0	1	2	3
5	کیا آپ کو اتنی بے قراری ہوتی ہے کہ آپ سے بیٹھے رہ پانا مشکل ہو جائے؟	0	1	2	3
6	کیا ایسا ہوتا ہے کہ آپ آسانی سے چڑ جائیں یا ناراض ہو جائیں؟	0	1	2	3
7	کیا ایسا ہوتا ہے کہ آپ کچھ ناگوار ہونے کے خدشے سے خوفزدہ رہیں؟	0	1	2	3

Anxiety score key: Severe: 15-21; Moderate: 10-14; Mild: 5-9

(سیکشن 4: معائنہ برائے سائکوسس)

		نہیں	ہاں
	دریافت کریں		
1	کیا آپ کو ایسی چیزیں دکھائی دیتی ہیں جو دوسرے نہ دیکھ سکتے ہوں یا ایسی آوازیں سنائیں دیتی جو دوسرے نہ سن سکتے ہوں؟	0	1
2	کیا آپ کو کچھ ایسا یقین ہے کہ آپ میں غیر معمولی خصوصیات ہیں جس کا دوسرے سمجھ بوجھ نہ رکھتے ہوں جیسے کہ آپ کوئی اہم یا بزرگ ہستی ہیں لیکن دوسرے نہ سمجھتے ہوں، کچھ لوگ آپ کو نقصان پہچانا چاہتے ہوں وغیرہ	0	1
	مشاہدہ کریں		
3	کیا ماں کے حلیے، اس کی گفتگو یا اس کی حرکات میں بے ترتیبی/بے ربطگی دکھائی دے جیسا کہ منہ ہی منہ میں بڑبڑانا، خود ہی خود ہنسنا یا گلوں جیسی حرکات کرنا وغیرہ؟	0	1
	اگر سکور 1 یا 2 ہے تو مشاورت کے ساتھ ادویات تجویز کریں اور اگر سکور 3 ہے تو ریفر کریں		

Appendix B

Interview Guide for Patients

Themes	Questions	Probes
Demographics	What is your name?	
	How old are you?	
	Are you educated?	How many grades have you studied?
	Are you married/ divorced/ separated?	
	How many children do you have?	
	Do you live in a nuclear family or a joint family?	If joint, who else lives with you?
Perceptions and Experiences of the women	What do you know about maternal depression?	How do you describe this illness?
	When did you start feeling unwell?	After a few days/ a few weeks…?
	What did you feel at first?	For example headaches, breathing issues, chest tightness, dreams, heart sinking (dil doobna), palpitations, see something, stay upset, crying etc?
	What was your perception about it? Why did you think was it happening to you?	Any medical reasons? Religious reasons (mannat poori na karna, sadqa na dena, nazar, bad-dua, hasad, aasaib, jinn etc)? Social evils (jadoo etc)?
	What was the perception of your family about it?	Esp. your parents, husband and mother-in-law (drama, kaam chori, nakhray or as mentioned above)?

	What was your behaviour towards people around you?	
	What was your behaviour towards your children?	Did you feel uncomfortable? Did you feel irritable for example?
	What was the behaviour of your family towards you?	Please shed light on the behaviour of your husband and your mother-in-law
	What was the frequency of this feeling?	Was it always there or something triggers it? If yes, what? Please explain
	Were there any consequences? If yes, please explain	Did it affect your other social and domestic activities? If yes, how? Was there any effect on your relationship with your husband? If yes, please explain Was there any effect on your other family members and children? If yes, please explain
	Did you talk to someone about it? What was his/her response?	If yes, who? Why?
Healthcare seeking behaviour	What were the possible coping mechanisms that you seeked to cater immediate effects?	e.g., praying, eating or drinking, talking to a friend/ acquaintance etc.

	Did you realize that you need to seek medical help?	If yes, how did you plan to? From where?
	Who told you about this health facility?	For example, someone already seeking health care, LHW etc?
Labelling	What were your feelings when you found out that you are 'depressed'?	Were you sad, numb, clueless etc?
	Could you accept the fact that you were depressed?	If yes/no, why?
	How did you accept the label (if the patient did)?	
	How did your family accept the label?	What was their response? Behaviour? Did they agree with it or rejected it?
	Were there issues in persuading them?	What were they? What was the outcome?
	What were the possible hurdles in pursuing medical help? (If any)	**Economic reasons** (costly)? **Social reasons** (family pressure, harassment on way, cannot go alone, family not willing to spend on woman/daughter-in-law etc)? **Religious reasons** (woman should not go out often, must need a family man along etc)?
	Did you use any parallel mechanisms for health care?	For example spiritual, homeopathic etc

Interview Guide for Families

Themes	Questions	Probes
Perceptions and Experiences of the family	What do you know about maternal depression?	How do you describe this illness?
	What was your perception about it? Why do you think was it happening to the patient?	Any medical reasons? Religious reasons (mannat poori na karna, sadqa na dena, nazar, bad-dua, hasad, aasaib, jinn etc)? Social evils (jadoo etc)? Any social reasons e.g. drama, kaam chori, nakhray etc.?
Attitude towards the patient	What were the possible coping mechanisms that you suggested the patient to cater immediate effects?	e.g., praying, eating or drinking, talking to a friend/ acquaintance etc.
	Did you realize that she needs to seek medical help?	If yes, how did you assist? If no, why?
	Did you help the patient?	If yes, in what ways?
Labelling	What were your feelings when you found out that she was 'depressed'?	Were you angry, numb, clueless etc?
	Could you accept the fact that she is depressed?	If yes/no, why?
	How did you accept the label (if you did)?	
	Did you permit them to pursue medical treatment in the future?	If not, why? What were the possible hurdles in pursuing it, if any? **Economic reasons** (costly)? **Social reasons** (societal pressure, not willing to spend on woman/daughter-in-law etc)? **Religious reasons** (woman should not go out often, must need a family man along etc)?

	Did you suggest any alternate mechanisms for health care?	For example spiritual, homeopathic etc

Interview Guide for LHWs/ Physicians

Themes	**Questions**	**Probes**
MNCH Programme	What do you know about the MNCH Programme?	Please elaborate
	Is it operational in your health facility?	If no, why?
	If yes, how many women are registered under this programme?	
	Has this programme helped in mainstreaming the notion of maternal depression?	If yes, how? If no, why?
	Has this programme helped in mainstreaming the notion of mental health in general?	If yes, how? If no, why?
Healthcare seeking behaviour	What role did you play in the registration of these women?	For example spreading awareness, counselling the patients and the families etc., reducing the stigma etc.
	What role did you play in the treatment of these women?	For example follow-up visits etc.
	What were the possible barriers for women in seeking medical treatment?	For example family not allowing, economic reasons, social reasons (women unable to travel alone etc)

	What were the possible barriers that you face in performing the duty?	For example families not cooperating, issues in making contact, follow-up visits etc.