Portfolio Volume 1: Major Research Project

Migrant Mothers' Experiences of Postnatal Depression in the UK

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A thesis submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree Doctor of Clinical Psychology

June 2025

Word Count: 29,962

(Excluding title page, acknowledgements, contents, abstract, tables, figures, references and appendices)

Acknowledgments

It took a village to 'raise' this thesis and I am forever grateful for all of the support I received along the way.

To the seven mothers who participated in this study - Thank you for allowing me to hear your stories and entrusting me to share these, I hope that this research does them justice.

Debbie, I could not have asked for a better principal supervisor to work with. I am beyond grateful for your dedication, patience, kindness and unconditional support; ***Aisling***, your thoughtful reflections and guidance were invaluable to this research; and ***Lizette***, your contributions were particularly meaningful in shaping the direction of this work.

Barbara, your unwavering support helped me incredibly to persevere from start to finish. Your values and commitment truly make the DClinPsy 'world' a better place.

Armie, Trusha & Aedín, thank you for being the absolute legends that you are. It has meant the world to have you by my side. I am so proud of how far we have come together and cannot wait to see what's next for us.

Vali, Kiera, Shaan, Dafni, Charlotte, Phoebe, Anna & Josh, you all reminded me of the reasons why I applied to this doctorate in the first place, in your own unique and wonderful ways. Your nuggets of wisdom and compassion continue to shape the clinical psychologist I am becoming.

Lucy, Sarah, Noush, Helen, Shannon and LES COUS', despite the distance, having you in my life makes me feel like home wherever I go.

Maman et Papa, je vous suis éternellement reconnaissante de m'avoir fait confiance et de m'avoir soutenue à travers cette aventure. Cette thèse est inspirée de notre vie de famille expatriée, qui m'a non seulement mené vers cette vocation professionnelle mais qui m'a aussi enrichie à travers plein de belles opportunités.

Matthieu, Marie-Caroline, Adèle, Charlotte, Guillaume, Ezgi & Elio, whether in times of celebration or hardship, thank you for uniting us and reminding me of what matters most. The strength and light you bring shines bright every day.

Vincent, thank you for unconditionally supporting me every step of the way and celebrating each milestone with me. You promised me that you would read my thesis- congratulations, you've made it through the first page! Only a few more to go…

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Abstract

Background: Despite the majority of migrants coming to the UK for voluntary reasons such as study, work or family, few studies explore their experiences of mental health. Prevalence of postnatal depression (PND) is higher amongst migrant women compared with non-migrant women. This qualitative study aimed to explore voluntary migrant mothers' experiences of postnatal depression (PND) in the UK.

Methodology: Seven migrant mothers who had experienced PND participated in individual semi-structured interviews. These were analysed using an Interpretative Phenomenological Analysis (IPA) approach which enabled an in-depth exploration of underlying meanings and significance of participant experiences.

Findings: Four Group Experiential Themes were identified along with associated subthemes. These captured the layers of disconnect, isolation, despair and grief participants reflected on when sharing their experiences of PND. The stories shared were embedded in participants' intersecting identities of being both mothers and migrants. The themes also captured testaments of resilience and growth through an ongoing journey of healing.

Discussion: This research builds on existing literature looking at migrant women's experiences of PND, by focussing on voluntary migrant mothers in the UK. The findings suggest that migrant mothers who experience PND would particularly benefit from community support in addition to tailored clinical interventions. Further research and clinical implications are discussed to help improve migrant mothers' experiences of seeking help for PND in the UK.

Keywords: *migration, migrant mental health, migrant mothers, postnatal depression*

Chapter 1: Introduction

This chapter provides relevant context and literature for the empirical study. It includes an overview of my relationship to the project along with an introduction to the critical realist epistemological lens through which it was conducted. Key terms are defined followed by a presentation of relevant literature. To conclude, the reader is presented with the aim and rationale of the systematic literature review which was conducted to provide further context to the empirical study.

Setting the context

Personal significance and positionality

I approached this study through broadly positioning myself as an 'insider-outsider' researcher, meaning that, to some extent, I could relate to certain attributes and characteristics of participant identities and experiences, whilst also feeling foreign to other aspects (Braun & Clarke, 2013; Bukamal, 2022).

I relate to being an 'insider', because of the migrant part of my identity, which has enabled fostering connections and familiarity to migrant communities since a young age (Aiello & Nero, 2019). However, migrants are a diverse and heterogenous group. My positionality is influenced by aspects of my identities such as being a white, middle class, cis gendered female, and raised in only Western societies. I recognise that the intersections of my privileges shaped my experience of migration in a way which may differ from participants in my study and the wider range of migrant communities.

Some key differences between myself and some of the participants are that I first migrated at an early age, providing me with the opportunity to become bilingual in English, learn to assimilate with the Anglophone culture early on, and benefit from accessing well-resourced support systems. If I had not intentionally reflected on these privileges, they may have precluded my ability to understand the unique challenges that participants faced when

moving to the UK as adults and/or underestimated the impact that they felt the lack of support and belonging had on their experiences of postnatal depression. The experience of postnatal depression (PND) is also one that I cannot relate to, as I am not a mother, reinforcing my 'outsider' position.

At times, my pre-existing beliefs around what it is like to be a migrant and parented by a migrant mother risked assuming understanding of my participants' experiences, prompting emotional involvement which could have led to a loss of curiosity and consistency within the interview process (Greene, 2014). To mitigate this, I regularly engaged in self and team reflexivity (Dodgson, 2019).

I notice the limitations of adopting the 'insider-outsider' terminology, which seems dichotomous and at times restrictive or inadequate (Liamputtong, 2022; Wiederhold, 2014). I recognise that identities and relationships are ever evolving and multi-faceted and therefore adopt Machaka's (2024) approach to positionality:

"… Identity is ever shifting. Awareness of my positionality in negotiating the reality in the research relationship aided my attentiveness to issues of power, positionality and representation in designing the study. From this lens, I will reveal the multiple identities I bring to the research process" (p. 283).

Reflexivity

Reflexivity is not only important, but "fundamentally intertwined with qualitative research processes" (Olmos-Vega et al., 2023, p. 241). To be a reflexive researcher is to have the ability to consciously and deliberately look inwards and self-examine with the aim to foster a continual awareness of one's self within the wider context of the research being conducted (Berger, 2013; Dodgson, 2019). The skill of reflexivity is improved on through the explicit repeated process of identifying one's beliefs, cognitive biases and emotional responses, as well as the impact this has on research processes and how this can be in turn

addressed (Dodgson, 2019). This includes multifaceted practices of self and team reflexivity, whereby reflections are shared through bracketing in a reflective journal and throughout supervision discussions (Greene, 2014; Olmos-Vega et al., 2023).

Power differentials between participants and interviewers are inherent to the research process (Grove, 2017). Practicing reflexivity is one way of attempting to address and re-balance the power dynamics within research processes (Solie, 2024). It aims to do this through recognition of researcher biases (Thambinathan & Kinsella, 2021) and questioning existing power relations (D'Cruz et al., 2007). Reflexivity enables researchers to take responsibility for their positionality and the impact this may have on the target population (Berger, 2013). It helps to encourage a critical examination of one's own political and social positions in relation to participants, leading to a more contextual, ethical and rigorous analysis (Solie, 2024). Attending to reflexivity consistently throughout qualitative research processes also allows for a deeper understanding of experiences and increases creditability of findings (Dodgson, 2019).

I believe it is impossible to conduct research from an entirely unbiased, objective stance. Together with my research team, I reflected on my biases as a migrant researcher who is not a mother and how this would impact the research. Relevant reflections are included throughout the chapters in italics, along with examples of reflective diary entries in Appendix A.

Epistemological position

The research was conducted through a critical realist epistemological stance, meaning that there has been an acknowledgement of experiences, events and causal mechanisms which shaped and influenced the interpretations and overall findings. Critical realism combines an ontological realism, which is concerned with the existence of an external reality outside of human interpretation, and epistemological relativism, which suggests that

knowledge is socially constructed through human perspectives and context (Willis, 2023). The Interpretative Phenomenological Analysis (IPA; Smith, 1996) method aligns with critical realist theory as there is a belief that there is a reality which exists independently to individual experiences whilst also challenging the notion that there is only one truth to this reality (Bhaskar, 1978).

As this research aimed to explore migrant mothers' experiences of PND, holding a critical realist position enabled me to make sense of findings whilst acknowledging the evolving context of migration and mental healthcare provision in the UK.

Relevant terminology

While some of the terminology may hold various definitions depending on context and culture, the ones presented were chosen due to their alignment with the literature reviewed on migration, motherhood and PND (see Table 1).

Table 1

Terminology and Definitions

Term	Definition
Migration	There is no universal definition of 'migration' but the International Organisation for Migration (IOM) defines it as "the movement of people away from their usual place of residence to a new place of residence, either across an international border or within a State" (2019, para. 1). In this research, when the term 'migration' is used, it refers to international migration, which occurs when people cross State boundaries (or international borders) to live in another country, and one that is voluntary, which means that individuals have chosen to migrate rather than having been involuntary or forced.
Migrant	Migrant is an umbrella term which is not defined under international law (IOM, 2019). There are multiple definitions for the term 'migrant' and within this research, it refers to someone "who changes their country of usual residence […] where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor" (Sturge & Bolton, 2025, pp. 8-10). This definition therefore

	does not refer to "refugees, displaced or others forced or compelled to leave their homes" (Sturge & Bolton, 2025, p. 10). Burns et al. (2021), highlight the common methodological challenges in conducting research within the field of migration health including but not limited to: imperfect categorisations (Abubakar et al., 2018) and limitations around recording migration status (Burns et al., 2021). There are various attempts to categorise migrants across socially constructed terms. Some (e.g. 'illegal' or 'irregular' migrants) which are often highly politicised and/or weaponised within social and media discourses compared with others (e.g. 'expatriates' or 'highly skilled migrant workers'). Although the term 'migrant' can be evocative at times within certain social discourses, it was chosen as the most consistent and clear term to use for the purposes of this research. In addition, this research will use the term 'migrants' when referring to first-generation migrants. First-generation migrants are foreign-born migrants as opposed to native-born migrants who come from migrant families.
Postnatal Depression (PND)	PND is a term used to identify major psychological distress experienced by mothers and birthing people, which is endured after giving birth, lasting a minimum of two weeks and starting at any point within a year of giving birth (American Psychiatric Association [APA], 2013). It can be characterized by persistent symptoms of low mood, guilt, tearfulness, loss of energy, anxiety and problems sleeping (APA, 2013). It is recognized as a common mental health problem that between 10-15% of mothers report experiencing (Halbreich & Karkun, 2006). For the purpose of the empirical study, the use of the term PND could refer to diagnosed PND or self-identified PND. Many individuals may have experienced PND without receiving a diagnosis due to multiple reasons including barriers to access (Moore et al., 2019). When referring more broadly to the time period after delivery, the terms postnatal and postpartum are at times used interchangeably, reflecting the language used across the existing literature on this period of time (Kumarasinghe et al., 2024).
Parenting	Parenting refers to the process by any parent to care for, educate and socialise with their child **(**Bhat et al., 2019; Rubilar & Richaud, 2018). It goes beyond the biological aspect of reproduction and involves the psychosocial process of becoming parents (Rubilar & Richaud, 2018). It encompasses the role of being a parent and the responsibilities that come with this role. In this research, parenting practices or child-rearing practices are terms which are used interchangeably.
Motherhood	Motherhood is defined as a state through which one experiences a maternal role and associated responsibilities. It is characterised by a transition that a female goes through when adapting to the physical,

psychosocial and relationship changes which occur after delivering a baby.

Overview of the empirical and theoretical literature

Migration context and challenges

Migrants make up approximately 16% of the United Kingdom's (UK) total population (Cuibus, 2024). There has been an estimated increase of migrants in the UK from approximately 7.9 million in 2011 to 10.7 million in 2022 (Cuibus, 2024). Despite the majority of migrants being considered as 'voluntary', approximately 87%, compared with those considered as 'forced', few migrant health studies report on their experiences (Burns et al., 2021; Cuibus, 2024).

There have been significant changes in UK immigration policies over the past decade including the 2016 Brexit referendum and the 2022 introduction of a 'points-based system' regulating migrant rights to stay and work. Brexit was a concern across all migrant communities (Bueltmann, 2018; Peñuela-O Brien et al., 2023; Reimers, 2018; Turcatti & Vargas-Silva, 2021), raising insecurities around immigration status and rights, leaving some particularly at risk of being in a position of legal vulnerability. Collinson (2022) argued that migrant family life was being negatively impacted by the 'points-based system'. Immigration and integration policies can have an impact on migrants' experiences of loneliness by further perpetuating challenges related to building social relationships and creating a sense of belonging (Delaruelle, 2023).

Against this backdrop, migrants also face migration-related inequalities and often require support through multiple layers of adjustments: language, employment, education, housing, daycare, health, social (Guo, 2010). They can also often be stereotyped into one group which is assumed to be homogeneous, creating barriers to support and services which may not be tailored to their specific needs (Guo, 2010). Furthermore, migrants can face

economic hardship due to discriminatory recruitment systems that devalue foreign qualifications and experience, placing many, especially women, into lower-skilled, lower-paid jobs despite being overqualified (Chatterjee, 2015; Webb, 2015; Man, 2004). This lack of recognition contributes to feelings of injustice and frustration (Washington Miller, 2008).

In this context, the experience of migration can be a challenging one even when this is voluntary (Ottonelli & Torresi, 2013). This can subsequently have adverse effects on migrant mental health (Brance et al., 2024; Close et al., 2016).

Migrant mental health

Migrant mental health studies in the UK have tended to concentrate on forced migrants rather than voluntary migrants (Burns et al., 2021). The nature of migration itself brings particular socio-cultural and psychological challenges such as experiencing 'homesickness' and acculturation stress (Brance et al., 2024; Choy et al., 2021). It is considered a significant life transition, regardless of whether this was voluntary or involuntary, which creates uncertainty and can negatively influence mental health (Brance et al., 2024; Deighton-O'Hara, 2018).

Brance et al. (2024) found that leaving their home country and previous group memberships could leave migrants with feelings of loss and emptiness, regardless of how able they are to develop new relationships. They may experience emotional distress including feeling of sadness and grief, related to issues of 'homesickness' (Brance et al., 2024; Office for Health Improvement and Disparities, 2022). The level of isolation that migrants face post-migration significantly increases feelings of loneliness which can be linked to psychological difficulties such as anxiety and depression (Hawkley & Cacioppo, 2010; Ho et al., 2022).

Migrants can find themselves subject to acculturation stress (Choy et al., 2021). This includes having to negotiate how to integrate into the host country through using a range of coping and cultural adaptation strategies (Choy et al., 2021). Berry (1997) suggested four

types of acculturation strategies: Integration, Assimilation, Separation, and Marginalisation. With each strategy comes a level of adoption and/or rejection of one's culture of origin and host culture (Choy et al., 2021). Choy et al. (2021) explored the degrees of impact of each strategy on migrant mental health and found that marginalisation, or the complete rejection of both the culture of origin and host culture, had the worst effects. Marginalisation is a complex phenomenon which can occur for many reasons, and can partly be understood as a result of feeling rejected and/or being discriminated against across both cultures (Choy et al., 2021). The findings are similar to Brance et al.'s (2024) study which highlighted that factors such as 'othering' and cultural stereotypes can have a harmful impact on migrants' level of integration, wellbeing and psychological sense of safety.

Acculturation stress, and particularly marginalisation, can negatively impact sense of identity (Brance et al., 2024; Butler et al., 2015; Choy et al., 2021). Social identity theory suggests that individuals construct their sense of self and esteem through their sense of belonging to social groups (Tajfel & Turner, 1979). An increased sense of social identification and belonging has been recognised as having a positive impact on overall wellbeing (Brance et al., 2023). If migrants experience prejudice and discrimination, they are more likely to suffer from poor mental health outcomes (Brance et al., 2024). Chou (2012) emphasised this by showing the apparent association between discrimination and depressive symptoms in migrants.

Acculturation stress is strongly linked to feelings of cultural alienation, which is recognised as a contributing factor to mental health challenges (Chandra, 2010). Migrant women face distinct issues that can increase their susceptibility to associated psychological distress (Almeida et al., 2016; Chandra, 2010). They are impacted by the interaction of migration-related psychosocial determinants including a generalised sense of insecurity, precarious employment conditions and barriers to accessing healthcare (Almeida et al., 2016).

Whilst both migrant men and women are susceptible to developing psychological difficulties, migrant women seem to be disproportionately affected (Thara & Raman, 2021).

Overall, studies have shown that refugee and migrant groups are likely to develop psychological distress such as depression and anxiety linked to the challenges they face in resettling and adapting to their adopted country (Butler et al., 2015; Deighton-O'Hara, 2018). Literature on migrant parenting suggests that migrants with children face additional stressors which migrants without children may not experience (Bornstein et al., 2020). Mothers are particularly vulnerable to these stressors which may lead them to develop mental health difficulties in the postpartum period (Almeida et al., 2016).

Migrant maternal mental health

In England and Wales, the percentage of births to non-UK-born mothers continues to increase, reaching just above 30% in 2023 (ONS, 2023). With migrant parenting comes unique opportunities and challenges related to multiple layers of adjustment and additional responsibilities (Bornstein et al., 2020). There are different social contexts and circumstances such as class, immigration status, and economic situation, which have a direct impact on migrant parenting and the varying levels of challenge experienced (Brahic, 2022).

Furthermore, female migrants seem to be more specifically disadvantaged compared to male migrants, especially those who become mothers who tend to be presented with less opportunities (Mikolai & Kulu, 2022). They are also considered disproportionately impacted compared to fathers, with them being more likely to be the primary caregiver (Erel & Reynolds, 2017). Benchekroun (2023) argued that "becoming mothers "creates new needs, challenges and responsibilities which can be particularly difficult to meet when marginalised economically, socially and legally" (p. 3317-3318).

The transition to motherhood can be understood as one that includes "a broader perspective [than traditional theories], including women becoming mothers, bonding with the

newborn, adapting to their role as a mother and considering their roles in social contexts" (Hwang et al., 2022, p. 8). The transition to motherhood includes adapting and responding to physical, psychological, social and relational dimensions (Hwang et al., 2022). This is deemed to be a complex and dynamic process through which mothers face nuanced challenges and additional responsibilities such as: adapting to changes in the body, navigating various psychological changes, facing a change in social perception in identity, and renegotiating relational dynamics between the self, baby and others around (Hwang et al., 2022). Indeed, existing research highlights the impact of becoming a mother as a significant life event which can impact an identity transition (Greenberg et al., 2016; Hennekam et al., 2019). These challenges of becoming mothers intersect with those of being migrants, which also include layers of adjustments and difficulties with a sense of identity (Bhugra, 2004; Brance et al., 2024; Choy et al., 2021).

Migrant mothers are faced with particular challenges and higher risk with regards to their overall physical and mental health, from pregnancy to delivery and throughout the postnatal period (Fair et al., 2020). Fair et al.'s (2020) review highlighted that for some, there is a recognised psychological impact of migration-related trauma that migrant women may have experienced, which can be further exacerbated during the perinatal period. There is also a higher risk of complications during pregnancy and birth for migrant women compared with native born women (Almeida et al., 2016; Fair et al., 2020). This may be in part due to the issues they encounter in accessing care in their new country (Fair et al., 2020).

In the UK, despite there being guidance for migrant women's access to perinatal healthcare (National Institute for Health and Care Excellence [NICE], 2010; Office for Health Improvement and Disparities, 2022), there continues to be known limitations to the implementation of this guidance, as well as identified gaps in safe and appropriate overall provision (Felker et al., 2024). Some charities such as Maternity Action and Refugee Council

offer tailored support, however this is usually targeted at undocumented refugees and asylum seekers. The majority of research around mental health is conducted with those who were forced to migrate rather than chose to do so (Burns et al., 2021).

Considering that some migrant mothers have been subject to discriminatory practices and decreased access to healthcare due to restrictions around who can and cannot benefit from the NHS according to their immigration status, this can leave them particularly vulnerable at times of need (Jones et al., 2022; Poya, 2021). Schmied et al. (2017) also noted that migrant women's emotional needs do not tend to be addressed within maternal healthcare. This is concerning considering that the perinatal period is a particularly vulnerable time for migrant mothers. Anderson et al. (2017) highlighted a higher prevalence in risk of migrant women developing depression during the perinatal period compared with non-migrant women. This leaves gaps in research around understanding how voluntary migrant mothers access maternal mental health care in the UK and the impact barriers may have on their experiences of PND.

Postnatal depression (PND)

In the UK, it is estimated that 1 in 5 women are estimated to develop mental health problems during the perinatal period, with anxiety and depression as the most prevalent diagnoses (Russell, 2017). The peri and postnatal periods are considered to be challenging for all mothers, but even more so for women with depression (Bhat et al., 2019).

Multiple theoretical positions have been suggested when exploring the nature and experiences of PND (Abdollahi et al., 2016). One of these is the biological model of understanding, which suggests that PND is brought on by a fluctuation of hormones during and after pregnancy and therefore considered to be a medical condition (Beck, 2002a). The sudden withdrawal of some reproductive hormones is thought to trigger depression symptoms (Hoefliger, 2003). From a biological perspective, PND is considered to be an 'illness' or

'disorder' (Edge & Rogers, 2005). The diagnoses of PND, and interchangeably Postpartum Depression (PPD) or Perinatal Depression, are rooted within the medical model (APA, 2013; World Health Organization [WHO], 2019). These are used to describe "a sustained depressive disorder in women following childbirth" (Shaikh & Kauppi, 2015, p. 460). They are identified through onset, intensity and duration of symptomology including but not limited to experiencing: persistent low mood, loss of interest or pleasure, fatigue, sleep disturbances, irritability, difficulties concentrating, changes in appetite, feelings of guilt, worthlessness and anxiety (APA, 2013). With this medical lens, antidepressants are often considered as the first line of treatment, with over 1 in 8 women receiving these during the first year after their delivery (Petersen et al., 2018).

Despite a common understanding within the existing literature that physiological changes can contribute to the development of PND, it is not consistently reported that hormonal changes would be a cause for it (Abdollahi et al., 2016). Furthermore, there is limited evidence to support the biological nature of postnatal depression (McMullen & Stoppard, 2006; Nicolson, 1999) and for the efficacy and safety of using antidepressants as treatment for PND (Molyneaux et al., 2014). Shaikh and Kauppi (2015) argued that the search for pharmacological interventions and therapies such as cognitive behaviour therapy can strengthen the position of medicalizing women's experiences, rather than understanding and addressing these within the context of larger societal, social, cultural and political forces.

With this in mind, PND could also be understood through the lens of psychosocial theories, which highlight psychosocial stressors and interpersonal struggles as key factors in developing PND (Abdollahi et al., 2016). This is now recognised as a predominant approach in understanding PND, as psychosocial risk factors have been identified extensively within the field (Boyce & Hickey, 2005). From this perspective, it is recognised that giving birth and becoming a mother are significant life events which inherently generate important

psychosocial fluctuations and that social support is pivotal in navigating these (Abdollahi et al., 2016). Some of the identified psychosocial risk factors include history of mental health difficulties, poor marital and other family relationships, low economic status, and limited social support (Çankaya, 2020; O'hara & Swain, 1996; Qi et al., 2021). These factors are likely to impact on mothers' mental health by contributing to stress, trauma, feelings of inadequacy and isolation (Çankaya, 2020; Qi et al., 2021).

Although neither the biological nor the psychosocial approaches are sufficient alone to fully explain the nature of PND and to understand women's varied and complex experiences, the psychosocial theoretical model of understanding is most in line with the current study's epistemological critical realist lens to exploring migrant mothers' experiences of PND (Arifin et al., 2020; Sword et al., 2012; Wittkowski et al., 2017).

Experiencing postnatal depression can be challenging in itself for any mother, but for migrant mothers, the layers of adjustment and additional migration-related barriers pose additional risks and challenges impacting overall mental health (Russell, 2017; Wittkowski et al., 2017). PND has been reported as nearly 20% higher in migrant mothers than in non-migrant mothers (Falah-Hassani et al., 2015).

Schmied et al. (2017) explored the impact of migration on mothers' experiences of PND through a meta-ethnographic study and found that most participants had felt a deep sense of loneliness, anger and worry. They also noted that participants tried to make sense of their experiences through relating them to stigma around PND, life as a migrant being difficult, a loss of social support, and heightened cultural expectations of being 'a good mother' (Schmied et al., 2017).

Some migrant mothers may be more likely to face stigma and marginalisation within their experiences of PND due to cultural expectations of motherhood and responses to mental distress (Maxwell et al., 2019; Rao et al., 2020; Schmied et al., 2017; Wittkowski et al.,

2017). Emotions associated with estrangement and isolation from one's own culture as well as the host culture may partly explain psychological difficulties experiences by migrants (Butler et al., 2015). Migrant mothers experiencing PND are having to grapple with renegotiating their own identities as migrants and as mothers across more than one culture (Rao et al., 2020; Schmied et al., 2017; Wittkowski et al., 2017).

In addition to this, migrant mothers are not only navigating layers of loss and for some, grief, through their migration experiences but also through that of their PND experiences (Nicolson, 1990). Lawler and Sinclair (2003) provided insight into women's experiences of PND and the loss of 'former self' they were confronted with. There was an identified cycle of grief that mothers go through when experiencing PND, around their previous selves, ideal selves and new selves (Abrams & Curran, 2011; Lawler & Sinclair, 2003). This echoes the challenges mothers may have faced through their experiences of migration, where cultural identities are being renegotiated (Bhugra, 2004).

Finally, having limited support around such a significant life event as giving birth, is a particularly significant risk factor for migrant mothers developing PND (Abdollahi et al., 2016). Having social support decreases the likelihood of developing PND, emphasising the need for increased formal and informal social support for first-time migrant mothers (Zlotnick et al., 2013). Social support could be a mediating role for immigrant mothers in overcoming feelings of loneliness (Wittkowski et al., 2017).

There seems to be an intersection of risk factors for migrant mothers developing PND and the strong impact this has on their sense of isolation and loneliness (Schmied et al., 2017; Taylor et al., 2021; Wittkowski et al., 2017). This highlights a need for building the evidence based for models of peer support for migrant mothers who experience PND and a better understanding of differences in individual experiences (Schmied et al., 2017).

Conclusion

Although migration can be associated with both positive and negative experiences, the literature which was presented has demonstrated that even if migrants voluntarily chose to resettle in the UK, they are likely to be faced with migration-related challenges and adjustments (Brance et al., 2024; Deighton-O'Hara, 2018; Ottonelli & Torresi, 2013). This has been shown to impact migrant mental health, with higher prevalence for experiencing anxiety and depression compared with non-migrant populations (Almeida et al., 2016; Brance et al., 2024; Deighton-O'Hara, 2018; Falah-Hassani et al., 2015; Mucci et al., 2020). Some migrants also have the added layers of adjustments of becoming new parents in their new country (Bornstein et al., 2020). Migrant mothers' mental health is particularly at risk with the interaction of these challenges (Almeida et al., 2016; Benchekroun, 2023; Das & Beszlag, 2021; Erel et al., 2018; Latif, 2014). Through synthesising existing literature on the parenting experiences of migrant mothers, key psychosocial stressors and resilience factors will be explored, which are likely to intersect with maternal mental health outcomes in the postnatal period, and more specifically PND. By understanding migrant mothers' experiences of parenting, we can gain a better perspective on the lived realities of migration and motherhood which provides a context within which some migrant mothers may experience PND. This is explored in the systematic literature review that follows.

Chapter 2: Systematic Literature Review

In this chapter, a Systematic Literature Review (SLR) on migrant mothers' experiences of parenting in the UK is presented. The chapter includes the aim, methodology, findings and discussion of the SLR.

Aim and scope

The aim of an SLR is to review literature within a specific topic area, to highlight gaps in the field and generate implications and future recommendations. This was done through a rigorous search strategy attempting to identify, synthesise and appraise relevant papers. This method was chosen over other types of review such as scoping or meta-analysis, as it aimed to identify the current state of knowledge and gaps within a migrant mother field of research, as well as provide an overview of the literature, to scaffold a rationale for the empirical study. This SLR aimed to address the following question:

What are migrant mothers' experiences of parenting in the United Kingdom (UK)?

To my knowledge, and through preliminary scoping through PROSPERO, no other identified SLR regarding this topic has previously been conducted.

Methodology

Search tool

I used the Sample Phenomenon of Interest Design Evaluation Research (SPIDER; Cooke et al., 2012) tool, which is most often used in qualitative research when focusing on 'samples' rather than populations (see Table 2). The SPIDER tool helps the researcher identify the five main concepts being addressed through the search, which are then defined through a variety of search terms and combination of these.

Table 2

SPIDER Tool (Cooke et al., 2012)

Concept

Sample	Migrant mothers
Phenomenon	Parenting in the UK
Interest **D**esign	Interviews or focus groups
Evaluation	Experiences and narratives
Research	Qualitative or mixed methods with a qualitative component

Search strategy

Pilot searches across three databases were initially conducted on 15.08.24 to determine the most relevant terms. Scopus was first searched to help determine the final combination of search terms that would yield the most relevant results. Scopus was chosen as the first database because it is interdisciplinary and includes broad content covering health, life and social sciences. Medline was also identified as relevant, covering health and biomedical science as well as social science journals. Finally, CINAHL Plus was used to search through the nursing and allied health fields. Two more searches were conducted on 13.09.24 and 11.10.24 for the purpose of scoping whether new relevant research had been published since the initial search. The final search results were imported to Covidence on 30.10.24.

The final search terms are outlined in Table 3. Boolean operations were used to help generate relevant results. The exact combination of search terms was tailored according to each database in order to yield an appropriate number of relevant results (see Appendix B). The use of additional filters was not required. There were no publication date restrictions as the phenomenon being studied transcends across different periods of time.

The snowballing technique was used to find further relevant papers, for example, by reviewing the references of identified papers. On this occasion, grey literature was not

searched systematically as the databases yielded a sufficient number of papers which were relevant to the review question.

Table 3

SLR Search Terms

Concept	Search terms
Migrant	Immigrant* OR Migrant* OR Expat*
	AND
Parenting	Mothering OR Parenting (OR Motherhood OR Matern* OR Mother*)
	AND
Qualitative	Qualitative OR Experience* (OR Reflection* OR Narrative OR Interview OR "focus group*")
	AND
UK	"United Kingdom" OR UK OR Britain

Screening and eligibility criteria

The searches across three databases generated a total of 736 results. These results were imported through the Covidence Systematic Review online software, which removed a total of 64 duplicate records. The first part of screening included reviewing the titles of each paper and determining their relevance to the question with the aid of predetermined inclusion and exclusion criteria (see Table 4).

Table 4

Literature Search Inclusion and Exclusion Criteria

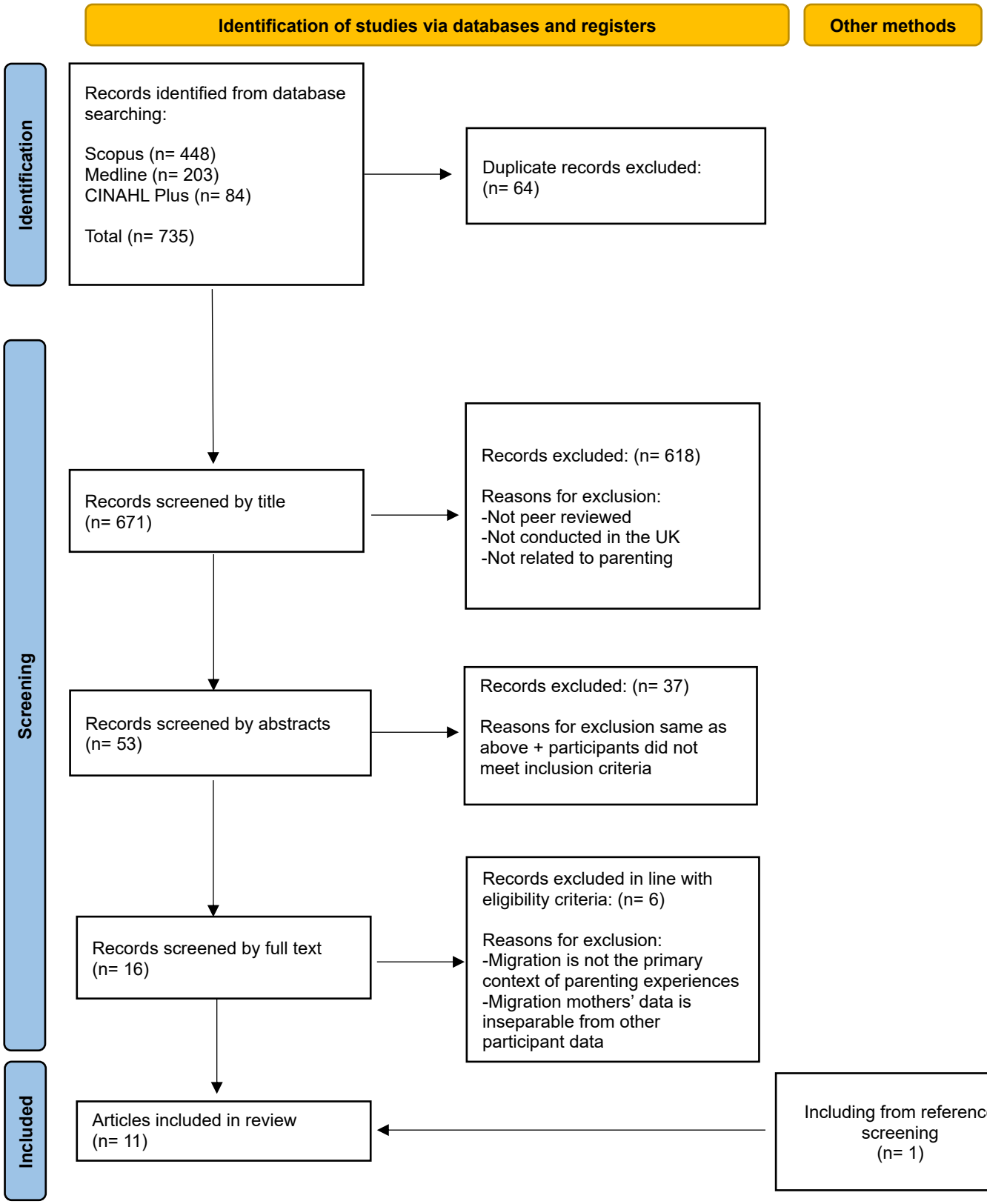
Inclusion criteria	Exclusion criteria
The study must address first generation voluntary migrant mothers' experiences of parenting in the UK. 'First generation voluntary migrant' is defined as someone	The study is focused on experiences of refugee, asylum seeking or internally displaced persons' (IDP) experiences.

who is the first in their family to have moved to the UK by choice.	
The study is published in a peer-reviewed journal.	The study is focused solely on a specific aspect of parenting (e.g. Feeding, schooling).
The study involves participants that live in the UK.	The study solely involves participants living outside of the UK.
At least 50% of the participants included in the study are migrant mothers and this data is separate from other participants.	More than 50% of participants included in the study are not migrant mothers (i.e. fathers, professionals, second generation…) and/or the data is collated.
The study is written and published in English.	The study is written and published in any other language than English and/or where no translated version is available.
The study uses a qualitative or mixed methods approach with a qualitative component.	The study uses a quantitative approach, or is classified as a type of review (scoping, literature etc.).
The study includes participants that were born outside of the UK.	The study solely includes participants that are British born.
The study includes participants over the age of 18.	The study includes participants under the age of 18 or both over and under the age of 18, where the data is collated.

Where this was not clear from the title, the second part of screening involved reading through the papers' abstracts. A total of 17 papers were identified through double screening of titles and abstracts with a second reviewer, which was followed by a final full text screening. A final number of 11 papers were identified for the SLR. The process of paper selection is shown in the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flowchart (see Figure 1; Page et al., 2021). PRISMA is a set of guidelines for conducting systematic reviews which, when followed, ensures that the research is being conducted in a transparent and replicable manner.

Figure 1

PRISMA Flowchart for SLR (Page et al., 2021)



Study characteristics

A summary table of the 11 studies chosen for the SLR was generated (see Table 5). The studies' publication dates ranged from 2008 to 2024 and were all conducted in full or in part within the UK. A total number of 141 first generation migrant mothers were represented across these studies, with sample sizes ranging from 3 to 37. Some studies also included other participants such as fathers (Condon & McClean, 2017; Machaka, 2024; Okpokiri, 2021) or second-generation migrants (Lam et al., 2012), but reported the data separately from the first-generation mothers, making them therefore eligible for review and analysis. All but two studies (Erel, 2011; Lisiak, 2018) provided the age of participants ranging from 17 to 64 years old. Countries of origin spanned across four continents: Europe, Africa, Asia and South America; with four studies including participants from Poland (Condon & McClean, 2017; Erel, 2011; Lisiak, 2018; Pustulka, 2016). All studies except for three (Brahic, 2022; Erel, 2011; Okpokiri, 2021) specified how long it had been since the participants arrived in the UK, and this ranged between 1 and 35 years prior to the study taking place.

All studies were qualitative as per the inclusion criteria defined for this SLR. All used in depth individual interviews except for one, which solely included focus groups (Condon & McClean, 2017). Some also included complementary methods such as focus groups (Okpokiri, 2021), observations (Brahic, 2022), field notes (Machaka, 2024) or image elicitation (Lisiak, 2018). Within the types of analyses that were mentioned, there were some common qualitative approaches such as thematic analysis (Machaka, 2024; Okpokiri, 2021) and grounded theory (Lam et al., 2012). There was also one non-western method used (Ozeki, 2008): the Japanese Kawatika Jiro (KJ; Kawakita, 1967), which is an equivalent method to content analysis and data reduction; and one anti-essentialist method used (Machaka, 2024): The Silences Framework (TSF) cyclic analysis (Serrant-Green, 2010), which aims to address sensitive issues or marginalised perspectives in health research. All

other studies omitted stating specific analysis methods, but referred to: using a 'reflexive ethnographic' approach (Roitman, 2020), using a 'progressive-regressive' approach (Erel, 2011), drawing on 'themes' (Bawadi & Ahmad, 2017; Brahic, 2022; Condon & McClean, 2017; Pustulka, 2016) or drawing on 'theoretical discussions to focus on stories' (Lisiak, 2018).

Table 5

Summary of Studies Included in the SLR

Author(s) & Date of Publication	Aim(s) of the study	Sample	Methodology	Summary of findings	Strengths & Limitations
Bawadi & Ahmad, 2017	Explore Arab migrant women's experiences of pregnancy, childbirth and postnatal experiences in the United Kingdom	8 migrant women Age range: 22-37 years old Duration since arrival in the UK: 1-10 years Socioeconomic background not specified by authors Ethnicity: Arab Country of origin: Jordan (2), Saudi Arabia (2), Algeria (1), Syria (1), Sudan (1) and Egypt (1)	Recruitment: purposive sampling Methods: In depth interviews across three time periods (28 weeks of pregnancy, 1 to 2 weeks after birth and 1 to 3 months later) Analysis: Specific analysis method not explicitly stated by authors but refers to emerging themes and interpretations being discussed	Themes identified around the displacement and reformation of self through: a change in social structures around the family as a result of migration, influencing the mother's sense of self; an increased need for self-reliance partly due to the absence of extended family; a freedom from cultural constraints and extended family expectations, forming a sense of liberation; and migration having offered a sense of freedom to making own decisions regarding parenting and family life. Findings related specifically to parenting	+ The in-depth interviews across three time points allows for participants to revisit missed themes in initial recollections. + There are detailed interpretations of experiences rather than specific focus on challenges as previously researched. + There is a broader lens on lives prior to migration, subsequent impact of migration and changing identities through becoming a mother rather than solely on maternity service experiences as previously researched. - The sample of participants is homogenous in terms of

				include the freedom to parent and make decisions about their child as the mother wishes, compared to back home where the extended family have a strong influence over this. There was also the impact noted around migration around limited childcare and an increased level of involvement in parenting from the husband.	socio-economic backgrounds (middle-class) and none were illiterate. - The sample size is small despite being appropriate to the methodology chosen.
Brahic, 2022	Explore the impact of migration policy changes and subsequent uncertainties on transnational family-making and mothering practices To compare datasets from two projects reflecting pre- and post-Brexit migratory contexts to explore the impact on French migrant mothers' experiences of	French migrant families (number not specified) including: 15 mothers Age range: 25-56 years old Duration since arrival in the UK: not specified by authors Socioeconomic background: middle class	Recruitment: identified through playgroup and subsequent purposeful and snowballing sampling Methods: Observations of families taking place during a bi-monthly free playground session over two years (2016-2018)	Prior to Brexit, participants shared their sentiment of reward and acknowledged their privilege as middle-class French nationals living in the UK. Post-Brexit, participants became more aware of their migrant status and the sense of injustice or change in privileges, subsequently influencing their experience of mothering. Themes included the pre-Brexit socially rewarding experiences of migrant	No strengths or limitations specified by authors.

	mothering and motherhood in the UK	Ethnicity: white Country of origin: France (15)	15 semi structured interviews conducted across 2 years Analysis: Specific analysis method not explicitly stated by authors but refers to it being 'spatio-temporal' and themes being drawn out from the data	mothering, the implications of raising a child bilingually, a reconsideration of a future in the UK post-Brexit due to a sudden sense of rejection and an overall consideration that the context of migration and changing policies influence migrant mothers' sense of citizenship and belonging.	
Condon & McClean, 2017	Highlight migrant parent experiences of bringing up children in the UK and keeping a healthy lifestyle for them	28 migrant parents including: 22 migrant mothers and 6 migrant fathers Age range: 17-47 years old Duration since arrival in the UK: 1-10 years Socioeconomic background: low	Recruitment: gatekeepers (interpreters and community link workers) identified participants within inner city areas of high socio-economic deprivation Methods: Five one off focus groups were held (one per country of origin)	Choice of migration was influenced by wanting optimal parenting conditions for their children's health (e.g. increased financial security, decrease in barriers to outside play and activity). There was variety in the findings regarding how integration ease depended on parent resources (e.g. education, professional qualifications, language skills).	+ The method highlights findings are indicative (albeit not representative) of attitudes and behaviours of the national and ethnic groups of those who participated, adding knowledge regarding factors which influence health behaviours within the context of migration and acculturation. +The study is innovative by including both parents and recruiting from communities that are rarely included in health research.

		Ethnicity: not specified by authors Country of origin: Romania (7), Roma Gypsy (6), Poland (6), Somalia (5), Pakistan (4)	Analysis: Specific analysis method not explicitly stated by authors but refers to drawing out themes from coding	Some groups faced more challenges due to systemic social exclusion and hardships. Although it was a choice to move for economic reasons (study or work), this group of participants faced challenges similar to those with a refugee seeking status (e.g. housing issues). Findings related specifically to parenting included better access to education, healthcare and leisure opportunities for children being raised in the UK; loss of informal childcare from extended family and the impact on parents balancing work and childcare.	+The study is inclusive by offering bilingual focus groups. - Research recruitment potentially biased due to influence of prior established rapport with the Roma community. -Some groups only had mother participants where fathers' views were not represented. -Having mixed gender groups may have influenced and/or limited what could be seen as culturally appropriate to speak about.
Erel, 2011	Pilot project exploring experiences of mothering, migration identification and citizenship.	5 migrant mothers Age range: not specified by authors	Recruitment: conducted via community centres, ethnically specific schools and personal contacts	Highlighting the distinctiveness in the participants' mothering styles compared to non-Polish mothers; e.g. a stricter mothering style	No strengths or limitations specified by the authors.

	Part of the article focusses specifically on the experience of mothering and bringing up children in the UK	Duration since arrival in the UK: not specified by authors Socio economic background: not specified by authors Ethnicity: not specified by authors Ethnicity: not specified by authors Country of origin: Poland	Methods: topical life-story interviews Analysis: Specific analysis method not explicitly stated but refers to using a progressive-regressive method	regarding education and respectful behaviour Noting the discourses that Polish migrant mothers have around raising their children to contribute to British society and be disciplined 'to be good citizens'	
Lam et al., 2012	Explore the interface between Chinese culture/traditions and the experience of being a Chinese mother living in the UK whilst investigating factors that contribute to their feelings and experiences	8 mothers including: 6 first generation Chinese migrants 2 second generation Age range: 24-34 Duration since arrival in the UK:	Recruitment: conducted via a charitable organisation for women in the Chinese community of Manchester and recruitment poster Methods: Interviews	All mothers felt a degree of isolation and experienced conflict attributed to cultural differences. The isolation was felt to a higher degree for those who did not speak English. Findings related specifically to parenting included: communication	+ Researcher background and insight into both cultures proved beneficial as close supervision and detailed footnotes were used to address assumptions. + Researcher notes it became apparent that participants were more

		less than 1 year – 32 years Socio economic background: not specified by authors Ethnicity: not specified by authors Country of origin: China (5), Hong Kong (2), Ireland (1)	Analysis: Grounded Theory	barriers with healthcare which influenced the extent to which mothers feel supported through their parenting; stress relating to child-caring, lack of support and a sense of isolation which led some mothers to connect with friends and relatives back home to help them with parenting advice; difficulties integrating divergent cultural parenting advice and value systems.	comfortable discussing their cultural beliefs with someone from the same background. + Providing a language interpretation service. No limitations specified by authors.
Lisiak, 2018	Analysing migrant mothering by focussing on migration-specific cultural and social capital within various classed urban contexts Exploring ways in which migrant mothering is performed, negotiated and framed	3 migrant mothers Age range: not specified by authors Duration since arrival in the UK: 2-6 years Socio economic background: working class (2), middle class (1)	Recruitment: not specified by authors Methods: Semi structured and image-elicitation interviews Analysis: Specific analysis method not explicitly stated but refers to drawing on theoretical discussions to focus	Three case studies were selected from a wider data collection and were identified due to the mothering practices and the attitudes to 'good mothering' they exhibit, and which exemplify the workings of intensive mothering in migration and urban contexts.	No strengths or limitations specified by authors.

		Ethnicity: not specified by authors Country of origin: Poland	and look at the stories provided		
Machaka, 2024	Explore how Zimbabwean parents experience bearing and raising children in the UK as well as their perspectives on how to sustain their children's health and wellbeing	10 migrant parents including 5 mothers and 5 fathers Age range: 36-50 Duration since arrival in the UK: 14-17 years Socio economic status: not specified by authors, range of employment status Ethnicity: Black Zimbabwean Country of origin: Zimbabwe	Recruitment: purposive and snowball sampling Methods: In-depth interviews (including a visual element and field notes) Analysis: The Silences Framework cyclic analysis (TSF; a framework for researching sensitive issues or marginalised perspectives in health) and thematic analysis	Four themes were identified: -*Shared worlds*: Parents embedded Zimbabwean and UK values to navigate their own sense of belonging as well as how to raise their children. -*Parenting in the UK system*: living as a racial minority implies being subject to discrimination and increased conflict around raising children in a way that is carefully monitored or policed by the state and child welfare institutions; this in turn fuels a sense of powerlessness in parenting	+ The study exposes the previous silence of stressors impacting migrant parents' experiences. +The study adds to a growing body of knowledge on the Zimbabwean diaspora in the UK: it speaks to a fuller picture of the migration journey and migrant life. +The TSF is a valuable framework for contextualising experiences of marginalisation and silences inherent to status: the study includes fathers, whose voices are usually silenced. -Outside researcher position may have been a barrier in

				in the UK. -*The parenting journey*: internalised social scripts and expectations around parenting are ever changing in the spaces where children are being brought up, and this adds an additional burden on parents' experience of belonging; there is a reconstruction of gender roles through migrant parenting experiences, which can be challenging to process. -*This is our home now*: the felt parenting environment helped parents adapt in the UK and make it their home; there is a reconsideration for family life and how it is organised around new aspects of migrant life (e.g. childcare).	the research process. -The silence around interview language was not addressed: it was conducted in English.
Okpokiri, 2021	Explore how Nigerian parents experience the British child welfare	25 parents including:	Recruitment: purposive sampling, conducted by	Four key participating parenting strategies were identified:	+ This paper helps provide context and better understanding of Nigerian

	system and navigate tensions within this system in relation to Western constructs of parenting styles which differ to Nigerian parenting	18 women and 7 men from separate families Age range: early 30s-late 50s Duration since arrival in the UK: not specified by authors Socio economic background: not specified by authors Ethnicity: Black African Country of origin: Nigeria	gatekeepers from community associations, religious organisations and other networks of Nigerien populations in the UK Methods: In-depth semi-structured interviews Two one off equally split focus groups including 8 participants who were able to attend following their individual interview Analysis: thematic analysis	-*Passive*: participants support the total adherence of UK norms and lifestyles in their child-rearing practices. -*Introvertive*: resistance to fully assimilate without necessarily entirely rejecting British child-rearing norms. -*Active*: choosing to engage with the adopted society; e.g. by taking part in socio political activities and being open to new child-rearing ideas while resisting poor practices. -*Transpositional*: experiences of child welfare management in Britain as too difficult and consequently reviewing the option of translocating their children back to Nigeria.	parenting strategies in the UK, for child safeguarding professionals to take into account when making decisions impacting these families. No further strengths or limitations specified by authors.
Ozeki, 2008	Explore Japanese mothers' experiences	10 migrant mothers	Recruitment: conducted via a	Findings were sorted into themes including: worries	-Small sample, meaning limited generalisability.

	of childbirth and child rearing in the UK and describe transcultural stressors	Age range: 28-41 years old Duration since arrival in the UK: 1 – 16 years Socio economic background: not specified by authors Ethnicity: not specified by authors Country of origin: Japan	voluntary Japanese mothers' self-help group Methods: Semi structured interviews; open-ended questions Analysis: Kawakita Jiro (KJ) analysis method equivalent to content analysis and data reduction	around losing traditional Japanese ways of child rearing, Japanese language and culture; experiencing the language barrier and the negative impact it has on feeling isolated and in general, the mother's mental health; difficulties adapting to the climate and being unable to bring the children outdoors more; and a stressor around socialising with British parents so that their children could have peers to play with.	No other strengths or limitations specified by authors.
Pustulka, 2016	Explore Polish migrant mothers' experiences of living and parenting in Germany and the UK Examine women's narratives on how mobility and gender intersect	37 Polish mothers Age range: 23-64 years old Duration since arrival in the UK: 5-35 years Socio-economic background:	Recruitment: non-probabilistic deliberate method Methods: narrative and semi-structured interviews Analysis: Specific analysis method not explicitly stated but	Three models of mothering were identified as 'ideal type' constructs: the Mother-Pole, the Intensive Motherhood and New Migrant Mothers . For the Mother-Poles, there is a turn towards traditionalism and a strive to maintain Polish culture	+ The cases presented pinpoint a diversity of adopted identities through the mothering constructs. -This study alone could imply a sense of heterogeneity of migrant experiences and oversee some complex realities which could be a concern

	variety of working class, middle class and upper-middle class Ethnicity: not specified by authors Country of origin: Poland	refers to open-coding and using a matrix for case-by-case and cross-case comparative thematic categorisations	and traditions despite the move, which is deemed a sacrifice for children to have a 'better life' rather than a personal choice. This type of mothering also inevitably implies 'othering' and absence of integration. 'Intensive mothering' implies maternal sacrifice and a full-blown involvement in the child's life, associated by some mothers as 'good mothering' under local standards rather than traditional Polish ones. The study suggests this is a contradicting, opposite, type of mothering compared with the Mother-Poles. New Migrant Mothers are identified as those who position themselves within a different, reflexive narrative compared with the other two mentioned types. There is a desire to	and should be addressed in future research.

				mother in a modern and integrative way, for their children to 'feel at home' in both cultures.	
Roitman, 2020	Explore individual experiences of women as migrants, how they experience their changing identity entering motherhood and how they straddled two cultures as their children grew up in the UK	10 migrant mothers Age range: 25-50 years old Duration since arrival in the UK: 2 years + Socio economic background: varied, not specified by authors Ethnicity: not specified by authors Country of origin: Ecuador	Recruitment: conducted via researcher personal network, social media and the Ecuadorian Consulate in London Methods: Semi-structured, extended interviews Analysis: Specific analysis method not explicitly stated but refers to reflexive ethnographic research	Mothering is a challenging and multifaceted reconnection to one's own mother, which is made complicated by being in a different country. There is an active process to re-create one's own Ecuadorian cultural values within mothering in the UK. E.g. Language and food play a critical role in cross-cultural mothering. It is also important for mothers to acknowledge their children as Ecuadorian, regardless of migrant status or citizenship.	-Interviewees are from three large cosmopolitan cities and therefore have a sense of belonging which is not necessarily representative of migrants in other, less multicultural areas. No other strengths or limitations specified by authors.

Quality appraisal of literature

The Critical Appraisal Skills Programme (CASP; 2024) is commonly referred to when assessing the quality of literature in health-related fields and it is recommended for use by novice qualitative researchers (Hannes & Bennett, 2017). The CASP (2024) qualitative checklist was used here with the aim to assess the robustness of the papers included in the review, through assessing their validity, results and relevance to the field. The CASP (2024) does not assess the quality of the research itself, but the quality of how it is reported in the identified paper. The checklist provides prompts and questions to consider when assessing the quality of each of the following aspects: research aims, method, design, recruitment, data collection, relationships, ethics, data analysis, findings and overall value (see Table 6).

Table 6

CASP (2024) Qualitative Checklist of Included Studies

Author(s) & Date	**Clear Aims** *Was there a clear statement of the aims of the research?*	**Method** *Is a qualitative methodology appropriate?*	**Design** *Was the research design appropriate to address the aims of the research?*	**Recruitment** *Was the recruitment strategy appropriate to the aims of the research?*	**Data Collection** *Was the data collected in a way that addressed the research issue?*	**Relationships** *Has the relationship between researcher and participants been adequately considered?*	**Ethics** *Have ethical issues been taken into consideration?*	**Data Analysis** *Was the data analysis sufficiently rigorous?*	**Findings** *Is there a clear statement of findings?*	**Overall Value** *Has the research contributed to existing knowledge or understanding?*	**Rating**
Bawadi & Ahmad, 2017	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes	9/10 High
Brahic, 2022	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Yes	Yes	8/10 High
Condon & McClean, 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10 High
Erel, 2011	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Cannot tell	Yes	Yes	7/10 Moderate
Lam et al., 2012	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	9/10 High
Lisiak, 2018	Yes	Yes	Yes	Cannot tell	Yes	Cannot tell	Cannot tell	Cannot tell	Yes	Yes	6/10 Moderate
Machaka, 2024	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10 High

Okpokiri, 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10 High
Ozeki, 2008	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10 High
Pustulka, 2016	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Cannot tell	Yes	Yes	Yes	7/10 Moderate
Roitman, 2020	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Yes	Yes	8/10 High

The appraiser answers 'yes', 'no' or 'cannot tell' to the main question associated with each aspect. While it enables appraisers to rate aspects of papers, it does not provide standardised scoring guidelines as the authors recognise the presence of reviewer bias and how this can lead to misleading appraisals (CASP, 2023). Due to the absence of standardised scoring, the appraiser needs to rely on their own skills in interpreting quality of the evidence, which means the rating is partly subjective (Long et al., 2020).

The papers were screened against an overall rating out of 10 points, representing the numbers of questions asked to assess the quality (Milner et al., 2020). The scores therefore ranged from 0-4 (low), 5-7 (moderate) and 8-10 (high). A total of eight papers scored within the 'high' overall quality range (Bawadi & Ahmad, 2017; Brahic, 2022; Condon & McClean, 2017; Lam et al., 2012; Machaka, 2024; Okpokiri, 2021; Roitman, 2020) and the other three (Erel, 2011; Pustulka, 2016; Lisiak, 2018) scored within the 'moderate' range. CASP (2024) deem papers to be of 'poor quality' if any of the first three questions are answered with a 'cannot tell' or 'no'. The first three questions for all papers were answered with a 'Yes', therefore, this paired with their moderate to high rating, confirmed an appropriate and sufficient quality to be used in this SLR.

All papers had clear aims and methodologies, for which qualitative designs were well suited. The findings were thorough and often collated into themes, which included some additional reflections linked to context through referring to migration and social studies literature. Although all papers included data analysis in one form or another, some did not explicitly state which method they used (Bawadi & Ahmad, 2017; Brahic, 2022; Condon & McClean, 2017; Erel, 2011; Lisiak, 2018; Pustulka, 2016; Roitman, 2020). Some authors did not clearly mention that ethical approval had been sought or gained, nor did they mention ethical dilemmas or potential considerations (Brahic, 2022; Erel, 2011; Lam et al., 2012; Lisiak, 2018; Pustulka, 2016; Roitman, 2020). It was concerning that the ethical

considerations were not mentioned as there is an additional level of risk of harm which could occur towards migrant populations due to a potential lack of legal status, experiences of trauma and language barriers (Bloemraad & Menjivar, 2022). It may have been that these authors reported on and analysed data that they did not collect themselves, such as Erel (2011), although they nonetheless could have reflected on ethical considerations.

In four studies, there was also a notable lack of researcher reflexivity reported, which was disappointing considering the qualitative nature of the studies. Although some may argue that quantitative research aims to be conducted in a way that is as free as possible from researcher bias (Young & Ryan, 2020), qualitative research is intertwined with subjectivity at its core (Olmos-Vega et al., 2023). It is therefore not only desirable but essential for qualitative researchers to acknowledge their positionality to prevent or minimise harm throughout the research process and increase the trustworthiness of the findings (Olmos-Vega et al., 2023).

I noticed a level of unease when I was first introduced to the CASP tool. I wondered where this came from and realised that I initially questioned whether this approach would risk perpetuating an exclusive and elitist approach to what is considered 'valuable' research, and subsequently a publication bias. Speaking about this in supervision helped me to recognise the tool's relevance in line with my SLR and the decision to solely select peer reviewed papers. I learned the benefits in being able to assess rigour through structure and consistency, whilst also acknowledging the limitations of excluding grey literature, such as offering diverse perspectives and concrete examples of practice.

Thematic Synthesis

Different methods can be used to synthesise qualitative research including meta-ethnographies, narrative and thematic syntheses (Barnett-Page & Thomas, 2009; Johnston et al., 2020).

A thematic synthesis approach was deemed the most appropriate to answer the broad research question in a flexible and accessible way given the novice researcher position and restricted timeframe (Thomas & Harden, 2008). The aim was to go beyond merely collating and describing data previously collected by other authors, and actively interpret and propose new knowledge, which could be interpreted from patterns within and across this data (Johnston et al., 2020). The thematic synthesis was conducted in three stages (see Table 7; Thomas & Harden, 2008).

Table 7

Stages of Conducting a Thematic Synthesis (Thomas & Harden, 2008)

Step	Description
Line by line coding	Developing codes for relevant information within the 'findings' or 'results' section of each selected paper.
Developing descriptive themes	Amalgamating codes together and forming themes that describe the information collated within the codes.
Generating analytical themes	Creating 'new knowledge' through transforming, breaking down or revisiting descriptive themes before drawing out interpretations, relevant to the SLR question. (Ryan et al., 2018).

When I conducted the SLR, my own experiences and assumptions of what it was like being raised by migrant parents came to the forefront. I realised that I held strong beliefs about the impact of migrant parenting, and that all of these were formed from the eyes of a child of a migrant mother. This SLR pushed me to set these assumptions aside and seek to better understand the parent perspective. I reflected on why I felt drawn to certain papers or quotes more than others, and made a conscious effort to include perspectives which were new to me or that I did not necessarily agree with, in the findings.

Findings

Four themes and nine sub-themes were identified through a thematic synthesis of the selected papers' findings (see Table 8; Thomas & Harden, 2008). Where possible, the coding targeted the papers' clearly identified results or findings sections (Bawadi & Ahmad, 2017; Brahic, 2022; Condon & McClean, 2017; Lam et al., 2012; Machaka, 2024; Okpokiri, 2021; Ozeki, 2008; Pustulka, 2016). An explicit choice was made to omit discussion sections in order to maintain a descriptive grounding and stay closer to the original data (Thomas & Harden, 2008). Although second order data within results or finding sections were coded, this remained directly relevant to participant quotes, which is different to including 'discussion' sections. The latter would have included wider contextual author interpretations linked to theoretical speculations, which could have risked creating a level of abstraction from the participants' direct experiences. Where the data did not include a clear heading such as 'results' or 'findings', the authors' identified themes were selected as areas to code (Erel, 2011; Lisiak, 2018; Roitman, 2020; Thomas & Harden). Only information that was deemed relevant to answering the research question was included within the coding process. First order (cited from participants) and second order (cited from authors) data were used to illustrate each theme. The themes aimed to answer the question 'What are migrant mothers' experiences of parenting in the UK?'. They encapsulated a variety of experiences shared by participants who took part in the 11 studies. The similarities and differences in experiences were described through this narrative of synthesised themes.

Table 8

Summary of SLR Themes

Theme	Sub-theme
Theme 1: Experiences of parenting within the context of migration	The impact of migration motivations on mothering

	Status and degrees of privilege within migrant parenting
Theme 2: Parenting experiences across various levels of integration	Parenting enacted through assimilation with UK culture Parenting enacted through integration of both UK and home cultures Parenting enacted through reluctance or resistance to adhere to UK culture
Theme 3: Changes in the family structure post-migration	A move towards collaborative parenting through gender role renegotiation From extended family involvement to a nuclear family model of parenting
Theme 4: The unique challenges of migrant parenting and mitigating factors	Language and cultural barriers as unique challenges of migrant parenting Mitigating factors which help migrant mothers navigate parenting in the UK

Theme 1: Experiences of parenting within the context of migration

Migrant mothers' experiences of parenting seemed to be partly shaped by their migration context, including their migration motivations (Bawadi & Ahmad, 2017; Brahic, 2022, Condon & McClean, 2017; Erel, 2011; Lam et al., 2012; Lisiak, 2018; Pustulka, 2016) and status, which appeared to determine a more or less privileged lens to parent from (Brahic, 2022; Condon & McClean, 2017; Erel, 2011; Lam et al., 2012; Lisiak, 2018; Machaka, 2024; Okpokiri, 2021; Roitman, 2020).

The impact of migration motivations on mothering. The participants shared the reasons for their move and subsequently spoke about the impact on their parenting experiences (Bawadi & Ahmad, 2017; Brahic, 2022; Condon & McClean, 2017; Erel, 2011; Lam et al., 2012; Lisiak, 2018; Pustulka, 2016). Although all participants met the inclusion criteria for 'voluntary migration', meaning they were not 'forced' to move countries, Pustulka

(2016) highlighted that for some of them, the decision to migrate was nevertheless an "*unwanted separation from one's home*" (p. 50). This put in perspective the many reasons why mothers migrated to the UK and highlighted the degree to which this move was wanted. Whether they were deemed 'accidental movers' or alternatively, 'aspirational movers', Brahic (2022) stated that the "*respondents' migratory trajectories informed their experiences of mothering in the UK*" (p. 2177).

For some mothers, the decision to move seemed to have been made reluctantly on a personal level, but nevertheless for the greater benefit of their child(ren) and family (Erel, 2011). One participant stated they had moved with the hope to offer their children a better life:

"We had to come here for our children, because of the situation in Poland, we had nothing, could not give them the lives that they deserved… I do not like it here, but we came, so that they can have a better future, not for us to enjoy life…" (Pustulka, 2016, p. 50).

Condon and McClean (2017) summarised that "*accessing better life chances for children was a major factor in deciding to live in the UK, notwithstanding the difficulties experienced by parents in living apart from home and family"* (pp. 456-457).

Brahic (2022) emphasised this point by stating that "*whilst some relished moving (…) the majority had not actively chosen to do so* (…) *these women became 'accidental', and occasionally reluctant, movers to keep the family together*" (p. 2176).

For others, the decision to move seemed to be a more intentional and preferable choice in line with their specific parenting practices (Lam et al., 2012; Lisiak, 2018; Pustulka, 2016). Mothers who valued cultural diversity and choice around their child rearing practices experienced the UK as a '*more attractive*' (Pustulka, 2016, p. 51) destination compared with their country-of-origin. One participant stated that "*freedom, diversity and tolerance are important*" (Pustulka, 2016, p. 52) values to her, and moving to the UK appeared to be an

opportunity to enact these within her way of parenting. Another mother stated that this had only been possible since moving to the UK: "*Here (…) I can bring up my son in the way that I want*" (Bawadi & Ahmad, p. 105). It seemed to have been an active reason for leaving their home country in the first place, which they deemed too restrictive in their child-rearing approaches: "*It is also why I would not want to raise my children there- everything is the same (…) measured against the typical formula of going to church, conservative, traditional…"* (Pustulka, 2016, p. 52).

Status and degrees of privilege within migrant parenting. Migrant mothers shared how their status and other degrees of privileges impacted their parenting experiences (Brahic, 2022; Condon & McClean, 2017; Lam et al., 2012; Lisiak, 2018; Machaka, 2024; Okpokiri, 2021; Roitman, 2020). Lisiak (2018) declared: "*Her deservedness relies formally on her legal status in the UK, but she reinforces it, renders it visible, by the way she performs mothering*" (p. 390).

It was suggested by Brahic (2022) that "*the migratory status of each woman at the time of their childbirth had a significant impact*" (p. 2176) on deciding whether to raise their children bilingually or not. Roitman (2020) further implied that being able to raise a child bilingually was a privilege because "*speaking in one's mother tongue may allow one to connect more immediately and directly with emotions that surround childhood memories and experiences (Ainslie et al., 2013, p. 668) (…) This connection might be one of the tools through which cultural roots are passed and nurtured*" (p. 20).

It was suggested that a mother's status also greatly influenced how isolated in her parenting she felt or not from family support: "*Another crucial factor contributing to the lack of perceived support was the mother's residential status. Bilingual mothers had gained permanent living status; thus, their family could visit relatively easily*" (Lam et al., 2012, p. 112). For one same sex couple, the recognition of both of their 'mother' status, compared

with back home, seemed significant and one of the mothers within that couple shared: "*that a clerk called me a parent, that was an amazing experience to me*" (Lisiak, 2018, p. 387). In this case, Lisiak (2018) suggested that the "*recognition of her family's realness*" (p.390) appeared to matter in how this mother perceived herself as a "*deserving migrant"* (p. 390).

Another key privilege which some mothers held was 'Whiteness' (Brahic, 2022; Erel, 2011). Brahic (2022) emphasised that certain White mothers had the privilege of identifying as 'expats' rather than 'migrants', which tended to be better perceived and less discriminated against:

"*The term 'migrant' is emotionally laden and often carries negative associations (…) 'constructions of migrants are frequently conflated with racialised, ethnic, national or religious Others' (Kunz, 2020, p. 2150)"* (p. 2172)

Other papers indirectly seemed to refer to 'Whiteness', with Roitman (2020) stating that "*mothering takes place in the crux of class, gender, ethnic, religious, regional and national boundaries. Motherhood gives us, therefore, an unforgiving lens on the power struggles within a state*" (p. 14). Mothers appeared to be deemed more or less privileged in their parenting experiences based on the intersectionality between their migrant status and their race and/or ethnicity (Brahic, 2022; Erel, 2011; Machaka, 2024; Okpokiri, 2021).

Amongst White mothers, Brahic (2022) stated that "*many recognised the privileged character of their lives as middle-class French mothers in affluent suburbs of Manchester where French nationals, (…) are often deemed 'desirable'"* (p. 2177). It seemed that even with this recognised degree of White privilege, mothers still feared rejection post-Brexit (Brahic, 2022). They questioned whether to relocate elsewhere, like one participant who shared: "*I don't want my children to live on a nationalist island*" (Brahic, 2022, p. 2178), and another who said "*I refuse to let my children grow up in this hostility*" (Brahic, 2022, p. 2179). The feeling of insecurity seemed even greater felt amongst White Eastern European

mothers, who were tentative when expressing their gratitude for settling in the UK, such as this participant who admitted: "*To be honest we are scared to say which things are better in this country, and do you know why, because we are afraid for someone to take these things from our children"* (Condon & McClean, 2017, p. 457).

It was suggested by Erel (2011) that Black mothers faced additional parenting pressures rooted in racism and oppression compared with White mothers and that they seemed to have "*developed particular practices of mothering to help their children deal with every day experiences of racism*" (p. 697). One participant illustrated this felt discrimination:

"No matter what you as an African are in this country, you are still seen as an immigrant; whatever they want to call you, they'll call you. No matter what you become, they will remind you where you came from, even if you don't know where you came from" (Okpokiri, 2021, pp. 438-439).

It appeared that recognising how intersectionality impacts mothering practices was crucial: "*Racialised migrant mothers remain 'decentred' and are marginalised in both contemporary theoretical and political debates in the UK*" (Erel et al., 2018, as cited in Brahic, 2022, p. 2169). Brahic (2022) cited Phoenix et al. (1991) to highlight that the notion of 'good mothering' was a concept that appeared closely associated with the privileges of "*White, middle class, educated citizens in a heterosexual monogamous relationship*" (p. 2169). This was subsequently pointed to as a suggested explanation for disparity between migrant mothers who were able to access extracurricular activities for their child's learning and social development, family support or childcare, and those who were not (Condon & McClean, 2017; Lisiak, 2018).

Theme 2: Parenting experiences across various levels of integration

Authors suggested three levels of integration in the UK which migrant mothers seemed to engage in: fully assimilating with UK culture (Brahic, 2022; Lisiak, 2018;

Okpokiri, 2021; Pustulka, 2016), integrating their home culture and UK culture (Brahic, 2022; Machaka, 2024; Okpokiri, 2021; Pustulka, 2016; Roitman, 2020), or feeling resistant or reluctant to adopt UK culture and wanting to maintain traditions from their home culture (Erel, 2011; Lisiak, 2018; Okpokiri, 2021; Ozeki, 2008; Pustulka, 2016).

Parenting enacted through assimilation with UK culture. It seemed that if the mother was previously misaligned with her own home country's culture and values, she may have shown particular enthusiasm towards actively participating in UK society and striving for an 'ideal motherhood' image shaped by Western societies. One participant demonstrated this by sharing: "*I am a happy parroting local (UK) woman*" (Pustulka, 2016, p. 52).

Some mothers seemed to fully assimilate with UK culture and one participant who aligned with this encouraged other migrants to do similarly: "*absorb any circumstances wherever you go; you must sink into the background and do like them*" (Okpokiri, 2021, p. 433). Brahic (2022) suggested that mothers performed a type of "*blending in"* (p. 2180) due to feeling different or stigmatised as a migrant and this having a direct impact on their parenting. This was further illustrated by a participant who said: "*I feel very uncomfortable to the point that I had to speak English with my daughters…to show that I am not French*" (Brahic, 2022, p. 2180). These could be interpreted as a fear response to the consequences they may face if they did not fully assimilate.

Brahic (2022) implied that some took it further and made a point to avoid those from their own community: "*Some described avoiding fellow French speakers to maximise opportunities to speak English and interact with anglophone residents"* (p. 2176). These mothers seemed to feel strongly about who they should or should not parent around, such as one participant who said: "*I think it's very bad for me and my child to be only around Poles*" (Lisiak, 2018, p. 388). They appeared to be critical of mothers who they deemed "*unwilling to adapt to life in the UK*" (Brahic, 2022, p. 2176) and seemed to negatively judge their way

of parenting (Lisiak, 2018). One participant shared judgment towards her own community: "*Poles here really don't take care of their children very well; I don't want [my son] to pick up this kind of behaviour*" (Lisiak, 2018, p. 389). Pustulka (2016) suggested that this highlighted a pattern of "*othering"* (p. 50) within migrant mothers, "*pinpointing a distinctive separation of 'us' versus 'them'"* (p. 49), where "*moral judgments were passed on other women*" (p. 49) and where the idea of 'good mothering' seemed to be negotiated according to the extent of adherence to traditional child-rearing practices.

Regardless of the reason for which mothers chose to assimilate: "*there is an argument for adopting local values and practices as a means of gaining access to significant resources in a foreign destination*" (Pustulka, 2016, p. 51).

Parenting enacted through integration of both UK and home cultures. Okpokiri (2021) suggested that "*the idea of obtaining the best from both cultures conveys a desire to culturally integrate but not completely assimilate*" (p. 436). Mothers who desired this seemed intentional in their child rearing practices in reminding their children of their culture of origin whilst also helping them adapt to UK society (Roitman, 2020). It appeared to have been, for them and their children, a way of keeping their sense of identity, whilst finding a new sense of belonging in their adopted country. With this, each mother tentatively negotiated which parts of their new culture they wished to integrate with their own parenting style, as illustrated by a participant who said: "*I think we should pick up the good in both societies and use them for our benefits to ensure that we get the best of both worlds (…) use it to your advantage and to the advantage of your children*" (Okpokiri, 2021, p. 436).

Different reasons were raised for having chosen to integrate and justify the degrees of adherence to UK culture. Okpokiri (2021) suggested that whilst some appeared actively engaged in their adopted society and stayed "*open to new child-rearing ideas while resisting bad practices in constructive ways*" (p. 436), others seemed "*disinclined to engage*

meaningfully with British child-rearing norms but did not want to overtly reject them" (p. 434). Some mothers seemed to argue that integration of both cultures was the solution because they felt "*UK values were insufficient to raise children*" (Machaka, 2024, p. 386). There appeared to be a unanimous aim for their children to feel a sense of belonging in both their country of origin and the UK (Pustulka, 2016).

However, it seemed more challenging to integrate their culture of origin compared to UK culture:

"*Interviewees did not state that only one culture could be held, but they did hold Ecuadorian culture as the one that was 'under threat', the one that needed to be actively promoted and defended.*" (Roitman, 2020, p. 19).

Post-migration, the dominant societal culture changed for families and some mothers may have felt they needed to do their utmost, and in a participant's words: "*fight tooth and nail to keep our culture*" (Roitman, 2020, p. 19). Despite the challenges of doing so, they seemed to have found ways of enacting their culture of origin through the vessels of language and food amongst other means (Brahic, 2022; Ozeki, 2008; Pustulka, 2016; Roitman, 2020).

It also appeared that in British society, some African traditional parenting practices may not have been accepted by the welfare system, and therefore Machaka (2024) argued: "*The parents find ways to renegotiate cultural differences and at times they painfully co-exist for them to effectively parent within the UK value systems"* (p. 389). A power imbalance appeared to be therefore endured, potentially prompting scepticism or mistrust from migrant mothers when interacting with social services.

Parenting enacted through reluctance or resistance to adhere to UK culture. Some mothers shared how they felt their parenting style was distinguished from a British mothering style, which Erel (2011) suggested as "*more laissez-faire, fostering earlier independence and 'cooler' familial relationships*" (p. 701). This distinction seemed to come

with a sense of "*moral superiority vis a vis British and other non-Polish counterpart, thus 'deforming implicit ethnicised ideas about both the notions of motherhood and citizenship*" (Erel, 2011, p. 706). Pustulka (2016) suggested that it may have been enacted by some mothers through looking down on *"women she knew had chosen to abandon their heritage and adopt foreign practices"* by *"restricting them from (their) circles*" (p. 50). Those mothers were deemed to "*re-traditionalise upon their move abroad*" (Pustulka, 2016, p. 49) and "*operate(d) as (a) peculiar females gate-keeper(s), set on protecting (her)self, (her) children and other women from the perceived negative influences of Western culture*" (Pustulka, 2016, p. 50).

It is possible that "*othering"* (Pustulka, 2016, p. 50) might have helped migrant mothers negotiate their own identities and sense of belonging in the UK. Doing this may have helped give them a sense of protection from their insecurities, which may have originally stemmed from the discriminatory and hostile context of immigration policies in the UK.

It could also speak to indirect pressures they continued to face despite having to move away from home, as stated by a participant in Ozeki (2008): "*I am worried […] that I can't get any information about traditional Japanese ways of child rearing. I don't want to be any different from others who are in Japan*" (p. 50). Migrant mothers seemed to be negotiating what their 'ideal mothering style' looked like in the adopted country, with some basing this on their own upbringing and family expectations (Lisiak, 2018).

In some cases, mothers appeared to reject UK culture to the point where they "*opted for an exit position if the challenges of managing children's welfare in Britain became untenable*" (Okpokiri, 2021, p. 437), with some having decided to send their children back home, possibly stemming from "*a desire for her daughter to have a sense of belonging and connection to her family*" (Okpokiri, 2021, p. 439).

Theme 3: Changes in the family structure post-migration

Regardless of their level of integration, all parents who had a connection back home with extended family seemed to experience a renegotiation of their parenting responsibilities and roles post-migration. Five studies referred to post-migration changes within gender roles and family structure (Bawadi & Ahmad, 2017; Condon & McClean, 2017; Lisiak, 2018; Machaka, 2024; Roitman, 2020).

A move towards collaborative parenting through gender role renegotiation. In some studies, it was highlighted that mothers had tended to be the primary caregivers and responsible parent for their child(ren) back home (Bawadi & Ahmad, 2017; Condon & McClean, 2017; Machaka, 2024). As families moved to the UK, there appeared to be a reported shift within heterosexual couples between the previously gendered roles of parenting: "*Observing 'British' fathers being involved in raising their children also influenced some of the participants' easing into more active fatherly roles and similar observations altered some mothers' beliefs*" (Machaka, 2024, p. 390). This seemed to have been a new experience for mothers coming from more traditional cultures, such as a participant who stated: "*If I go outside on a Saturday morning, I just see dads with their strollers down the street*" (Condon & McClean, 2017, p. 458).

For some, this shift appeared to have been met with a level of resistance "*especially amongst women due to low confidence in man's nurturing ability, conformity to idealised womanhood and the negative perceptions of the extended family on men's involvement*" (Machaka, 2024, p. 390).

For others, the shift seemed welcomed as they "*avidly described the benefits of fathers assuming an active parent role*" (Machaka, 2024, p. 390). This was seen for some as a shift that would not have occurred without migration and which they seemed to value: "*Women valued experiencing this new family arrangement (…) this included the husband's*

non-traditional role of supporting his wife during childbirth" (Bawadi & Ahmad, 2017, p. 105).

From extended family involvement to a nuclear family model of parenting. It appeared that there was a common post-migration "*emerging dominance of the nuclear family over the extended family*" (Bawadi & Ahmad, 2017, p. 104; Condon & McClean, 2017; Lisiak, 2018; Machaka, 2024; Roitman, 2020). Back home, the extended family, and sometimes even whole communities, may have held key roles in child rearing, regardless of the mothers' wishes. Some found that having extended family support back home allowed for opportunities to mother in a culturally traditional way (Roitman, 2020) and that this may have been lost, or more difficult to embed, once arriving in the UK.

Having to reimagine family life whilst adapting in a new country as a migrant, was deemed to be very expensive and time consuming. The loss of family support seemed to have impacted some mothers who reported a sense of increased responsibility in their parenting role (Condon & McClean, 2017). Many mothers found that without extended family support, navigating childcare in the UK was significantly challenging (Condon & McClean, 2017; Lisiak, 2018; Machaka, 2024). Some needed to sacrifice time working in order to look after their child due to childcare costs being too high. One participant shared: *"(...) I stay with her [daughter] instead of working both of us full time, because the nursery is really expensive. It's so expensive*" (Condon & McClean, 2017, p. 458). Another stated:

"When you are two in a couple and you don't have children, you can both go to work, but when you have a child then one needs to stay at home, and you don't have a big income and the benefits are low" (Condon & McClean, 2017, p. 458).

Despite the loss of extended family nearby, a focus towards the nuclear family was nevertheless welcomed by some mothers who, in contrast to those above, seemed to have felt restricted in their child rearing practices back home: "*The most obvious example of freedom*

attained in the United Kingdom is that she can raise her children as she wants instead of according to the wishes of her extended family" (Bawadi & Ahmad, 2017, p. 105).

There was praise and gratitude for a greater felt sense of freedom and independence in some mothering experiences such as this participant's: "*(Back home) I was doing what they wanted [but] without really believing it. Here in the United Kingdom, I can do what I want*" (Bawadi & Ahmad, 2017, p. 105). Mothers may have found a sense of comfort in their nuclear family, away from extended family. One participant illustrated this by saying: "*Here I am more settled in my married life. I can bring up my son in the way that I want. I feel that we are a family and that the family surrounds me, and this thought comforts me*" (Bawadi & Ahmad, 2017, p. 105).

Theme 4: The unique challenges of migrant parenting and mitigating factors

It appeared overall that migrant mothers were not faced only with the challenge of navigating how to parent, but also that of navigating how to parent in an unfamiliar country. Authors presented the unique set of adaptation challenges migrant mothers seemed to face, whether big or small, that British mothers who have always lived in the UK would not have necessarily experienced (Bawadi & Ahmad, 2017; Condon & McClean, 2017; Lam et al., 2012; Machaka, 2024; Ozeki, 2008). There were also mitigating factors and unique opportunities which were deemed to have benefitted some mothers' parenting experiences (Bawadi & Ahmad, 2017; Brahic, 2022; Condon & McClean, 2017; Lam et al., 2012; Lisiak, 2018; Machaka, 2024; Pustulka, 2016; Roitman, 2020).

Language and cultural barriers as unique challenges of migrant parenting. Language and cultural barriers appeared to be two of the main challenges mothers faced across their experiences of migrant parenting (Bawadi & Ahmad, 2017; Lam et al., 2012; Ozeki, 2008). Socialising within the parenting sphere seemed to be particularly difficult on both a practical interpersonal and personal emotional level. One mother noted: "*It is difficult*

for me to speak in English to my child's British friends. I don't understand their English, and the most embarrassing thing is that they don't seem to be understanding my English either" (Ozeki, 2008, p. 51). Lam et al. (2012) suggested that these "*communicating difficulties (...) have stopped many mothers accessing English-speaking services, forcing them to rely on their own resources*" (p. 112).

According to Machaka (2024), "*migrant parents might find parenting isolating because of loss of support from the extended family*" (p. 380). This seemed to have been further complicated "*due to language barriers*" (Condon & McClean, 2017, p. 460). Some of them may not have been aware of existing mother support groups, or if they were, they may not have felt able to join and meaningfully engage, as experienced by a participant who shared: "*I would suggest them having some Chinese mother there too, just one more perhaps. So, I can talk to… I really wanted to go*" (Lam et al., 2012, p. 114).

Mitigating factors which help migrant mothers navigate parenting in the UK. It became apparent throughout the analysis that 'community' was a recurrent theme when it came to identifying mitigating factors which helped migrant mothers navigate experiences of parenting in the UK (Brahic, 2022; Lam et al., 2012; Lisiak, 2018; Machaka, 2024; Roitman, 2020). Some mothers appeared to have actively sought connections with their community to help their children feel more attuned to their own culture whilst adapting to the UK. Machaka (2024) noted that "*Religious spaces were highlighted for their role in maintaining a sense of belonging and reinforcing cultural identity*" (p. 387). Connection may have also been formed through a bond over "*common experience of discrimination*", as suggested by a participant (Lisiak, 2018, p. 389). It seemed that by voicing these shared experiences, migrant parents could feel validated, understood and less isolated in their experiences of parenting in an unfamiliar country.

Living in large cosmopolitan cities was noted by a participant as facilitating these social connections, whether it was between migrants from the same community or with any other migrant community: "*We have friends of every country and our children are growing up with the idea that we all belong here and that their differences are interesting, nothing weird*" (Roitman, 2020, p. 22).

Direct social contact did not appear to be the only way of feeling connected to one's home culture. Mothers who reported a feeling of longing for their culture and home comforts may have found it helpful to rediscover these for the purpose of transmitting them to their children (Lisiak, 2018; Machaka, 2024; Roitman, 2020): "*Transmitting aspects of Zimbabwean culture is a dynamic process. Participants draw on elements of the Zimbabwean culture from memories of how they were raised*" (Machaka, 2024, p. 389). It appeared that mothers intentionally parented their children in a way that helped them connect to their country of origin. One mother shared how she did this: "*I ask her (daughter) to help me make things (...) We make things like I used to do when I was little in Ecuador. I try to give her the same memories, to grow up with the same smells, the same flavors, I did*" (Roitman, 2020, p. 21).

Financial security was another common factor which affected the migrant mothers' experience of parenting (Condon & McClean, 2017; Machaka, 2024; Pustulka, 2016). If the migrant mothers were middle-class, they may have been more likely to be able to access child care (Brahic, 2022; Lisiak, 2018). In contrast, some seemed to struggle to even afford housing, let alone childcare (Condon & McClean, 2017). Beyond the practical aspect of financial stability, Machaka (2024) stated that: "*gaining financial capital and social capital as they (mothers) integrated has helped to settle in the UK and build a sense of belonging*" (p. 391). It was argued that "*the upward social mobility (...) could be seen as a sign of a*

successful integration and being in possession of locally legitimized capital" (Pustulka, 2016, p. 51).

Evaluation

This SLR aimed to capture experiences of migrant mothers who parent in the UK. It highlighted various personal, familial and societal changes which mothers navigate throughout their migrant parenting journey.

New knowledge was generated from the synthesis of findings based on pre-existing literature within a migrant mother research field. The literature available regarding migrants who have voluntarily migrated to the UK is limited (Burns et al., 2021). Despite making up the majority of migrants who settle in the UK, the voices of those who move for work, study or family reasons are often overlooked (Burns et al., 2021; Kierans, 2020). This can be due to difficulties in studying a heterogeneous population who have diverse experiences, evolving migrant categorisations, and limited data available regarding migration status (Burns et al., 2021). This SLR builds on the limited existing research and goes further by identifying and bringing together common themes which migrant mothers voice in their parenting experiences. The review has not only contributed to the research field but is also applicable to various audiences. This was made possible through a careful execution of the thematic synthesis process outlined by Thomas and Harden (2008), particularly within the development of analytic themes which went beyond describing data from individual studies and generated interpretations in response to the research question (Ryan et al., 2018).

Furthermore, the use of consistent reflexivity throughout the process, starting from developing the research question through to the final written draft, was a strength of this review. Introspection through journaling and intersubjective reflection through supervision helped foreground an awareness of researcher biases and the common pitfalls created by the subjective nature of qualitative research (Finlay, 2002). Unexamined power dynamics could

have led to making overgeneralised or overstating claims (Finlay, 2002; Olmos-Vega et al., 2023). This reflexivity helped to capture the nuances of migrant mothers' experiences and contextualise relevant data by actively considering broader societal and migrant narratives of parenting (Thomas & Harden, 2008). It was this use of reflexivity which also helped to consider the following limitations of this review.

The decision was made to solely include peer-reviewed articles within this SLR because these are usually deemed superior quality compared with grey literature (Xiao & Watson, 2017). This inevitably introduced a publication bias and may have inadvertently perpetuated an elitism around the value accorded towards published research compared with other meaningful sources of knowledge (Galdas, 2017). As a researcher who argues for social justice values within personal and professional spheres, it was deemed a justified decision but nevertheless one with limitations. To include non-peer reviewed materials such as theses, blogs or videos, where migrant mothers' voices may be present, would need careful consideration in future.

Despite a breadth of diversity amongst participants being represented in this SLR, coming from 19 countries across four continents, the voices of White mothers (approximately 100) remained dominant, which implied a bias in the findings. Most participants were also living in large cosmopolitan UK cities (Brahic, 2022; Erel, 2011; Pustulka, 2016; Roitman, 2020), therefore leaving out the voices of those who may not have settled in diverse locations. Even with attention to these factors, the risk of stereotyping and generalizing, although mitigated with reflexivity, remained present when conducting the SLR.

Implications

Several research implications were identified across the studies which can be extended to this SLR. This review offers a qualitative approach to better understanding migrant mothers' experiences of parenting in the UK. Research within migrant populations is

particularly relevant considering the recent review of immigration policies by the newly elected Labour government (Starmer, 2024). The government strategy is focused on reducing immigration flows (Home Office, 2025). With research being a key element to developing policies, it is important to hear from the people directly affected in order to understand the impact these may have (Brahic, 2022).

Immigration policies provide a legal framework for migrant motivations and status inevitably influencing how migrant mothers experience parenting in the UK. Therefore, it is important to continue researching not only migrant status and flow statistics but also direct experiences in order to better understand how to support those directly affected (Bawadi & Ahmad, 2017; Condon & McClean, 2017). Further research could also help better understand these experiences within specific communities (Ozeki, 2008) and what factors facilitate or challenge migrant parenting experiences depending on their context and individual migration circumstances (e.g. migration motivations, status and privilege).

Following a scoping for dissemination opportunities across relevant academic and research fields, it seems feasible to apply for submission through to a peer-reviewed journal such as the Journal of Cross-Cultural Psychology, and/or a presentation at conferences such as the Children and Families Research Centre (CFRC) conference. Dissemination will also be key across general public forums, for example, by posting infographics on social media platforms such as migrant or expatriate parent support groups (with permission) on Facebook and/or through the Migrant Mothers Mental Health (@migrantmothersmh) empirical study Instagram page.

Clinically, this review could benefit professionals who work with migrant populations (Ozeki, 2008). This does not just include healthcare professionals but also those working in social care and education. It is important to question why migrant mothers may not be accessing services (e.g. language and cultural barriers, access to resources), or if they are,

whether or not they feel the support is being tailored to their needs. This could be done by conducting a quality improvement project or service evaluation, looking at Equality and Diversity information within referrals and/or asking migrant mothers who access the service for feedback about their experience of care.

If professionals are aware of migrant mother experiences, they may be able to challenge some of their own biases and stereotypes, which could help prevent harmful practices and improve quality of care (Lam et al., 2012; Okpokiri, 2021). In order to improve this awareness, staff could receive training around cultural competency, which could in turn help them feel more confident in their abilities to work with families who are from different backgrounds to them. They could ask questions around the individual's level of integration and the impact of this on their mental health, about their lived experience of being parented, their child-rearing preferences, and their family structure or how gender roles shape their experiences. This could help generate reflexivity and curiosity around how to adapt the care they offer to each unique migrant mother or family.

The aim would be for migrant mothers to feel heard and listened to non-judgmentally when navigating these foreign systems, leaving them to feel more empowered in their parenting abilities and choices (Okpokiri, 2021). This could be done, for example, by including additional questions within assessments or reviews, about the migrant mother's support system, connection to their community, and/or access to child care.

Conclusion

The aim of the SLR was to better understand migrant mothers' experiences of parenting in the UK using a thematic analysis of relevant qualitative studies (Thomas & Harden, 2008). By limiting included studies to qualitative research, the synthesis puts forward the experiences of migrant mothers from multiple backgrounds. There were apparent differences and commonalities in migrant mothers' narratives around what they believed to

be the best and most 'ideal' way of mothering in their newly adopted country. This varied depending on the different individual and wider cultural styles of parenting, in addition to the level of integration they adopted within the UK. The reasons for migrating to the UK, although deemed 'voluntary', were varied and this impacted how mothers adapted their parenting style in line with or despite UK culture. There were different and complex reasons for why mothers may have chosen to adopt a more traditional versus Western style of mothering, all within a context of immigration attitudes and with the aim to build on a sense of belonging and identity in a country away from home.

Aims and rationale for current empirical study

The literature presented has shown the context in which migrant parenting occurs and the unique challenges as well as opportunities that migrant mothers are particularly faced with. Whilst there are clear patterns of circumstances which help or hinder mothers' experiences of parenting, it remains unclear how migrant mothers may experience particular phases of parenting, such as the perinatal period, and associated maternal mental health difficulties, and particularly postnatal depression (PND). These mothers seem particularly at risk of feeling isolated and having to navigate layers of complexity in their parenting experiences (e.g. barriers to accessing support, loss of family support). Whilst all stages of parenting can be uniquely challenging, the perinatal period is considered to be a critical one (Dei, 2023). This includes the time frame between the beginning of pregnancy all the way to the end of the postpartum period. During this period, psychological changes are likely to occur due to the multiple stressors associated with such a transition into parenthood (Bhat et al., 2019).

"The postpartum period is challenging for all women, but is particularly challenging for women with depression" (Bhat et al., 2019, p. 2). Migrants are already facing multiple layers of adjustment and stressors linked to their experiences, which could be negatively

impacting their mental health (Almeida et al., 2016; Brance et al., 2024; Deighton-O'Hara, 2018; Falah-Hassani et al., 2015; Mucci et al., 2020). With the conjunction of these intersecting identities, migrant mothers are at particular risk of developing mental health difficulties (Almeida et al., 2016; Benchekroun, 2023; Das & Beszlag, 2021; Erel et al., 2018). A systematic review and meta-analysis suggested that approximately 20% of migrant women experience PND symptoms, which is one and a half to twice as likely when compared with non-migrant women (Falah-Hassani et al., 2015). This can be understood within the context of the current SLR findings which help make sense of challenges specific to migrant parenting.

The aim of the empirical study was to hear migrant mothers' experiences of PND in the UK. Experiencing PND can be challenging in itself but the layer of migration contexts can add additional challenges (Wittkowski et al., 2017). Being away from the familiar safety and containment of your own culture, language, and support adds a complex challenge that new mothers face, which can feel intimidating and overwhelming. We know that the experience of migration can be a challenging one even when this is voluntary (Ottonelli & Torresi, 2013). Therefore, it felt important to hear these experiences along with resilience factors which helped these mothers manage PND depression in a country that was not their country of birth/origin. This research aims to shed light on the gaps in literature by sharing the importance of hearing individual stories of in-depth experiences. It provides an opportunity to understand how migrant mothers experience PND in the UK.

Chapter 3: Methodology

This section presents the methodological approach used for the empirical study addressing the research question 'What are migrant mothers' experiences of postnatal depression (PND) in the UK?'. This includes the design, recruitment process, participant details, ethical considerations, study procedure and analysis method.

Design

A qualitative design was deemed most appropriate to answer the research question and explore the rich and complex nuances of PND experiences amongst migrant mothers in the UK. Qualitative research offers an in-depth understanding of participant perspectives, meaning and sense making through exploring life experiences (Lim, 2024). In mental health research, qualitative methods "allow people to speak in their own voice, rather than conforming to categories and terms impose on them by others" (Sofaer, 1999, p.1105). Qualitative research can be cathartic in nature as it encourages participants to reflect and, through this process, share experiences which they may not have had a chance to in other settings. This can leave them feeling more empowered by regaining ownership of their accounts and embodies a sense that research is being done '*with*', rather than *'to'* participants (Perry & Bigelow, 2020).

Methodology

Rationale for Interpretative Phenomenological Analysis (IPA)

IPA is grounded in two philosophical concepts of phenomenology and hermeneutics (Smith et al., 2022). Phenomenology, because there is an interest in the individual's experience and the meaning they create from it rather than assuming predetermined categories of meaning. Hermeneutics, because of the circular and dynamic process of understanding and analysing parts of an experience, by considering the whole experience and vice versa. Double hermeneutics occur when contextual interpretations of individual

perspectives are being made by another being, in this case, the researcher, who holds and acknowledges their own assumptions and understanding of the world. IPA is also idiographic in nature, meaning there is a focus on the individual's unique experiences rather than an aim to construct generalised patterns or claims about a phenomenon. Nevertheless, it does seek to better understand the phenomena in relation to cautious interpretations of those individual experiences.

This positions IPA as being commonly used when researching topics which can be particularly ambiguous and complex (Smith et al., 2022). PND is recognised within diagnostic frameworks (APA, 2013) but Cromby et al. (2013) argue that diagnoses can at times oversimplify complex experiences by focussing on symptomology rather than the meaning attributed to the distress experienced. In line with a critical realist epistemology, using IPA allowed for attending to the interpretative nature of experiences as well as the external reality which influences those interpretations (Grace & Priest, 2015).

IPA is a relatively accessible approach to analysis often best conducted with support from a supervisor and peers (Larkin & Thompson, 2012). The idiographic nature of IPA means that it seeks to have an in depth focus on the individual's experience, which allows for rich data to be produced. It also positions participants as experts in their own experience, which is deemed a meaningful step towards addressing power dynamics between participants and researchers. IPA not only acknowledges subjectivity but it values its inherent nature and recognises its utility (Noon, 2018).

Expert by Experience (EbE) consultation

The search for EbEs was conducted at the stage of designing the study and interview guide. This was done through the second supervisor's professional network, by attending an already established perinatal service user group. One experienced member of this group came forward and offered to contribute their time for the development of the study. They were

offered remuneration for this but declined, stating they wanted to support on a voluntary basis. A draft interview guide was reviewed and edited in line with recommendations made by the EbE. Important changes were made around the language used for the questions to participants. It was fed back that this needed to be more direct, clear and free of jargon, especially considering the targeted population who may not have English as their first language.

Ethical considerations

Ethical approval

An ethics application to the University of Hertfordshire Ethics Committees with Delegated Authority (ECDAS): Health, Science, Engineering and Technology was originally approved on July 25th, 2024 (see Appendix C). Within this, a research ethics protocol was outlined detailing how participants would be invited to take part and how they would be interacted with. An amendment application was subsequently submitted and approved on August 23rd, 2024 (see Appendix D). This allowed for a minor change to be made in the wording of the study advertisement poster regarding participant inclusion criterion. This change more accurately reflected the intention to recruit participants who moved to the UK as adults rather than only as children, enabling a wider pool of participants to become eligible.

Risk considerations

The physical and mental health risks considered were those that could take place within the participants' vicinity and/or online. Participants were asked to find a quiet, safe and confidential space in which they could proceed with the online interview. I had a distress protocol (see Appendix E) to follow in case of need. Participants were told that they could share as little or as much as they felt comfortable regarding their experiences, and had a right to withdraw from the interview at any point. They had control over the recording and meeting features, which were explained to them before the interview started.

It was explained that if at any point they noticed themselves experiencing distress, they could choose to take a break and/or discuss their difficulty with me, within the limits of a research context. If they felt they needed further support, they would be signposted to seek this from their local GP and/or mental health service.

If information was disclosed which indicated sufficient concern about participant safety or the safety of others, it was agreed that it may be necessary to inform an appropriate third party without formal consent. I had the ability to contact my supervisor to discuss possible concerns. Confidentiality could be overridden if it was deemed that the risk was imminent and required immediate attention and this was made clear to participants.

Confidentiality and data protection

Participants were informed that any data collected would be stored in line with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016. They were made aware that all interview transcripts would be anonymised by using pseudonyms and redacting any identifiable information (e.g. specific locations, job companies etc.). All data was stored electronically via my University of Hertfordshire protected OneDrive. Identifiable participant data including consent forms, interview recordings and demographic information were kept separately from the anonymised interview transcripts. Full anonymised interview transcripts were accessible to be reviewed by the research team including myself and both supervisors. Extracts of anonymised interview analysis were shared with colleagues within the IPA working group as part of the Clinical Psychology Doctorate programme at the University of Hertfordshire with participants' consent.

Participants were informed that all interview recordings, transcripts, consent forms and any other identifiable participant data would be deleted upon project completion and result ratification.

Informed consent

The risks, consent and confidentiality terms were outlined within the participant information sheet (see Appendix F). Prospective participants were sent the information sheet via email ahead of a screening call and this was reviewed collaboratively. This ensured that prospective participants could ask questions and/or raise any concerns they may have had regarding the study. After confirming that they understood the information, and where participants felt willing to partake in the study, they were asked to review and sign a consent form (see Appendix G). Participants shared their informed consent verbally during the screening call, via signing the consent form, and one final time before starting the interview.

Researcher wellbeing

Although interviews were delivered online, minimising physical risk, content which was discussed was deemed to potentially elicit distress, especially from an insider-outsider perspective (Ross, 2017). Where discomfort was experienced, this was discussed in supervision. Reflections were also noted in a diary to help process the impact and consider how this may affect the analysis process.

Participants

Sampling

The participant inclusion and exclusion criteria are summarised in Table 9 below. The inclusion criteria were for participants to identify as mothers, be aged 18 or above, be fluent in English, to have voluntarily migrated to the UK as adults, and have previously self-identified or been diagnosed with PND.

This study did not include participants who identified as refugees, asylum-seekers or internally displaced persons (IDPs; European Commission, n.d.) to maintain sample homogeneity (Smith et al., 2022). It was assumed that migrating through forced displacement (European Commission, n.d.), due to exceptional circumstances in the country of origin (such

as conflict or violence), would entail additional significant layers of complexity and trauma compared with those who migrated voluntarily. Participants self-identified as 'voluntary migrants' and were not asked about their residency status.

Mothers who suffered from acute and current PND or any other significant mental health difficulty at the time of recruitment, were unable to take part due to the sensitive nature of the interview topic, which could risk triggering and exacerbating psychological distress.

Table 9

Participant Inclusion and Exclusion Criteria

Inclusion criteria	**Exclusion criteria**
Migrant mothers who moved to the UK as adults* (first generation)	British mothers born and raised in the UK; Second or third generation migrant mothers
Migrants who moved to the UK voluntarily	Migrants who were forced to move to the UK and/or identify as 'refugees', 'asylum-seekers', or internally displaced persons
Participants are 18 years old or above	Participants are under 18 years old
Fluent in English: to be able to understand, read and speak English fluently	Unable to understand, read or speak English; unable to understand crucial components of the study (e.g., participant information, consent form, interview questions and/or debrief) due to language barriers
Having a previous experience of PND (self-identified or diagnosed by a professional)	Having no previous experience of PND; Experiencing current significant mental health difficulties (PND related or other) at the time of recruitment

* This criterion was changed from "moved to the UK within the last 5 years" to "move to the UK as adults", following the approved ethics application amendment

Demographics

Seven participants were recruited for this study, which was deemed an appropriate number of participants (between 6-10) for an IPA study as indicated by Smith et al. (2022). All were migrant mothers who had moved voluntarily to the UK as adults between three to 20

years ago, for various reasons including: study, work, family reasons or initial temporary travel. The countries of origin ranged across Asia (1), Europe (2), South America (2) and North America (2). Participants were aged between 34 and 45 years old. They reported having experienced PND within the last 10 years and there was a mixture of participants self-identifying this versus receiving a diagnosis, some of which was in retrospect. Participant characteristics are presented in Table 10.

Table 10

Participant Demographics

Pseudonym	Age	Country of birth	Ethnicity	First language	Initial reason for migrating to the UK
Rosie	37	Ireland	White Irish	English (Irish)	Study
Monica	40	United States	White American	English (American)	Family reasons, Work
Aisha	36	Lebanon	Arab	Arabic	Study
Valeria	45	Brazil	White 'other'	Portuguese	Travel
Melany	44	United States	White American	English (American)	Study
Sofi	41	Slovakia	White European	Hungarian	Study
Lana	34	Ecuador	Mixed - Latina	Spanish	Work

Recruitment

A mixed purposive and snowballing sampling method was chosen to recruit participants for this study. This combination allowed for a targeted recruitment of participants with specific characteristics and experiences relevant to the inclusion criteria (Palinkas et al., 2015). Using deliberate approaches meant that there was a potential bias with regards to which groups were targeted; however, this was mitigated by broadening the search to both

migrant and mother online groups. Additional careful consideration for maintaining confidentiality was also required with regards to using a snowballing method. This was done by using removing specific locations and/or other participant characteristics in addition to using pseudonyms, so that anonymity was respected.

A research advertisement poster (see Appendix H) was circulated via social media platforms via my professional accounts (e.g., LinkedIn, X, Instagram). Administrator consent was sought and granted to post on targeted group pages via Facebook and Whatsapp. Prospective participants were able to contact me directly and arrange a screening call via a booking platform. They were sent the information sheet along with the confirmation email.

Challenges

When developing the recruitment strategy, there was consideration around how to prevent fake participants from signing up to the study (Sharma et al., 2024). Individuals who registered their interest were offered a screening call, where specific questions about their migration journey and experience of PND were asked, making it easier to verify their identity and narrative accounts. The financial remuneration for participants was not advertised, and those who registered their interest in participating were only made aware of the remuneration once they had signed the consent form. Finally, all participants turned their cameras on during the interviews.

There were challenges in recruiting migrant mothers for this study partly due to their limited availabilities. Most of the participants had full time jobs and were therefore juggling work, motherhood and their own needs. Participants were offered flexible options for interview slots (e.g. evenings, weekends) and a possibility to reschedule if needed and where possible.

Although the term PND was defined through the information sheet and also verbally through the screening call, participants who did not receive an official diagnosis were unsure

whether or not they could self-identify with having experienced PND. The screening call allowed for a conversation with them around their experiences, PND symptoms and any associated doubts they held.

Data collection

Screening process

After registering their interest, participants joined a screening call where the information sheet was reviewed and they could ask questions and/or raise concerns they might have had about taking part. In addition to screening whether prospective participants met the study criteria, this call was an opportunity to start building rapport. I introduced myself, along with the rationale for why I chose to study this topic. If the participant met criteria and consented to proceed, they were asked if they required any additional adjustments for the interview process. When the participant had no further questions, they signed the necessary consent and payment forms electronically (see Appendix I). An interview time and date was scheduled around mutual availability.

Data collection method

In-depth interviews were the chosen data collection method because they allow for accessing rich, detailed, first-person accounts of participant experiences (Smith et al., 2022). They were considered to be an optimal method for collecting data within this IPA study because they provided the intimate focus required to elicit stories around PND experiences of migrant mothers (Smith et al., 2022). The interviews were held online as this allowed for flexibility around participants' needs for childcare and also to consider geographical constraints (Heiselberg & Stepinska, 2023).

Interview schedule

The interview schedule (see Appendix J) was reviewed by an EbE and their feedback was incorporated, before being piloted with a migrant mother colleague. The schedule

included a brief introduction and participants were informed of the style of interview. I explained that I would interact minimally, to limit external influence on their answers. They were told to share their experiences in as little or as much detail as they were comfortable with. They were reminded to ensure they were in a private space due to the nature of the topics discussed, which could elicit distress.

There were seven questions in total, which were open ended and aimed to encourage participants to provide detailed descriptions of their experiences. These questions were used as general guiding prompts when they were needed. The questions were divided into three overarching themes: the experience of moving and adapting to the UK, the experience of PND, and the intersection of experiencing PND as a migrant in this country. Prompts (e.g. 'Can you tell me more about that') and follow up questions (e.g. 'What was your experience of navigating support?') were available, to help participants expand their responses further if needed.

Interview procedure

Individual semi-structured interviews were conducted, asking participants questions around their experience of PND within the context of having moved to the UK. These interviews were all conducted in English and they took place online, via Microsoft Teams (MS Teams).

All participants took their own initiative to join the interview with cameras on from the start, which seemed helpful in establishing a connection and fostering a more personable interview process (Heiselberg & Stepinska, 2023). Participants were asked about their level of comfort with using MS Teams (Heiselberg & Stepinska, 2023; Irani, 2019). All participants confirmed that they were able to engage with the video platform and had knowledge as well as access around using the recording functions. They were encouraged to notify me if they felt uncomfortable and/or changed their mind about their consent and that

they could terminate the recording at any point. Participants chose if they wanted any pre-planned breaks during the interview and/or there was also a discussion to establish how participants could prompt for an unplanned break where and/or if needed. It was emphasised that there were no 'right' or 'wrong' answers, and that as long as participants spoke to their own experiences, the data would be relevant (Durkin et al., 2020). These considerations seemed to enable participants to have an increased sense of control over their data and the overall interview process.

Three of the interviews included short breaks, whereas others declined needing this. On average, interviews lasted just over an hour, with the shortest one lasting 41 minutes and the longest, 78 minutes. At the end of the interview, a debrief form was sent to participants (see Appendix K) along with a £20 voucher as remuneration for their time.

Analysis

Stages of IPA (Smith et al., 2022)

The recorded interviews were automatically transcribed with the MS Teams feature using intelligent speech recognition technology. As digital tools and emerging technology are prone to accuracy and bias errors, I performed detailed manual checking and re-read transcripts (Eftekhari, 2024). The data was then analysed manually as opposed to using an analysis software, for the purpose of encouraging deep immersion in the data, which is a crucial element of IPA. The analysis process is not clearly linear or prescriptive. It is an iterative and inductive cycle that draws on various strategies (Smith et al., 2022). Nevertheless, as a first time IPA researcher, it was important to initially learn the process within a structure, which was as follows (see Table 11 supported by Appendices L, M, N, O, P & Q; Smith et al., 2022).

Table 11

IPA Steps (Smith et al., 2022)

Step	Description
Step 1. Reading and re-reading	This stage involved reading the transcript and was accompanied by re-watching the video interview. Reading the transcript multiple times was important in order to be immersed in the original data, ensuring that the participant remained at the centre of the analysis. Reflective diary entries written at the time of the interview were also reviewed, as a means to maintain awareness of researcher biases and emotions, which may have been elicited throughout the process. By reviewing the transcript and keeping reflections bracketed, it allowed a focus on the data and active engagement with participants' experiences rather than assumptions.
Step 2. Exploratory noting	Descriptive, linguistic and conceptual notes were recorded throughout the transcript (see Appendix L). Descriptive notes were the closest to participants' account because they described elements of it at face value. Linguistic notes explored the specific use of participants' language and allowed for consideration around how the linguistic features contributed to the participants' sense making. This included taking notes of metaphors, idioms and/or changes in tone or pace. Conceptual notes were more interrogative and encouraged the analyst to go further in their reflexivity, by taking into consideration the participants' context and identifying potential patterns of meaning. As previously mentioned, the process was not linear and therefore, exploratory noting started taking place within the first few re-readings of the transcript. Exploratory noting enabled a deeper familiarisation with the transcript and generated further curiosity around anything of interest, ultimately guiding to a better understanding of the 'why' and 'how' behind these experiences.
Step 3: Constructing experiential statements	Experiential statements were constructed in order to consolidate the exploratory noting into a smaller amount of detail, whilst still capturing the complexities and nuances of the transcript (see Appendix L). The data was re-organised and analysed through taking a wider contextualised perspective. This became a collaborative effort in keeping close to the

	participant's meaning making of their experiences as well as incorporating meaning making of the participant's experiences. This was one layer of the double hermeneutics process.
Step 4: Searching for connections across experiential statements	The experiential statements were then printed out, in order to separate them individually and scatter them randomly across a table (see Appendix M). Taking the data away from the computer allowed to take a wider overview and a more immersive exploration of patterns across the statements. It was a choice made with the intent to construct patterns of meaning in a more creative way than possible on a screen. Clusters were created from experiential statements which were related in some way. This process required an openness to the possibility of clusters merging, evolving and/or splitting along the way.
Step 5: Naming the Personal Experiential Themes (PETs) and consolidating and organising them in a table	Once the clusters were formed, it was important to reflect on the experiential nature which each one encompassed. This led to the naming of PETs which intended to describe that particular participant's experience (see Appendix N). It was important that these PETs resonated throughout their whole transcript. Once the PETs were finalised, these were organised into a wider table and remained linked to the associated experiential statements as well as direct quotes, to ensure that these were rooted within the data (see Appendix O).
Step 6: Continuing the individual analysis of other cases	This involved repeating Steps 1 through 5 with each case, one after the other. Continuing the analysis of subsequent cases with some preconceived ideas of patterns and interpretations was inevitable. It was therefore even more so important to treat each case individually by bracketing any biases or assumptions that would have previously been generated. Maintaining this awareness allowed for new analytical notes and patterns to arise.
Step 7: Working with PETs to develop Group Experiential Themes (GETs) across cases	Once the PETs table was finalised, it was time to print this out and scatter the individual PETs and subthemes across a table in order to work through similarities and differences across them (see Appendix P). The analytical process was taken further in this stage of analysis, from interpretations having been individualised and specific to each participant, to being grouped through connections across cases. The process remained dynamic and iterative in nature, in that different levels of interpretation and organizing were generated by exploring, not only the PETs, but also reviewing the experiential statements and participant quotes linked to these. Through this process, new GET labels were produced, each underpinning

convergence across participant experiences. The GETs were then organised into a table, which was drawn on in order to create a narrative of findings (see Appendix Q).

Chapter 4: Findings

This chapter presents the findings generated from the Interpretative Phenomenological Analysis (IPA) that was conducted (Smith et al., 2022) with the aim to answer the research question "*What are migrant mothers' experiences of postnatal depression (PND) in the UK?*". Group Experiential Themes (GETs; see Table 12) illustrate interpretations of participant experiences through the use of selected direct participant quotes and summaries, as a means to capture convergence and divergence across experiences. I deliberately chose not to correct participants' grammar or syntax to preserve the authenticity of their stories. The themes aim to cover the breadth of experiences whilst also capturing the unique elements of each.

Table 12

Summary of GETs and Subthemes

GETs	Subthemes
GET 1: Navigating layers of disconnect	• "*It doesn't feel like my culture*": Cultural displacement • Grappling with old and new relationships • Feeling estranged from partner and baby • "*Always around but not present*": Loss of self
GET 2: The burden of *"learning the ropes by yourself"*	• "*Building everything, from nothing*" • An isolating silence • Longing for a '*village'* • "*It's just all on me*": Bearing the weight of sole responsibility
GET 3: Unrelenting confrontation: "*Another wave was pushing me down*"	• "*Everything's survival*"

	• Spiralling into despair • Grieving expectations
GET 4: A winding journey of resilience	• Finding strength in solidarity • A liberating shift towards healing • "*I'm still putting myself together*": the struggle continues

My interpretations and choice of themes were influenced by my critical realist epistemological stance and my beliefs, which were shaped by my own experience of migration. I was aware of the 'reality' of the current political climate impacting immigration and mental health experiences of care, as well as the evolving narratives and societal expectations around motherhood. I noticed that, at times, my biases led me astray throughout the iterative process of my analysis, as they influenced me to place greater importance on the participants' migration journey and context compared with their specific experience of PND as migrant mothers. By reflecting on this regularly within supervision and within my reflective journal, I was able to bracket these biases and reframe my thinking by recentring my research question at the core of my interpretations. I used visual aids to help with this, for example by centring the research question within each step of generating PETs. This enabled me to compile the findings using a primary lens of migrant mothers' experiences of PND rather than PND experiences which happen to be told by migrant mothers.

GET 1: Navigating layers of disconnect

This GET illustrates the multiple layers of disconnect experienced by participants, which exacerbated their sense of isolation and loneliness throughout their journey of PND. The subthemes differentiate these layers of disconnect whilst also remaining interlinked with a weaved through sense of recurrent loneliness. The sense of disconnect appeared to be at the core of these experiences of PND, through the intersections of migrant and mother identities. Participants spoke to an overall sense of displacement and cultural alienation, which seemed to have originated within the migration experience. This seemed to have become more

apparent throughout their experience of motherhood and PND, along with a realisation that the lack of connection was taking its toll on their sense of belonging and their sense of self.

"It doesn't feel like my culture": Cultural displacement

A sense of disconnect towards British culture left most participants feeling increasingly isolated from others around them and their environment during their period of PND. Sofi alluded to a social distance that was created between herself and British peers, due to her lack of understanding of British cultural references, leaving her feeling alienated:

"I feel that I don't necessarily know the cultural references of the everyday life references. […] So that creates a kind of distance. […] I was kind of left out because of that".

Lana, who learned English before migrating to the UK, continued to feel 'othered' through language differences, amongst other socio-cultural elements, and seemed adamant that this sentiment would be unlikely to subside over time, setting her apart from British peers:

"I feel like I will never 100% understand the British culture because I wasn't born here, I wasn't raised here. […] I will never speak like a British person or will never have a British accent or I will never fully understand the culture".

Despite her multiple attempts to connect and assimilate, Melany also felt that British culture was overall too different from her own, preventing her from fully adopting it and finding a sense of belonging: *"I just don't get a lot of English culture […] it's just so foreign. […] It doesn't feel like <u>my</u> culture"*. For most participants, finding it *"really difficult to get the grips of the culture"* (Valeria) seemed to have profound consequences on their increased sense of isolation during the crucial postnatal period, having become new mothers.

For Valeria, there seemed to be a clear distinction between her own culture and British culture with respect to motherhood, leading to an increased sense of isolation: *"You're isolated quite a lot and I think motherhood in this country is very different… from back*

home" (Valeria). Aisha also made reference to differences between what seemed to be a collectivist approach to motherhood back home, compared to a more individualistic one within British culture. She appeared to paint a clear contrast between the comforting sense of community back home versus the lack of this in the UK, exacerbating her sense of loneliness:

"In [country of origin], if you have a baby then your aunts […], cousins […], friend pop by, you feel very comforted by how well surrounded you are versus in London, where it felt really, really lonely."

Grappling with old and new relationships

At the same time as navigating cultural displacement, participants referred to the physical and emotional distance from their roots and previously established relationships, *"the distance […] feels like it's multiplied by 100 since having the kids"* (Rosie). Most participants struggled to deal with the relational disconnect which was created, at a time when they most needed to feel understood and heard. For Valeria, attempts to connect with loved ones back home felt unsuccessful: *"Even when I talk to old friends and people that stayed behind, they couldn't understand what I was talking about, really"*. This huge shift in relationships was echoed by Sofi who also pointed out: *"I had my friends at home, but they were far away and they didn't go through the same experiences, they had no idea what it felt like to live in the UK"*. When sharing these unsuccessful attempts at connection, there seemed to have been a common sense of disappointment regarding the loss of relationships which once formed their primary source of support. It appeared to be through becoming mothers and experiencing PND that participants were most confronted with the realisation of the impact of these losses.

For some, it may have been these relational losses which motivated them to seek new, local connections. However, what may have initially been perceived as a hopeful endeavour, appeared more challenging in reality, for participants like Valeria and Monica:

"It's very difficult to make those friendships and the network, the support, or the village around you. […] It takes a flipping long time to build any kind of relationship" (Valeria).

"*In my attempts to connect with people here, nobody's connected back enough to where we felt comfortable asking for childcare."* (Monica).

It seemed that, as if forming relationships was not difficult enough for migrant mothers, maintaining these appeared to also feel short lived:

"It's much harder to build or to keep those relationships. […] They end up disappearing over the years, because they end up relying more on family support, so they don't need you anymore." (Valeria).

Finally, whilst options such as joining online neighbourhood groups may have been a viable and practical solution to connect with others, this seemed to further exacerbate feelings of disconnection due to the nature of superficial and sporadic interactions not necessarily materialising into meaningful friendships. For Aisha, it was as though:

"Everyone was answering all these very transactional questions, you know, like, informational stuff, whatever, but not many people were talking about how you feel. […] You're not connected to a human soul anymore".

Feeling estranged from partner and baby

Beyond the struggles to connect with the local community, participants appeared to find themselves disconnected even from those closest to them. This may have been particularly challenging as their support system was already very limited, potentially adding pressures within the home and straining nuclear family relationships. For Lana, it felt like *"we were like two strangers in the same house"*, when referring to herself and her British partner. She explained that her sense of connection with her partner grew weaker during the postpartum period, partly due to the cultural differences they were grappling with within their

own relationship and which had become much more apparent to her when becoming a family unit:

"I noticed all those differences with my husband, cultural differences, and I felt more distance. That cultural difference with my husband, is even amplified, when you are struggling with a newborn so… The first time it can be even more… overwhelming 'cause, […] even with your own husband, the father of your child, you feel like […] we are foreigners [to each other]."

For Aisha, it seemed like she and her partner were beyond feeling like strangers or foreigners and instead experienced total alienation from one another: *"At some point he just couldn't relate to me anymore. We were on two different planets"*. This emotional disconnection from their partners seemed to be a common characteristic of participants' experiences of PND.

For Sofi, the depths of loneliness that she experienced were not necessarily about being physically alone, but more to do with an overall emotional detachment:

"I wasn't alone. My husband was here with me. My baby was here, […] but the loneliness, of the mothering and the motherhood experience was […] just numbing and paralysing."

Rosie echoed the struggles in bonding with her baby, leaving her with an increased sense of incomprehension and guilt: *"I'm a terrible mother. Why are we not connected? Why are we not bonded?"*

"Always around but not present": Loss of self

Becoming a mother was experienced as *"such a big… shift […] in identity"* (Melany) for some participants. Navigating the new role of becoming a mother appeared to be challenging for most, to different degrees. There were participants who struggled to relate to the new identity of 'mother' entirely:

"In retrospect, all of the like getting together with other moms… I didn't want to… I wasn't a mom, you know, it wasn't my identity (shakes head with eyes rolling up), as a person. And so it was really horrible." (Melany).

Others felt, that on the contrary, their new identity completely replaced their previous sense of self: *"I definitely lost my own identity… when having my kids. I'm not Monica anymore. I'm mummy"* (Monica). Aisha seemed to relate to this slightly differently, in feeling able to connect with the identity itself, but not feeling in touch with the associated instincts throughout her experience of PND: *"It's like […] you're not connected to your instinct anymore. You're becoming disconnected from your mother instinct"*.

It appeared that participants moved through the early years of motherhood with little energy and connection to life, instead navigating this time on autopilot by being *"Always around but not present"* (Aisha). Sofi echoed this by stating:

"*I feel that…grief is about, you know, like losing presence with my son… losing… presence with… even with myself, like I just zombied through the first few months. […] I felt so disconnected from myself."*

This suggested that although she had been physically present and attended to her baby's needs, she felt detached and nearly apathetic throughout her experience.

GET 2: The burden of "learning the ropes by yourself"

This GET speaks to the experiences of participants who voiced the challenges they faced around having to *"learn the ropes"* (Aisha) of becoming migrant mothers by themselves and the unique pressures they endured in doing so whilst also navigating PND. The subthemes shed light on the multiple layers of adjustment they experienced through wanting to build a family and home in the UK, the isolating silence which compounded these struggles, their yearning for a 'village', and the overall repercussions of these challenges on creating an excessive sense of responsibility.

"Building everything, from nothing"

With the same intent as Monica to *"make this house a home"*, Valeria found it challenging to do this entirely from scratch in a new country:

"Building from scratch is learning everything […] from scratch. […] It's like it's a blank page and building everything, from nothing."

She spoke about everything that she felt she lacked as a migrant mother, compared to *"people that live in the same place forever or in the same areas"* and reflected on the disadvantages she felt this created for her:

"They know everyone. They know their space, they know the environment, they know who to count on, to go to. They have the resources there for them, which is something I did not have… and I struggled a lot."

Learning to navigate a new country, away from the usual support system, whilst also learning to become a new mother seemed to add multiple layers of overwhelm:

"I think the first weeks my son was born because it was so overwhelming, I was tired and just doing everything on my own, I didn't notice but then when days started being the same and my husband was at work and I was… feeling actually I don't have anyone around." (Lana).

This suggests the confronting loneliness participants were faced with whilst juggling the relentless responsibilities and pressures of becoming a mother as a migrant. Lana reflected on the impact that this intersection between becoming a new mother as a migrant had on her experience of support:

"As a first-time mom especially, you don't know what you need as a new mom so… I think for us migrant mothers who don't have the continuous family support, […] physical support really makes a difference."

This particular importance around feeling that more support was needed throughout the multiple adjustments required throughout early motherhood, was also shared by Aisha: *"You're basically on your own learning the ropes by yourself… and especially for something that actually requires so much support around you"*.

It seemed that Melany instinctively looked for this support by wanting to learn from other immigrant mothers, but instead found herself *"just so inexperienced with babies"* and explained:

"We just haven't seen babies. […] A lot of us have come to this country at the same age, single, hanging out with single people… and… no babies anywhere […] So like having no experience", when referring to herself and other new immigrant parents.

Aisha emphasised, *"there was nobody to guide me",* which may have suggested a sense of feeling lost and looking for direction in her experience of learning and building everything from scratch. It seemed as though she was hoping for someone to show her the ropes, or have some resemblance of instructions as to how to navigate becoming a new mother. This appeared to be similar for Sofi who expressed a lack of direction as to where to gain support: "*I don't feel that… I was… prepared or informed… about… what support I can get as a mother*". This absence of support and guidance during the crucial early months of motherhood, seemed to have a significant impact on participants' moods, such as Lana's who remembered: "*I just burst into tears […] because of the way I feel and I can't even speak about it with anyone because I don't have anyone to talk to*".

An isolating silence

Participants reflected on the impact that silence and stigma around PND had on them. *"I felt alone with my struggles, or I thought that it was […] a rarity. […] I didn't see my experience reflected back to me, in my community"* (Sofi). Aisha shared this sentiment but questioned whether it was truly a rarity to experience PND or whether PND was just not

spoken about: *"I mean none of my friends said that they had postpartum depression, so either everyone's just pretending to be fine all the time or people just don't talk about it. So it's very isolating."*

Because of this lack of discussion around PND, participants seemed to feel like they were the only ones experiencing it. Rosie questioned why motherhood felt so difficult, and attempted to find this out through wondering how others experienced it:

"I'm just trying to understand, like, what has happened to me in my life. (uncomfortable laughter) You know, how can I […] learn what this is supposed to be like. […] What's this like for other people or other people struggling with this as well?"

However, for some, the lack of opportunities to feel validated and understood left them feeling alone in their experience and over normalising difficulties: *"I just kind of assumed everybody felt that terrible […] I just thought that was normal. Like nobody told me otherwise, that that wasn't normal."* (Melany), before realising in hindsight, that PND was underlying the postpartum experience: *"A lot of people don't realise that even though it's normal, ie. a lot of people feel that way. It doesn't <u>have to be</u> that way and that that actually is depression rather than just like, oh, 'it's tough being a mom'"*.

Without this external validation in recognising PND or hearing about similar experiences, Sofi and Monica appeared to internalise their struggles in isolation. For Monica, this isolating silence seemed to contribute to the lack of understanding as to why she felt so unhappy, and led her to believe that she was the problem: "*I just thought there was something wrong with me, […] why am I not happier?"*. The isolating silence seemed to perpetuate a sense of rumination and self-blame, which she reiterated throughout her interview: *"It's me, I'm doing something wrong, I'm a terrible mother"* and *"I suck at this, I've sucked from the beginning, I'm terrible"*. Sofi similarly concluded that she was to blame, which may have

worsened as a result of not feeling able to connect with others and staying silent in her struggles:

"*[…] I just brushed it off, that I just couldn't manage, or I just couldn't live up to the standard or the norm. So I just brushed it off with "I'm just not good enough".*

It seemed that at the time, participants had attributed an internalised blame as a way of making sense as to why they were feeling so terrible throughout the postpartum period, possibly worsened by having no one around to suggest other reasons or echo their experiences.

For Valeria, who had wanted to attempt sharing her experience, it felt disheartening when she was met with responses that in turn perpetuated her feelings of shame:

"People don't want to get much involved anyway. I still think depression is a taboo. To this day, when I tell people, that I have […] depression… […] I notice there's a change in relationship. People don't want to get involved. They're either scared or they don't know what to do, so they just… leave you alone. And it can be quite a scary place to be because the only thing you need is someone just to listen to you (tearful). […] I think the world would be a better world if you could actually listen to each other, or not make you feel shamed about what happened to you."

This highlighted the multiple barriers to accessing support which participants seemed to face when experiencing PND, ultimately perpetuating an all-encompassing, isolating silence.

Longing for a 'village'

It seemed apparent that most participants' sense of increased isolation throughout their PND experiences was also intrinsically linked to being physically far away from their families: *"I think it does come from the lack of support, so if you don't have family around, you will not have the support […] I think it's because of the lack of family"* (Lana). Sofi

shared this assumption by stating: *"The lack of village was 100%... Contributor to it (PND) because my family, our family… Live in a different country".* The absence of familial support, traditionally a critical buffer against the stresses of early motherhood, seemed to exacerbate feelings of vulnerability and emotional exhaustion.

For Aisha, it went beyond assumption and into her own rooted beliefs such as *"[…] having a kid in a nuclear family, in a country where you don't live anywhere near family, it's not right*".

There seemed to be a shared struggle amongst participants when coming to terms with the impact which being far away from family had on their PND experience. This led some participants, like Valeria, to reflect on what they thought would have been different if they had stayed back home:

"It doesn't seem much, but those little hours that you're really stressed out… that you really want to breathe… and you can just walk away for a few hours and leave them [family] to look after your child for few hours. That's gold. I've never had that. […] I think […] the main difference if I had my child back home, would be the support. And the village that is not around me at all."

This longing for a 'village' remained a recurrent theme which participants referred back to: *"Especially as a mother like not having your own family there like you just want your own family. […] I wanted my own mum, you know?"* (Rosie), suggesting that no one could replace the special bond of one's own family. This seemed to be accompanied by a deepened sense of sadness and grief, around not having had a 'village' during the postpartum period. This sentiment of longing seemed apparent through Aisha's reflections: *"I really did wish I had that 'village' everyone talks about"*; *"I just wish I had more of a community around me, while that was happening (PND) 'cause that would have just made a huge difference"*.

"It's all just on me": Bearing the weight of sole responsibility

Through their journeys of navigating PND, participants were not only faced with the realities of migrant mothering pressures but also seemed to be feeling solely responsible in carrying these. Some of this responsibility taking appeared to be out of their control, due to the logistical nature of migrant mothering away from home and not having practical support: *"It's just all on me because there's just no one else […] somebody's gotta pick up the slack"* (Monica). Aisha came to a similar conclusion in feeling that there was little choice in taking sole responsibility: *"You have to rely on yourself. Nobody's going to look after you. There's nobody to fall back on here"*. For Valeria, this burden had been one she carried prior to her experience of PND, but became even more heightened through becoming a mother:

"I did a lot, because you learn to do things by yourself and you learn that you're alone anyway, you're gonna have to do this yourself or I had to do the things myself as a migrant. I thought I could do this as well (motherhood). So it took me a long, much longer time to ask for help."

It may have been that by taking on sole responsibility throughout the postpartum period, participants were also attempting to cope with their own overwhelm by seeking to gain control over mothering duties: *"I knew that I was anxious about everything, and I tried to control everything… and that […] was consuming me and it was forever present through my days and nights"* (Sofi). By coping similarly in this way, Rosie recognised that it may have, in hindsight, left her feeling stuck in a vicious cycle of PND symptoms including anxiety:

"I think I was very much just trying to sort of... get control. I was trying to like read everything which I now recognise as bit of an obsessional vicious cycle that all my efforts to kind of get controlled has made me feel more out of control in a way."

GET 3: "*Another wave was pushing me down*": Unrelenting confrontation

This GET speaks to the participants' iterative and non-linear experiences of feeling confronted by the traumatic nature of PND, spiralling into despair and at the same time, grieving idealised expectations of motherhood. It highlights the shock that participants were faced with when experiencing PND, what remained in the aftermath. and how they continued to process the loss of what they had expected or hoped for throughout their postpartum experience.

"Everything's survival"

Participants' personal accounts suggested that the emotional and physical impact of postpartum was traumatic for them. For some, like Rosie, it was the transition into becoming a mother which was experienced as an intense shock: "*For a mother […] it's so physical. And so, you become so vulnerable. And <u>everything changes</u> for you so much, in a much more sort of visceral and profound way*" (Rosie). It seemed that for any new mother, the transition from giving birth to looking after a baby can feel immense, and for some participants the challenges that came with this persisted, eventually becoming relentless over time.

Lana described being on 'survival mode', indicating that she was experiencing a prolonged state of stress and exhaustion whilst managing day to day mothering responsibilities: "*I think survival mode is just being sleep deprived, trying to just do the basics of keeping the house tidy and make breakfast and cook. And just look after my son. So no time to think about anything else*". Sofi echoed similarities in her experience by using a harrowing metaphor highlighting the unpredictability and power of the constant pressures she was faced with: "*I felt like I was just in survival mode 24/7 […] It felt like… every time I would […] not even get out of the water to get some breath, but even just an <u>attempt</u> of doing that, felt like another wave was pushing me down*". There seemed to be a common experience of feeling powerless when faced with the relentless nature of PND. For Aisha, it was the all-

encompassing sense of urgency, which she found herself stuck with, following a traumatic delivery: *"[…] my body was behaving as if I'm saving her every single day. Like, if she didn't have her bottle, how is she going to survive? If she didn't have a nap, how's she gonna survive? So, everything's survival*".

Rosie shared that she was in a conscious state of wanting to slow down but not feeling able to, reflecting a high level of uncontrollable alertness: "*For me it's almost like my body goes into like this fight or flight state. And I can't stand it. I need to make it stop. But then sometimes you just can't make it stop*".

For Valeria on the other hand, her mind seemed determined to continue powering through the pain, "*it was just all about 'I can do it. I can do it. I can do it'*", until she physically felt unable to any longer or as she said:

"*Until my body just gave up on me basically, and I think that's when postnatal depression comes up. It was like the proper physical symptoms because I don't think I would ever stop. Until my body had enough (pause, tearful, takes breath, wipes tears)."*

The aftermath was so intense that it eventually left her feeling paralysed: "*I basically couldn't go back to work for nine months. That's how long it took me to get my head around... I couldn't even make a cup of tea without thinking, I was completely frozen in*".

Through her own deeply personal and individual account, Sofi summarised her experience as follows, "*for me, it feels like it was a traumatic experience […] it was the postpartum that broke me and it broke me into pieces"*, suggesting an enduring fragmentation of self.

Spiralling into despair

When participants reflected on their experiences of PND, it became apparent that with hindsight, they were able to see more clearly how difficult the postpartum period was for them: "*Now, in reflection, I can see how how dark and deep I was, and I couldn't enjoy…That*

postpartum period, mothering and…I was anxious all the time" (Sofi). This vivid use of language and reference to darkness suggested PND may have tainted the whole experience of the postpartum period for participants: "*There was just no like, there was nothing light about having… a baby in the UK, like it would it just felt heavy and dark*" (Aisha).

Melany explained having developed a colour code at the time with her partner, to help each other check in with how they were feeling and she remembered: *"I don't think I had a 'Green' [feeling OK or good in self] day, the first year, after the baby was born and then I had a couple of 'green' days kind of afterwards*", suggesting the near absolute lack of light or hope that was recollected during the first year of motherhood.

This overwhelming sense of despair led some participants to reflect on their increasing suicidal ideation at the time. For Monica, this seemed to be rooted in feeling completely helpless at the time, despite her numerous attempts to seek support: "*Time of feeling, very helpless. Feeling useless. And just absolutely wanting to disappear. Because I just felt like I can't do anything right*".

Valeria referred to an unconscious process of preparing for the eventuality of her ending her life, possibly stemming from feelings of guilt, self-blame and hopelessness:

"*I convinced myself very much that I wasn't good enough for my daughter. And I was unconsciously preparing myself to leave her. I was letting go of her care and let my husband take the care. And convincing myself that I wasn't good enough at all. And that went on for a very long time until I crashed.*"

The hopelessness was echoed by various participants who alluded to having tried at the time to find solutions to alleviate distress, but these feeling repeatedly unsuccessful: "*Nothing seems to be working*" (Rosie) and "*nothing worked*" (Monica). The sense of overwhelm seemed to come hand in hand with hopelessness, creating a vicious cycle which participants felt stuck within. For Sofi, this made everyday tasks feel impossible to conquer:

"*I couldn't even make like simple decisions like, literally… what to have for dinner […] I felt so overwhelmed*".

Aisha was left feeling drained of enjoyment or any other positive emotion she may have hoped for or expected during motherhood: "*There was nothing I loved, […] I didn't care about anything […] I had no zest for life*". For Melany, PND seemed to have robbed her of any positive memories of her baby:

"*I have no memories [tearful] of my first child's babyhood [...] It's basically a blank. I have really no positive memories when I think about it. […] I just picture the sleeplessness and the crying and I know that there were good times, but I can't… access them*".

Grieving expectations

There seemed to be a common sense of disappointment transforming into enduring grief for those who looked back and struggled to recognise any positive moments: "*I think there's a grief about… kind of losing those months*" (Sofi). Whilst reflecting on their experiences of PND, some participants pointed out that things had not turned out how they imagined they would, "*nothing got […] to work the way that I'd hoped*" (Monica), suggesting a fragmentation of idealised expectations around motherhood. Even for Monica, who was the only participant to speak about her second experience of PND after having had her first in a different country, there was still an element of being taken by surprise by the turn of events and finding this deeply unjust: "*All these things that I so looked forward to doing, were just all being taken away from me*". It seemed like she had been robbed not once, but twice of the idealised version of motherhood she could have hoped for, and which may have inadvertently perpetuated PND symptoms.

Sofi recognised this in herself with hindsight, "*I had this… probably <u>idealised</u> idea of how things will go. And of course, they didn't go that way*" and shared the impact of falling from such expectations, which felt like a failure: "*I felt like I <u>failed</u> from the beginning*

because I literally did not feel the joy I was supposed to feel, or I should have felt". Expectations of motherhood being joyful and exciting seemed to be a wider reflection of societal expectations which lead mothers astray in their PND experiences, as stated by Sofi: "*Mothers are set up for failure from the very beginning*". It may have been these external pressures which corroborated with participants' narratives of themselves:

"*I feel like there is pressure for us new moms to not only go back to before physically, but also just being as functional as before without slowing down… So inside we're struggling because having a baby forces you to slow down, but if you are expected to have the same 'efficiency' as before then, of course you're gonna feel like you're failing because you can't do everything*" (Lana).

The impact of PND not only seemed to be influenced by the individual's circumstances or events, but also by the disillusionment that mothers were suddenly confronted with, exacerbating their sense of disappointment.

"*I wish somebody told me about becoming a mother in the UK 'cause, that's huge, that took a lot of adapting. […] It was a shock to my system, what it was like to be a mom in the UK. […] Something needs to be said about becoming a mother in the UK*" (Aisha)

GET 4: A winding journey of resilience

This GET includes participant accounts of personal and interpersonal signs of resilience throughout their journey of PND and beyond. These reflect the glimmers of hope and strength found amongst support groups and other forms of solidarity, primarily amongst migrant mothers. They also shed light on their personal growth along their individual healing journeys, as well as the struggles most of them continue to endure to this day.

Finding strength in solidarity

Throughout their accounts of PND, there seemed to be rare but meaningful mentions of key relationships or change of circumstances which helped participants see the light at the

end of the tunnel. Monica recalled reaching out to her husband's distant relative's partner who was from the same country of origin as her and living in the UK, referring to her as a lifeline: "*She was sort of my lifeline as far as: how do I manage this?"*. Similarly, Aisha met a mother from the same country of origin as her, whom she intrinsically bonded with and provided her a sense of reassurance at a time when she was suffering the most:

"*I can't emphasise enough how important that friend was in the process of getting me out of my rut, because I finally had somebody to share my experiences with and somebody that was open to listen to them and somebody who didn't need to schedule appointments and somebody that could, would drop everything and come over if I couldn't handle something. […] It was such a solid foundation, I <u>needed</u> […] that. If I had that from the beginning, I wouldn't have… I don't know if I would have needed therapy*". It seemed that being able to relate to another mother from a similar background was key in helping these participants overcome PND.

For Valeria, it was her move to a more multicultural area which finally seemed to provide her with much awaited relief and ability to feel understood with regards to her circumstances:

"[…] *everyone feels like it's in the same boat, in the same situation, because we all have families far away. So we tend to support, each other, little bit more. So it's more open to the kind of complaints that we wouldn't discuss with someone that has family and stuff around.*"

For Lana, the sense of solidarity was found amongst a support group she accessed after eventually referring to her GP, and this appeared to be the catalyst in feeling able to overcome her difficulties. This solidarity was not necessarily founded on the basis of migration compared to Monica, Aisha and Valeria, but more so on common experiences of motherhood, which in itself provided Lana with an increased sense of belonging: "*I*

remember even just talking, listening to the other moms it felt like. Recharging and refreshing and I felt like I wasn't alone."

According to her, it was essential for migrant mothers to have a support network when having a child: "*In order to prevent postnatal depression, for certain people, I think it's having the support, at least in my case, it's having the support around*". She noticed this making a huge difference in her experience after having her second child, which she found much easier compared to her first when she had little support and suffered PND.

Although it was challenging for most participants to open up about their experiences, Valeria felt that "*in a way, will be good for the world to know, because that could help another mum that doesn't know what to do and who feels in the same place. It's good to help*". Other participants also shared what appeared to feel like a sense of duty in giving back to the community and offering their solidarity to any future migrant mothers, which would also in turn fulfil their own gratitude and healing: "*If it helps, just one other mother. Then, I will be even more grateful*" (Sofi) and that this could potentially help others going through similar experiences to feel less alone in this. For Aisha, it felt important to share her story and "*contribute to research that would spare people from… [tearful] feeling how I felt*" (Aisha). By offering acts of solidarity, this appeared to benefit participants who continued to grow through a sense of unity and belonging.

A liberating shift towards healing

On their journeys to recovery, participants noticed that although it was confronting, once they seemed able to recognise their state of mind, they were then able to start healing. For Aisha, it made the difference between feeling able to access her emotions on a deeper level and reconnect with a sense of groundedness:

"*The big thing was realising that I was in survival mode. […] I had this huge realisation where I finally could feel grateful, […] I had a huge perspective shift.*"

This sense of gratitude also resonated by Valeria who, in hindsight, seemed to recognise that by facing PND she was also starting to overcome past traumatic experiences, which had been worsening her mental health:

"*Some people see it like a bad thing (PND), but I think I, after so many years, I think it's such an opportunity because if I didn't have [Child] and I didn't have my diagnosis and I didn't look into it with real eyes, I probably would be dead by now. That's the truth."*

Through receiving a diagnosis of PND, some participants not only seemed to gain a better understanding of themselves and their postpartum experience, but they also received the validation and crucial support that they had been lacking:

"*Thinking about my diagnosis, I think it was important to open doors from personal point of view […] I probably wouldn't be in the same level of understanding and same level of support I had today.*" (Valeria).

Part of being able to receive this support also seemed intertwined with their ability to seek it in the first place, which they found difficult to recognise due to the aloneness and stigma around PND. Monica shared how she had learned to communicate with her partner earlier on the second time she experienced PND compared to the first: "*I started to recognise the signs the second time around and I thought I need to be more open, more upfront. Because it got to a very dark place, after my first son*".

Rosie reflected on how far she had come with her husband since her experience of PND. During her account of PND, she had spoken about how the impact on him, who simultaneously suffered from depression himself, compounded the challenging life circumstances and transitions they were faced with as a family at the time. She contemplated on how they evolved on a personal level and as a couple: "*We really grew from the experience […] so there was a whole post-traumatic growth arc that we've been on*", suggesting that

they had managed to process some of the pain and distress experienced at the time, and reframed it into a testament of resilience.

Some participants seemed to recognise this resilience in themselves and gauged it with regards to how they felt they had coped when sharing their stories during the interviews. For Valeria, although it was "*quite painful*" to talk about her experience of PND, she said:

"*I feel proud that I can talk about it because I wouldn't have been able to do this a year ago. And this just shows me how strong I am now and… how much… I've been through my journey. It actually feels good to, to know that. It's extremely painful. It's true. There's a lot of emotions involved.*"

This suggests that for some participants it had been a while since they were given the opportunity to open up in retrospect about their experiences, and for them it may have come as a surprise to see their progress in feeling able to revisit painful memories.

Sofi never sought or received a diagnosis of PND but realised at the point of recruitment for this study that her experiences could be made sense of in this way. Similarly to Valeria, Sofi appeared to feel proud about how far she had come in being able to recognise, accept and validate her own experience:

"*I could just put a luggage down, like a bag of rocks. And it was liberating. So, I think in a way, it's liberating and it's empowering […] I feel that, I can talk about this now without breaking down into tears and… I am […] honouring this experience as it was.*"

"I'm still putting myself together": The struggle continues

The participants' testaments of resilience highlighted the complex and lengthy process of healing from and beyond PND, and although they had already come far in their journeys, there continued to be struggles.

Valeria seemed caught off guard by the fact that she still experienced episodes of depression despite having 'done the work', speaking to the complex nature of mental health and lifelong journey of recovery for some:

"*I adjusted my life and managed to go back to work in a part time and adjusted things, had gone into therapy and… Worked out a lot of things. I thought I had resolved that and that's fine. Moved on. But for the following five years, I end up having kind of really low episodes for a few months.*"

For most participants, it seemed that although their struggles had decreased in intensity since the time of PND and being 'in survival mode', there were still complex feelings associated with grief, which they continued to grapple with: "*There's still, like something that lingers about the burden, like in the background*" (Aisha). Sofi spoke to the inherent process of healing through time after having felt 'broken' by PND, and seemed to take an active role in bringing her different parts of self, back together: "*Even though the, the guilt and the shame… have been healing, there is still grief that I am navigating and processing […] I'm still putting myself together*" (Sofi). There seemed to be a common recognition that the PND diagnosis may not entirely account for the on-going grief and/or impact of traumatic experiences that mothers continued to face beyond the first year of motherhood:

"*I still have like… underlying things to work on with myself. […] It wasn't over after one year, so this kind of arbitrary cut off of like 'one year', I understand why they they do it, but really it's probably until the kid's like three… is when people need support.*" (Melany)

Participants often referred to the enduring psychological distress that extended well beyond the scope of their PND experiences, largely due to the complex interplay of structural and socio-cultural challenges they encountered as migrants in the UK. For Monica, there were still difficulties in renegotiating her sense of self, identity and belonging as a migrant:

"*I'm still having to find the new identity of 'Monica in the UK'"*. For Lana, it was the on-going challenges related to familial distance and lack of childcare which seemed to continue taking its toll on her but that she felt compelled to come to terms with:

"*It's still difficult because…Sometimes I wish like I could just leave the kids for a half an hour and take a nap. With my mom, in [country of origin], grandmothers are the babysitters and I don't have that but this what I have.*"

Overall, there seemed to be certain circumstances and struggles which are bound to last due to the realities of being a migrant mother in the UK: "*I think this is the major impact of… being an immigrant. I think the isolation was always gonna be there*" (Valeria).

Chapter 5: Discussion

This chapter offers a summary of the findings, contextualising them within the existing research literature. The cross-literature examination is divided into sections encompassing each group experiential theme (GET), and subthemes are referenced in italics within each of these sections. The implications, strengths and limitations, suggestions for future research and opportunities for dissemination are discussed before concluding the chapter.

Summary of findings

The aim of the research was to "*Explore migrant mothers' experiences of postnatal depression (PND) in the United Kingdom (UK)*". Seven migrant mothers were interviewed for this Interpretative Phenomenological Analysis (IPA) study, who originated from Europe, Asia, North and South America. I identified four GETs which were subcategorised into subthemes to share migrant mothers' individual and collective experiences of PND in the UK. Participants spoke about the impact of having to navigate multiple layers of disconnect from their own culture, their loved ones, their environment, and themselves. Through building new lives and becoming mothers in the UK, participants realised in hindsight how alone and isolated they felt throughout their journeys of PND. This left them with exacerbated feelings of heightened responsibility and guilt when navigating early motherhood challenges, in addition to being confronted with repeated disillusionment. As their ideas of what motherhood would look like became tainted by their experience of PND, participants were left with feelings of grief. Feelings of resilience and growth nevertheless prevailed and were evoked when participants reflected on how far they had come since their experience of PND, with their ability to cope and share their stories.

This qualitative study contributes to the existing literature which addresses migration, motherhood and mental health experiences. It offers a new perspective on the intersection of

these, with a specific lens on the unique, complex and layered challenges migrant mothers face throughout their experiences of PND in the UK.

Literature cross-examination

Navigating layers of disconnect

The first GET encompassed the layers of internal and external displacement that participants felt through their journeys of PND as migrant mothers. The concept of cultural displacement is well documented within migration research. The subtheme *"It doesn't feel like my culture": Cultural displacement* evokes the impact of migration on participants' cultural identities and the process of acculturation (Bhugra & Becker, 2005). Acculturation is a concept which "refers to changes that take place as a result of contact with culturally dissimilar people, groups and social influences" (Gibson, 2001, p. 19) and which is most often studied within the field of migration, particularly when regarding individuals who settle long term in their newly adopted country (Schwartz et al., 2010). Through this process of acculturation comes a loss of one's own culture and support systems, as well as an adaptation to one's new culture and environment. Participants evoked this sense of cultural confusion and feelings of alienation, which are not uncommon in the literature that identifies post-migration stresses (Bhugra, 2004; Bhugra & Becker, 2005). Roitman (2020) highlights the uniqueness of migrant mothers having to renegotiate their national identity and new roles as mothers simultaneously.

Alienation is described as "an individual's sense of separation between themselves and various objects, such as other people, their community or society" (Yang et al., 2022, p. 567). According to a qualitative scoping review, there is a higher risk for migrants to experience a sense of alienation due to the complex and multiple adjustments they face when adapting to a new environment (Yang et al., 2022). This seemed to contribute to the current study's participants' sense of isolation, which is a risk factor associated with mental health

disorders in research with migrants (Bhugra & Becker, 2005). Furthermore, together with the experience of becoming mothers in their new communities, Yang et al. (2022) suggest that the sense of alienation may be exacerbated through the unique challenges that migrant mothers face.

Through facing multiple adjustments and changes in identity, migrant mothers' sense of relating to others and self can become fragmented (Bhugra & Becker, 2005). Participants shared their continued sense of alienation within UK culture, despite making efforts to assimilate and build new relationships. Bhugra and Becker (2005) note that if the migrant individual feels isolated within their new culture and lacks social support, this can lead to a sense of rejection and poor self-esteem. This was echoed within participants' experiences of feeling left out and misunderstood, withing the subtheme *Grappling with old and new relationships*. Similarly to participant experiences within Brance et al.'s (2024) study, it seemed that the findings in the current study also showed the irreplaceability of long established and meaningful relationships. With most participants having moved to the UK for study or work reasons and the associated privileges, there nonetheless remained extensive challenges in building new friendships (Povrzanovic Frykman & Mozetic, 2019), compounded with becoming new mothers (Yang et al., 2022). Findings in the current study highlighted that participants experienced a lack of close friendships during the postnatal period, which contributed to their sense of isolation and hopelessness. Friendships "enable a sense of belongingness and social support" (Languilaire & Carey, 2017, p. 102), which is deemed essential for social integration (Povrzanovic Frykman & Mozetic, 2019). The literature also points to the bi-directional impact between lack of support and PND (Letourneau et al., 2012), with PND placing mothers at increased risk of social isolation due to their symptoms.

Research suggests that lack of social support and poor interpersonal relationships are some of the strongest risk factors for developing PND (Qi et al., 2022). In addition to the lack of friendships or wider support, participants spoke about the alienation they experienced within their own relationships with their partners, leaving them feeling increasingly isolated and disconnected even within their own home. This was encompassed by the finding *Feeling estranged from partner,* which highlighted participant experiences of marital tensions especially around the postpartum period, exacerbating feelings of loneliness. During the postpartum period, the partner is often the primary support provider, and this is especially the case within migrant couples who are away from extended family and other forms of support (Qi et al., 2022; Vo et al., 2024). The intimate relationship becomes increasingly strained as migrant mothers are more likely to rely on their partners for support (Holopainen, 2002). Multiple studies conducted across various ethnic groups have explored the link between marital satisfaction and PND (Escriba-Aguir & Artazcoz, 2011; Clout & Brown, 2016; Hassert & Kurpius, 2011; Kim & Yang, 2018; Qi et al., 2022). These suggest that the marital relationship plays a key role in the prevention or deterioration of PND symptoms (Qi et al., 2022). Overall, research shows that PND impacts the whole family, despite interventions often targeting mothers in isolation (Boath et al., 1998; Letourneau et al., 2012).

The impact of PND on the nuclear family is apparent in the findings where a sense of *Estrangement from baby* was also evoked by participants. The influences of PND on parent-infant relationships has been extensively explored across previous literature (Field, 2010; Letourneau et al., 2012; Zajicek-Farber, 2010). Beck (1999, p. 41) describes PND as a "thief that steals motherhood", which seemed to be echoed in participants' accounts of disconnection from their babies. They seemed paralysed by PND, leaving them struggling to bond with their baby. Research has often focussed on the negative consequences of PND on

parent-infant relationships and links to poorer child outcomes with regards to their health, cognitive, social and behavioural development (Letourneau et al., 2012).

It was clear that participants in this study not only evoked difficulties in navigating and renegotiating their interpersonal relationships, but also their relationship to themselves (Bhugra & Becker, 2005). Through migration and PND, participants experienced a multi-layered shift in identity and sense of self. This is unsurprising considering social identity theory which refers to a sense of self being derived from a belonging or membership to social groups (Tajfel, 1974, 1982; Turner, 1987). This could provide context for understanding the findings related to *"Always around but not present": Loss of self*. If participants felt a lack of connection to others and their cultural environment, it would make sense for them to feel a further disconnection from their sense of self. According to the Social Identity Model of Identity Change (SIMIC), the sense of identity is particularly prone to shifting throughout the process of migration (Iyer et al., 2009; Jetten et al., 2010).

Beyond a change in identity for some, the loss of self has also been previously echoed, notably in Lawler and Sinclair's (2003) phenomenological hermeneutical study of women's lived experience of PND. In addition, a meta-ethnographic study on qualitative research about migrant women's experiences of PND highlighted personal accounts of identity loss (Schmied et al., 2017). Mollard's (2014) qualitative meta-synthesis also identified the 'loss of sense of self' as one of the five major themes which underlined lived experiences of PND. This was evidenced within Mollard's (2014) research by 'depersonalising feelings' which were similar to this study's participant accounts of having 'zombied' through postpartum. The experiences of feeling "alien to their core, internal or authentic selves" (Abrams & Curran, 2011, p. 382) are not only captured within the field of PND, but also within that of migration (Ballentyne et al., 2021; Bhugra & Becker, 2005).

Research shows that social identification plays an important role in individual wellbeing and psychological distress (Brance et al., 2024). This is especially relevant to acknowledge in research with migrant populations, who navigate a complex relationship with their self-identity. Brance et al. (2024) built on the social identity approach to mental health and explored how migration shapes social identities, in turn impacting on psychological well-being (Tajfel & Turner, 1979). They suggest that taking on new social identities after relocating is one of the main hurdles that migrants experience, and therefore emphasise the importance of offering community and social support to help migrants cope with adjustment challenges (Brance et al., 2024).

Overall, the findings from this first GET contribute to research which suggests that assimilation and cultural identity are significant factors in understanding the relationship between migration and mental health distress (Bhugra, 2004). It identifies further possible links between migration, postnatal stressors and the experience of depression through facing multiple layers of disconnect with self and others (Bhugra, 2004).

The burden of "learning the ropes by yourself"

The second GET highlighted the different layers of learning that participants had to face alone through navigating a new country as migrants and also having a child. Participants shared the burden of *Building everything from nothing*. They seemed to be faced with the dual shock of the new: becoming mothers and doing so in a new country, leaving them in unfamiliar territory facing layers of economic and immigration status pressures (Coates et al., 2014). Schwartz et al. (2010) suggest that unless migrants are seen to be contributing to the country's economy or culture, they may be more likely to face discrimination (Louis et al., 2007, Schwartz et al., 2010). Some of the participants who had to start their career all over when coming to the UK, shared the complexities and heaviness of learning to build a new life from scratch. Existing research provides further context to explain these complexities, by

showing that migrant women are considerably disadvantaged compared with migrant men (Llacer et al., 2007) and that the inequalities increase when becoming parents (Udayanga, 2024).

Findings from the current study suggest that participants felt particularly disadvantaged when comparing themselves to mothers who had always lived in the UK. Previous research suggests that migrant women are more vulnerable to mental health difficulties during the postpartum period compared to native mothers, due to lack of access to support and local resources, which supports the finding that they are building a new family life with limited existing resources (Rao et al., 2020). Zlotnick et al. (2023) highlight that migrant mothers, irrespective of their immigration status, may be more isolated therefore increasing their risk of developing PND. The postpartum period is a particularly vulnerable time for women, especially for those becoming mothers for the first-time (Zlotnick et al., 2023) who may lack knowledge in noticing signs or symptoms of PND (McLoughlin, 2013). Although seeking help and/or accessing support during postpartum can be challenging for all new mothers (Dennis & Chung-Lee, 2006), there are many reasons why migrant mothers may be more impacted compared with native-born mothers, including a lack of knowledge of available healthcare services or the lack of culturally adapted care being offered (Zlotnick et al., 2023).

An isolating silence left participants feeling alone in their struggles with PND. A meta synthesis conducted in the UK found that one of the three main factors which affected women's decision to seek help for perinatal distress, was stigma (Button et al., 2017). Stigma was not explicitly named by participants within their narrative accounts but it may have contributed to their experiences of *An isolating silence,* along with their confusion as to why others around them were not talking about PND. Edwards and Timmons (2005) conducted a qualitative study with mothers suffering from PND and suggested that stigma was felt both

internally and externally. Mauthner (1998) suggested that mothers may be actively silencing themselves, due to fear of judgment and invalidation from others.

Another explanation for why mothers may be silencing themselves is that they may not be aware of others in their community who may have also been suffering from PND. This was apparent in the current study's mothers' accounts when they shared not knowing whether anyone else was suffering or whether they were pretending not to suffer. This is similar to Tobin et al.'s (2018) meta synthesis findings which highlighted mothers "suffering in silence (and solitude) from an invisible illness" (Tobin et al., 2018, p. 97).

In line with the current study findings, stigma and silenced experiences are shown to perpetuate self-blame and a tendency to minimise symptoms (Button et al., 2017), which subsequently lead to downplaying the severity of these and feeling reluctant to seek help (Baines & Wittkowski, 2013). The silence is therefore all encompassing for participants who struggle to speak about their experiences, and are also feeling silenced when they do seek help due to experiences of discrimination and rejection (Tobin et al., 2018).

Through facing new motherhood alone and experiencing layers of silence around their journeys of PND, participants shared their increased awareness and sense of *Longing for a 'village'*. This was similar to participant experiences within Roitman's (2020) study who realised they started feeling homesick only after giving birth. Mothers around the world have adopted the proverb 'it takes a village' to highlight their subjective experiences of what it is like raising a child and the importance of community support. In the current study, participants made sense of their PND experiences through relating it to being physically distant from their families and friendships. This was similar to participants in Schmied et al.'s (2017) study, who also understood their experience of stress and PND to be linked to the lack of community in their host country. With this realisation, participants in the current study shared their fantasies about what they felt it could have been like to have family close by for

support, which was a similar lamentation that Foster (2013) witnessed when also interviewing migrant mothers.

Existing literature mentions the impact of specifically being away from one's own mother during this time of vulnerability (Ozeki, 2008; Rubin, 1984), which was echoed by participants in the current study. The psychological process of migrant mothering can be particularly complex where there is physical distance between new mothers and their own mothers (Chodorow, 2000; Roitman, 2020).

Giving birth brings about sudden and significant changes in a woman's roles and responsibilities, as she transitions into motherhood and takes on the demands of caring for a newborn, managing new emotional and physical challenges and often balancing these with other personal, familial, or professional obligations (Slomian et al., 2019). The weight and increased sense of responsibility that participants evoked is captured in the subtheme "*It's all just on me": Bearing the weight of sole responsibility*. Mothers in general can experience a sense of overwhelm related to their mothering responsibilities when suffering from PND (Coates et al., 2014; Homewood et al., 2009). Homewood et al. (2009) developed a psychological process model comprised of five phases to explain the transition to motherhood. Within this, they identified an 'overwhelming responsibility phase', where mothers found maternal responsibilities unmanageable. This supported the current study's findings, where mothers also doubted their maternal adequacy and ability to keep their child safe, subsequently contributing to feelings of guilt, shame and fear, which seems to have perpetuated their PND symptoms. The sense of 'overwhelming responsibility' was also identified within one of Coates et al.'s (2014) themes resulting from an Interpretative Phenomenological Analysis (IPA) on women's experiences of postnatal distress. This stemmed from participants' accounts of feeling overpowered by their baby whom they felt demanded so much of them.

In the qualitative study "But who takes care of the mom?", Ettinger De Cuba et al. (2025) argue that migrant mothers not only experience the mental load of raising their children and addressing household needs all with constrained access to resources but also that of wider political and social climate. They offer an opposing perspective to locating vulnerability within women by supporting the concept of an existing "structural vulnerability to describe economic and political processes that impose physical and emotional suffering […] in a structured manner" (Ettinger De Cuba et al., 2025, p. 1). This is in line with the existing feminist body of literature on motherhood, which argues that motherhood needs to be understood within the social contexts and constraints that perpetuate idealised roles and expectations of mothers (Homewood et al., 2009). This literature provides a lens through which the overwhelming sense of responsibility experienced by this current study's participants can be better understood.

Unrelenting confrontation: "Another wave was pushing me down"

The third GET gathered participant accounts of the sense of relentlessness and hopelessness they experienced throughout their PND journey and how they felt this tainted their postpartum period. In the subtheme "*Everything's survival"*, participant quotes evoked sentiments of PND as a visceral experience of survival for them. They voiced this in relation to remembering feeling like they were in survival mode during the postpartum period, and reflected on the imprint this left for them. This finding can be contextualised within Beck's (2023) reviewed 4-stage theory of PND: stage 3, 'struggling to survive', includes various dimensions of survival that migrant mothers particularly struggle with.

Literature suggests that mothers may have experienced postpartum as traumatic due to it having deviated from perceived expectations (O'Donovan et al., 2014). Participants suggested being in a state of 'fight or flight' during postpartum indicating that they may have faced a sense of threat and shock. The physical symptoms they experienced seemed

intertwined with this state of survival, which is common within experiences of PND (Schmied et al., 2017). In Schmied et al.'s (2017) study, physical symptoms of depression were described as debilitating. This is similar to the current study's narratives around feeling paralysed by PND symptoms.

Mothers were not only sharing their own experience of survival but that of keeping their baby alive. This was at the forefront of participants' minds, when describing their sense of being 'on survival mode'. Similarly, Homewood et al.'s (2009) participants shared a sense of 'unwelcome powerfulness over their infant's survival'. It seemed that the priority for mothers at the time was to meet their and their baby's basic needs, with no space left to address any other additional needs. Existing literature argues that migrant mothers require a network of support to survive (Ward, 2004); however, in the absence of this, participants in the current study seemed to be left with additional layers of challenges in their experiences of surviving PND.

Participants' experiences of hopelessness and helplessness were captured in the subtheme *Spiralling into despair*. This is similar to Beck's (2002b) theme 'spiralling downwards' in the conceptualisation of PND experiences. Some metaphors used related to the absence of light, representing the lack of hope, and the presence of darkness, representing the struggles, which have been commonly highlighted within the literature on mothers' experiences of PND. In Yu and Bowers' (2020) study, for example, one participant initially offered a more nuanced perspective that "Everything is greyscaled" (p. 1451) when referring to her postpartum distress, but then subsequently went on to describe it as being the darkest moment in her life.

Feeling hopeless is one characteristic of PND which is captured within the 10-item Edinburgh Postnatal Depression Scale, commonly used in the UK to help screen for PND (Cox et al., 1987). Coates et al.'s (2014) participants evoked feelings of wanting to

temporarily 'walk away' from their situation. Feeling hopeless and helpless may leave any mother struggling with depression to contemplate a form of escape, either temporarily or permanently. Women experiencing PND may be at increased risk of suicidal behaviour, particularly within the first year of receiving a diagnosis (Yu et al., 2024). These feelings could be exacerbated for migrant mothers who face additional challenges and limited options for support or temporary solutions to 'walk away'. Within the current study, participants alluded to their own experiences of suicidal ideation when reflecting on a gradual and unconscious process of handing over care to their partner.

A sense of helplessness and hopelessness are also common across migrant experiences. In their scoping review, for example, Yang et al. (2022) identified key themes related to migrant parents' experiences of alienation. Stressors associated with migration and acculturation, such as isolation from their host society, were cited amongst other factors as reasons for experiencing helpless feelings (Yang et al., 2022). It is those intersected experiences of hopelessness and helplessness stemming from participants identifying as both migrants and mothers, that may have contributed to the unique, complex and layered challenges they faced throughout their journey of PND.

In the subtheme *Grieving expectations*, it was not just the "shock of the new" (Coates et al., 2014, p. 4) which participants were confronted with, but the shock of the discrepancy between their expectations and the reality of their experiences of migrant motherhood (Bhugra & Becker, 2005). Existing literature suggests that there is an unhelpful idealisation of motherhood, which can adversely affect women who do not experience an expected sense of fulfilment when having a baby (Homewood et al., 2009). These identified discrepancies between expectations of motherhood and women's actual experiences have been linked to the development of PND (Hall, 2006; Homewood et al., 2009). Feminist literature further suggests that some women who reported experiences of PND may have in reality endured

typical adjustments of the transition to motherhood, which may have not been experienced in this way due to unmatched expectations (Homewood et al., 2009). Mamisachvili et al. (2013) found that first-generation migrant mothers' feelings of guilt and fear of failing in relation to ideals of motherhood seemed exacerbated by their disappointment in the lack of support around. Similarly, Brance et al. (2024) found that as a result of migrating, some participants experienced feelings of frustration and despair when their high expectations for social bonding were not met.

Participants in the current study made sense of their unmet expectations in a variety of ways. Some recognised, in hindsight, that their expectations had been idealised and blamed themselves for 'failing' to meet these. Jackson et al. (2024) found that all of the women they interviewed regarding their experiences of guilt and shame in the postpartum period, had "internalised unrealistic mothering ideals" (p. 3019). There was associated grief with the loss of idealised expectations and opportunities, which participants in the current study also evoked. The subtheme *Grieving expectations* appears to be in line with Mollard's (2014) identification of the theme 'crushed maternal role expectation' which they found across their qualitative meta-synthesis focussed on women's accounts of PND, highlighting a consistent and recurring notion of "incongruity between the expectations and reality of motherhood" (Beck, 2002, p. 458) present across existing literature.

A winding journey of resilience

The final GET encompassed participant narratives of resilience and growth. This is particularly important to present in contrast with the dominant narratives in literature about the vulnerabilities of migrant populations (KC, 2024; Keskinen & Andreassen, 2017) and mothers who suffer from PND (Hannon et al., 2022; Phua et al., 2020). Participants from the current study attributed factors such as finding a sense of solidarity, recognising PND,

seeking professional support, and talking about their experiences as all contributing to their recovery.

As previously mentioned, participants shared the negative impact that their initial lack of support had on their experiences of PND. This finding is common within existing literature on risk factors for PND (Beck, 2001). Therefore, it was understandable when participants also credited the eventual building of key relationships as a factor in helping them overcome PND. This is supported by research demonstrating the importance of social support in preventing PND (Scrandis, 2005). The subtheme *Finding strength through solidarity* captured the importance that finding connections had in helping participants address and feel validated in their experiences of PND. Building these connections has been shown to be difficult, especially for migrant mothers, however taking a step towards this then enabled further gains in the journey of seeking help (Beck, 2002b). Bhugra (2004) hypothesised that individuals who migrate from collectivist cultures to individualistic cultures would be likely to struggle adjusting and acculturating. Some participants in the current study mentioned that they experienced this struggle themselves, before eventually finding a sense of solidarity through single connections with other migrant mothers. With hindsight, participants further suggested that if they had discovered these connections sooner, they may have not needed therapy and that having support early on could play a part in preventing PND.

Indeed, a participant from the current study shared that she eventually accessed a peer support group which is part of what helped her to overcome PND. She explained that it had been an opportunity to connect, hear and share feelings which had contributed to her healing. In line with Cronin's (2015) study on friendships within motherhood and Benchekroun's (2024) findings on solidarity practices amongst migrant mothers, it may have been that the aspect of receiving emotional support was key for those participants in the current study, who described their eventual connections as 'life lines'. The European Network of Migrant

Women (2019) considers the act of sharing stories as one form of solidarity for migrant women to "heal, exchange, learn as well as co-creating their own lives and stories" (p. 6). In line with these values, participants from the current study expressed their gratitude for being provided what felt like a safe space to share their experiences and for these to be disseminated, with the shared hope of helping other migrant mothers feel less alone in their journeys of PND.

The subtheme *A liberating shift towards healing* foregrounded participant reflections on having their experiences of PND eventually recognised and validated, helping them grow beyond these. Signs of depression can often be missed by healthcare professionals, as was the case for participants in Ahmed et al.'s (2008) study which explored experiences of immigrant new mothers with symptoms of depression. For some migrant mothers, PND is not recognised within their culture (Schmied et al., 2017; Wittkowski et al., 2017). Schmied et al. (2017) further suggested that throughout the studies included in their meta-ethnographic study, migrant women rarely recognised the PND symptoms themselves. Through finally recognising the symptoms and/or having these recognised by a professional, some participants in the current study felt that this 'opened the doors' to gaining better understanding and accessing support. Just as in Beck's (2002b) meta synthesis, participants in the current study voiced a start to regaining control once they had recognised their needs and found ways of addressing them.

By sharing their experiences of PND, participants appeared to reclaim a sense of self and move toward recovery, with some expressing pride and validation in telling their stories and participating in the study (Stone & Kokanovic, 2016). This aligns with Williams' (2013) findings, where recovery was seen as a form of empowerment.

Despite their own acknowledgment of resilience and growth, participants also admitted to the ongoing struggles they faced beyond PND. These reflections were captured in

the final subtheme "*I'm still putting myself together": the struggle continues*. When depression lifts, mothers are often confronted with grief regarding to the postpartum moments they felt PND had robbed from them (Beck, 1999). This seemed to be congruent with the current study's findings which highlighted participants' recovery as ongoing: participants spoke about the continued struggle that they were having with their mental health, even 4 or 5 years later. This is similar to participants within Hadfield et al.'s (2019) study who had received psychological therapy within the National Health Service (NHS), and highlighted that "it's [low mood] probably not gonna go away" (p. 3526) so they would continue to use the tools they had learnt for "moments in my life where […] I feel that way again" (p. 3526).

Participants in the current study described their sense of brokenness after experiencing PND and the steps they were taking to 'put themselves back together'. This was similarly echoed in Lawler and Sinclair's (2003) findings, where participants voiced the cycle of grief they underwent before feeling able to move towards acceptance of their experiences as 'normal'. Through their research, Lawler and Sinclair (2003) suggested a review of the meaning of 'normal' and the implications this may have for labelling women as suffering from PND. In the current study, participants queried the arbitrary one year 'cut off' they were subjected to with regards to support for PND. This raises the ongoing dilemma that mental health practitioners grapple with regarding the benefits and limitations of diagnoses in general and how to differentiate between types of distress (Cromby et al., 2013). It seemed that some participants felt that their PND diagnosis had not encompassed the full spectrum of ongoing complex contextual factors they continued to face as migrant mothers beyond the one year following delivery. It was important to them for professionals to recognise the ongoing challenges they faced relevant to their migrant identities, journeys and ongoing adaptation within the UK. As participants in the current study stated, the lack of childcare and the feelings of isolation were examples of particular difficulties they continued to struggle

with beyond PND, consistent with other research on migrant mothers' experiences (Condon & McClean, 2017; Lam et al., 2012; Lisiak, 2018; Machaka, 2024; Ozeki, 2008).

Implications

Wider system and policy levels

This study suggested that there was a burdening silence and sense of isolation felt by participants within their experiences of PND. This seemed to fuel their interest in helping to raise awareness by participating in the study, with the hope that this would reach other migrant mothers and help them feel less alone in their experiences of PND. This study contributes to existing research which highlights the importance of tackling stigma through raising awareness (Elliott et al., 2020; The Lancet Regional Health-Europe, 2024). The Lived Experience in Policymaking Guide stipulates the value of involving those with first-hand, personal experience and offers underlying principles to guide policymakers when considering this type of work (Policy Lab, 2024). In line with this ethos, I suggest that immigration and mental health policymakers consider working with those who have lived experience when carrying out research and/or implementing new policies which are likely to impact migrant mothers who have experienced PND. By foregrounding and disseminating their stories, the media involved in reporting on policies and/or research could also influence societal narratives more positively and contribute towards lifting the isolating silence around PND, instead promoting avenues for support (Elliott et al., 2020).

Community

One way of accessing support for PND could be through the community, which is particularly important given the barriers to accessing healthcare (Das & Beszlag, 2021; Fair et al., 2020). Access to support can be improved through community outreach in migrant spaces, for example by having NHS or charity staff hold a stall at community or local events with the aim to raise awareness around postnatal distress. Experts by Experience can also be

further consulted to identify strategies for raising awareness and support amongst migrant mothers.

It is important for awareness around common experiences of isolation and other migration challenges that may impact mental health to be raised amongst various migrant communities, from a community led perspective. Initiatives such as meal chains, buddy systems and local café events are some ideas for how to potentially address the reported overwhelming sense of isolation migrant mothers can feel due to being away from family and friends. Overall, local community initiatives are necessary, not only to promote migrant mothers' sense of belonging but to combat the growing anti-immigrant sentiment and generate a greater sense of community wellbeing through fostering social connections and inclusivity (Stevenson, 2020; Zhang et al., 2023).

Online communities can also be an important source of support (McSorley et al., 2022; Veazey, 2021), but to varying degrees (Yamashita et al., 2022). According to the findings in the current study, migrant mothers would benefit from the types of online support where they can access emotional support in addition to the common transactional and practical types of support.

Clinical

For those who do manage to access NHS services within the first year of giving birth, it is particularly important for staff to have a greater understanding of the potential layers of risks and challenges migrant mothers face which may be contributing to their overall presentation. This awareness could prompt further opportunities for screening for PND and for conducting tailored assessments which include particular attention to their experience of being migrant mothers. These would need to be sensitively conducted so as to not increase the power imbalance and/or fear regarding immigration status as such. With this in mind, there are questions such as "How long have you lived in the UK for?" and "What has your

support system been like since moving to the UK?" that practitioners could ask which may help them better understand the individual's experience of PND within the context of migration and inform a collaborative signposting or treatment decision. Building on Wittkowski et al.'s (2017) recommendations, healthcare professionals should be supported, for example through training, with cultural awareness and culturally appropriate practices when working with migrant mothers. This could help ease the burden on migrant mothers who report finding it difficult to integrate into British culture, like participants in the current study.

As suggested through this study and considering the complexities of accessing and receiving NHS care within a specific timeframe, migrant mothers may present to services beyond the time period of eligibility in accessing specialised postnatal support. In these instances, it is important for migrant mothers to be made aware of long-term support available in their community and/or through charities, in addition to other mental health services which they may be eligible to access. The wider impact of migrant mothers' experiencing PND on their partners, babies and family was also acknowledged, suggesting that support could be offered from a systemic lens, whether or not that directly includes others depending on individual circumstances (Cluxton-Keller & Bruce, 2018; Letourneau et al., 2012). Finally, this study suggested that feeling heard and hearing others' stories was key in participants' journeys of recovery. Therefore, in addition to specialised support for PND, local peer support groups should be considered (Fang et al., 2022; McLeish et al., 2023).

Critical appraisal

The same tool applied for the systematic literature review, the Critical Appraisal Programme (CASP; 2024), has been used to assess the quality, rigour and relevance of the current study (Long et al., 2020). This is summarised in Table 13 below.

Table 13

CASP Qualitative Checklist of the Current Study

Clear Aims *Was there a clear statement of the aims of the research?*	**Method** *Is a qualitative methodology appropriate?*	**Design** *Was the research design appropriate to address the aims of the research?*	**Recruitment** *Was the recruitment strategy appropriate to the aims of the research?*	**Data Collection** *Was the data collected in a way that addressed the research issue?*	**Relationships** *Has the relationship between researcher and participants been adequately considered?*	**Ethics** *Have ethical issues been taken into consideration?*	**Data Analysis** *Was the data analysis sufficiently rigorous?*	**Findings** *Is there a clear statement of findings?*	**Overall Value** *Has the research contributed to existing knowledge or understanding?*
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
The study highlighted a clear research aim which was identified within the context of existing literature. Whilst there is an array of literature looking at refugee and asylum seeker experiences as well as literature around women's experiences of PND, there is	The study aimed to explore subjective experiences. It looked at migrant mothers' experiences of PND. Using a qualitative methodology to address this was therefore appropriate.	The study design was justified in line with the epistemological stance and each step was relevant to addressing the research aim (e.g. developing the interview guide with EbE consultation).	Recruitment was conducted online through social media, particularly targeting migrant and mother groups (with prior written permission). This was an appropriate strategy and resulted in recruiting participants who met criteria. There were limitations to using an online recruitment strategy for example,	Data collection included using semi-structured interviews which were deemed an appropriate method to explore participant experiences. These were conducted online. Each interview was recorded and transcribed via MS teams which enabled data analysis.	The role of the researcher (including potential biases) has been considered at every stage of the study including: determining research aims, receiving EbE consultation, drafting the interview schedule, recruiting participants, conducting interviews, offering debriefing, engaging in supervision, using the	Approval was gained from the university ethics committee. Ethical standards were maintained throughout each stage of the study.	IPA was chosen as the analysis method for this study and the process is described in depth. The analysis was conducted in line with the four markers of high-quality IPA (Nizza et al., 2021). Potential influence of researcher role and biases were examined through reflections.	The findings are explicit and highlight a clear narrative of experiences, which are also situated within the context of existing literature. These findings are discussed in relation to the original research question.	This study considered migrant mothers' experiences of PND in the UK, using an IPA approach. The findings contributed additional insight to existing literature and evidence-base. Implications and relevance of findings were discussed.

limited research looking at the intersection of voluntary migrant experiences of PND.	missing opportunities to connect with mothers who do not access social media.	reflective journal and through writing processes.

Strengths

In terms of strengths and to the best of my knowledge, this was the first study to explore voluntary migrant mothers' experiences of PND. It shed light on the layers of challenges that participants faced when becoming mothers in the UK and experiencing PND. The use of IPA allowed for an in-depth exploration of these experiences and how participants made sense of these (Lim, 2024; Smith et al., 2022). It addressed an important gap in research by sharing the voices of voluntary migrants who are often overlooked in the field (Burns et al., 2021; Cuibus, 2024). It contributed to the wider understanding of migrant mothers' experiences of PND and highlighted recommendations for further research as well as for clinical practice.

The consistent use of reflexivity, particularly regarding my insider-outsider researcher position, enabled me to re-address power imbalances where possible, for example by offering participants transparency about intersecting parts of my identity and how this led me to choose the research topic. Whilst positioning myself partly as an 'insider' researcher, this enabled me at times to be more attuned to ethical considerations when designing the recruitment strategy and establish stronger rapport with those showing interest in the study (Dwyer & Buckle, 2009; Greene, 2014). The reflections around similarities and differences between myself and the participants were shared in order to bring my unconscious biases into my awareness throughout the research process (Dodgson, 2019).

I showed advocacy through sharing the personal reasons for why I am passionate about this research, signposting participants to relevant services for support where appropriate and planning to disseminate the findings through creating infographics which will be more accessible to the public than the academic paper (Greene, 2014).

Limitations

Certain design and methodology decisions were made in line with the research scope and time constraints of completing a Doctorate of Clinical Psychology. Although these were appropriate to the study, they presented limitations that are worth acknowledging.

My position as an insider researcher also generated limitations for my study. At times, my pre-existing beliefs around what it is like to be a migrant and parented by a migrant mother risked assuming understanding of my participants' experiences, prompting emotional involvement which may have in turn led to a loss of curiosity, objectivity and consistency within the interview process (Greene, 2014). The associated biases were mitigated through regular self and team reflexivity, as well as addressed throughout the analysis (Dodgson, 2019).

Recruitment was carried out via social media using mixed purposive and snowballing techniques. The first limitation this created was the absence of potential participants who were not accessing social media. Furthermore, it was stipulated that participants would need to have a fluent level of English and/or be able to understand and speak English to a standard which would enable them to participate. This excluded migrant mothers who had a lower level of English, and/or felt less confident with their English, and/or who felt less able to talk about emotional experiences in English.

Finally, my position as a partly outsider researcher meant that there were barriers in recruitment that I faced. For example, there were certain social media groups which I was not able to join, despite transparently sharing my intent for joining and requesting access, because I was not a mother myself. I also underestimated the busy schedules and lives of migrant mothers, which meant that I initially received little interest until creating a more easily accessible way of participants contacting me directly.

Suggestions for future research

This study contributes to the wider literature around the intersections between migration, motherhood and mental health by offering new insight into migrant mothers' experiences of PND in the UK. It helps to partly fill the gap in research looking at voluntary migrant experiences (Burns et al., 2021; Cuibus, 2024). Considering the complex and diverse experiences amongst migrant populations, it is key that further research is conducted with participants from varied backgrounds. Inequalities in maternal care for Black and Brown women compared to White women have long been evidenced in research (Felker et al., 2024). Further research is needed to hear the voices of Black and Brown migrant mothers and their experiences of postnatal distress as these are significantly underrepresented (Esegbona-Adeigbe, 2023; House of Commons, 2023; Lovell et al., 2023).

Existing literature identifies partner involvement as crucial in addressing mothers' distress during the postnatal period (Pilkington et al., 2015; Stein et al., 2014). Participants in the current study mentioned the importance of their partner's involvement or lack thereof and the impact on their experiences. Building on Atkinson et al.'s (2021) qualitative evidence synthesis and Vo et al.'s (2024) systematic review, in addition to the findings of this current study, further research is needed to hear from and involve partners of migrant mothers who suffer from PND.

Dissemination

The goal of dissemination is to share the study's findings with the aim of creating changes in awareness and understanding around migrant mothers' mental health, particularly their experiences of PND. By sharing these stories, the hope is that others will be able to better understand the context and unique layers of challenges migrant mothers face in order to encourage maintaining a curiosity towards the individual rather than making assumptions or generalisations.

The findings will be submitted for publication within a relevant journal such as the British Journal of Midwifery, Ethnicity & Health, or Public Library Of Science (PLoS) One. These journals were identified in line with the research aim and design, through searching where similar studies had previously been published. A poster and oral presentation will be created from the findings which will be shared at the University of Hertfordshire DClinPsy conference. Other potential conferences such as the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK Perinatal virtual conference and the UK Marcé Society conference, were scoped and organisers will be contacted to request a presentation slot. Participants will receive a written summary of the findings, along with an invitation for a post interview call to discuss these in more detail if they wish. Infographics will be designed to summarise the findings which can then be distributed across social media platforms. Separate infographics will be created for an NHS professional audience across NHS perinatal mental health services.

Conclusion

Overall, this research showed that migrant mothers' experiences of PND in the UK are layered, complex and unique due to the intersecting experiences of becoming mothers while also being migrants. This dual identity, compounded by cultural barriers and limited access to support amongst other factors, seemed to contribute to pervasive feelings of isolation during and beyond experiences of PND. The findings contributed to the breadth of existing literature around experiences of PND, whilst specifically acknowledging the additional complexities influenced by a context of voluntary migration. These contributed to recommendations for sustained, culturally appropriate and contextually attuned interventions. Further research exploring voluntary migrant mothers' experiences of PND is needed to build on wider prevention, support and long-term healing strategies.

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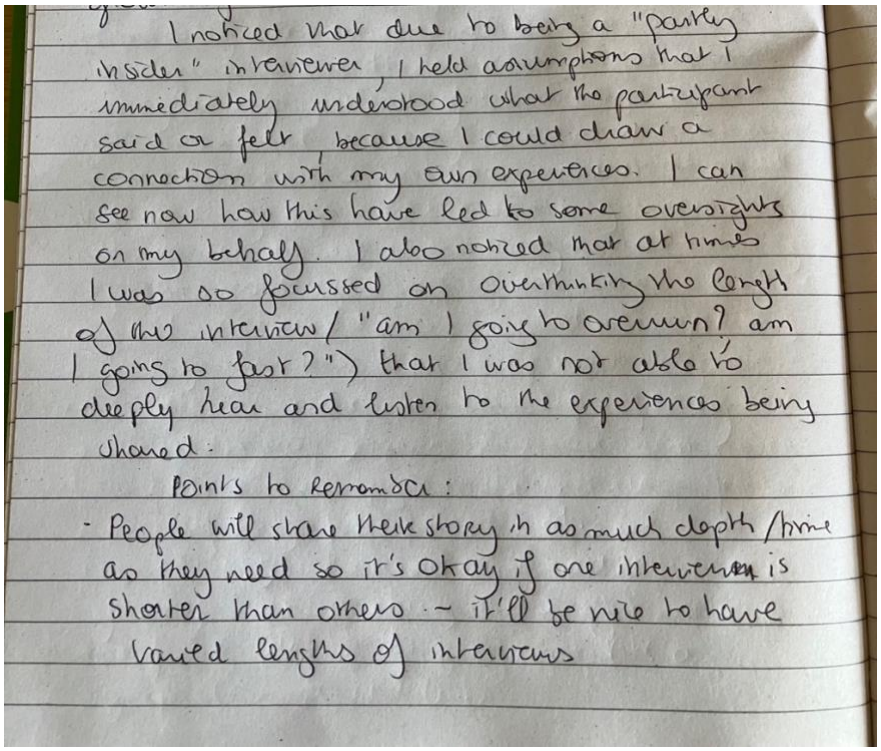
Appendices

Appendix A

Examples of Reflective Diary Entries

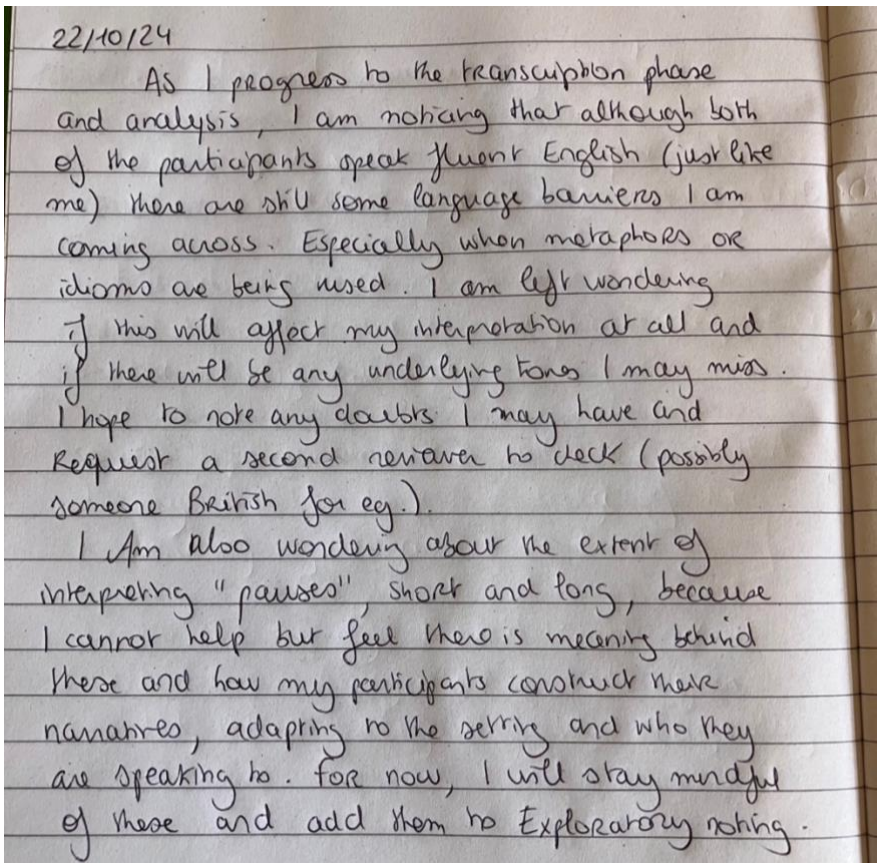
11/10/24



I noticed that due to being a "partly insider" interviewer, I held assumptions that I immediately understood what the participant said or felt because I could draw a connection with my own experiences. I can see now how this have led to some oversights on my behalf. I also noticed that at times I was so focussed on overthinking the length of the interview ("am I going to overrun? am I going too fast?") that I was not able to deeply hear and listen to the experiences being shared.

Points to remember:

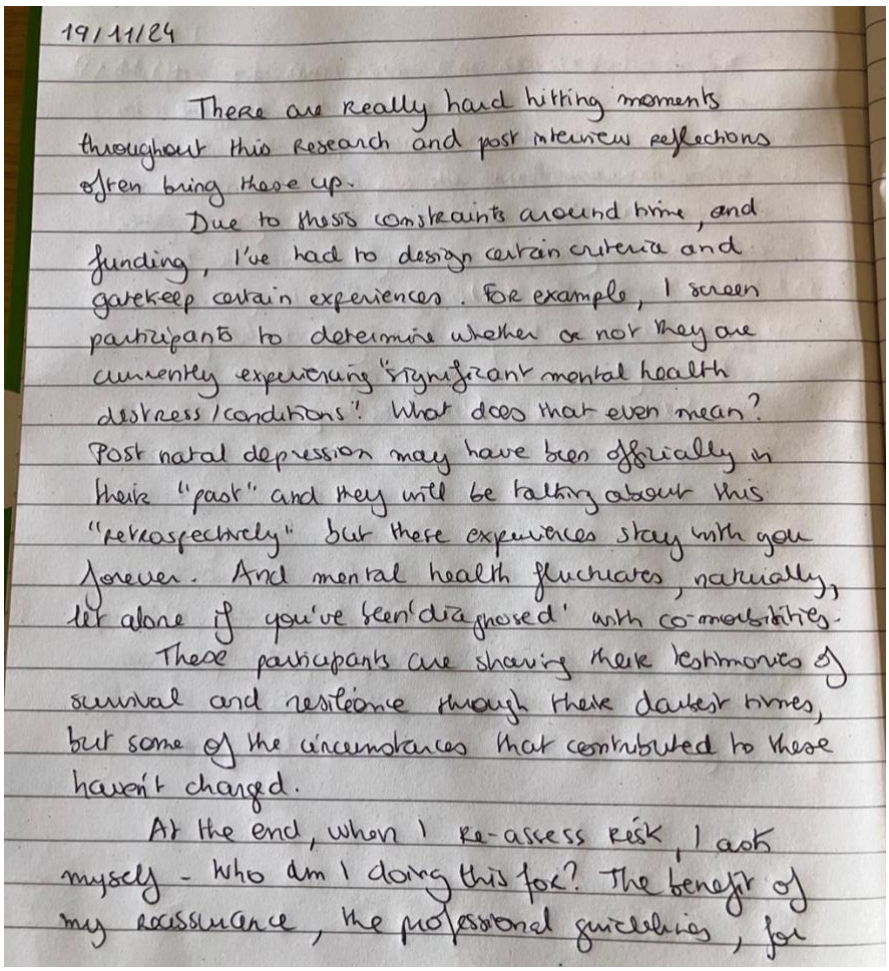
- People will share their story in as much depth/time as they need so it's okay if one interview is shorter than others - it'll be nice to have varied lengths of interviews



22/10/24

As I progress to the transcription phase and analysis, I am noticing that although both of the participants speak fluent English (just like me) there are still some language barriers I am coming across. Especially when metaphors or idioms are being used. I am left wondering if this will affect my interpretation at all and if there will be any underlying tones I may miss. I hope to note any doubts I may have and Request a second reviewer to check (possibly someone British for eg.).

I Am also wondering about the extent of interpreting "pauses", short and long, because I cannot help but feel there is meaning behind these and how my participants construct their narratives, adapting to the setting and who they are speaking to. For now, I will stay mindful of these and add them to Exploratory noting.



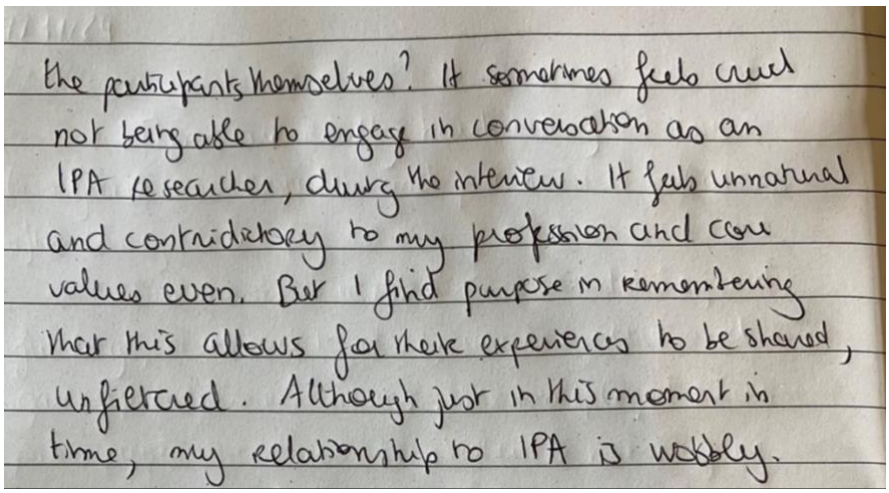
19/11/24

There are really hard hitting moments throughout this research and post interview reflections often bring these up.

Due to thesis constraints around time, and funding, I've had to design certain criteria and gatekeep certain experiences. For example, I screen participants to determine whether or not they are currently experiencing "significant mental health distress/conditions". What does that even mean? Post natal depression may have been officially in their "past" and they will be talking about this "retrospectively" but these experiences stay with you forever. And mental health fluctuates, naturally, let alone if you've been 'diagnosed' with co-morbidities.

These participants are sharing their testimonies of survival and resilience through their darkest times, but some of the circumstances that contributed to these haven't changed.

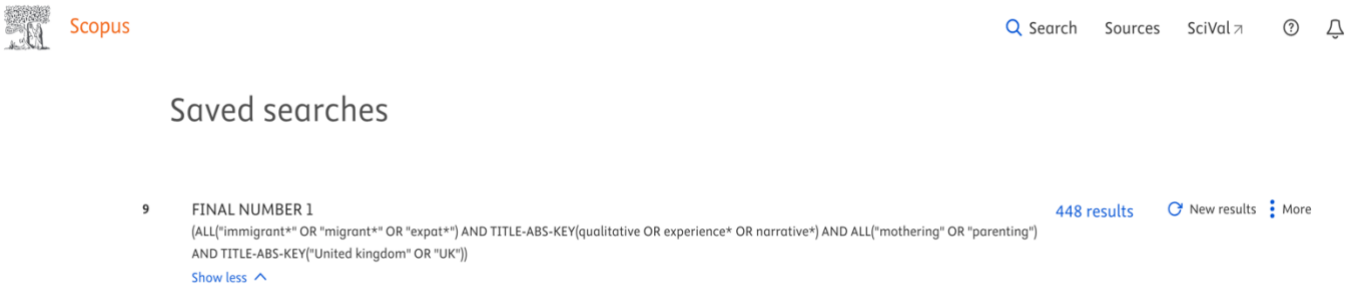
At the end, when I re-assess risk, I ask myself - Who am I doing this for? The benefit of my reassurance, the professional gatekeeping, for



the participants themselves? It sometimes feels cruel not being able to engage in conversation as an IPA researcher, during the interview. It feels unnatural and contradictory to my profession and core values even. But I find purpose in remembering that this allows for their experiences to be shared, unfiltered. Although just in this moment in time, my relationship to IPA is wobbly.

Appendix B

Database Specific Search Terms for SLR



EBSCOhost

#	Query	Limiters/Expanders	Last Run Via
S1	("immigrant*" OR "migrant*" OR "expat*") AND (qualitative OR experience* OR "reflection*" OR "narrative" OR "interview*" OR "focus group*") AND ("mothering" OR "parenting" OR "motherhood" OR "matern*" OR "mother*") AND ("United kingdom" OR "UK" OR "Britain")	Expanders - Apply equivalent subjects Search modes - Proximity	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Ultimate;MEDLINE

Appendix C

Original Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Laetitia Rater
CC	Dr Debra Marais
FROM	Dr Simon Trainis, Health, Science, Engineering and Technology ECDA Chair
DATE	25/07/2024

Protocol number: **LMS/PGR/UH/05737**

Title of study: Exploring migrant mothers' experiences of post-natal depression in the UK

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Aisling Kelly, [redacted] CNWL Maternity Trauma & Loss Care Service (M-TLC)

General conditions of approval:

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

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

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

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

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

Validity:

This approval is valid:

From: 25/07/2024

To: 01/07/2025

Appendix D

Amended Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	**Laetitia Rater**
CC	**Dr Debra Marais**
FROM	**Dr Rosemary Godbold, Health, Science, Engineering and Technology ECDA**
DATE	**23/08/2024**

Protocol number:	aLMS/PGR/UH/05737(1)
Title of study:	Exploring migrant mothers' experiences of post-natal depression in the UK

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

Dr Aisling Kelly, [redacted] CNWL Maternity Trauma & Loss Care Service (M-TLC)

Modification:

Modification as described in the EC2 application form

General conditions of approval:

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

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

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

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

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

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

Validity:

This approval is valid:

From: 23/08/2024

To: 01/07/2025

Appendix E

Distress Protocol

The researcher will intervene if the participant is:

• Experiencing anxiety or distress during the interview. The participant will be asked if they would like to take a break and if they wish for the recording to be switched off.

• Continuing to show signs of upset. The participant will be asked if they would like the interview to end and if they would like the researcher to support them to call someone to spend time with them, such as a family member or friend.

• Unduly distressed. The researcher will remain with the participant until they are calm and composed. The participant may then decide to continue with the interview or not. The interview will be terminated if:

• The participant decides to terminate the interview.

• The participant decides to participate in the interview at another time or place.

• The researcher considers the levels of distress too high and the interview process as not supportive.

The researcher will, with the participant's consent:

• Discuss the potential support services available for them to access.

• Seek permission and ask if they would like a family member, friend or someone from the local community to call them to offer support.

• Offer relevant contact details and places of emotional support will be provided to all participants.

The researcher will:

• Use their professional duty of care and code of conduct accordingly, if there is high risk of serious harm, the researcher will contact services such as, emergency services, to support and keep the participant safe.

Appendix F

Participant Information Form

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE'). UH Protocol number: aLMS/PGR/UH/05737(1)

FORM EC6: PARTICIPANT INFORMATION SHEET

1 **Title of study**

Exploring migrant mothers' experiences of post-natal depression in the UK

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 **What is the purpose of this study?**

The aim of this study is to explore migrant mother's experiences of post-natal depression in the UK. Post-natal depression is a medicalised term used to describe a very common experience mothers have within the first year of giving birth which can include *but is not limited to*: having negative thoughts about self and identity as a mother, feelings of sadness, guilt, hopelessness; loss of enjoyment and/or motivation; difficulties concentrating and struggles bonding with your baby. We are using this term as it is the most common in Western societies, but we hope to capture various experiences, regardless of whether you have had a formal diagnosis or not. By hearing these stories, we hope to highlight some of the particular challenges that come with these experiences within the context of recent and voluntary migration. This research will hopefully contribute to a better understanding of how migrant mothers experience post-natal depression in the UK, what challenges they face and what helps during this time. The research will be shared within the medical field (e.g. post-natal services),

communities (e.g. expatriate groups) and the general public. No personally identifying information will be included in what is shared.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. At any point of the interview, you are allowed to change your mind and decide to withdraw your participation from the research without stating a reason. You are also free to withdraw your data at any stage after the interview, up until the data analysis, which will start in September 2024.

5 **Are there any age or other restrictions that may prevent me from participating?**

You are eligible to participate if you:
-Have moved to the UK voluntarily as an adult
-Are a mother aged over 18 years old
-Are fluent in English
-Have had an experience of post-natal depression since being in the UK

You are unfortunately not eligible to participate if you:
-Are currently under an NHS mental health service
And/or
-Are currently experiencing acute and/or severe mental health difficulties or any other conditions that would impact on your capacity to consent or participate in the interview

If you are unsure about whether or not you meet the criteria above, we can discuss this in the pre-interview screening call.

6 **How long will my part in the study take?**

If you are willing to participate, you will be invited to have a brief phone call lasting up to 15 minutes with myself (lead researcher) to assess your suitability for this study, and have an opportunity to ask any questions or raise any concerns you may have. After this call and if we collaboratively agree it is suitable for you to participate, you will be invited for a 1-hour interview via MS Teams.

7 **What will happen to me if I take part?**

If you decide to take part, you can provide your full name, email address and contact number. I will then contact you to review participation suitability and share the consent form. Once you have consented to participate, the lead researcher will interview you online for 1 hour. The content of our discussions will be kept anonymous and confidential; some quotations may be used with your pseudonym and no confidential information attached.

In the event of any significant change to the aim(s) or design of the study, you will be informed, and asked to renew your consent to participate in it.

8 **What are the possible disadvantages, risks or side effects of taking part?**

This research does not intend to cause intentional harm, although it is recognised that reflecting on or discussing your experiences could feel difficult at times. Post-natal depression and migration experiences in particular can be triggering topics. You are under no obligation to answer any questions that you do not feel comfortable answering. At any point, you are entitled to take a break and will be supported if any difficulties arise. Following the interview, you will receive a debrief sheet with information on how to seek further support should you need it.

I am feeling distressed - what if I need some help or support?
There are external organisations which can provide information or support regarding your mental health or more specifically, post-natal depression:

Mental health support

• Your GP

• The Samaritans (telephone: 116 123) is a helpline available 24 hours a day, 365 days a year. The service offers listening and support to anyone who is struggling to cope or is experiencing difficulties. https://www.samaritans.org/

• You can text "SHOUT" to 85258 for free from all UK mobile networks. You'll then be connected to a volunteer for an anonymous conversation by text. https://giveusashout.org/

• NHS urgent mental health helplines – you can find your local NHS urgent mental health helpline at the following web address: https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

Peri and post-natal mental health support

- PaNDAS has a free helpline 0808 1961 776 between 11am-10pm everyday for those with perinatal mental health difficulties including depression and trauma

- Family Action provide practical, emotion and financial support for those experiencing poverty, disadvantage and social isolation across the country. They are available to contact via telephone 0808 802 6666 or email info@family-action.org.uk

- HealthProm provides support for migrant women from Eastern Europe and Central Asia. You can contact them via telephone 020 7832 5832 or via email getintouch@healthprom.org

- The Oremi Centre is for African, Carribean and Arabic speakers with mental health difficulties and can be contacted via phone 0203 879 3605

This list is not exhaustive, please contact the researcher if you are looking for a different kind of support and do not feel these organisations are suitable.

9 **What are the possible benefits of taking part?**

By participating in this study, you may gain insights into your own experiences and resilience. You will get a chance to share your story and be heard in a non-judgmental and compassionate way. Your involvement also plays a role in destigmatising post-natal depression and migration experiences. Your participation is entirely voluntary, and you can withdraw in the given time limit without facing negative consequences. Confidentiality measures are in place to protect your privacy throughout the research process.

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

The information collected about you alongside the interview will be kept strictly confidential. Any identifiable information, including the consent form, will be anonymised and kept separately from the interview up until project completion (September 2025) after which it will be destroyed by the principal investigator. Interview transcripts will also be anonymised during the data analysis and kept up to five years for dissemination purposes after which it will be destroyed by the principal investigator. Verbatim extracts (e.g. quotations) used in the report will also be fully anonymised. Data will be stored electronically on the lead researcher's University of Hertfordshire OneDrive. This data will only be accessed by authorised researchers involved in analysis. This may include colleagues within the Interpretative Phenomenological Analysis (IPA) forum taking place within the Clinical Psychology Doctorate programme at the University of Hertfordshire. The interview recording and interview transcript will be stored on the lead researcher's University of Hertfordshire OneDrive. Forms related to the research, such as consent forms and participant information forms, will be scanned onto a computer and stored in an encrypted file in the university cloud. In the event that confidentiality needs to be breached, it will be managed in accordance with the regulations set out by the British Psychological Society code of conduct. If information is disclosed which indicates sufficient concern about your safety or the safety of others, it may be necessary to inform an appropriate third party without formal consent. The researcher may contact their principal supervisor discuss possible concerns. This may be overridden if it is deemed that the risk is imminent and requires immediate attention.

11 **Audio-visual material**

We intend to record the interviews that take place with participants to aid the analysis process. This will include audio and may include video content depending on your consent and preference. This is only for the purpose of analysis and all interview recordings will be deleted once the analysis is completed. The interview recordings will not be shared with anyone.

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

The data collected will be stored electronically, in a password-protected environment, until Summer 2025, after which time it will be destroyed under secure conditions;
• The data will be anonymised prior to storage.
• The data will be analysed for research purposes, focusing on the study's objectives and research questions. Quotes, findings and/or conclusions drawn from the data will be presented whilst ensure anonymity by using pseudonyms throughout.

• Personal data will be retained for the minimum period necessary for the research, and after this period, all identifiable information will be securely deleted.
The results of the study may be disseminated through academic publications, presentations, or reports, with a commitment to maintaining the confidentiality of participants.
• If you choose to withdraw from the study, any data collected from you will be treated with the same level of confidentiality and included in the overall data analysis up to the point of withdrawal. You have the right to request the deletion of your data up until the start of data analysis (September 2024).

13 **Will the data be required for use in further studies?**

The data will not be used in any further studies.

14 **Who has reviewed this study?**

This study has been reviewed by: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is <**aLMS/PGR/UH/05737(1)**>

15 **Factors that might put others at risk**

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

16 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with the Lead Researcher, by email: Laetitia Rater, [redacted] or the primary supervisor of this research: Dr Debra Marais, [redacted]

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

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

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

Appendix G

Consent Form

University of Hertfordshire UH Ethics Committee

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

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

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

…..……
hereby freely agree to take part in the study entitled

'Exploring migrant mothers' experiences of post-natal depression in the UK'

(UH Protocol number: aLMS/PGR/UH/05737(1))

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

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason, up until data analysis, which will start in September 2024.

3 In giving my consent to participate in this study, I understand that voice or video will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been given information about the potential risks of participating in this study and have been signposted to relevant helplines/services in case I require further support regarding my mental health.

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of the results of the study being disseminated through academic publications, presentations, or reports, with a commitment to maintaining the confidentiality of participants.

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

7 I confirm that I am 18 years old or above

Signature of participant……..…Date……

Signature of (principal) investigator…… Date……

Name of (principal) investigator: LAETITIA RATER

Appendix H

Recruitment Poster

University of Hertfordshire UH

University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority
UH Protocol number: aLMS/PGR/UH/05737(1)

Have you migrated to the UK voluntarily?

Have you experienced 'post natal depression'?

WE WANT TO HEAR FROM YOU!

What does the study look at?

We are interested in hearing the stories of mothers (18+ years old) who have experienced post natal depression after having migrated to the UK as an adult. We hope that this research will help contribute to a better understanding of migrant mothers' needs within services that support those with mental health difficulties.

What will you need to do?

You will be invited to take part in a 1-1 online interview via MS Teams which will last up to 1 hour.

THIS IS YOUR CHANCE TO HAVE YOUR EXPERIENCES HEARD

Hello! My name is Laetitia Rater and I am a migrant trainee clinical psychologist in my second year at the University of Hertfordshire

For more information contact me via [redacted]

Appendix I

Payment Agreement Form

AGREEMENT FOR VOLUNTEERS & LAY MEMBERS INVOLVEMENT IN RESEARCH

Doctorate in Clinical Psychology research study:

Title: Exploring migrant mothers' experiences of post-natal depression in the UK

This research project is a study based at the University of Hertfordshire. The researcher is Laetitia Rater. The purpose of the study is to understand how migrant mothers make sense of their experiences of post-natal depression in the UK.

Payment will be made to volunteers and lay members of the public for their participation in meetings and other research involvement activities. The project will finish on 09/2025.

This form must be completed by the participating volunteer before payment can be made. Any queries concerning this Agreement should be referred to the relevant Head of Research Centre at the University of Hertfordshire

Between: **The University of Hertfordshire**

and
Insert name **(The "Participating Volunteer")**

Address

Tel No.
Email Address

ACTIVITY Volunteer for Doctorate in Clinical Psychology research study

The **Participating Volunteer** has agreed to assist the University by voluntarily taking part in the research **Activity**.

1. The Activity to be undertaken is described below and it is the Activity for which you have given your consent/agreement.

Participating in the study interview

CONFIRMATION OF ATTENDANCE

2. The Researcher will confirm the Participating Volunteer has attended the Activity outlined above.

PAYMENT

3. The Participating Volunteer will receive a one-off participation payment of £20 in the form of vouchers for completion of the activities described above. Payment will be made once the activity has been completed.

RELATIONSHIP BETWEEN THE UNIVERSITY AND THE PARTICIPATING VOLUNTEER

4. **The University does not regard the Participating Volunteer as an employee of the University nor as a worker, and the payment made to the Participating Volunteer for the participation is not made with respect to any employment relationship with the University.**
5. **The Participating Volunteer is advised that it is their personal responsibility to declare any payment for participation to HM Revenue & Customs under Self-Assessment, if that is appropriate to their personal circumstances. The University will not deduct income taxes from the payment.**

SIGNED FOR AND ON BEHALF OF THE UNIVERSITY
The signatory for the University confirms they have authority to enter into this agreement on behalf of the University e.g., Principal Investigator

SIGNED	L. Rater
PRINT NAME	Laetitia Rater
Position at UH	Post-graduate researcher
DATE	21/11/2024

SIGNED BY THE PARTICIPATING VOLUNTEER

I acknowledge receipt of a copy of this agreement and accept its terms.

SIGNED	.....
PRINT NAME	.....
DATE	.....

Appendix J

Interview Schedule

Part 1: Setting the context

-Introductions
-This should last about 1 hour, please let me know if you need a break at any point. *Should we plan this in now? What time? How long for?*
-It is important that you are alone in the room. *Is this possible?*
-If at any point you change your mind, please let me know and we can talk through this.
-As a reminder, the video call will be recorded and transcribed. The files are kept on a secure UH OneDrive and separate to any confidential information – transcripts will be anonymised. *Do you consent for this?*

Set up: The way I will ask you questions might feel a bit strange – I will not necessarily comment or reply to what you have said, in order to make sure I hear your full experience and interfere/influence this as little as possible. If you find yourself feeling distressed at any point, of course we will be able to take a pause to address this. If at any point, we need to move on to the next question to complete the interview in the time we agreed, *how would you like me to indicate this to you? I can give you a gently nudge verbally or by message if you would like.*

Essentially, I am really interested in hearing about your experience, and I might ask follow up questions to explore your answers further if needed. I have approximately 7 questions for you today; the first part will be about your experience of moving to the UK and then I will ask more specific questions about your experience of postnatal depression. *How does that sound?*

-Do you have any final questions or concerns before we start?

Part 2: Interview questions

General prompts: Can you say more about that? You used the word '…', what does that mean for you? Can you give me an example?

General tips for interviewer: Do not respond like a clinician – avoid paraphrasing, explicit validation, summarising ect. except 'I can tell this is really hard; would you like a pause' if needed.

1. **To start with, can you tell me about how you came to live in the UK?**

Prompts: How did you come to decide moving to the UK? How do you feel about this decision?

2. **What was it like for you, moving to the UK?**

Prompts: What has it been like to leave your birth country? What challenges did you face? What benefits did you experience? How did you experience the change in culture/language? What was your support system like when you arrived? How does it feel to be a migrant in this country?

'Postnatal depression' is a term used to describe "depression suffered by a mother following childbirth, typically arising from the combination of hormonal changes, psychological adjustment to motherhood, and fatigue" (as stated by the Oxford dictionary).

However, we also know that people have similar experiences, without necessarily using this term or definition. I will now ask questions about your experience.

3. **How do you experience the term 'postnatal depression' and when did you first notice things started to shift for you?**

Prompts: When did you first notice that things became a bit more difficult? When did you notice this changing into post-natal depression difficulties? What was it like when you first noticed post-natal depression difficulties? What was your experience of navigating support for this? How did it feel to experience postnatal depression?

4. **Tell me about the impact this experience had on you and how you responded to this?**

Prompts: What would you say was most challenging about your experience? What would you say was most helpful throughout your experience?

5. **How do you think your identity as a migrant (someone who moved to the UK) influenced your experience (of PND)?**

Prompts: How is your identity as a migrant linked to your experience of PND?

6. **Is there anything I have not asked about which you think is important to share regarding the topics we discussed today?**

Prompts: Can you tell me more about that? Can you tell me about your experience of this?

7. **Can you tell me what it was like for you, taking part in the interview today?**

Prompts: What was it like for you, being asked these questions? Can you tell me about what it feels like to participate in this study?

<u>Part 3: Debrief (signposting, next steps…)</u>

Thank you for taking part in the interview today.

There are services and support resources that you might find helpful on the information sheet

List from information sheet

Please do not hesitate to contact me if any questions or concerns come up following from today. I will send you this information via email along with your voucher.

Appendix K

Debrief Form

Thank you for taking part in the interview. This study has been reviewed by The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH protocol number is <**aLMS/PGR/UH/05737(1)**>. You will receive a 20-pound voucher as a thank you for your time and contributions.

This study aims to explore migrant mothers' experiences of post-natal depression in the UK, with hope to better understand any additional challenges they may face due to the context of migration. We hope that by sharing these experiences, others who experience this will feel less alone, and designated services will have a greater awareness of how best to tailor their support in an effective way.

We hope that you found the interview experience positive, manageable and supportive. We understand that the topics covered are emotive, so if you are left feeling distressed afterwards and require further support please request help via one or more of the options below:

Mental health support

• Your GP

• The Samaritans (telephone: 116 123) is a helpline available 24 hours a day, 365 days a year. The service offers listening and support to anyone who is struggling to cope or is experiencing difficulties. https://www.samaritans.org/
• You can text "SHOUT" to 85258 for free from all UK mobile networks. You'll then be connected to a volunteer for an anonymous conversation by text. https://giveusashout.org/
• NHS urgent mental health helplines – you can find your local NHS urgent mental health helpline at the following web address: https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

Peri and post-natal mental health support

- PaNDAS has a free helpline 0808 1961 776 between 11am-10pm everyday for those with perinatal mental health difficulties including depression and trauma
- Family Action provide practical, emotion and financial support for those experiencing poverty, disadvantage and social isolation across the country. They are available to contact via telephone 0808 802 6666 or email info@family-action.org.uk
- HealthProm provides support for migrant women from Eastern Europe and Central Asia. You can contact them via telephone 020 7832 5832 or via email getintouch@healthprom.org
- The Oremi Centre is for African, Carribean and Arabic speakers with mental health difficulties and can be contacted via phone 0203 879 3605

This list is not exhaustive, please contact the researcher if you are looking for a different kind of support and do not feel these organisations are suitable. If you have any further questions or concerns, please do not hesitate to reach out.

Laetitia Rater (Trainee Clinical Psychologist) – [redacted]

Dr Debbie Marais (Counselling Psychologist & Senior Lecturer) – [redacted]

Appendix L

Analysed Transcript Extracts (Steps 2 & 3)

Experiential statements	Transcript	Exploratory notes
Feeling homesickness is prominent	But then I was like, yeah, I was quite homesick. And. *(pause)*	Repeats 'home sick'. There is emphasis on this feeling, it feels clear and memorable to her.
Feeling excluded and abandoned by friendship groups back home, amplifying a sense of loneliness	Yeah I was missing home. I was missing my home friends. I think cause my best, like, well, my good group of friends from home. Obviously they were just like having fun without me and stuff, which is my choice to move to [UK], but it still felt like I'd sort of, yeah, cut myself off from my support network a bit. So it was a *(deceleration)* It was lonely few years, I would say.	'I was missing home', 'I was missing my home friends" a lot of repetition with 'missing' and 'home' – what is the feeling of home? describes it here through friendships considering she experienced a friendship breakdown at the time, this would have emphasised feeling homesick "obviously they were just like having fun without me and stuff" – feeling left out? Sentiment that all friends are having fun but she's not? Similar to the feeling previously mentioned with the other friend having fun Then referring to 'my choice' placing responsibility on her voluntarily moving, as if she asked to be cut off – she did this to herself, remorse? Starts acknowledging the depth/emphasis of loneliness more – swaps between light heartedness and brushing it off or minimising the pain – to then acknowledging it was

Personal experiential statements (with quotes)

Recognition of PND using hindsight: "For me that it felt like difficult, but it was a month and 1/2 after I gave birth that…Was the 1st… *(pauses)* Like I would pinpoint in a timeline that, that was the first deep dive into the *shithole"* (p.20, [redacted]); "Now in, in reflection I can see how how dark and deep I was, and I couldn't enjoy…That postpartum period, mothering and…I was anxious all the time." (p.21, [redacted])

Recognising idealised expectations of motherhood: "I had this…Probably idealised idea of how things will go. And of course, they didn't go that way." (p.20, [redacted])

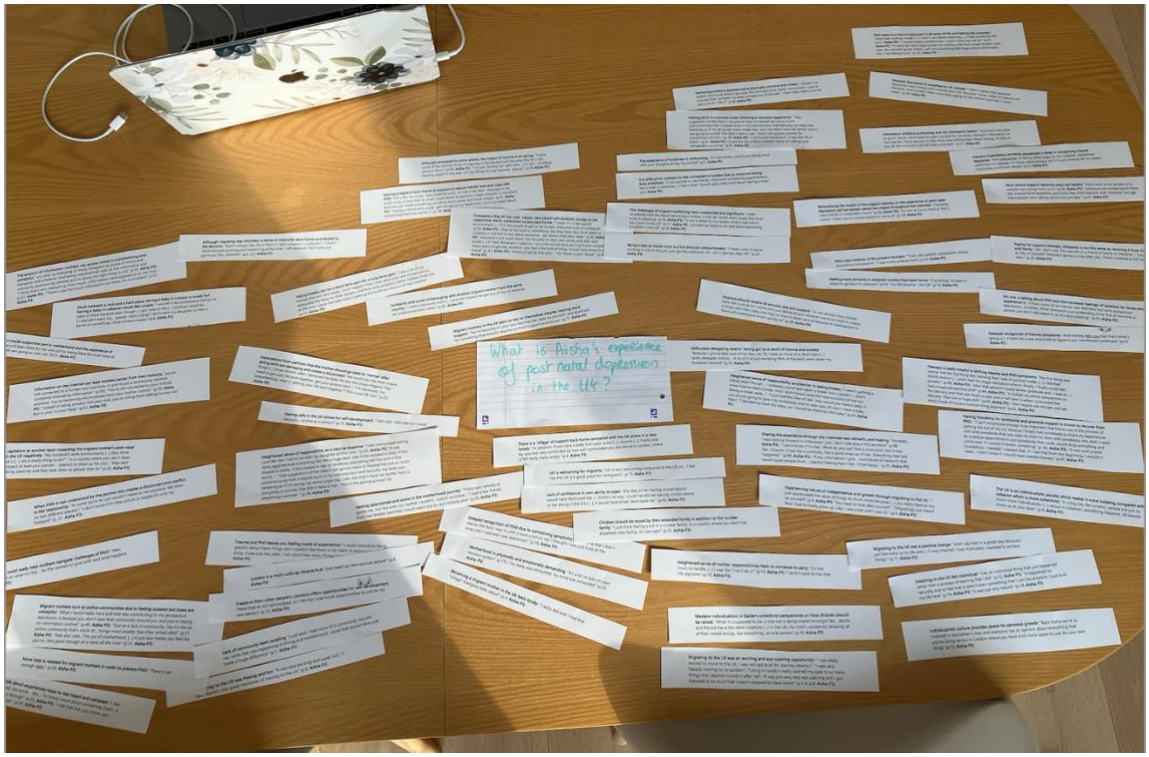
The traumatic experience of birth and post birth: "I felt like I was very dissociated from the whole experience. I felt like I was just in survival mode 24/7 […] It felt like… Every time I would even… not even get out of the water to get some breath. But even just an attempt of doing that, felt like another wave was pushing me down" (p.21, [redacted])

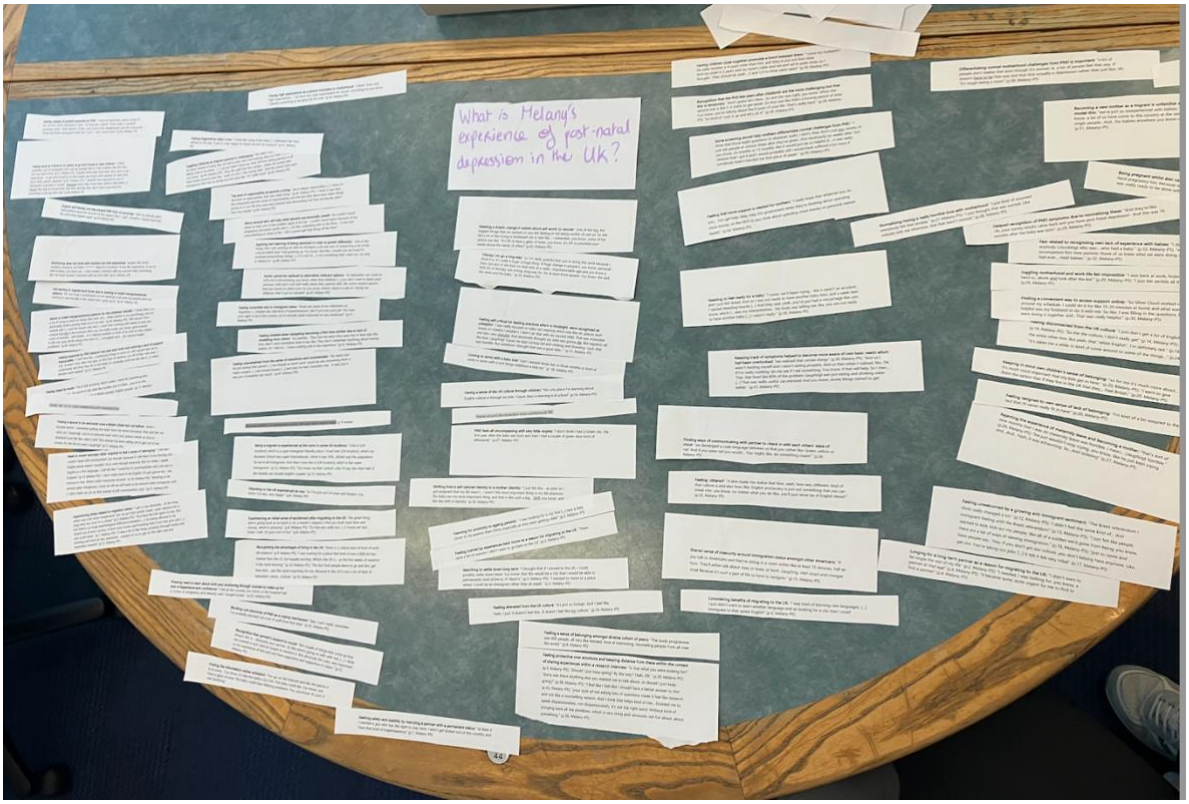
Feeling like a failure as a mother due to falling short of idealised expectations: "I felt like I failed from the beginning because I literally did not feel the joy I was supposed to feel, or I should have feel" (p.22, [redacted])

Transcript	Exploratory notes (descriptive, linguistic and conceptual)
as you know, like, I, I had this…	Recognises having an idealised idea of what giving birth and motherhood would be like
Probably idealised idea of how things will go.	
And of course, they didn't go that way. And my baby had silent reflux. The nights were hideous. I think I was sleep deprived, like maybe I had four or five hours broken sleep during the nights.	The exhaustion from sleepless nights
And…	
My baby had…	Complications piled on after giving birth
A silent reflux. And then I had my…	What it was like to have the parents in law around? And the contrast of not having own family there.
Parents in law here *(sighing)*, which was awful and then at week nine, we all had COVID, we had to go to the A&E and then when I felt like, OK, now I'm coming out from that, he had…	Relentless, one challenge after another
Eczema. And so it felt like every time I was, I felt like I was very dissociated from the whole experience.	Dissociation – emotional? Physical? Mental? Feeling disconnected
I felt like I was just in survival mode 24/7. It felt like…	Survival mode – dissociation- fight/flight; felt like she was drowning – lots of metaphors around this 'deep dive', 'get out of the water' 'another wave pushing down' really highlighting the sustained, prolonged, level of distress
Every time I would even… not even get out of the water to get some breath. But even just an attempt of doing that, felt like another wave was pushing me down and…	Powerful metaphor to describe attempts to save self when drowning – what were the waves? The complications, one after the other?
Now in, in reflection I can see how how dark and deep I was, and I couldn't enjoy…	
That postpartum period, mothering and…	
I was anxious all the time.	Clouded the post partum experience entirely; no memory of enjoying this. Clouded by anxiety and survival
Yeah.	

Appendix M

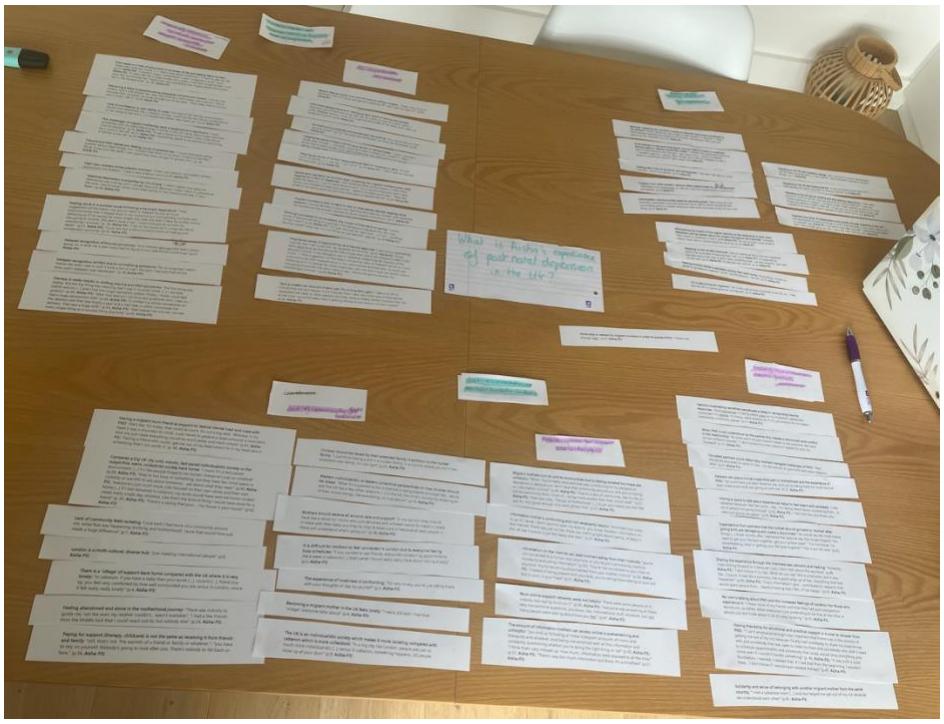
Example Photos of Analysis (Step 4)

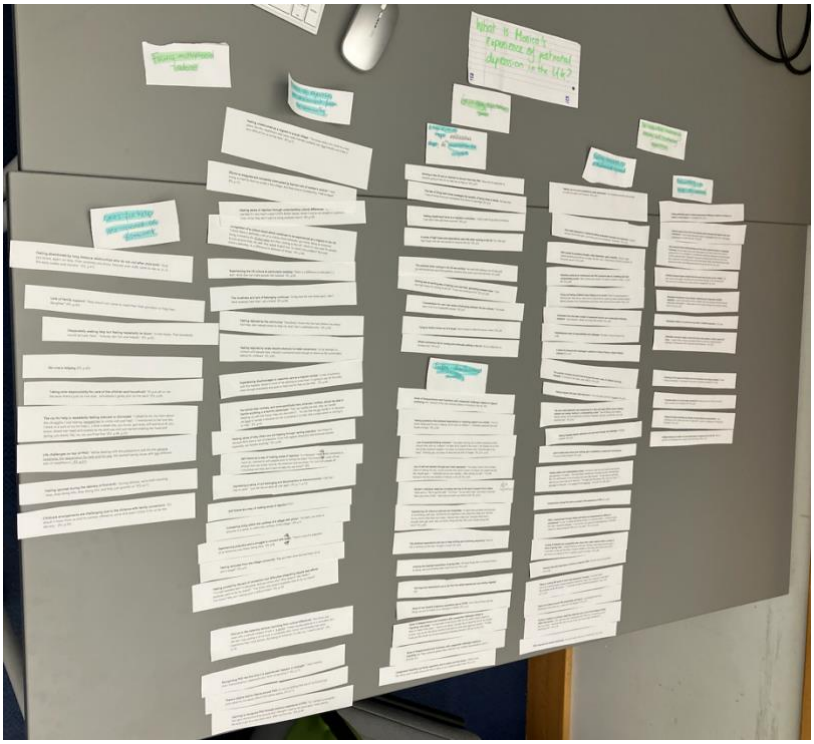




Appendix N

Example Photos of Analysis (Step 5)





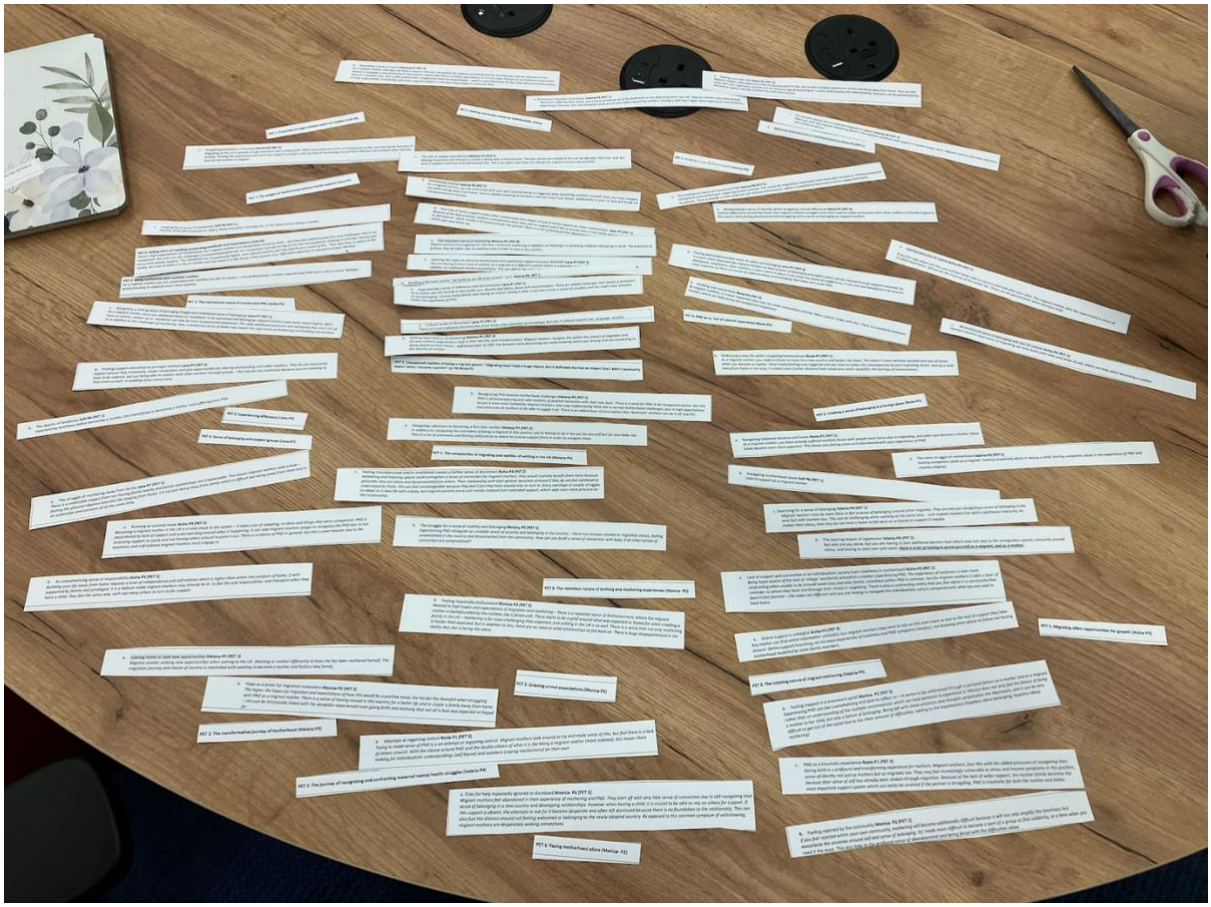
Appendix O

Extracts from the PETs Table (Step 5)

Participant	Personal Experiential Themes and subthemes	Experiential statements and quotes
[redacted]		
	PET 1: Unexpected realities of being a migrant parent: "Migrating hasn't had a huge impact, but it definitely has had an impact that I didn't necessarily expect when I became a parent" (p.79) [redacted]	
	a. Navigating relational distance and losses [redacted]	**Comparison of migrant parenting versus what parenting at home would be like and the differences in access to support:** "And I was like, well, imagine I could have had this like. You know, other people have this all like any any time they want, they can just go out to their parents if they live near them." (p. 65, [redacted]) **Migrant mothering away from family support is challenging:** "the main thing is the obvious one, just not having my family to hand" (p. 63, [redacted]) **Navigating long distance familial relationships becomes more complex when having children:** "when one set of grandparents has so much more time than the other set, you know with the grandchildren. And I think that's...Especially as a mother like not having your own family there like you just want your own family." (p.76, [redacted])
	PET 2: Experiencing difference [redacted]	
	a. Cultural levels of disconnect [redacted]	**An on-going sense of disconnect with British culture:** "I feel like I will never 100% understand the British culture because I wasn't born here, I wasn't raised here. And then... even the language [...] I will never speak like a British person or will never have a British accent or I will never fully understand the culture" (p.13-14, [redacted]) **Communicating in the UK is harder than expected regardless of English-speaking level:** "I was someone who speaks very good English but then when I came it's completely different when you actually live with the people who speak British-English and it's not like from the book that you learn from" (p.4, [redacted])
	PET 3: The relentless nature of birthing and mothering experiences [redacted]	**Experiential statements and quotes**
	a. Feeling trapped in a downward spiral [redacted]	**Relentlessness sense of responsibilities and challenges**: "But again, it was all rushed" (p.36, [redacted]) **Comparing living within the confines of a village with prison**: "I've been, you know, a prisoner in a sense, in within the confines of this village." (p.7, [redacted]) **Overwhelm from the sheer number of unexpected barriers and complications following childbirth**: "It just became. Literally one thing after another" (p.40, [redacted]) **Feeling out of control amplified by sleep deprivation**: "Up constantly and that really started to make me spiral out of control." (p.41, [redacted])

Appendix P

Photo of Analysis (Step 7)



Appendix Q

Extracts from the GETs Table

Theme/subtheme	*Participant quotes*
b. An isolating silence	[redacted] "I just burst into tears [...] because of the way I feel and I can't even speak about it with anyone because I don't have anyone to talk to" (p.17) "So I think there is, there is a lot that is not spoken about enough" (p.27) [redacted] "I felt alone with my struggles, or I thought that it was... It was a very... it was a rarity. It wasn't. *(pauses) (...)* I didn't see my experience reflected back to me, in my community" (p.31) [redacted] "I mean none of my friends said that they had post postpartum depression, so either everyone's just pretending to be fine all the time or people just don't talk about it. So it's very isolating." (p.35) "And nobody tells you that that's what's going on. It took me a year and a half to figure it out. (*tearfulness continues)" (p.31)* [redacted]

Theme/subtheme	*Participant quotes*
c. Grieving expectations Grief of what was idealised/envisioned Disillusionment Loss of idealised motherhood 'The removal of the rose coloured glasses'	[redacted] "I wish somebody told me about becoming a mother in the UK 'cause, that's huge, that took a lot of adapting" (p.16) "It was a shock to my system, what it was like to be a mom in the UK" (p.17) "Something needs to be said about becoming a mother in the UK" (p.18) [redacted] "I have no memories *(starts crying)* of my first child's babyhood [...] It's basically a blank. I have really no positive memories when I think about it. [...] I just picture the sleeplessness and the crying and I know that there were good times, but I can't... access them" (p.54) [redacted] "Every time I went home, I had to realise that it might have been just an illusion. It wasn't like that in reality anymore as I wanted it to be in my head, or as I remembered it (when) living in [redacted]. So then that home kind of evaporated as well, or the feeling of that home evaporated as well. And I think that I was clinging on to... Memories of [...] idealised, romanticised, time spent with my family" (p.10)

Theme/subtheme	*Participant quotes*
d. The struggle continues	[redacted] "I'm still having to find the new identity of '[redacted] in the UK' (p.58) [redacted] "There's still, like something that lingers about the burden, like in the background." (p. 32) [redacted] "I adjusted my life and managed to go back to work in a part time and adjusted things, had gone into therapy and... Worked out a lot of things. I thought I had resolved that and that's fine. Moved on. But for the following five years, I end up having kind of really low episodes for a few months." (p.18) "I feel there is a lot of lack of...Especially support...In the long term." (p.23) "I think this is the major impact of... being an immigrant. I think the isolation was always gonna be there." (p.32) [redacted] "I still have like...Underlying things to work on with myself that we're not...It wasn't over after one year, so this kind of arbitrary cut off of like 'one year', I understand why they they do it, but really it's probably until the kids like 3...Is when people need support" (p.53) [redacted] "Even though the, the guilt and the shame... Have been healing. there is still grief that I'm, I am navigating and processing [...] I'm still putting myself together" (p.32) [redacted] "But I still struggle, but not to the same extent" (p.31) "It's still difficult because...Sometimes I wish like I could just leave the kids for a half an hour and take a nap. With my mom, in [redacted], grandmothers are the babysitters and I don't have that but this what I have." (p.38)